

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

- ▶ Do not enter Social Security numbers on this form as it may be made public.
- ▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

Open to Public Inspection

A For the 2021 calendar year, or tax year beginning 07/01/2021 **and ending** 06/30/2022

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION		D Employer identification number 21-0635009
	Doing Business As		E Telephone number (609) 853-7107
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite		
	ONE PLAINSBORO ROAD City or town, state or province, country, and ZIP or foreign postal code		
	PLAINSBORO, NJ 08536		G Gross receipts \$ 538,199,154.
F Name and address of principal officer: GUILHERME VALLADARES ONE PLAINSBORO ROAD, PLAINSBORO, NJ 08536		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527	J Website: WWW.PRINCETONHCS.ORG		H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶	L Year of formation: 1919	M State of legal domicile: NJ	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: TO PROVIDE EXCEPTIONAL, COMPASSIONATE CARE TO ENHANCE THE HEALTH AND WELLNESS OF OUR PATIENTS, THEIR FAMILIES AND OUR COMMUNITY.
	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 22
	4 Number of independent voting members of the governing body (Part VI, line 1b) 4 18
	5 Total number of individuals employed in calendar year 2021 (Part V, line 2a) 5 3,912
	6 Total number of volunteers (estimate if necessary) 6 578
	7a Total unrelated business revenue from Part VIII, column (C), line 12 7a NONE 7b Net unrelated business taxable income from Form 990-T, line 34 7b NONE

		Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)	11,376,755.	3,149,539.
	9 Program service revenue (Part VIII, line 2g)	463,316,188.	511,436,550.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	10,335,060.	22,251,760.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	606,842.	1,361,305.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	485,634,845.	538,199,154.
	COPY FOR PUBLIC INSPECTION		
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	NONE	NONE
	14 Benefits paid to or for members (Part IX, column (A), line 4)	NONE	NONE
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	214,153,556.	229,173,331.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	NONE	NONE
	b Total fundraising expenses (Part IX, column (D), line 25) ▶	NONE	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	263,147,460.	290,162,804.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	477,301,016.	519,336,135.	
19 Revenue less expenses. Subtract line 18 from line 12	8,333,829.	18,863,019.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 873,542,381.	End of Year 818,562,186.
	21 Total liabilities (Part X, line 26)	429,442,394.	374,528,662.
	22 Net assets or fund balances. Subtract line 21 from line 20.	444,099,987.	444,033,524.

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
	▶ Type or print name and title	

Paid Preparer Use Only	Print/Type preparer's name ANTONIO C RUSSO	Preparer's signature	Date 05/03/2023	Check <input type="checkbox"/> if self-employed	PTIN P00858539
	Firm's name ▶ PRICEWATERHOUSECOOPERS LLP	Firm's EIN ▶ 13-4008324			
	Firm's address ▶ 2001 MARKET ST, SUITE 1800 PHILADELPHIA, PA 19103	Phone no. 267-330-3000			

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2021)

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:

SEE SCHEDULE O

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

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

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

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

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

4a (Code:) (Expenses \$ 404,434,564. including grants of \$ NONE) (Revenue \$ 437,348,900.)

PRINCETON MEDICAL CENTER PROVIDES COMPREHENSIVE PATIENT CARE AND SUPPORT SERVICES RELATING TO PATIENT CARE. IT IS AN ACUTE CARE FACILITY WITH 319 BEDS COMPRISED OF 288 ACUTE CARE, 17 PHYSICAL REHABILITATION AND 14 SPECIAL CARE NURSERY BASSINETS. IN FY2022, PATIENT DAYS TOTALED 68,320 AND OUTPATIENT VISITS/ENCOUNTERS TOTALED 153,094. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

4b (Code:) (Expenses \$ 59,775,166. including grants of \$ NONE) (Revenue \$ 59,860,506.)

PRINCETON HOUSE BEHAVIORAL HEALTH PROVIDES COMPREHENSIVE PSYCHIATRIC AND SUBSTANCE ABUSE RECOVERY PROGRAMS. ITS 116 BEDS PRODUCED 25,933 PATIENT DAYS IN FY2022. OUTPATIENT VISITS AND TREATMENTS ACROSS MULTIPLE SITES AMOUNTED TO 86,676. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

4c (Code:) (Expenses \$ 13,679,940. including grants of \$ NONE) (Revenue \$ 14,227,144.)

PRINCETON HOMECARE SERVICES IS A HOME CARE AND VISITING NURSE, AND HOSPICE SERVICE. IN FY2022, THERE WERE 51,216 OCCASIONS OF SERVICE AND 13,457 HOSPICE VISITS RECORDED. THIS GROWING SERVICE IS VITAL IN THE CAPACITY TO PROVIDE CARE AT THE PATIENT'S HOME RATHER THAN REQUIRING A STAY IN THE HOSPITAL. PRINCETON HOMECARE SERVICES ALSO OPERATES A HOSPICE. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

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

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

4e Total program service expenses 477,889,670.

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>	<input checked="" type="checkbox"/>	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X.</i>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		<input checked="" type="checkbox"/>
14a Did the organization maintain an office, employees, or agents outside of the United States?.		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H.</i>	<input checked="" type="checkbox"/>	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>

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 non-cash 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? Note: All Form 990 filers are required to complete Schedule O.	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

		Yes	No
1a	Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable		
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)		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. 2a 3,912		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. See instructions.	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		X
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i>		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		X
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? 12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? 13a Note: See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i>		
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? 15 If "Yes," see the instructions and file Form 4720, Schedule N.		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O. 16		X
17	Section 501(c)(21) organizations. Did the trust, any disqualified person, or mine operator engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? 17 If "Yes," complete Form 6069.		

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 [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (22), 1b (18), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NJ,
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
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

GUILHERME VALLADARES, MBA, ONE PLAINSBORO ROAD, PLAINSBORO, NJ 08536 (609) 853-7107

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
 - List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/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 B. MAHONEY CEO - UPHS	1.00 54.00	X		X				2,559,636.	NONE	405,970.
(2) BARRY S. RABNER FORMER PRES/CEO	NONE NONE						X	NONE	1,029,408.	4,753.
(3) ROBERT VONDERHEIDE TRUSTEE	1.00 54.00	X						NONE	844,856.	54,542.
(4) JAMES G. DEMETRIADES CEO	47.00 8.00	X		X				614,851.	NONE	83,744.
(5) GUILHERME VALLADARES, MBA SVP & CFO - ASST. TREAS.	38.00 17.00			X				471,332.	NONE	14,875.
(6) CRAIG GRONCZEWSKI, M.D. ACTING SRVP MED AFF.	55.00 NONE			X				428,691.	NONE	14,724.
(7) PAUL ORTIZ VP BUS. SVC. LINE DEV.	55.00 NONE				X			NONE	359,834.	51,917.
(8) SHEILA G. KEMPF CNO & VP PATIENT SVCS.	55.00 NONE				X			377,788.	NONE	20,082.
(9) YISRAEL KRAUS VP PHYSICIAN ALIGNMENT	55.00 NONE				X			331,798.	NONE	39,098.
(10) HYONA REVERE SENIOR VP DEVELOPMENT	54.00 1.00				X			345,636.	NONE	24,002.
(11) MARGUERITE PEDLEY SENIOR VICE PRESIDENT PHBH	55.00 NONE				X			344,886.	NONE	19,790.
(12) SIDDIQ FAISAL, M.D. MED. DIR., OCCUPATIONAL HEALTH	55.00 NONE					X		345,682.	NONE	11,270.
(13) ARUN RAO MED.DIR. CARE COORDIN.	55.00 NONE					X		328,866.	NONE	25,528.
(14) NANCY FLETCHER VP CORP. COMPL. & REG. AFFAIRS	55.00 NONE				X			290,725.	NONE	35,539.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) PETER THOMAS VP, OUTPATIENT ADMINISTRATION	55.00 NONE				X			262,644.	NONE	28,241.
(16) JACQUELINE R. KAVOURAS VP POPULATION HEALTH	55.00 NONE				X			272,236.	NONE	17,091.
(17) STEPHANIE D. TIEKU NURSE MANAGER	55.00 NONE					X		255,459.	NONE	27,009.
(18) CAROL NORRIS-SMITH VP PR - MARKETING	55.00 NONE				X			249,804.	NONE	26,874.
(19) CHING-YI LIU VP, FINANCE	55.00 NONE				X			254,616.	NONE	20,840.
(20) MARGARET DEFALCO ASSISTANT VICE PRESIDENT	55.00 NONE					X		242,610.	NONE	24,256.
(21) REINALDINE FLEURY CHRO & VP HUMAN RESOURCES	55.00 NONE				X			254,602.	NONE	10,060.
(22) KARYN BOOK ASSOC. CHIEF NURSING OFFICER	55.00 NONE				X			242,996.	NONE	22.
(23) FAYEZ LABIB CLINICAL NURSE II	55.00 NONE					X		210,184.	NONE	23,175.
(24) DEBORAH CASARELLA ENTITY INFO. OFFICER(EIO)	55.00 NONE				X			206,721.	NONE	1,305.
(25) BARBARA A. YOST FMR VP NETWORK DEVELOPMENT	NONE NONE						X	172,328.	NONE	12.
1b Sub-total								9,064,091.	2,234,098.	984,719.
c Total from continuation sheets to Part VII, Section A								112,848.	25,994.	24,247.
d Total (add lines 1b and 1c)								9,176,939.	2,260,092.	1,008,966.

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 ▶ 410

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual		
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		
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		

Section B. Independent Contractors

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) ROSEMARIE COSTAGLIOLA DIR. OF CORPORATE GOVERNANCE	44.00 11.00			X				112,848.	NONE	24,247.
(27) W. THOMAS GUTOWSKI, M.D. TRUSTEE	1.00 24.00	X						NONE	25,994.	NONE
(28) ANTHONY KUCZINSKI TRUSTEE - CHAIR	1.00 4.00	X		X				NONE	NONE	NONE
(29) HEATHER M. VAN RAALTE, M.D. TRUSTEE	1.00 1.00	X						NONE	NONE	NONE
(30) JAMES L. DOMINICK TRUSTEE - VICE CHAIR	1.00 3.00	X		X				NONE	NONE	NONE
(31) JESSE I. TREU, PH.D. TRUSTEE	1.00 1.00	X						NONE	NONE	NONE
(32) KENNETH A. GOLDMAN, M.D., FAC TRUSTEE	1.00 1.00	X						NONE	NONE	NONE
(33) LEONARD GROSSMAN, M.D. TRUSTEE	1.00 1.00	X						NONE	NONE	NONE
(34) MARIA JUEGA TRUSTEE	1.00 1.00	X						NONE	NONE	NONE
(35) MARK POLLARD TRUSTEE - SECRETARY	1.00 3.00	X		X				NONE	NONE	NONE
(36) MICHAEL MARDY TRUSTEE - TREASURER	1.00 3.00	X		X				NONE	NONE	NONE
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

Section B. Independent Contractors

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(37) PHILIP CARCHMAN ----- TRUSTEE	1.00 ----- 1.00	X						NONE	NONE	NONE
(38) ROBERT C. DOLL, JR. ----- TRUSTEE	1.00 ----- 1.00	X						NONE	NONE	NONE
(39) CALVIN L. BUTTS, JR. ----- TRUSTEE (AS OF 3/1/21)	1.00 ----- 1.00	X						NONE	NONE	NONE
(40) LORI FELDSTEIN ----- TRUSTEE (AS OF 3/1/21)	1.00 ----- 1.00	X						NONE	NONE	NONE
(41) MYRON M. GELLMAN ----- TRUSTEE (AS OF 3/1/21)	1.00 ----- 1.00	X						NONE	NONE	NONE
(42) SAMIT HIRAWAT, M.D. ----- TRUSTEE (AS OF 3/1/21)	1.00 ----- 1.00	X						NONE	NONE	NONE
(43) BARRY PERLEMAN, M.D. ----- TRUSTEE (AS OF 3/1/21)	1.00 ----- 3.00	X						NONE	NONE	NONE
(44) KIM PIMLEY ----- TRUSTEE	1.00 ----- 1.00	X						NONE	NONE	NONE
(45) PAUL VON AUTENREID ----- TRUSTEE	1.00 ----- 1.00	X						NONE	NONE	NONE
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		X

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 55

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514		
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a							
	b Membership dues	1b							
	c Fundraising events	1c							
	d Related organizations	1d	1,413,125.						
	e Government grants (contributions) . .	1e	1,736,414.						
	f All other contributions, gifts, grants, and similar amounts not included above .	1f							
	g Noncash contributions included in lines 1a-1f	1g	\$						
	h Total. Add lines 1a-1f			3,149,539.					
	Program Service Revenue				Business Code				
2a NET PATIENT SERVICE REVENUES			541900	506,206,988.	506,206,988.				
b OTHER HEALTHCARE RELATED REVENUES			541900	5,229,562.	5,229,562.				
c _____									
d _____									
e _____									
f All other program service revenue									
g Total. Add lines 2a-2f				511,436,550.					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			3,291,710.			3,291,710.		
	4 Income from investment of tax-exempt bond proceeds .			NONE					
	5 Royalties			NONE					
	6a Gross rents	6a	(i) Real	1,336,947.					
			(ii) Personal						
			b Less: rental expenses	6b					
			c Rental income or (loss)	6c	1,336,947.	NONE			
	d Net rental income or (loss)			1,336,947.			1,336,947.		
	7a Gross amount from sales of assets other than inventory	7a	(i) Securities	18,960,050.					
			(ii) Other						
			b Less: cost or other basis and sales expenses . .	7b					
			c Gain or (loss)	7c	18,960,050.				
	d Net gain or (loss)			18,960,050.			18,960,050.		
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a		NONE					
			b Less: direct expenses	8b	NONE				
c Net income or (loss) from fundraising events					NONE				
9a Gross income from gaming activities. See Part IV, line 19	9a		NONE						
		b Less: direct expenses	9b	NONE					
		c Net income or (loss) from gaming activities			NONE				
10a Gross sales of inventory, less returns and allowances	10a		NONE						
		b Less: cost of goods sold	10b	NONE					
		c Net income or (loss) from sales of inventory			NONE				
Miscellaneous Revenue				Business Code					
	11a VENDING MACHINE REVENUES		900099	24,358.			24,358.		
	b _____								
	c _____								
	d All other revenue								
	e Total. Add lines 11a-11d			24,358.					
12 Total revenue. See instructions			538,199,154.	511,436,550.		23,613,065.			

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]

Table with 5 columns: (A) Total expenses, (B) Program service expenses, (C) Management and general expenses, (D) Fundraising expenses. Rows include categories like Grants, Salaries, Pension, and Total functional expenses.

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	78,001,219.	1	83,392,231.
	2 Savings and temporary cash investments	35,528,683.	2	292,813.
	3 Pledges and grants receivable, net	NONE	3	NONE
	4 Accounts receivable, net	51,953,491.	4	57,333,417.
	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	NONE	5	NONE
	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)	NONE	6	NONE
	7 Notes and loans receivable, net	NONE	7	NONE
	8 Inventories for sale or use	6,501,129.	8	6,898,232.
	9 Prepaid expenses and deferred charges	1,939,699.	9	1,906,813.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 794,040,917.		
	b Less: accumulated depreciation	10b 433,666,208.		
		383,882,401.	10c	360,374,709.
	11 Investments - publicly traded securities	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11	229,910,962.	12	229,433,468.
	13 Investments - program-related. See Part IV, line 11	NONE	13	NONE
	14 Intangible assets	22,000,000.	14	22,000,000.
15 Other assets. See Part IV, line 11	63,824,797.	15	56,930,503.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	873,542,381.	16	818,562,186.	
Liabilities	17 Accounts payable and accrued expenses	32,120,616.	17	38,486,604.
	18 Grants payable	NONE	18	NONE
	19 Deferred revenue	7,786,084.	19	3,739,817.
	20 Tax-exempt bond liabilities	268,276,806.	20	261,126,824.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	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	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	NONE	23	NONE
	24 Unsecured notes and loans payable to unrelated third parties	NONE	24	NONE
	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	121,258,888.	25	71,175,417.
	26 Total liabilities. Add lines 17 through 25	429,442,394.	26	374,528,662.
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	422,009,577.	27	419,590,639.
	28 Net assets with donor restrictions	22,090,410.	28	24,442,885.
	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	444,099,987.	32	444,033,524.
33 Total liabilities and net assets/fund balances	873,542,381.	33	818,562,186.	

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	538,199,154.
2	Total expenses (must equal Part IX, column (A), line 25)	2	519,336,135.
3	Revenue less expenses. Subtract line 2 from line 1	3	18,863,019.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	444,099,987.
5	Net unrealized gains (losses) on investments	5	-19,475,802.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	546,320.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	444,033,524.

Part XII Financial Statements and Reporting

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

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

	Yes	No
2a		X
2b	X	
2c	X	
3a	X	
3b	X	

Form 990 (2021)

**SCHEDULE A
(Form 990)**

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization **PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY
NONPROFIT CORPORATION**

Employer identification number
21-0635009

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

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

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

Schedule A (Form 990) 2021

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

Section A. Public Support

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 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

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (f) Total. Rows include: 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); 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.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)); 15 Public support percentage from 2020 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2021; 16b 33 1/3% support test - 2020; 17a 10%-facts-and-circumstances test - 2021; 17b 10%-facts-and-circumstances test - 2020; 18 Private foundation.

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

Section A. Public Support

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

Section B. Total Support

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

14 First 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

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

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2021. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2020. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

	Yes	No
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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?		
b A family member of a person described on line 11a above?		
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>		

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>		
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>		

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.		Yes	No
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).		

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

**Schedule B
(Form 990)**

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2021

Name of the organization

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY
NONPROFIT CORPORATION

Employer identification number

21-0635009

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).

Name of organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION	Employer identification number 21-0635009
---	---

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	N/A	\$ 1,413,125.	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input checked="" type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>
_____	_____	\$ _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>
_____	_____	\$ _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>
_____	_____	\$ _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>
_____	_____	\$ _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>
_____	_____	\$ _____	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Person <input type="checkbox"/></p> <p>Payroll <input type="checkbox"/></p> <p>Noncash <input type="checkbox"/></p> </div> <div style="width: 35%; text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>

Name of organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION	Employer identification number 21-0635009
---	---

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
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION	Employer identification number 21-0635009
--	--

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

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(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	
_____ _____ _____		_____ _____ _____	

**SCHEDULE C
(Form 990)**

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2021

Open to Public Inspection

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.**

Department of the Treasury
Internal Revenue Service

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 PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION	Employer identification number 21-0635009
--	--

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

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

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

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

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

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

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

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

Schedule C (Form 990) 2021

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"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>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?			<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below.

See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: Description, (a) Yes/No, and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; 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).

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

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."

Table with 2 main columns: Description and Amount. Rows include: 1 Dues, assessments and similar amounts from members; 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; b Carryover from last year; c Total; 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues; 4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?; 5 Taxable amount of lobbying and political expenditures. See instructions.

Part IV Supplemental Information

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

SEE PAGE 4

Blank lines for supplemental information.

Part IV Supplemental Information (continued)

SCHEDULE C, PART II-B; LINE 1G

DETAIL OF LOBBYING ACTIVITIES

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION, IS A MEMBER OF THE AMERICAN HOSPITAL ASSOCIATION, THE NEW JERSEY HOSPITAL ASSOCIATION AND THE FAIR SHARE HOSPITALS COLLABORATIVE. EACH ENGAGE IN LOBBYING EFFORTS ON BEHALF OF THEIR MEMBER HOSPITALS. A PORTION OF THE DUES PAID TO THESE ORGANIZATIONS HAS BEEN ALLOCATED TO LOBBYING ACTIVITIES PERFORMED ON BEHALF OF THE ORGANIZATION. THIS ALLOCATION AMOUNTED TO \$78,614 FOR FY2022.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION

Employer identification number 21-0635009

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: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Includes rows for total number at end of year, aggregate values, and yes/no questions about donor advisement.

Part II Conservation Easements.

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

Table with 3 columns: Line number, Description, and Held at the End of the Tax Year. Includes rows for purpose(s) of easements, total number, acreage, 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: Line number, Description, and Amount. Includes rows for art and historical treasures held for public service and those received for financial gain.

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

Schedule D (Form 990) 2021

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 on Part XIII

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	220,229,853.	156,468,152.	151,517,441.	141,836,854.	NONE
b Contributions	11,442,469.	10,129,993.	8,757,911.	1,457,785.	135,128,514.
c Net investment earnings, gains, and losses	92,658.	64,669,242.	5,071,531.	8,431,963.	6,382,755.
d Grants or scholarships	NONE	NONE	NONE	NONE	NONE
e Other expenditures for facilities and programs	12,245,633.	11,037,534.	8,878,731.	209,161.	-325,585.
f Administrative expenses	NONE	NONE	NONE	NONE	NONE
g End of year balance	219,519,347.	220,229,853.	156,468,152.	151,517,441.	141,836,854.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment ▶ 100.0000 %
 - b Permanent endowment ▶ NONE %
 - c Term endowment ▶ NONE %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|--|---------------|----|
| (i) Unrelated organizations | 3a(i) | X |
| (ii) Related organizations | 3a(ii) | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b | X |
- 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		41,322,800.		41,322,800.
b Buildings		519,219,027.	261,188,082.	258,030,945.
c Leasehold improvements		22,530,422.	9,056,242.	13,474,180.
d Equipment		173,831,026.	134,355,021.	39,476,005.
e Other		37,137,642.	29,066,863.	8,070,779.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				360,374,709.

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) FIXED INCOME & MUTUAL FUNDS	219,583,718.	FMV
(B) BOND PROCEEDS HELD BY TRUSTEE	9,849,750.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) . ▶	229,433,468.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	7,324,833.
(2) INVESTMENT IN PHS FOUNDATION	24,315,084.
(3) RIGHT TO USE LEASED ASSETS	25,290,586.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	56,930,503.

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) ACCRUED INTEREST PAYABLE	4,152,007.
(3) ACCRUED BENEFIT LIABILITY	12,515,042.
(4) EST 3RD-PARTY RETRO PAYABLE	15,027,232.
(5) PARK ASSESSMENT BOND	957,606.
(6) OTHER LIABILITIES	5,735,031.
(7) LEASE LIABILITIES	26,471,086.
(8) WORKER'S COMP LIABILITY	3,050,413.
(9) MEDICAL MALPRACTICE	3,267,000.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	71,175,417.

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 a final column for totals. Rows include: 1 Total revenue, gains, and other support per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part VIII, line 12, but not on line 1; 5 Total revenue. Add lines 3 and 4c.

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 a final column for totals. Rows include: 1 Total expenses and losses per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part IX, line 25; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part IX, line 25, but not on line 1; 5 Total expenses. Add lines 3 and 4c.

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.

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information (continued)

SCHEDULE D, PART V, LINE 4

INTENDED USES OF THE ORGANIZATION'S ENDOWMENT FUNDS

ALL ENDOWMENT FUNDS ARE USED IN FURTHERANCE OF THE ORGANIZATION'S
TAX-EXEMPT PURPOSES.

SCHEDULE D, PART X, LINE 2

TEXT OF FIN 48 (ASC 740) FOOTNOTE

THIS ORGANIZATION IS AN AFFILIATE OF THE TRUSTEES OF THE UNIVERSITY OF
PENNSYLVANIA ("UNIVERSITY"). THE FIN 48 (ASC 740) FOOTNOTE BELOW DERIVES
FROM THE CONSOLIDATED JUNE 30, 2022 FINANCIAL STATEMENTS OF THE
UNIVERSITY:

THE UNIVERSITY REGULARLY EVALUATES ITS TAX POSITION AND DOES NOT BELIEVE
IT HAS ANY UNCERTAIN TAX POSITIONS THAT REQUIRE DISCLOSURE OR ADJUSTMENT
TO THE CONSOLIDATED FINANCIAL STATEMENTS.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2021

Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization **PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY
NONPROFIT CORPORATION**

Employer identification number
21-0635009

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	<input checked="" type="checkbox"/>	
1b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
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 _____ %	<input checked="" type="checkbox"/>	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> %	<input checked="" type="checkbox"/>	
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"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
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?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			4,905,964.	1,227,866.	3,678,098.	0.71
b Medicaid (from Worksheet 3, column a)			58,790,947.	42,379,657.	16,411,290.	3.16
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			63,696,911.	43,607,523.	20,089,388.	3.87
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,499,664.	127,662.	1,372,002.	0.26
f Health professions education (from Worksheet 5)			11,273,770.	2,761,931.	8,511,839.	1.64
g Subsidized health services (from Worksheet 6)			2,170,469.	741,628.	1,428,841.	0.28
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			399,374.		399,374.	0.08
j Total. Other Benefits			15,343,277.	3,631,221.	11,712,056.	2.26
k Total. Add lines 7d and 7j			79,040,188.	47,238,744.	31,801,444.	6.13

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

Schedule H (Form 990) 2021

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?	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.		
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		
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)	109,378,929.
6 Enter Medicare allowable costs of care relating to payments on line 5	138,132,810.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	-28,753,881.
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 checked="" type="checkbox"/> Cost accounting system <input 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?	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	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 %
1UMCP SURGICENTER	MEDICAL SERVICES	0.26470		0.73530
2PARTNERS, LLC				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

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

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
<p>1 PENN MEDICINE PRINCETON MEDICAL CTR ONE PLAINSBORO ROAD PLAINSBORO NJ 08536 WWW.PRINCETONHCS.ORG</p>	LICENSE	#	11103							1
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group PENN MEDICINE PRINCETON MEDICAL CTR

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>2021</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SCH H, PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>2022</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?		X
a	If "Yes," (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	X	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group PENN MEDICINE PRINCETON MEDICAL CTR

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>500.0000</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 his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input 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>SCH H, PART V, SECT. C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SCH H, PART V, SECT. C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SCH H, PART V, SECT. 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)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group PENN MEDICINE PRINCETON MEDICAL CTR

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

Policy Relating to Emergency Medical Care

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? If "No," indicate why:	X	
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

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 PENN MEDICINE PRINCETON MEDICAL CTR

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<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

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 5 (INPUT FROM COMMUNITY)

IMPROVING THE HEALTH OF THE COMMUNITY IS ESSENTIAL TO ENHANCING THE QUALITY OF LIFE FOR RESIDENTS IN THE REGION AND SUPPORTING FUTURE SOCIAL AND ECONOMIC WELL-BEING. IN 2018, PRINCETON HEALTHCARE SYSTEM (PRINCETON HEALTH) ENGAGED HEALTH RESOURCES IN ACTION (HRIA), A NON-PROFIT PUBLIC HEALTH CONSULTANCY ORGANIZATION, TO CONDUCT A COMMUNITY HEALTH PLANNING PROCESS TO GATHER INFORMATION ABOUT THE HEALTH OF RESIDENTS IN PRINCETON HEALTH'S THREE-COUNTY REGION (MERCER, MIDDLESEX, AND SOMERSET). THIS EFFORT INCLUDED TWO PHASES: (1) A COMMUNITY NEEDS HEALTH ASSESSMENT (CHNA) TO IDENTIFY THE HEALTH-RELATED NEEDS AND STRENGTHS OF THE REGION AND (2) A STRATEGIC IMPLEMENTATION PLAN (SIP) TO IDENTIFY MAJOR HEALTH PRIORITIES, DEVELOP GOALS, AND SELECT STRATEGIES AND IDENTIFY PARTNERS TO ADDRESS THESE PRIORITY ISSUES ACROSS THE REGION.

THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS GUIDED BY A PARTICIPATORY, COLLABORATIVE APPROACH, WHICH EXAMINED HEALTH IN ITS BROADEST SENSE. THIS PROCESS INCLUDED INTEGRATING EXISTING SECONDARY DATA ON SOCIAL, ECONOMIC, AND HEALTH ISSUES IN THE REGION WITH QUANTITATIVE INFORMATION FROM A COMMUNITY HEALTH SURVEY AND QUALITATIVE INFORMATION FROM 9 FOCUS GROUPS WITH COMMUNITY RESIDENTS AND SERVICE PROVIDERS AND 14 INTERVIEWS WITH COMMUNITY STAKEHOLDERS. FOCUS GROUPS WERE CONDUCTED WITH SENIORS, PARENTS, EMTS, MEMBERS OF PRINCETON HEALTH'S CANCER COMMITTEE, PUBLIC HEALTH OFFICERS, HOSPITAL STAFF AND VOLUNTEERS, SCHOOL NURSES AND GUIDANCE COUNSELORS, AND MEMBERS OF THE PENN MEDICINE PRINCETON HEALTH MEDICAL ADVISORY BOARD.

INTERVIEWEES INCLUDED LOCAL PUBLIC HEALTH OFFICIALS, SOCIAL SERVICE PROVIDERS, HEALTH CARE PROVIDERS, COMMUNITY LEADERS, AND PRINCETON HEALTH STAFF. THE COMMUNITY HEALTH SURVEY WAS ADMINISTERED ONLINE AND DISSEMINATED THROUGH MULTIPLE CHANNELS TO INDIVIDUALS WHO LIVE OR WORK IN MERCER, MIDDLESEX, AND SOMERSET COUNTIES. A TOTAL OF 1,037 PEOPLE COMPLETED THE SURVEY.

FOR MORE INFORMATION, PLEASE SEE:

[HTTPS://WWW.PRINCETONHCS.ORG/COMMUNITY?_GA=2.182835430.1738351937.1648747859-861487823.1582304010](https://www.princetonhcs.org/community?_ga=2.182835430.1738351937.1648747859-861487823.1582304010)

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 6B (JOINT CHNA)

AS A WAY TO ENSURE THAT PRINCETON HEALTH IS ACHIEVING ITS MISSION AND MEETING THE NEEDS OF THE COMMUNITY, AND IN FURTHERANCE OF ITS OBLIGATIONS UNDER THE AFFORDABLE CARE ACT, PRINCETON HEALTH ENGAGED HEALTH RESOURCES IN ACTION (HRIA), A NON-PROFIT PUBLIC HEALTH CONSULTANCY ORGANIZATION, TO CONDUCT THE CHNA.

PART V, SECTION B, LINE 7 (CHNA PUBLIC AVAILABILITY)

A COPY OF THE ORGANIZATION'S CHNA CAN BE ACCESSED AT:

[HTTPS://WWW.PRINCETONHCS.ORG/-/MEDIA/FILES/COMMUNITY-WELLNESS/PMPH-CHNA-FINAL-REPORT_2021.PDF?LA=EN](https://www.princetonhcs.org/-/media/files/community-wellness/pmph-chna-final-report_2021.pdf?LA=EN)

PART V, SECTION B, LINE 11 (ADDRESSING SIGNIFICANT NEEDS)

FOR A COMPLETE DESCRIPTION ON HOW THE ORGANIZATION IS ADDRESSING THE NEEDS IDENTIFIED IN THE MOST RECENTLY COMPLETED CHNA, SEE THE FOLLOWING:

[HTTPS://WWW.PRINCETONHCS.ORG/-/MEDIA/FILES/COMMUNITY-WELLNESS/PMPH-CHNA-FINAL-REPORT_2021.PDF?LA=EN](https://www.princetonhcs.org/-/media/files/community-wellness/pmph-chna-final-report_2021.pdf?LA=EN)

PART V, SECTION B, LINE 16 (FINANCIAL ASSISTANCE POLICY AVAILABILITY)

A COPY OF THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY CAN BE ACCESSED AT:

[HTTPS://WWW.PENNMEDICINE.ORG/-/MEDIA/DOCUMENTS%20AND%20AUDIO/PATIENT%20GUIDES%20AND%20INSTRUCTIONS/HEALTH%20SYSTEM/FINANCIAL_ASSISTANCE_POLICY.ASHX?LA=EN](https://www.pennmedicine.org/-/media/documents%20and%20audio/patient%20guides%20and%20instructions/health%20system/financial_assistance_policy.ashx?LA=EN)

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? 16

Name and address	Type of Facility (describe)
1 PRINCETON HOUSE BEHAVIORAL HEALTH 351 NEW ALBANY ROAD MOORESTOWN NJ 08057	OUTPATIENT BEHAVIORAL PROGRAM
2 PRINCETON HOUSE BEHAVIORAL HEALTH 1460 LIVINGSTON AVENUE NORTH BRUNSWICK NJ 08902	OUTPATIENT BEHAVIORAL PROGRAM
3 PRINCETON HOUSE BEHAVIORAL HEALTH 300 CLOCKTOWER ROAD, SUITE 101 HAMILTON NJ 08690	OUTPATIENT BEHAVIORAL PROGRAM
4 PRINCETON HOUSE BEHAVIORAL HEALTH 1000 HERRONTOWN ROAD PRINCETON NJ 08542	OUTPATIENT BEHAVIORAL PROGRAM
5 PRINCETON HOUSE BEHAVIORAL HEALTH 741 MOUNT LUCAS ROAD PRINCETON NJ 08542	OUTPATIENT BEHAVIORAL PROGRAM
6 PRINCETON HOMECARE SERVICES 88 PRINCETON HIGHTSTOWN ROAD WEST WINDSOR NJ 08550	HOMECARE & VISITING NURSE
7 BREAST HEALTH CENTER 300B PRINCETON HIGHTSTOWN ROAD EAST WINDSOR NJ 08512	OUTPATIENT DIAGNOSIS & TREATMENT
8 PRINCETON HOUSE BEHAVIORAL HEALTH 615 HOPE ROAD EATONTOWN NJ 07742	OUTPATIENT BEHAVIORAL PROGRAM
9 UMCPD OUTPATIENT REHABILITATION 1225 STATE ROAD PRINCETON NJ 08542	PHYSICAL THERAPY & OCCUPATIONAL MEDICINE
10 UMCPD OUTPATIENT REHAB AT MONROE 2 CENTRE DRIVE, SUITE 500 MONROE NJ 08831	PHYSICAL THERAPY & OCCUPATIONAL MEDICINE

Schedule H (Form 990) 2021

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? _____

Name and address	Type of Facility (describe)
1 UMCPP OUTPATIENT REHAB AT HAMILTON 1315 WHITEHORSE-MERCERVILLE RD, STE 100 HAMILTON NJ 08619	PHYSICAL THERAPY & OCCUPATIONAL MEDICINE
2 UMCPP EAST WINDSOR PATIENT SVC. CENTER 300A PRINCETON HIGHTSTOWN ROAD EAST WINDSOR NJ 08512	LAB DRAW CENTER
3 SOUTH BRUNSWICK WELLNESS CENTER 540 RIDGE ROAD MONMOUTH JUNCTION NJ 08852	LAB DRAW CENTER
4 UMCPP LAWRENCEVILLE PATIENT SVC. CENTER 132 FRANKLIN CORNER ROAD LAWRENCEVILLE NJ 08648	LAB DRAW CENTER
5 UMCPP ALEXANDER ROAD PATIENT SVC. CENTER 731 ALEXANDER ROAD, SUITE 103 PRINCETON NJ 08540	LAB DRAW CENTER
6 UMCPP PRINCETON PATIENT SVC. CENTER 281 WITHERSPOON STREET, SUITE 100 PRINCETON NJ 08540	LAB DRAW CENTER
7 	
8 	
9 	
10 	

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C (OTHER FACTORS IN DETERMINING ELIGIBILITY)

IN ADDITION TO THE FEDERAL POVERTY GUIDELINES, PRINCETON HEALTHCARE SYSTEM ("PHCS") USES OTHER FACTORS IN DETERMINING ELIGIBILITY CRITERIA FOR FREE AND DISCOUNTED CARE. OTHER FACTORS TO DETERMINE ELIGIBILITY INCLUDE:

- ASSET LEVEL;
- MEDICAL INDIGENCY;
- INSURANCE STATUS;
- UNDERINSURANCE STATUS; AND
- RESIDENCY.

ADDITIONAL INFORMATION WITH RESPECT TO PHCS' ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE IS OUTLINED BELOW.

CHARITY CARE

Part VI Supplemental Information

Provide the following information.

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

CHARITY CARE ASSISTANCE IS FREE OR REDUCED CHARGE CARE WHICH IS AVAILABLE TO PATIENTS WHO RECEIVE INPATIENT AND OUTPATIENT SERVICES AT ACUTE CARE HOSPITALS THROUGHOUT THE STATE OF NEW JERSEY. CHARITY CARE DISCOUNTS ARE IN COMPLIANCE WITH REGULATIONS ESTABLISHED IN NJAC 10:52, SUBCHAPTERS 11, 12, 13.

CHARITY CARE IS AVAILABLE TO NEW JERSEY RESIDENTS WHO:

- 1) HAVE NO HEALTH COVERAGE OR HAVE COVERAGE THAT PAYS ONLY PART OF THE BILL;
- 2) ARE INELIGIBLE FOR ANY PRIVATE OR GOVERNMENTAL SPONSORED COVERAGE (SUCH AS MEDICAID); AND
- 3) MEET THE INCOME AND ASSETS CRITERIA DESCRIBED BELOW.

CHARITY CARE IS AVAILABLE TO THOSE THAT DO NOT QUALIFY FOR STATE OR

Part VI Supplemental Information

Provide the following information.

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

FEDERAL PROGRAMS.

INCOME CRITERIA - PATIENTS WITH FAMILY GROSS INCOME LESS THAN OR EQUAL TO 200% OF THE FEDERAL POVERTY GUIDELINES ("FPG") ARE ELIGIBLE FOR 100% CHARITY CARE COVERAGE. PATIENTS WITH FAMILY GROSS INCOME GREATER THAN 200% BUT LESS THAN OR EQUAL TO 300% OF FPG ARE ELIGIBLE FOR DISCOUNTED CARE UNDER THE CHARITY CARE PROGRAM.

FREE OR DISCOUNTED CHARGES ARE DETERMINED BY THE FOLLOWING FEE SCHEDULE:

INCOME AS A PERCENTAGE OF HHS POVERTY INCOME GUIDELINES

LESS THAN OR EQUAL TO 200% -- 0% OF MEDICAID RATE

GREATER THAN 200% BUT LESS THAN OR EQUAL TO 225% -- 20% OF MEDICAID RATE

GREATER THAN 225% BUT LESS THAN OR EQUAL TO 250% -- 40% OF MEDICAID RATE

GREATER THAN 250% BUT LESS THAN OR EQUAL TO 275% -- 60% OF MEDICAID RATE

GREATER THAN 275% BUT LESS THAN OR EQUAL TO 300% -- 80% OF MEDICAID RATE

GREATER THAN 300% -- UNINSURED DISCOUNT RATE AVAILABLE

Part VI Supplemental Information

Provide the following information.

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

ASSETS CRITERIA - A PATIENT'S INDIVIDUAL ASSETS CANNOT EXCEED \$7,500 AND FAMILY ASSETS CANNOT EXCEED \$15,000 AS OF THE DATE OF SERVICE IN ORDER TO BE ELIGIBLE.

CHARITY CARE MAY BE AVAILABLE TO NON-NEW JERSEY RESIDENTS, SUBJECT TO SPECIFIC PROVISIONS (SUCH AS EMERGENCY MEDICAL CONDITIONS).

CHARITY CARE IS AVAILABLE ONLY FOR EMERGENCY OR OTHER MEDICALLY NECESSARY HOSPITAL CARE. SOME SERVICES SUCH AS PHYSICIAN FEES, ANESTHESIOLOGY FEES, AND RADIOLOGY INTERPRETATION ARE SEPARATE FROM HOSPITAL CHARGES AND MAY NOT BE ELIGIBLE FOR REDUCTION.

NEW JERSEY UNINSURED DISCOUNT

THE NEW JERSEY UNINSURED DISCOUNT (NJ LAW - BILL S-1797/A-2609) IS AVAILABLE TO UNINSURED PATIENTS WHOSE FAMILY GROSS INCOME IS LESS THAN

Part VI Supplemental Information

Provide the following information.

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

500% OF FPG. HOWEVER, PRINCETON HAS ELECTED TO APPLY THIS DISCOUNT TO ALL UNINSURED PATIENTS IRRESPECTIVE OF INCOME LEVEL OR RESIDENCY. PRINCETON OFFERS DISCOUNTED RATES TO ALL UNINSURED INDIVIDUALS. UNDER THIS PROGRAM, AN ELIGIBLE PATIENT WILL BE CHARGED AN AMOUNT NO GREATER THAN 115% OF THE MEDICARE FEE SCHEDULE. UNINSURED BILLING LIMITS ARE IN ACCORDANCE WITH NJ P.L. 2008 C60.

MEDICAID

MEDICAID PROVIDES HEALTH COVERAGE TO MILLIONS OF AMERICANS, INCLUDING CHILDREN, PREGNANT WOMEN, PARENTS, SENIORS AND INDIVIDUALS WITH DISABILITIES. IN GENERAL FOR THIS BENEFIT PROGRAM, A PATIENT MUST BE A UNITED STATES CITIZEN, LEGAL ALIEN OR PERMANENT RESIDENT, AND HAVE LOW INCOME. ADDITIONALLY, PATIENTS MUST ALSO BE A RESIDENT OF THE STATE OF NEW JERSEY. THERE ARE SEVERAL TYPES OF MEDICAID AVAILABLE THROUGH THE NEW JERSEY DEPARTMENT OF HEALTH. PRINCETON FINANCIAL COUNSELORS WILL HELP DETERMINE ELIGIBILITY BASED UPON EACH PATIENT'S CIRCUMSTANCES.

Part VI Supplemental Information

Provide the following information.

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

NJ FAMILYCARE

NJ FAMILYCARE IS NEW JERSEY'S PUBLICLY FUNDED HEALTH INSURANCE PROGRAM WHICH INCLUDES CHIP, MEDICAID AND MEDICAID EXPANSION POPULATIONS. NJ FAMILYCARE IS A FEDERAL AND STATE FUNDED HEALTH INSURANCE PROGRAM CREATED TO HELP QUALIFIED NEW JERSEY RESIDENTS OF ANY AGE ACCESS TO AFFORDABLE HEALTH INSURANCE. NJ FAMILYCARE IS FOR PEOPLE WHO DO NOT HAVE EMPLOYER INSURANCE. FINANCIAL ELIGIBILITY FOR INDIVIDUALS SEEKING ELIGIBILITY FOR NJ FAMILYCARE WILL BE BASED ON THEIR MODIFIED ADJUSTED GROSS INCOME OR MAGI. NJFAMILYCARE ELIGIBILITY GUIDELINES ARE ESTABLISHED BY THE STATE OF NEW JERSEY AND CAN BE FOUND AT WWW.NJFAMILYCARE.ORG. A PATIENT CAN BE PRESUMED ELIGIBLE FOR NJFAMILYCARE ONLY ONCE IN A TWELVE MONTH PERIOD.

CATASTROPHIC ILLNESS IN CHILDREN'S RELIEF FUND

Part VI Supplemental Information

Provide the following information.

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

THE CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND PROVIDES FINANCIAL ASSISTANCE TO FAMILIES OF CHILDREN WITH A CATASTROPHIC ILLNESS. IN ORDER TO BE ELIGIBLE HOSPITAL EXPENSES MUST EXCEED 10% OF THE FAMILY'S GROSS INCOME, PLUS 15% OF ANY EXCESS INCOME OVER \$100,000, THE CHILD MUST HAVE BEEN 21 YEARS OR YOUNGER WHEN THE MEDICAL EXPENSES WERE INCURRED AND THE FAMILY MUST HAVE LIVED IN NEW JERSEY FOR 3 MONTHS IMMEDIATELY PRIOR TO THE DATE OF APPLICATION.

NEW JERSEY VICTIMS OF CRIME COMPENSATION OFFICE

THE STATE OF NEW JERSEY HAS ESTABLISHED THE NEW JERSEY VICTIMS OF CRIME COMPENSATION OFFICE TO COMPENSATE VICTIMS OF CRIME FOR LOSSES AND EXPENSES, INCLUDING CERTAIN MEDICAL EXPENSES, RESULTING FROM CERTAIN CRIMINAL ACTS. IN ORDER TO BE ELIGIBLE FOR NEW JERSEY VICTIMS OF CRIME COMPENSATION OFFICE THE CRIME MUST HAVE OCCURRED IN NEW JERSEY OR MUST RELATE TO A NEW JERSEY RESIDENT VICTIMIZED OUTSIDE OF THE STATE, THE VICTIM MUST HAVE REPORTED THE CRIME TO POLICE WITHIN 9 MONTHS AND THE

Part VI Supplemental Information

Provide the following information.

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

VICTIM MUST COOPERATE WITH THE INVESTIGATION AND PROSECUTION OF THE
 CRIME. THE CLAIM MUST BE FILED WITHIN 3 YEARS OF THE DATE OF THE CRIME
 AND THE PATIENT MUST BE AN INNOCENT VICTIM OF THE CRIME.

AMOUNT GENERALLY BILLED ("AGB")

PURSUANT TO INTERNAL REVENUE CODE §501(R)(5), IN THE CASE OF EMERGENCY OR
 OTHER MEDICALLY NECESSARY CARE, FAP-ELIGIBLE PATIENTS WILL NOT BE CHARGED
 MORE THAN AN INDIVIDUAL WHO HAS INSURANCE COVERING SUCH CARE.

ALL PATIENTS ELIGIBLE FOR ASSISTANCE UNDER THIS FAP MAY BE ELIGIBLE FOR
 THIS DISCOUNT. THIS INCLUDES UNINSURED PATIENTS AND UNDERINSURED
 PATIENTS IF THEIR FAMILY GROSS INCOME IS GREATER THAN 200% BUT LESS THAN
 OR EQUAL TO 500% OF FPG.

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 7 (BAD DEBT EXPENSE, COSTING METHODOLOGY USED)

CONSISTENT WITH PRIOR YEAR, DUE TO THE ADOPTION OF ACCOUNTING
PRONOUNCEMENT ASC 606, IMPLICIT PRICE CONCESSIONS ARE TREATED AS A
CONTRA-REVENUE ITEM ON THE STATEMENT OF REVENUE.

THE COSTING METHODOLOGY USED IN CALCULATING THE AMOUNTS REPORTED ON THE
LINE 7 TABLE ARE BASED ON A COST TO CHARGE RATIO. THE COST TO CHARGE
RATIO WAS DERIVED FROM WORKSHEET 2 OF THE FORM 990, SCHEDULE H
INSTRUCTIONS.

Part VI Supplemental Information

Provide the following information.

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

PART II (DETAIL OF COMMUNITY BUILDING ACTIVITIES)

COMMUNITY BUILDING ACTIVITIES UNDERTAKEN BY THIS ORGANIZATION IMPROVE THE MEDICAL AND SOCIOECONOMIC WELL-BEING OF THE COMMUNITIES IN ITS CARE. THIS IS ACCOMPLISHED THROUGH SERVICE ON STATE AND REGIONAL ADVOCACY COMMITTEES AND BOARDS, VOLUNTEERISM WITH LOCAL COMMUNITY-BASED NON-PROFIT ADVOCACY GROUPS, PARTICIPATION IN CONFERENCES AND OTHER EDUCATIONAL ACTIVITIES TO PROMOTE UNDERSTANDING OF THE ROOT CAUSES OF HEALTH CONCERNS.

THIS ORGANIZATION PROVIDES EDUCATIONAL MATERIALS, CONDUCTS COMMUNITY HEALTH FAIRS AND HOLDS HEALTH EDUCATION SEMINARS AND OUTREACH SESSIONS FOR ITS PATIENTS AND FOR COMMUNITY PROVIDERS. PRESENTATIONS ARE PROVIDED BY PHYSICIANS, NURSES AND OTHER HEALTHCARE PROFESSIONALS.

IN ADDITION TO PROVIDING DIRECT PATIENT CHARITY CARE AND IN FURTHERANCE OF ITS EXEMPT PURPOSE TO BENEFIT THE COMMUNITY, THE SYSTEM PROVIDES COMMUNITY EDUCATION, OUTREACH, LECTURES, TRAININGS, HEALTH SCREENINGS AND SPECIAL EVENTS TO PATIENTS RESIDING IN MERCER, MIDDLESEX AND SOMERSET

Part VI Supplemental Information

Provide the following information.

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

COUNTIES. MAJOR PROGRAMS INCLUDE SPECIAL HEALTH OUTREACH EFFORTS DIRECTED TO DIVERSE POPULATIONS. THE SYSTEM IS ALSO LIAISONED WITH PARTNERSHIPS IN THE LOCAL YMCAS, YWCAS, SCHOOLS, SENIOR CENTERS, CORPORATIONS, PLACES OF WORSHIP AND PUBLIC LIBRARIES FOR A VARIETY OF HEALTH ISSUES ACROSS ONE'S LIFESPAN.

PART III, SECTION A, LINE 2 (IMPLICIT PRICE CONCESSIONS/BAD DEBT EXPENSE)

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES 2 AND 3 ARE BASED ON AN ESTIMATE OF AGED UNCOLLECTIBLE ACCOUNTS RECEIVABLE (AMOUNTS THAT ARE DEEMED TO BE UNCOLLECTIBLE AND RECORDED AS IMPLICIT PRICE CONCESSIONS UNDER ACCOUNTING PRONOUNCEMENT ASC 606).

PART III, SECTION A, LINE 3 (IMPLICIT PRICE CONCESSIONS ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY)

Part VI Supplemental Information

Provide the following information.

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

THE ESTIMATED COST OF PROVIDING CHARITY SERVICES IS BASED ON VALUING ALL CHARITY CARE CLAIMS USING THE SYSTEM'S DECISION SUPPORT SYSTEM THAT UTILIZES COST TO CHARGE RATIOS DERIVED FROM THE MOST RECENTLY FILED MEDICARE COST REPORTS. DEPARTMENT OF HEALTH AND HUMAN SERVICES CHARITY CARE GUIDELINES REQUIRE PARTICIPATION AND SPECIFIC DOCUMENTATION OF THE PATIENT IN ORDER TO BE IDENTIFIED AS A CHARITY CARE ACCOUNT. IN ADDITION TO CHARITY CARE, THE SYSTEM PROVIDES A SIGNIFICANT AMOUNT OF COMMUNITY BENEFIT THAT INCLUDES COMMUNITY OUTREACH PROGRAMS, SUBSIDIZED MEDICAL EDUCATION COSTS AND UNREIMBURSED COSTS OF PROVIDING CARE TO MEDICARE AND MEDICAID BENEFICIARIES.

PART III, SECTION A, LINE 4 (IMPLICIT PRICE CONCESSION FOOTNOTE)

THE IMPLICIT PRICE CONCESSION (BAD DEBT EXPENSE) FOOTNOTE DISCLOSURE CAN BE FOUND ON PAGE 11 OF THE ELECTRONICALLY ATTACHED CONSOLIDATED FINANCIAL STATEMENTS FOR THE UNIVERSITY OF PENNSYLVANIA.

Part VI Supplemental Information

Provide the following information.

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

PART III, SECTION B, LINE 8 (COSTING METHODOLOGY, MEDICARE SHORTFALL)

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 6
IS BASED ON THE ORGANIZATION'S MEDICARE COST REPORT.

CONSISTENT WITH THE CHARTIABLE HEALTHCARE MISSION OF UPHS AND THE
COMMUNITY BENEFIT STANDARD SET FORTH IN IRS REVENUE RULING 69-545, UPHS
PROVIDES CARE FOR ALL PATIENTS COVERED BY MEDICARE SEEKING MEDICAL CARE
AT UPHS. SUCH CARE IS PROVIDED REGARDLESS OF WHETHER THE REIMBURSEMENT
PROVIDED FOR SUCH SERVICES MEETS OR EXCEEDS THE COSTS INCURRED BY UPHS TO
PROVIDE SUCH 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 (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, SECTION B, LINE 9B (COLLECTION PRACTICES)

THE PRIMARY MISSION OF THE ORGANIZATION IS TO IMPROVE THE OVERALL HEALTH STATUS OF THE COMMUNITY IT SERVES. PRINCETON HEALTH IS COMMITTED TO PROVIDING HIGH QUALITY AND AFFORDABLE HEALTHCARE TO ALL INDIVIDUALS WHO SEEK SERVICES. THEREFORE, THE ORGANIZATION MAKES EVERY EFFORT TO WORK WITH ITS PATIENTS TO HELP IN THE PAYMENT OF BILLS. THIS ASSISTANCE INCLUDES PROVIDING PATIENTS WITH ACCESS TO A FINANCIAL COUNSELOR, ASSISTING NEW JERSEY STATE RESIDENTS OBTAIN FINANCIAL ASSISTANCE AND ESTABLISHING PAYMENT PLANS FOR EASE OF PAYMENT.

ALL PATIENTS WILL BE SCREENED BY A PRINCETON HEALTH FINANCIAL ASSISTANCE COUNSELOR TO DETERMINE IF THEY QUALIFY FOR INSURANCE PRIOR TO THE DETERMINATION OF FAP-ELIGIBILITY.

THE ORGANIZATION ADHERES TO ALL FEDERAL, STATE, LOCAL AND PFS DEEMED CONTRACTUAL REGULATIONS AND STANDARDS TO ENSURE PROPER AND LEGAL OPERATIONS. THIS ENCOMPASSES, BUT IS NOT LIMITED TO, THE FOLLOWING:

Part VI Supplemental Information

Provide the following information.

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

- 1) BILLING PROCEDURES, BOTH INSURANCE AND INPATIENT;
- 2) COLLECTIONS, BOTH BAD DEBT AND MEDICARE BAD DEBT;
- 3) BAD DEBT RECOVERY, BOTH "REGULAR" BAD DEBT AND MEDICARE BAD DEBT; AND
- 4) MAINTENANCE OF THE CONFIDENTIALITY AND SECURITY OF PROTECTED HEALTH INFORMATION.

PRINCETON HEALTH WILL NOT ENGAGE IN ANY ACTIONS THAT DISCOURAGE INDIVIDUALS FROM SEEKING EMERGENCY MEDICAL CARE, SUCH AS BY DEMANDING THE EMERGENCY DEPARTMENT PATIENTS PAY BEFORE RECEIVING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS OR BY PERMITTING DEBT COLLECTION ACTIVITIES IN THE EMERGENCY DEPARTMENT OR OTHER AREAS WHERE SUCH ACTIVITIES COULD INTERFERE WITH THE PROVISION OF EMERGENCY CARE ON A NON-DISCRIMINATORY BASIS.

PRINCETON HEALTH UTILIZES PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR PATIENTS IN ITS EMERGENCY DEPARTMENT AND ITS MATERNITY CLINICS. IF A PATIENT IS PRESUMPTIVELY DETERMINED TO BE ELIGIBLE FOR LESS THAN THE MOST

Part VI Supplemental Information

Provide the following information.

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

GENEROUS ASSISTANCE AVAILABLE UNDER THE FAP, PRINCETON HEALTH WILL NOTIFY THE PATIENT, IN WRITING, REGARDING THE BASIS FOR THE PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION AND HOW THEY MAY APPLY FOR MORE GENEROUS ASSISTANCE. A COPY OF THE PLS WILL ALSO BE PROVIDED IN THESE INSTANCES.

IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 501(R)(6), PRINCETON HEALTH DOES NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTIONS ("ECAS") PRIOR TO THE EXPIRATION OF THE "NOTIFICATION PERIOD". THE NOTIFICATION PERIOD IS DEFINED AS A 120-DAY PERIOD, WHICH BEGINS ON THE DATE OF THE 1ST POST DISCHARGE BILLING STATEMENT, IN WHICH NO ECAS MAY BE INITIATED AGAINST THE PATIENT.

PRINCETON HEALTH MAY AUTHORIZE THIRD PARTIES TO INITIATE ECAS ON DELINQUENT PATIENT ACCOUNTS AFTER THE NOTIFICATION PERIOD. PRINCETON HEALTH WILL ENSURE REASONABLE EFFORTS HAVE BEEN TAKEN TO DETERMINE WHETHER AN INDIVIDUAL IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER ITS FINANCIAL ASSISTANCE PROGRAM. PRINCETON HEALTH WILL TAKE THE FOLLOWING

Part VI Supplemental Information

Provide the following information.

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

ACTIONS AT LEAST 30 DAYS PRIOR TO INITIATING ANY ECA:

1) THE PATIENT HAS BEEN PROVIDED WITH WRITTEN NOTICE WHICH:

- INDICATES THAT FINANCIAL ASSISTANCE IS AVAILABLE FOR ELIGIBLE PATIENTS;
- IDENTIFIES THE ECAS THAT PRINCETON INTENDS TO INITIATE TO OBTAIN PAYMENT FOR THE CARE; AND
- STATES A DEADLINE AFTER WHICH SUCH ECAS MAY BE INITIATED.

2) THE PATIENT HAS RECEIVED A COPY OF THE PLAIN LANGUAGE SUMMARY WITH THIS WRITTEN NOTIFICATION; AND

3) REASONABLE EFFORTS HAVE BEEN MADE TO ORALLY NOTIFY THE INDIVIDUAL ABOUT THE FAP AND HOW THE INDIVIDUAL MAY OBTAIN ASSISTANCE WITH THE FINANCIAL ASSISTANCE APPLICATION PROCESS.

SUBSEQUENT TO THE NOTIFICATION PERIOD PRINCETON HEALTH, OR ANY THIRD PARTIES ACTING ON THEIR BEHALF, MAY INITIATE THE FOLLOWING ECAS AGAINST A

Part VI Supplemental Information

Provide the following information.

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

PATIENT FOR AN UNPAID BALANCE IF THE PATIENT HASN'T APPLIED FOR OR IS
DEEMED INELIGIBLE FOR FINANCIAL ASSISTANCE:

- 1) REPORTING ADVERSE INFORMATION ABOUT THE INDIVIDUAL TO CONSUMER CREDIT
REPORTING AGENCIES OR CREDIT BUREAUS;
- 2) PLACING A LIEN ON AN INDIVIDUAL'S PROPERTY;
- 3) FORECLOSING ON AN INDIVIDUAL'S REAL PROPERTY;
- 4) COMMENCING A CIVIL ACTION AGAINST AN INDIVIDUAL; AND
- 5) CAUSING AN INDIVIDUAL TO BE SUBJECT TO A WRIT OF BODY ATTACHMENT

PART VI, LINE 2 (NEEDS ASSESSMENT)

FOR MORE INFORMATION REGARDING HOW PRINCETON HEALTH IS ASSESSING THE
NEEDS OF THE COMMUNITIES IT SERVES, PLEASE SEE:

[HTTPS://WWW.PRINCETONHCS.ORG/COMMUNITY?_GA=2.182835430.1738351937.16487478](https://www.princetonhcs.org/community?_GA=2.182835430.1738351937.16487478)

59-861487823.1582304010

Part VI Supplemental Information

Provide the following information.

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

PART VI, LINE 3 (PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE)

PRINCETON HEALTH ACTIVELY INFORMS AND EDUCATES PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE AND PROMOTES ITS PATIENT FRIENDLY BILLING AND COLLECTION PROCESS THROUGH MULTIPLE CHANNELS. THIS IS AN INTEGRAL PART OF ITS CODE OF ETHICS AND VALUE STATEMENT.

THE ORGANIZATION INFORMS AND EDUCATES PATIENTS WHO MAY BE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY FOR FINANCIAL ASSISTANCE IN THE FOLLOWING WAYS:

PRINCETON HEALTH HAS CREATED A PLAIN LANGUAGE SUMMARY ("PLS") OF ITS FINANCIAL ASSISTANCE POLICY ("FAP"). A PLS IS A WRITTEN STATEMENT THAT NOTIFIES AN INDIVIDUAL THAT THE HOSPITAL FACILITY OFFERS FINANCIAL ASSISTANCE UNDER THE FAP AND PROVIDES ADDITIONAL INFORMATION IN LANGUAGE THAT IS CLEAR, CONCISE AND EASY TO UNDERSTAND.

Part VI Supplemental Information

Provide the following information.

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

PRINCETON HEALTH'S FAP, APPLICATION AND PLS ARE AVAILABLE IN ENGLISH AND IN THE PRIMARY LANGUAGE OF POPULATIONS WITH LIMITED PROFICIENCY IN ENGLISH ("LEP") THAT CONSTITUTE THE LESSER OF 1,000 INDIVIDUALS OR 5% OF THE ORGANIZATION'S PRIMARY SERVICE AREA. ADDITIONALLY, PRINCETON HEALTH PROVIDES LANGUAGE INTERPRETING AND TRANSLATION SERVICES, AND PROVIDES INFORMATION TO PATIENTS WITH VISION, SPEECH, HEARING OR COGNITIVE IMPAIRMENTS IN A MANNER THAT MEETS THE PATIENT'S NEEDS.

THE FAP, APPLICATION AND PLS ARE ALL POSTED ON THE FOLLOWING PRINCETON HEALTH WEBSITE: WWW.PRINCETONHCS.ORG, AND ARE AVAILABLE FREE OF CHARGE, UPON REQUEST. PAPER COPIES OF THESE DOCUMENTS ARE ALSO AVAILABLE IN VARIOUS AREAS THROUGHOUT THE HOSPITAL, WHICH INCLUDE THE EMERGENCY DEPARTMENT AND ADMISSION/REGISTRATION DEPARTMENTS.

SIGNS AND DISPLAYS, TO INFORM PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE, ARE POSTED IN EMERGENCY ROOMS AND THE ADMITTING/REGISTRATION DEPARTMENTS. THESE SIGNS ARE POSTED IN ENGLISH AND

Part VI Supplemental Information

Provide the following information.

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

IN SPANISH.

ALL PATIENTS WILL BE OFFERED A COPY OF THE PLS AS PART OF THE INTAKE OR DISCHARGE PROCESS.

THE AVAILABILITY OF ALL PROGRAMS APPEARS ON BILLING STATEMENTS. EACH BILLING STATEMENT INCLUDES CONSPICUOUS WRITTEN NOTICE WHICH INFORMS THE RECIPIENT ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE. THE STATEMENT ALSO INCLUDES THE WEBSITE OF WHERE AN INDIVIDUAL CAN OBTAIN COPIES OF THE FAP, APPLICATION AND PLS. ADDITIONALLY, IT INCLUDES THE TELEPHONE NUMBER THAT PATIENTS CAN CALL IF THEY HAVE QUESTIONS REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS.

IN AN EFFORT TO ENSURE THAT THE COMMUNITY SERVICED BY PRINCETON IS AWARE OF THE FINANCIAL ASSISTANCE PROGRAMS AVAILABLE UNDER THIS FAP, PRINCETON HEALTH DISSEMINATES INFORMATION TO THE COMMUNITY THROUGH ITS COMMUNITY EDUCATION DEPARTMENT.

Part VI Supplemental Information

Provide the following information.

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

PART VI, LINE 4 (COMMUNITY INFORMATION)

FOR INFORMATION REGARDING THE COMMUNITY BEING SERVED BY PRINCETON HEALTH,

PLEASE SEE:

[HTTPS://WWW.PRINCETONHCS.ORG/COMMUNITY?_GA=2.182835430.1738351937.16487578](https://www.princetonhcs.org/community?_ga=2.182835430.1738351937.16487578)

59-861487823.1582304010

PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)

DETAILS REGARDING THE VARIOUS COMMUNITY OUTREACH ACTIVITIES CONDUCTED BY PRINCETON HEALTH DESIGNED TO PROMOTE COMMUNITY HEALTH IS INCLUDED IN OUR RESPONSE TO SCHEDULE H, PART VI, LINE 2, AS WELL AS IN FORM 990, PART III, STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS.

Part VI Supplemental Information

Provide the following information.

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

PART VI, LINE 6 (AFFILIATED HEALTHCARE SYSTEM INFORMATION)

THIS ORGANIZATION IS AN AFFILIATE OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM.

THE MISSION OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM IS EXCELLENCE IN EDUCATION, RESEARCH, AND CLINICAL CARE. WE STRIVE TO ACHIEVE THESE GOALS BY HAVING THE BEST PEOPLE IN MEDICAL EDUCATION, HEALTH-RELATED RESEARCH, AND PATIENT CARE; MAKING USE OF KNOWLEDGE GAINED FROM NEARLY TWO AND A HALF CENTURIES OF LEARNING AND DISCOVERY AS PART OF A WORLD-CLASS UNIVERSITY; DELIVERING HIGH-QUALITY MEDICINE TO PATIENTS ACROSS A FULLY-INTEGRATED ACADEMIC HEALTH SYSTEM; AND FULFILLING A COMMITMENT TO IMPROVE THE HEALTH OF PEOPLE IN THE COMMUNITIES SERVED BY THE HEALTH SYSTEM AND AROUND THE WORLD.

AS PART OF AN AFFILIATED HEALTHCARE SYSTEM, THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM CONSISTS OF CERTAIN OPERATING DIVISIONS OF THE TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA (THE "UNIVERSITY") AND

Part VI Supplemental Information

Provide the following information.

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

AFFILIATED ENTITIES, INCLUDING:

- THE CHESTER COUNTY HOSPITAL ("CCH"), INCLUDES A 245 BED COMPLEX IN WEST CHESTER, PENNSYLVANIA, AND SATELLITE LOCATIONS IN EXTON, WEST GOSHEN, NEW GARDEN, JENNERSVILLE, AND KENNETT SQUARE, PENNSYLVANIA;

- THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA ("HUP"), A 727 LICENSED BED QUATERNARY CARE HOSPITAL AND ACADEMIC MEDICAL CENTER LOCATED ON THE CAMPUS OF THE UNIVERSITY IN THE WEST PHILADELPHIA AREA OF PHILADELPHIA, PENNSYLVANIA;

- PENN PRESBYTERIAN MEDICAL CENTER OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM ("PRESBYTERIAN"), A 317 LICENSED BED ACUTE CARE HOSPITAL LOCATED ADJACENT TO THE CAMPUS OF THE UNIVERSITY IN THE WEST PHILADELPHIA AREA OF PHILADELPHIA, PENNSYLVANIA;

- PENNSYLVANIA HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM ("PENNSYLVANIA HOSPITAL"), A 550 LICENSED BED ACUTE CARE HOSPITAL LOCATED

Part VI Supplemental Information

Provide the following information.

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

IN THE CENTER CITY AREA OF PHILADELPHIA, PENNSYLVANIA;

- THE CLINICAL PRACTICES OF THE UNIVERSITY OF PENNSYLVANIA ("CPUP"), THE APPROVED FACULTY PRACTICE PLAN FOR THE CLINICAL PRACTICES OF MEMBERS OF THE MEDICAL FACULTY OF THE UNIVERSITY'S PERELMAN SCHOOL OF MEDICINE;

- CLINICAL CARE ASSOCIATES OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM ("CCA"), A PRIMARY CARE PHYSICIAN NETWORK THAT INCLUDES LOCATIONS IN SOUTHEASTERN PENNSYLVANIA AND SOUTHERN NEW JERSEY THROUGH ITS NEW JERSEY AFFILIATE;

- LANCASTER GENERAL HEALTH ("LGH") AND ITS AFFILIATES. LGH OPERATES THREE HOSPITALS IN SOUTH CENTRAL PENNSYLVANIA, INCLUDING LANCASTER GENERAL HOSPITAL, A 533-BED GENERAL ACUTE CARE HOSPITAL, WOMEN & BABIES HOSPITAL, A 98-BED FACILITY SPECIALIZING IN WOMEN'S HEALTH AND MATERNITY SERVICES, AND LANCASTER REHABILITATION HOSPITAL, A 59-BED REHABILITATION HOSPITAL, AS WELL AS 14 OUTPATIENT CENTERS, THREE URGENT CARE SITES, AND A PHYSICIAN PRACTICE NETWORK WITH NEARLY 200 PRIMARY CARE AND SPECIALTY

Part VI Supplemental Information

Provide the following information.

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

PRACTICES AT 40 PRACTICE SITES:

- WISSAHICKON HOSPICE, A HOSPICE CARE FACILITY SERVING THE TERMINALLY ILL, LOCATED IN BALA CYNWYD, PENNSYLVANIA; AND

- PRINCETON HEALTHCARE SYSTEM ("PRINCETON") AND ITS AFFILIATES. PRINCETON INCLUDES A COMPREHENSIVE HEALTHCARE PROVIDER LOCATED IN CENTRAL NEW JERSEY THAT PRINCIPALLY INCLUDES THE MEDICAL CENTER OF PRINCETON, A GENERAL ACUTE CARE HOSPITAL FACILITY IN PLAINSBORO, NJ, WITH 319 INPATIENT BEDS (PLUS 24 NEWBORN BASSINETS), AND PRINCETON HOUSE BEHAVIORAL HEALTH, WHICH INCLUDES A 116 BED INPATIENT FACILITY IN PRINCETON, NJ, AS WELL AS FOUR ADDITIONAL OUTPATIENT LOCATIONS.

Part VI Supplemental Information

Provide the following information.

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

PART VI, LINE 7 (STATE FILING OF COMMUNITY BENEFIT REPORT)

NOT APPLICABLE. THE ENTITY AND RELATED PROVIDER ORGANIZATIONS ARE
LOCATED IN NEW JERSEY. THE STATE OF NEW JERSEY DOES NOT REQUIRE HOSPITALS
TO ANNUALLY FILE A COMMUNITY BENEFIT REPORT WITH THE STATE OF NEW JERSEY.

**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

2021

Open to Public Inspection

Name of the organization PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION	Employer identification number 21-0635009
--	--

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"/> Travel for companions
<input type="checkbox"/> Tax indemnification and gross-up payments
<input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Housing allowance or residence for personal use
<input type="checkbox"/> Payments for business use of personal residence
<input type="checkbox"/> Health or social club dues or initiation fees
<input type="checkbox"/> Personal services (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 checked="" type="checkbox"/> Independent compensation consultant
<input type="checkbox"/> Form 990 of other organizations | <input type="checkbox"/> Written employment contract
<input checked="" type="checkbox"/> Compensation survey or study
<input checked="" type="checkbox"/> Approval by the board or compensation committee |
|---|---|

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		

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

Schedule J (Form 990) 2021

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				
BARRY S. RABNER 1 FORMER PRES/CEO	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	348,831.	498,013.	182,564.	NONE	4,753.	1,034,161.	NONE
CAROL NORRIS-SMITH 2 VP PR - MARKETING	(i)	197,058.	50,766.	1,980.	NONE	26,874.	276,678.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DEBORAH CASARELLA 3 ENTITY INFO. OFFICER(EIO)	(i)	174,220.	31,862.	639.	NONE	1,305.	208,026.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
GUILHERME VALLADARES, 4 SVP & CFO - ASST. TREAS.	(i)	376,427.	94,095.	810.	NONE	14,875.	486,207.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JACQUELINE R. KAVOURAS 5 VP POPULATION HEALTH	(i)	228,044.	44,192.	NONE	NONE	17,091.	289,327.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JAMES G. DEMETRIADES 6 CEO	(i)	454,614.	141,739.	18,498.	65,313.	18,431.	698,595.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
MARGUERITE PEDLEY 7 SENIOR VICE PRESIDENT PHBH	(i)	273,513.	68,609.	2,764.	NONE	19,790.	364,676.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
NANCY FLETCHER 8 VP CORP. COMPL. & REG. AFFAIRS	(i)	290,725.	NONE	NONE	NONE	35,539.	326,264.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
PAUL ORTIZ 9 VP BUS. SVC. LINE DEV.	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	259,081.	86,450.	14,303.	26,000.	25,917.	411,751.	NONE
REINALDINE FLEURY 10 CHRO & VP HUMAN RESOURCES	(i)	205,969.	48,260.	373.	NONE	10,060.	264,662.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
SHEILA G. KEMPF 11 CNO & VP PATIENT SVCS.	(i)	300,539.	77,249.	NONE	NONE	20,082.	397,870.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
YISRAEL KRAUS 12 VP PHYSICIAN ALIGNMENT	(i)	260,808.	70,593.	397.	NONE	39,098.	370,896.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
HYONA REVERE 13 SENIOR VP DEVELOPMENT	(i)	273,408.	71,359.	869.	NONE	24,002.	369,638.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
BARBARA A. YOST 14 FMR VP NETWORK DEVELOPMENT	(i)	111,000.	61,328.	NONE	NONE	12.	172,340.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KARYN BOOK 15 ASSOC. CHIEF NURSING OFFICER	(i)	205,803.	36,757.	436.	NONE	22.	243,018.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
PETER THOMAS 16 VP, OUTPATIENT ADMINISTRATION	(i)	217,908.	42,518.	2,218.	NONE	28,241.	290,885.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE

Schedule J (Form 990) 2021

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				
CHING-YI LIU 1 VP, FINANCE	(i)	214,576.	39,550.	490.	NONE	20,840.	275,456.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
SIDDIQ FAISAL, M.D. 2 MED. DIR., OCCUPATIONAL HEALTH	(i)	345,178.	NONE	504.	NONE	11,270.	356,952.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
CRAIG GRONCZEWSKI, M.D. 3 ACTING SRVP MED AFF.	(i)	428,691.	NONE	NONE	NONE	14,724.	443,415.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
STEPHANIE D. TIEKU 4 NURSE MANAGER	(i)	230,684.	24,389.	386.	NONE	27,009.	282,468.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
MARGARET DEFALCO 5 ASSISTANT VICE PRESIDENT	(i)	202,537.	38,742.	1,331.	NONE	24,256.	266,866.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBERT VONDERHEIDE 6 TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	601,275.	242,270.	1,311.	37,093.	17,449.	899,398.	NONE
ARUN RAO 7 MED.DIR. CARE COORDIN.	(i)	305,218.	22,500.	1,148.	NONE	25,528.	354,394.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
FAYEZ LABIB 8 CLINICAL NURSE II	(i)	186,970.	23,015.	199.	NONE	23,175.	233,359.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KEVIN B. MAHONEY 9 CEO - UPHS	(i)	1,477,722.	717,600.	364,314.	385,800.	20,170.	2,965,606.	230,330.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE J, PART I, QUESTION 4B

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN PARTICIPATION

CERTAIN TRUSTEES, OFFICERS AND/OR KEY EMPLOYEES OF THIS ORGANIZATION ARE COMPENSATED BY A RELATED ORGANIZATION, THE TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA ("UNIVERSITY").

THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM ("HEALTH SYSTEM") MAINTAINS A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN ("SERP") DESIGNED FOR SENIOR ADMINISTRATORS OF THE HEALTH SYSTEM, AS DESIGNATED BY THE BOARD OF TRUSTEES, WHO ARE ACTIVELY EMPLOYED BY THE HEALTH SYSTEM WHEN THE CONTRIBUTIONS ARE MADE.

VESTING IN THE SERP OCCURS AFTER EACH THREE YEARS OF PARTICIPATION AND UPON THE OCCURRENCE OF CERTAIN EVENTS (ATTAINMENT OF AGE 65, DEATH, DISABILITY, OR INVOLUNTARY TERMINATION WITHOUT "CAUSE"). CONTRIBUTIONS FOR THOSE WHO HAVE REACHED AGE 65 WILL BE FULLY VESTED WHEN MADE. UPON

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.

REACHING A VESTING DATE, PARTICIPANTS WILL AUTOMATICALLY RECEIVE A FULL DISTRIBUTION WHICH IS TAXABLE AS EARNED INCOME. PARTICIPANTS WHO VOLUNTARILY TERMINATE BEFORE VESTING WILL FORFEIT THE BALANCE IN THEIR ACCOUNTS.

THE FOLLOWING INDIVIDUALS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A PARTICIPATED IN THE UNIVERSITY/HEALTH SYSTEM SERP PLAN DURING THE YEAR AND/OR RECEIVED DISTRIBUTIONS DURING THE YEAR:

MAHONEY, KEVIN B.- \$230,330

SCHEDULE J, PART I, QUESTION 7

PROVISION OF NON-FIXED PAYMENTS

PRINCETON HEALTH PROVIDES DISCRETIONARY BONUS AND/OR INCENTIVE COMPENSATION PAYMENTS TO ELIGIBLE EMPLOYEES. PAYMENTS MADE TO ANY DISQUALIFIED PERSON IS APPROVED BY THE COMPENSATION COMMITTEE THROUGH THE

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.

PROCESS DESCRIBED IN FORM 990, PART VI, SECTION B, LINE 15.

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization **PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION** Employer identification number **21-0635009**

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A NJ HEALTH CARE FACILITIES ATHRTY SERIES 2016 A,B,C	22-1487148	64579F8G1	01/20/2016	303,785,061.	REFUND SERIES 2010B,C,D; CAP EXP		X		X		X
B											
C											
D											

Part II Proceeds

	A	B	C	D
1 Amount of bonds retired	40,844,176.			
2 Amount of bonds legally defeased	NONE			
3 Total proceeds of issue	303,884,205.			
4 Gross proceeds in reserve funds	NONE			
5 Capitalized interest from proceeds	NONE			
6 Proceeds in refunding escrows	NONE			
7 Issuance costs from proceeds	3,282,231.			
8 Credit enhancement from proceeds	NONE			
9 Working capital expenditures from proceeds	NONE			
10 Capital expenditures from proceeds	2,000,000.			
11 Other spent proceeds	298,601,974.			
12 Other unspent proceeds	NONE			
13 Year of substantial completion	2016			
	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			
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		
16 Has the final allocation of proceeds been made?	X			
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X			

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

Schedule K (Form 990) 2021

Part III Private Business Use

TAX-EXEMPT BONDS

	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						
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X						
3a Are there any management or service contracts that may result in private business use of bond-financed property?		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?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		NONE %		%		%		%
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 ▶		NONE %		%		%		%
6 Total of lines 4 and 5		NONE %		%		%		%
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X						
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							

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						
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?								
b Exception to rebate?	X							
c No rebate due?								
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							

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

TAX-EXEMPT BONDS- ADDITIONAL CUSIP INFORMATION

FORM 990, SCHEDULE K, PART I, COLUMN (C) - ROW A

THE FOLLOWING ADDITIONAL CUSIP NUMBER RELATES TO THE NEW JERSEY
HEALTHCARE FACILITIES AUTHORITY SERIES 2016 A, B, C REVENUE BONDS:
64579F8P1, 64579F7R8, 64579F7S6, 64579F7T4, 64579F7U1, 64579F7V9,
64579F7W7, 64579F7X5, 64579F7Y3, 64579F7Z0, 64579F8A4, 64579F8B2,
64579F8C0, 64579F8D8, 64579F8E6, 64579F8F3, 64579F8H9, 64579F8J5,
64579F8K2, 64579F8L0, 64579F8M8, 64579F8N6

TAX-EXEMPT BONDS- ADDITIONAL DETAIL FOR PROCEEDS OF ISSUE

FORM 990, SCHEDULE K, PART II, LINE 3

FOR NJ HEALTH CARE FACILITIES AUTHORITY SERIES A, B, C OF 2016, THE TOTAL
PROCEEDS OF ISSUE REPORTED INCLUDES \$99,144 IN TOTAL INVESTMENT EARNINGS.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

21-0635009

FORM 990, PART III

STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

THIS ORGANIZATION IS AN AFFILIATE OF PRINCETON HEALTHCARE SYSTEM HOLDING,
INC. AND AFFILIATES (COLLECTIVELY "PRINCETON HEALTH").

PRINCETON MEDICAL CENTER IS PART OF THE UNIVERSITY OF PENNSYLVANIA HEALTH
SYSTEM (UPHS). IN KEEPING WITH ITS CHARITABLE PURPOSE, UPHS ACCEPTS
PATIENTS IN SERIOUS NEED OF MEDICAL CARE REGARDLESS OF THEIR FINANCIAL
STATUS. UPHS MAINTAINS RECORDS TO IDENTIFY AND MONITOR LEVELS OF CHARITY
CARE PROVIDED, INCLUDING THE AMOUNT OF PAYMENT FORGONE, BASED ON
ESTABLISHED RATES, FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS CHARITY
CARE POLICY. UPHS ALSO PROVIDES CARE TO PATIENTS WHO DO NOT HAVE HEALTH
INSURANCE OR MEET THE CRITERIA TO QUALIFY FOR ITS CHARITY CARE POLICY,
AND CERTAIN AMOUNTS CHARGED FOR SUCH SERVICES ARE DEEMED TO BE
UNCOLLECTIBLE. IN FY 2022, UPHS PROVIDED \$389.7 MILLION IN CHARITY AND
UNDERFUNDED CARE FOR MEDICAID FAMILIES.

IN KEEPING WITH ITS CHARITABLE MISSION, PRINCETON HEALTH HAS A ROBUST
COMMUNITY WELLNESS PROGRAM. PRINCETON HEALTH'S COMMUNITY-BASED WORK
SERVES AS ANOTHER EXAMPLE OF HOW PRINCETON HEALTH IS REDEFINING CARE BY
OFFERING A DYNAMIC CURRICULUM OF INNOVATIVE HEALTH- AND LIFESTYLE-RELATED
PROGRAMMING, SCREENINGS AND SUPPORT AT LITTLE OR NO COST TO THE
COMMUNITIES WE SERVE. PRINCETON HEALTH IS DEDICATED TO PROMOTING HEALTHY
LIVING AT EVERY STAGE OF LIFE AND TO ENHANCING QUALITY OF LIFE BY

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

Department of the Treasury
Internal Revenue Service

Name of the organization

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

21-0635009

ADDRESSING THE UNIQUE NEEDS OF WOMEN, MEN, SENIORS, CHILDREN, ADOLESCENTS
AND DIVERSE POPULATIONS.

PROGRAMS ARE DEVELOPED AND FACILITATED BY THE OUTSTANDING PHYSICIANS,
NURSES AND HEALTH PROFESSIONALS OF PRINCETON HEALTH. PRINCETON HEALTH
ALSO WORKS CLOSELY WITH LEADING HEALTH ORGANIZATIONS - THE AMERICAN
CANCER SOCIETY, THE AMERICAN HEART ASSOCIATION AMONG OTHERS - TO RAISE
FUNDS, HEIGHTEN AWARENESS AND DELIVER COMPREHENSIVE COMMUNITY HEALTH
PROGRAMMING. FOLLOWING PLEASE FIND SERVICES AND PROGRAMS COLLECTIVELY
BENEFITING THE COMMUNITY AND SERVICE AREA OF PRINCETON HEALTH. THESE
SERVICES AND PROGRAMS ARE PARTIALLY OR FULLY SUBSIDIZED BY PENN MEDICINE:

- CHILDBIRTH AND FAMILY CARE: PRINCETON HEALTH'S COMPLETE RANGE OF
CHILDBIRTH AND FAMILY PROGRAMS ENSURES THAT NEW PARENTS, AND EVERY MEMBER
OF THE FAMILY, HAVE IMPORTANT INFORMATION AND SUPPORT SO THEY CAN SHARE
IN THE JOY OF ONE OF LIFE'S MOST PRECIOUS MOMENTS. PRINCETON HEALTH'S
PROGRAMS HELP FAMILIES FEEL FULLY PREPARED TO CARE FOR THEIR NEW BABIES
IN THE FIRST YEARS OF LIFE. SERVICES INCLUDE: BABY CARE, CAR SEAT CHECKS,
CHILDBIRTH PREPARATION AND BIRTHING OPTIONS INCLUDING SPECIALTY CLASSES
SUCH AS CESAREAN SECTION AND TWINS AND MULTIPLES, COURSES FOR SIBLINGS,
GRANDPARENTS AND BABYSITTERS, DADDY BOOTCAMP, EARLY PREGNANCY, LACTATION
SERVICES INCLUDING BREASTFEEDING CLASSES, SUPPORT GROUPS, AND PRIVATE
OUTPATIENT CONSULTATIONS, VIRTUAL TOURS OF MOTHER BABY UNIT, BRIGHT
BEGINNINGS, AND POSTPARTUM ADJUSTMENT SUPPORT GROUP. NEW CHILDBIRTH
PROGRAMS IN 2021 INCLUDE: LABOR FUNDAMENTALS; ASK THE LACTATION

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

CONSULTANT; PREGNANCY AND POSTPARTUM SUPPORT GROUP; BUMPS, BANDS AND
BALLS; POSTPARTUM POWER; AND PRENATAL YOGA.

- CPR AND FIRST-AID: PRINCETON HEALTH'S EXPERT HEALERS TEACH THE LATEST
FIRST AID TECHNIQUES AND LIFE-SAVING SKILLS SO THAT YOU CAN PROTECT
YOURSELF AND YOUR FAMILY. PRINCETON HEALTH IS AN ACCREDITED AMERICAN
HEART ASSOCIATION BASIC LIFE SUPPORT TRAINING CENTER. PRINCETON HEALTH
OFFERS PEDIATRIC AND ADULT CPR AND FIRST AID TRAINING, HEARTSAVER CPR
CERTIFICATION COURSE, AS WELL AS BLS, PALS, ACLS AND NRP CERTIFICATION
FOR HEALTHCARE PROVIDERS. WE ALSO RECENTLY BEGAN OFFERING MENTAL HEALTH
FIRST AID TRAINING.

- CANCER CARE AND SCREENINGS: PRINCETON MEDICAL CENTER'S CANCER PROGRAM
AND THE COMMUNITY WELLNESS PROGRAM ARE DEDICATED TO OFFERING PATIENTS
WITH CANCER AND THEIR LOVED ONES HIGH-QUALITY, INDIVIDUALIZED SERVICES
WITH A FOCUS ON PREVENTION, LIVING WITH CANCER, PEER SUPPORT AND MORE.
PRINCETON HEALTH OFFERS EDUCATIONAL SEMINARS CONDUCTED BY LEADING
PHYSICIANS AND HEALTH PROFESSIONALS, AS WELL AS SUPPORT GROUPS FOR
PATIENTS AND THEIR LOVED ONES, AND FREE SCREENINGS AND PREVENTIVE
MEASURES FOR COMMUNITY MEMBERS.

- SENIOR SERVICES: PRINCETON HEALTH REGULARLY OFFERS PROGRAMS AT LOCAL
SENIOR CENTERS AND ACTIVE ADULT COMMUNITIES, INCLUDING MONROE TOWNSHIP
OFFICE ON AGING/SENIOR CENTER, WEST WINDSOR SENIOR CENTER, SOUTH
BRUNSWICK SENIOR CENTER, AND PRINCETON SENIOR RESOURCE CENTER.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

21-0635009

- PATIENT AND COMMUNITY SUPPORT GROUPS: PRINCETON HEALTH OFFERS A NUMBER OF SUPPORT GROUPS FOR PATIENTS AND THEIR FAMILIES TO LEARN FROM AND SHARE EXPERIENCES WITH OTHERS. THESE SUPPORT GROUPS INCLUDE: BARIATRIC SURGERY, BREAST CANCER, BREASTFEEDING, CANCER, DIABETES, HOSPICE BEREAVEMENT, POSTPARTUM ADJUSTMENT, PROSTATE CANCER, STROKE, UNITE - PERINATAL LOSS BEREAVEMENT, AND WEIGHT LOSS.

- HEALTH FAIRS AND SCREENINGS: THROUGH PROACTIVE COMMUNITY HEALTH EDUCATION AND AN ONGOING EFFORT TO INCREASE ACCESS TO FREE OR LOW-COST SCREENINGS, PRINCETON HEALTH IS HELPING TO SAVE LIVES BY BUILDING AWARENESS OF THE SIGNS AND SYMPTOMS OF DISEASE AND BY PROMOTING EARLY DETECTION AND TREATMENT. IN 2021, PRINCETON HEALTH OFFERED THE FOLLOWING: VISION, FOOT, BODY FAT, AND BLOOD PRESSURE SCREENINGS; PROSTATE AND EDUCATIONAL SEMINARS, EXHIBITS, AND CHILDREN'S ACTIVITIES.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

PRINCETON HEALTH AFFIRMS ITS COMMITMENT TO THE COMMUNITY BY WAY OF A DYNAMIC CURRICULUM AND INNOVATIVE HEALTH AND LIFESTYLE-RELATED SERVICES OFFERED THROUGH ITS COMMUNITY WELLNESS PROGRAM. TO ENSURE THAT THESE ACTIVITIES ARE MEETING THE HEALTH NEEDS IN THE COMMUNITY, PRINCETON HEALTH CONDUCTED A COMPREHENSIVE COMMUNITY NEEDS ASSESSMENT. THE REPORTS PROVIDE AN OVERVIEW OF THE KEY FINDINGS OF THE COMMUNITY HEALTH ASSESSMENT, WHICH EXPLORES A RANGE OF HEALTH BEHAVIORS AND OUTCOMES,

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

SOCIAL AND ECONOMIC ISSUES, HEALTH CARE ACCESS, AND GAPS AND STRENGTHS OF EXISTING RESOURCES AND SERVICES WITH A PRIMARY FOCUS ON PRINCETON HEALTH AS A WHOLE.

THE COMMUNITY HEALTH ASSESSMENT UTILIZED A PARTICULARLY, COLLABORATIVE APPROACH TO LOOK AT HEALTH IN ITS BROADEST CONTEXT. THE ASSESSMENT PROCESS INCLUDED SYNTHESIZING EXISTING DATA ON SOCIAL, ECONOMIC AND HEALTH INDICATORS IN THE REGION AS WELL AS INFORMATION FROM FOCUS GROUPS CONDUCTED WITH COMMUNITY RESIDENTS, INTERVIEWS WITH COMMUNITY STAKEHOLDERS, AND AN ONLINE SURVEY EXAMINING LARGER EXTERNAL FACTORS THAT AFFECT HEALTH.

- PENN MEDICINE CARES GRANT: IN COLLABORATION WITH THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM, PRINCETON HEALTH AWARDS PENN MEDICINE CARES GRANTS TO COMMUNITY-BASED PROGRAMS ON BEHALF OF EMPLOYEES WHO VOLUNTEER THEIR TIME AND EFFORT AT THE INITIATIVES. BY FUNDING THESE PROGRAMS, PENN MEDICINE HELPED SUPPLY HEALTH SERVICES, FOOD, MEDICINE, CLOTHING, PLACES TO LIVE FOR THOUSANDS OF UNDERSERVED IN THE REGION EVERY YEAR. SINCE THE FIRST ROUND OF RECIPIENTS WAS ANNOUNCED IN JANUARY 2012 AND TO THE END OF FY22, PENN MEDICINE HAS SUPPORTED 880 SERVICE PROJECTS WITH OVER \$880,000 IN FUNDING. FOLLOWING PLEASE FIND PRINCETON HEALTH EMPLOYEES WHO RECEIVED THE CARES GRANT FOR THE 2022 FISCAL YEAR:

DEFIBRILLATOR FOR HILLSBOROUGH TOWNSHIP CONNIE JOHNSON: WITH APPROXIMATELY 450,000 VICTIMS PER YEAR, SUDDEN CARDIAC ARREST IS ONE OF

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

THE LEADING CAUSES OF DEATH IN THE UNITED STATES. THE ONLY EFFECTIVE IMMEDIATE TREATMENT FOR SUDDEN CARDIAC ARREST IS AN ELECTRIC SHOCK FROM AN AUTOMATED EXTERNAL DEFIBRILLATOR (AED), ADMINISTERED AS SOON AS POSSIBLE. POLICE AND LAW ENFORCEMENT OFFICERS ARE OFTEN THE FIRST RESPONDERS IN A CARDIAC EMERGENCY, ARRIVING EVEN BEFORE EMERGENCY MEDICAL PERSONNEL. CONNIE JOHNSON'S GRANT ALLOWS THE HILLSBOROUGH TOWNSHIP POLICE DEPARTMENT TO PURCHASE A DEFIBRILLATOR, WHICH WILL EQUIP ONE OF ITS TWO MOTORCYCLES. JOHNSON ALSO OFFERS CPR TRAINING IN THE COMMUNITY AND TO THE HILLSBOROUGH POLICE DEPARTMENT.

FORM 990, PART III (CONTINUED)

P.U.R.E. GIRLS CHRISSETTA HANNAH: CHRISSETTA HANNAH AND COMMUNITY PARTNERS ARE PLANNING TO REMODEL THE GIRLS' BATHROOMS AT THREE LOCAL NEW JERSEY MIDDLE SCHOOLS. THEIR GOAL IS TO MAKE THE BATHROOMS A PLACE OF POSITIVITY AND EMPOWERMENT, WITH WORDS OF ENCOURAGEMENT PAINTED ON THE STALL DOORS AND IN THE VANITY MIRRORS. CHRISSETTA'S FUNDS WILL ALSO HELP CREATE "BEAUTY CARTS" IN EACH BATHROOM, FILLED WITH DAILY ESSENTIALS SUCH AS HAIR TIES, SANITARY NAPKINS AND TAMPONS, BODY SPRAYS, COMBS, AND HAND LOTIONS.

INNOVATIONS MINISTRIES ARABIA LARAMORE: THE OUTREACH ACTIVITIES OF INNOVATIONS MINISTRIES, IN LINDENWOLD, NJ, PROVIDE A WIDE RANGE OF SERVICES TO PROMOTE THE PHYSICAL, EMOTIONAL, AND SPIRITUAL WELL-BEING NEEDED FOR ACHIEVING OPTIMAL HEALTH. ARABIA LARAMORE PREVIOUSLY RECEIVED TWO CARES GRANTS FOR THE ORGANIZATION, DEALING WITH CHRONIC DISEASE IMPROVEMENT WORKSHOPS. THIS TIME AROUND, HER FUNDING WILL SUPPORT THE

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

JUST FOR YOU AND LETTERS OF LOVE PROGRAM, WHICH HELPS SATISFY SENIOR CITIZENS' NEEDS FOR ACCESS TO FRESH PRODUCE AND ADDRESSES THE ISSUE OF SOCIAL ISOLATION, AS THEY GATHER FOR THE DISTRIBUTION OF FOOD. THROUGH THE OTHER PART OF THE PROGRAM, THEY RECEIVE CARDS AND LETTERS FROM YOUTHS, HELPING TO BRIDGE THE GENERATIONAL GAP.

FRANCIS S. KELEEKAI SR. TECH INSTITUTE FOOD PROGAM NOWAI KELEEKAI-BRAPOH:
FRANCIS S. KELEEKAI SR. TECHNICAL INSTITUTE IS A TUITION-FREE VOCATIONAL SCHOOL FOR 350 STUDENTS IN RURAL LIBERIA, WEST AFRICA. THE SCHOOL DOES NOT HAVE A CONSISTENT PROGRAM FOR FREE LUNCH, AND RESEARCH SHOWS THAT FOOD INSUFFICIENCY IS ASSOCIATED WITH POOR HEALTH OUTCOMES AND COGNITIVE FUNCTIONING AS WELL AS LOW SCHOOL ATTENDANCE AND ACADEMIC PROBLEMS. EVERY CHILD IN THIS COMMUNITY LIVES IN POVERTY, AND THE FOOD PROVIDED BY THE SCHOOL MAY BE THE ONLY NUTRITIOUS MEAL THAT A STUDENT RECEIVES EACH DAY. FUNDS FROM NOWAI KELEEKAI-BRAPOH'S CARES GRANT WILL BE USED FOR FOOD, SUPPLIES, AND TRANSPORTATION TO PROVIDE LUNCH FOR THE STUDENTS AS WELL AS FOR TEACHERS AND STAFF WHO WORK ON REDUCED SALARIES.

DEFEND YOUR DIABETIC FEET TAYLOR LACORTE: ELDERLY DIABETIC PATIENTS ARE PARTICULARLY BURDENED BY FOOT DISEASE, WHICH CAN LEAD TO MORE MEDICAL COMPLICATIONS - EVEN AMPUTATION - AND HIGH COSTS FOR MANAGING THE DISEASE. TAYLOR LACORTE, A WOUND OSTOMY NURSE AT PRINCETON HEALTH CARE SYSTEM, WILL PROVIDE QUARTERLY FOOT SCREENINGS FOR ELDERLY DIABETIC PATIENTS AT THE HILLSBOROUGH SENIOR CENTER, SEEKING TO PREVENT DIABETIC WOUNDS. HER GRANT COVERS THE COSTS OF FOOT-SCREENING TOOLS, WRITTEN

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

EDUCATIONAL MATERIALS FOR THE PATIENTS, AND OTHER EDUCATIONAL GIVEAWAYS.

COMING UP FOR AIR MARLENE SISTI: ATTITUDES IN REVERSE (AIR) IS A
NONPROFIT ORGANIZATION THAT EDUCATES MORE THAN 2,000 STUDENTS IN FOUR
WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT SCHOOLS YEARLY ON GOOD
MENTAL HEALTH AND SUICIDE PREVENTION. SUICIDE IS THE THIRD LEADING CAUSE
OF DEATH IN THE COMMUNITY. AS WITH ALL ILLNESSES, THE EARLIER THAT
SUICIDAL FEELINGS ARE IDENTIFIED AND TREATMENT IS BEGUN, THE MORE LIKELY
THE SUCCESS OF THE TREATMENT. COVID-19 KEPT AIR VOLUNTEERS FROM GOING
INTO SCHOOLS, BUT THEY PLAN TO REVAMP THE EFFORT WITH THEIR THERAPY DOGS
THIS YEAR.

FORM 990, PART V, LINE 1A

FORMS 1099

THIS ORGANIZATION IS AN AFFILIATE OF THE TRUSTEES OF THE UNIVERSITY OF
PENNSYLVANIA ("TRUSTEES"). THE FORMS 1099 DISTRIBUTED AS PART OF THIS
ENTITY'S ACTIVITIES ARE DONE SO THROUGH THE UNIVERSITY HEALTH SYSTEM AND
CONSOLIDATED WITH TRUSTEES.

FORM 990, PART VI, SECTION A, LINES 6 & 7

FORM 990 REVIEW PROCESS

INFORMATION RELATED TO THIS ORGANIZATION'S FORM 990 FILING IS GATHERED BY
FINANCE STAFF AND PROVIDED TO PRICEWATERHOUSECOOPERS LLP FOR REVIEW AND

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

RETURN PREPARATION. A DRAFT COPY OF THE JUNE 30, 2022 FORM 990 WAS
REVIEWED BY VARIOUS SENIOR FINANCIAL MANAGEMENT OFFICIALS BEFORE IT WAS
SUBMITTED TO THE BOARD FOR THEIR REVIEW. A COPY OF THE FINAL JUNE 30,
2022 FORM 990 WAS THEN MADE AVAILABLE TO EACH BOARD MEMBER PRIOR TO THE
FILING DEADLINE.

FORM 990, PART VI, SECTION B, LINES 11B

FORM 990 REVIEW PROCESS

INFORMATION RELATED TO THIS ORGANIZATION'S FORM 990 FILING IS GATHERED BY
FINANCE STAFF AND PROVIDED TO PRICEWATERHOUSECOOPERS LLP FOR REVIEW AND
RETURN PREPARATION. A DRAFT COPY OF THE JUNE 30, 2022 FORM 990 WAS
REVIEWED BY VARIOUS SENIOR FINANCIAL MANAGEMENT OFFICIALS BEFORE IT WAS
SUBMITTED TO THE BOARD FOR THEIR REVIEW. A COPY OF THE FINAL JUNE 30,
2022 FORM 990 WAS THEN MADE AVAILABLE TO EACH BOARD MEMBER PRIOR TO THE
FILING DEADLINE.

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

CONFLICT OF INTEREST POLICY

THIS ORGANIZATION IS AN AFFILIATE OF THE TRUSTEES OF THE UNIVERSITY OF
PENNSYLVANIA ("UNIVERSITY").

EACH COVERED PERSON* ANNUALLY SHALL COMPLETE A CONFLICT OF INTEREST
QUESTIONNAIRE PROVIDED BY THE UNIVERSITY AND SHALL UPDATE SUCH

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

Department of the Treasury
Internal Revenue Service

Name of the organization

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

21-0635009

QUESTIONNAIRE PROMPTLY AS NECESSARY TO REFLECT CHANGES DURING THE COURSE OF THE YEAR. FORMER BOARD MEMBERS WHO ARE NOT TRUSTEE EMERITI ARE ENCOURAGED BUT NOT REQUIRED TO COMPLETE THE QUESTIONNAIRE DURING THE FIVE-YEAR PERIOD FOLLOWING COMPLETION OF THEIR TERMS. COMPLETED QUESTIONNAIRES SHALL BE RETURNED TO THE OFFICE OF THE SECRETARY AND SHALL BE SUBJECT TO REVIEW BY SUCH OFFICE AND THE OFFICE OF THE GENERAL COUNSEL, AS WELL AS BY ANY OUTSIDE LEGAL COUNSEL AND/OR AUDITORS WHO MAY BE APPOINTED TO ADVISE THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES APPOINTED TO OVERSEE THIS POLICY. COMPLETED QUESTIONNAIRES ALSO SHALL BE AVAILABLE FOR INSPECTION BY ANY BOARD MEMBER.

*COVERED PERSONS INCLUDE: (1) VOTING MEMBERS OF THE BOARD OF TRUSTEES (INCLUDING CHARTER TRUSTEES, TERM TRUSTEES, ALUMNI TRUSTEES, AND COMMONWEALTH TRUSTEES); (2) TRUSTEE EMERITI WHO HAVE SERVED IN THAT CAPACITY FOR FIVE YEARS OR LESS; (3) OTHER FORMER VOTING TRUSTEES FOR A PERIOD OF FIVE YEARS FROM THE END OF THEIR TERM AS SUCH; (4) OFFICERS AS DEFINED IN THE STATUTES; AND (5) MEMBERS OF THE INVESTMENT BOARD. EACH COVERED PERSON (EXCEPT FORMER BOARD MEMBERS WHO ARE NOT TRUSTEE EMERITI) SHALL BE REQUIRED TO ACKNOWLEDGE, NOT LESS THAN ANNUALLY, THAT HE OR SHE HAS READ AND IS IN COMPLIANCE WITH THIS POLICY.

FORM 990, PART VI, SECTION B, LINE 15

COMPENSATION PROCESS

THIS ORGANIZATION IS AN AFFILIATE OF THE TRUSTEES OF THE UNIVERSITY OF

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

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

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

▶ Attach to Form 990 or 990-EZ.

2021

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

PENNSYLVANIA ("UNIVERSITY"). COMPENSATION ARRANGEMENTS INVOLVING ANY OF
OUR OFFICERS AND/OR KEY EMPLOYEES ARE ESTABLISHED BY THE UNIVERSITY
PURSUANT TO A PROCESS THAT SATISFIES THE REBUTTABLE PRESUMPTION PROCEDURE
AVAILABLE FOR SECTION 4958 EXCESS BENEFIT TRANSACTION TAX PURPOSES (WHICH
REQUIRES A REVIEW OF COMPENSATION DETERMINATIONS BY DISINTERESTED
PERSONS, USE OF APPROPRIATE COMPARABILITY DATA, AND CONTEMPORANEOUS
DOCUMENTATION OF THE PROCESS).

FORM 990, PART VI, SECTION C, LINE 19

DOCUMENTS AVAILABILITY TO PUBLIC

OUR FORMS 1023 AND 990, GOVERNING DOCUMENTS, AUDITED FINANCIAL
STATEMENTS, AND CONFLICT OF INTEREST POLICY ARE AVAILABLE TO THE PUBLIC
UPON REQUEST.

FORM 990, PART XI, LINE 9

DETAIL OF OTHER CHANGES IN NET ASSETS OR FUND BALANCE:

CHANGE IN PERMANENTLY RESTRICTED ASSETS	\$ 124,817
CHANGE IN TEMPORARILY RESTRICTED ASSETS	2,227,658
CHANGE IN NET PERIODIC DB PENSION	2,348,007
PENSION PLAN ADJUSTMENT	(4,140,065)
OTHER	(14,097)

TOTAL	\$ 546,320

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

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

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

▶ Attach to Form 990 or 990-EZ.

2021

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

Name of the organization

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

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

THE MISSION OF PRINCETON HEALTHCARE SYSTEM IS TO PROVIDE EXCEPTIONAL, COMPASSIONATE CARE TO ENHANCE THE HEALTH AND WELLNESS OF OUR PATIENTS, THEIR FAMILIES AND OUR COMMUNITY.

PRINCETON HEALTHCARE SYSTEM PROVIDES INPATIENT AND OUTPATIENT CARE, COMMUNITY HEALTH EDUCATION, MEDICAL EDUCATION AND ALSO PROMOTES MEDICAL AND SCIENTIFIC RESEARCH WHEN APPROPRIATE.

IT IS INTEGRAL TO THE MISSION OF PRINCETON HEALTHCARE SYSTEM TO CONTINUALLY IMPROVE QUALITY OF SERVICE TO OUR PATIENTS AND COMMUNITY AND TO PROVIDE APPROPRIATE HEALTHCARE TO ALL.

PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O FOR ADDITIONAL INFORMATION.

Name of the organization

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY**21-0635009**

FORM 990, PART VII-COMPENSATION OF THE 5 HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HEITMAN AMERICA REAL ESTATE HO P.O. BOX 21578 NWE YORK, NY 10087-1578	PROPERTY LEASE SRVCS	6,720,186.
SYMMETRY WORKFORCE SOLUTIONS 5930 CORNERSTONE CT, STE 300 SAN DIEGO, CA 92121	MEDICAL SERVICES	5,416,215.
UMCP SURGICENTER PARTNERS LLC 1 PLAINSBORO RD PLAINSBORO, NJ 08536-1913	MEDICAL SERVICES	2,545,095.
ALLIED UNIVERSAL COMPANY 1551 N TUSTIN AVE, STE 650 SANTA ANA, CA 92705	OUTSOURCED STAFFING	1,796,897.
RESPIRATORY & SLEEP SPECIALISTS LLC 252 GRANDVIEW RD SKILLMAN, NJ 08558	MEDICAL SERVICES	1,066,280.

Name of the organization

Employer identification number

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY**21-0635009**

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
CORPORATE SERVICES	39,075,118.	35,167,606.	3,907,512.	NONE
PROFESSIONAL FEES - MEDIC	20,745,922.	18,671,330.	2,074,592.	NONE
TEMPORARY EMPLOYMENT	17,044,127.	17,044,127.	NONE	NONE
OTHER FEES	13,889,532.	12,500,579.	1,388,953.	NONE
STATE, CITY & COUNTY ASSE	13,844,256.	12,459,830.	1,384,426.	NONE
PROFESSIONAL FEES - OTHER	6,679,551.	6,011,596.	667,955.	NONE
OUTSOURCED LABOR	4,917,941.	4,426,147.	491,794.	NONE
TOTALS	----- 116,196,447. =====	----- 106,281,215. =====	----- 9,915,232. =====	----- NONE =====

**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

2021

**Open to Public
Inspection**

Name of the organization **PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY
NONPROFIT CORPORATION**

Employer identification number
21-0635009

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
SEE SUPPLEMENTAL PAGE							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2021

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	
(1) SEE SUPPLEMENTAL PAGE												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) SEE SUPPLEMENTAL PAGE									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
ARI 1740 FUND 32-0472404 N SETSON AVE, STE 5500 CHICAGO	INVESTMENT	IL	N/A									X
CYRUS 1740 FUND, LP 82-1211542 65 E 55TH STREET, 35TH FLOOR N	INVESTMENT	NY	N/A									X
CYRUS 1740 MASTER FUND LP 98-1 89 NEXUS WAY CAMANA BAY, GR K	INVESTMENT	CJ	N/A									X
DVG 1740 FUND, LP 80-0961539 ONE FAWCETT PLACE GREENWICH, C	INVESTMENT	CT	N/A									X
EAST MARSHALL STREET PARTNERSH 701 E. MARSHALL STREET WEST CH	INVESTMENT	PA	N/A									X
FERN HILL PARTNERSHIP III, LP 701 E. MARSHALL STREET WEST CH	RENTAL	PA	N/A									X
FERN HILL, LLC 23-3005147 701 E. MARSHALL STREET WEST CH	RENTAL	PA	N/A									X
GALLOPAVO, LP 46-4621967 2000 MCKINNEY AVE, STE 2125 DA	INVESTMENT	TX	N/A									X
JOG V C LIMITED PARTNERSHIP STE 2370 440 2ND AVE SW CALGAR	INVESTMENT	CA	N/A									X
JOG VI C LIMITED PARTNERSHIP STE 2370 440 2ND AVE SW CALGAR	INVESTMENT	CA	N/A									X

990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
KINGSTOWN 1740 FUND LP 84-3119 34 EAST 51ST STREET NEW YORK,	INVESTMENT	NY	N/A								X	
LANCASTER PET PARTNERSHIP, LLP PO BOX 4216 LANCASTER, PA 1760	MEDICAL SERVICES	PA	N/A								X	
LG HEALTH COMM. CARE COLLAB. I 555 NORTH DUKE STREET LANCASTE	ACO	PA	N/A								X	
LG HEALTH COMMUNITY CARE COLLA 555 NORTH DUKE STREET LANCASTE	ACO	PA	N/A								X	
MRI GROUP, LLP 33-1011386 PO BOX 4216 LANCASTER, PA 1760	MEDICAL SERVICES	PA	N/A								X	
NEIGHBRHD PRES & DEV FUND, LP 240 NEW YORK DR, STE 1 FORT WA	RENTAL	PA	N/A								X	
OAKLANDS WAY MEDICAL BUILDING 701 E. MARSHALL STREET WEST CH	RENTAL	PA	N/A								X	
SRP INVESTORS FUND A, LP 61-17 2001 ROSS AVE, SUITE 400 DALLA	INVESTMENT	TX	N/A								X	
TURK'S HEAD SURGERY CENTER 20- 915 OLD FERN HILL ROAD, BLDG B	MEDICAL SERVICES	PA	N/A								X	
ST-TO RIBBIT OPPORTUNITY V, LL 364 UNIVERSITY AVENUE PALO ALT	INVESTMENTS	CA	N/A								X	

990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
UNIVERSA BLACK SWAN PROTECTION 2601 S. BAYSHORE DR, SUITE 203	INVESTMENT	FL	N/A									X
AXIS UKA GP LLC 27-3617178 240 NEW YORK DRIVE, SUITE 1 FO	INVESTMENT	PA	N/A									X
LIFT REAL ESTATE PARTNERS FUND 180 SUTTER STREET, SUITE 400 S	INVESTMENT	CA	N/A									X
BEXP II (PARALLEL), LP 87-3188 5914 W COURTYARD DRIVE AUSTIN,	INVESTMENT	TX	N/A									X
FORERUNNER BUILDERS F-G, LP 87 ONE LETTERMAN DRIVE, BLDG. C,	INVESTMENT	CA	N/A									X
GCM CARRIAGE SPV, L.P. 87-2075 250 WEST 55TH STREET, 36TH FLO	INVESTMENT	NY	N/A									X
INITIALIZED CBH SPV LLC 87-112 464 TEHAMA STREET SAN FRANCISCO	INVESTMENT	CA	N/A									X

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY

21-0635009

990 SCH R, PART IV-IDENTIFICATION OF REL. ORG. TAXABLE AS CORP/TRUST

(A) NAME/ADDRESS/EIN	(B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) ENTITY TYPE	(F) SHARE OF TOT INCOME	(G) SHARE OF EOY	(H) % OWNERSHIP	(I) SEC 512(B)(13) YES NO
ARCM 1740 LTD 27 HOSPITAL ROAD , GRAND CAYMAN CJ KY1-9008	INVESTMENTS	CJ	TRUSTEES	C-CORP				X
CYRUS 1740 FUND LTD 98-1361907 89 NEXUS WAY CAMANA BAY, GRAND CAYMAN CJ KY1-9009	INVESTMENTS	CJ	TRUSTEES	LIMITED COMPANY				X
CIRCLE MEDICAL ASSURANCE CO. 83-3556286 2929 WALNUT STREET, STE 460 PHILADELPHIA, PA 19104	INSURANCE	PA	TRUSTEES	C-CORP				X
CLINICAL HEALTH CARE ASSOC OF NJ, PC 23-2865181 250 KING OF PRUSSIA RD, 4TH FL RADNOR, PA 19087	PHYS MGMT	PA	CCA	C-CORP				X
DELANCEY CORPORATION 23-2060159 800 SPRUCE STREET PHILADELPHIA, PA 19106	RENTAL	PA	PA HOSPITAL	C-CORP				X
FRANKLIN CASUALTY INSURANCE CO. 04-3378984 P.O. BOX 530 BURLINGTON, VT 05402	INSURANCE	VT	TRUSTEES	C-CORP				X
LANCASTER GENERAL 457 DEFERRED COMP PLAN 23-2250941 555 NORTH DUKE STREET LANCASTER, PA 17604	TRUST	PA	LG HEALTH	TRUST				X
LANCASTER GENERAL INSURANCE COMPANY 98-0176655 PO BOX 1109 GT , GRAND CAYMAN CJ KYI-1102	INSURANCE	CJ	LG HEALTH	C-CORP				X
LANCASTER GENERAL SERVICES INC. 23-2250128 555 NORTH DUKE STREET LANCASTER, PA 17604	PROPERTY SVCS	PA	LG HEALTH	C-CORP				X
NAYA 1740 FUND LTD. P.O. BOX 309 UGLAND HOUSE, GRAND CAYMAN CJ KY1-1104	INVESTMENTS	CJ	TRUSTEES	C-CORP				X

990 SCH R, PART IV-IDENTIFICATION OF REL. ORG. TAXABLE AS CORP/TRUST

(A) NAME/ADDRESS/EIN	(B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) ENTITY TYPE	(F) SHARE OF TOT INCOME	(G) SHARE OF EOY	(H)% OWNERSHIP	(I) SEC 512(B)(13) YES NO
PENN MEDICINE LONDON LIMITED RADIUS COMMERCIAL SERVICES LTD, 11T , WHITEFRIARS, LEWINS	NETWORKING	UK	UPENN INT'L	LIMITED COMPANY				X
PENN WHARTON CONSULTING (BEIJING) CO LTD CHINA WORLD TOWER 1, 14F , CHAOYANG DIST CH 100004	BUS. CONSULTING	CH	UPENN INT'L	C-CORP				X
PHI PHARMACY, INC. 22-3467899 ONE PLAINSBORO ROAD PLAINSBORO, NJ 08536	INACTIVE	NJ	PHCS HOLDING	C-CORP				X
PRINCETON HEALTH, INC. & SUBS 22-3450093 ONE PLAINSBORO ROAD PLAINSBORO, NJ 08536	MEDICAL	NJ	PHCS HOLDING	C-CORP				X
QUAKER INSURANCE COMPANY LTD 30-0708282 VICTORIA STREET, PO BOX HM 1826 VICTORIA HALL, HAMILTON B	SELF-INSURANCE	BD	TRUSTEES	C-CORP				X
THE PAM 1740 FUND LTD. P.O. BOX 309 GEORGE TOWN, GRAND CAYMAN CJ KYI-1104	INVESTMENTS	CJ	TRUSTEES	C-CORP				X
TURK'S HEAD HEALTH SERVICES, INC. 23-2329753 701 E. MARSHALL STREET WEST CHESTER, PA 19380	MEDICAL SERVICES	PA	CCH&HS	C-CORP				X
UPENN HOSPITALITY, INC. 23-3076589 3401 WALNUT STREET, SUITE 440A PHILADELPHIA, PA 19104	HOTEL/RESTAURANT	PA	TRUSTEES	C-CORP				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.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		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)			
(2)			
(3)			
(4)			
(5)			
(6)			

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII Supplemental Information

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

SCHEDULE R, PART V

PRINCETON HEALTHCARE SYSTEM, A NEW JERSEY NONPROFIT CORPORATION ("PHCS") AND ITS AFFILIATES CONSTITUTE A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. PRINCETON HEALTHCARE SYSTEM HOLDING, INC. IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. PHCS ROUTINELY PAYS EXPENSES FOR VARIOUS AFFILIATES WITHIN THE SYSTEM IN THE ORDINARY COURSE OF BUSINESS. THESE RELATED PARTY TRANSACTIONS ARE RECORDED ON THE REVENUE/EXPENSE AND BALANCE SHEET STATEMENTS OF THIS ORGANIZATION AND ITS AFFILIATES. THESE ENTITIES WORK TOGETHER TO DELIVER HIGH QUALITY HEALTHCARE AND WELLNESS SERVICES TO THE COMMUNITIES IN WHICH THEY ARE SITUATED.

Part VII Supplemental Information

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

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
AFFILIA HOME HEALTH 1811 OLDE HOMESTEAD LANE	23-1352572 LANCASTER, PA 17601 HOME HEALTH	PA	501(C)(3)	7	LG HEALTH		X
CARL V S PATTERSON 19 UN OF PA C/O PNC BANK, 620 LIBERTY AVE,	23-6415355 PITTSBURGH, PA 15222 SUPPORT TRUST	PA	4947(A)(1)	N/A	N/A		X
CHESTER COUNTY HOSPITAL 701 E. MARSHALL STREET	23-0469150 WEST CHESTER, PA 19380 HEALTHCARE	PA	501(C)(3)	3	CCH&HS		X
CHESTER COUNTY HOSPITAL & HEALTH SYSTEM 701 E. MARSHALL STREET	26-4233321 WEST CHESTER, PA 19380 MGMT SRVCS	PA	501(C)(3)	12, I	TRUSTEES		X
CLINICAL CARE ASSOCIATES OF UPHS 250 KING OF PRUSSIA RD, 4TH FL	23-2729852 RADNOR, PA 19087 HEALTHCARE	PA	501(C)(3)	10	TRUSTEES		X
HAJOCA 3025, INC. 3451 WALNUT STREET, ROOM 737	84-3379653 PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	TRUSTEES		X
Laise, CA TUW FBO UNIV. OF PENN 3451 WALNUT STREET, SUITE 305	82-3434615 PHILADELPHIA, PA 19104 SUPPORT TRUST	PA	4947(A)(1)	N/A	N/A		X
LANCASTER GENERAL HEALTH 555 NORTH DUKE STREET	23-2250941 LANCASTER, PA 17604 SUPPORT ORG	PA	501(C)(3)	12, II	TRUSTEES		X
LANCASTER GENERAL HEALTH COLUMBIA CENTER 306 NORTH 7TH STREET	23-0485650 COLUMBIA, PA 17512 FACILITY MGMT	PA	501(C)(3)	3	LG HOSPITAL		X
LANCASTER GENERAL HEALTH FOUNDATION 555 NORTH DUKE STREET	20-5767147 LANCASTER, PA 17604 FUNDRAISING	PA	501(C)(3)	7	N/A		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
LANCASTER GENERAL HEALTH HOLDINGS 555 NORTH DUKE STREET	20-4943109 LANCASTER, PA 17604 HEALTHCARE	PA	501(C)(3)	3	LG HEALTH		X
LANCASTER GENERAL HOSPITAL 555 NORTH DUKE STREET	23-1365353 LANCASTER, PA 17604 HEALTHCARE	PA	501(C)(3)	3	LG HEALTH		X
LANCASTER GENERAL MEDICAL GROUP 1030 NEW HOLLAND AVENUE	23-2777286 LANCASTER, PA 17601 HEALTHCARE	PA	501(C)(3)	3	LG HEALTH		X
MORRIS EST LYDIA T DECD T/W 6325 S RAINBOW BLVD STE 300	23-6210940 LAS VEGAS, NV 89118 SUPPORT TRUST	NV	501(C)(3)	12, III-FI	N/A		X
NEIGHBORHOOD HEALTH AGENCIES, INC. 795 E. MARSHALL STREET	23-2324782 WEST CHESTER, PA 19380 NURSING	PA	501(C)(3)	12, I	CCH&HS		X
NEIGHBORHOOD LEAGUE HEALTH SERVICES 795 E. MARSHALL STREET	23-2324787 WEST CHESTER, PA 19380 HEALTH SRVCS	PA	501(C)(3)	10	CCH&HS		X
NEIGHBORHOOD VISITING NURSE ASSOCIATION 795 E. MARSHALL STREET	23-1352243 WEST CHESTER, PA 19380 NURSING	PA	501(C)(3)	7	CCH&HS		X
OAP, INC. 3451 WALNUT STREET, ROOM 748	23-1986931 PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	TRUSTEES		X
PENN CENTER FOR REHAB AND CARE 3609 CHESTNUT STREET	23-2422635 PHILADELPHIA, PA 19104 HEALTHCARE	PA	501(C)(3)	3	PMC		X
PENN CLUB OF NEW YORK, INC. 30 WEST 44TH STREET	23-2726687 NEW YORK, NY 10036 CLUB	NY	501(C)(7)	N/A	N/A		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
PENN PRAXIS, INC. 210 SOUTH 34TH STREET 75-2974931	PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	TRUSTEES		X
PENN PRESS, INC. 3905 SPRUCE STREET 23-1876142	PHILADELPHIA, PA 19107 PUBLISHING	PA	501(C)(3)	12, I	TRUSTEES		X
PENNSYLVANIA COLLEGE OF HEALTH SCIENCES 850 GREENFIELD ROAD 06-1645496	LANCASTER, PA 17601 HEALTH EDU	PA	501(C)(3)	2	LG HOSPITAL		X
PENNSYLVANIA HOSPITAL OF UPHS 800 SPRUCE STREET 31-1538725	PHILADELPHIA, PA 19107 HEALTHCARE	PA	501(C)(3)	3	TRUSTEES		X
PGH DEVELOPMENT CORP. 426 CURIE BLVD 23-2351015	PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	N/A		X
PHOENIXVILLE HOSPITAL OF UPHS 3001 MARKET STREET, 3RD FLOOR 23-2901089	PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	3	TRUSTEES		X
PRESBYTERIAN MEDICAL CENTER OF UPHS 51 NORTH 39TH STREET 23-2810852	PHILADELPHIA, PA 19104 HEALTHCARE	PA	501(C)(3)	3	TRUSTEES		X
PRINCETON CAREGIVERS, INC. ONE PLAINSBORO ROAD 22-2842773	PLAINSBORO, NJ 08536 HOMECARE SVCS	NJ	501(C)(3)	3	PHCS HOLDING		X
PRINCETON HEALTHCARE AFFILIATED PHYS, PC ONE PLAINSBORO ROAD 26-4203938	PLAINSBORO, NJ 08536 HEALTHCARE	NJ	501(C)(3)	10	PHCS HOLDING		X
PRINCETON HEALTHCARE SYSTEM FDN, INC. ONE PLAINSBORO ROAD 22-2225911	PLAINSBORO, NJ 08536 SUPPORT PHCS	NJ	501(C)(3)	7	PHCS HOLDING		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
PRINCETON HLTHCARE SYSTEM HOLDING, INC. ONE PLAINSBORO ROAD	22-3493256 PLAINSBORO, NJ 08536 SUPPORT ORG	NJ	501(C)(3)	12, I	TRUSTEES		X
PRINCETON MEDICAL PROPERTIES, INC. ONE PLAINSBORO ROAD	22-0022702 PLAINSBORO, NJ 08536 REAL ESTATE	NJ	501(C)(2)	N/A	PHCS HOLDING		X
THE ASC TRUST OF THE UNIV OF PA 1500 MARKET ST, STE 3500E	81-0550464 PHILADELPHIA, PA 19102 BUS. TRUST	PA	501(C)(3)	8	N/A		X
THE HEART GROUP OF LANCASTER GEN. HEALTH 217 HARRISBURG AVENUE	30-0634510 LANCASTER, PA 17603 CARDIOLOGY	PA	501(C)(3)	3	LG HEALTH		X
THE LEONARD AND MADLYN ABRAMSON INST. 421 CURIE BLVD, 450 BRB II/III	23-2929823 PHILADELPHIA, PA 19104 MED RESEARCH	PA	501(C)(3)	4	N/A		X
TRUSTEES OF THE UNIVERSITY OF PENN. 3451 WALNUT STREET, ROOM 305	23-1352685 PHILADELPHIA, PA 19104 EDUCATION	PA	501(C)(3)	2	N/A		X
UNIVERSITY CITY ASSOCIATES INC. 3451 WALNUT STREET, ROOM 329	23-3021159 PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	TRUSTEES		X
UNIVERSITY CLUB AT PENN, INC. 3611 WALNUT STREET	23-6299508 PHILADELPHIA, PA 19104 FAC. CLUB	PA	501(C)(3)	12, I	TRUSTEES		X
UPENN INTERNATIONAL 3451 WALNUT STREET, SUITE 731	45-4985731 PHILADELPHIA, PA 19104 SUPPORT ORG	PA	501(C)(3)	12, I	TRUSTEES		X
UPENN MASTER RETIREMENT TRUST 3451 WALNUT STREET, ROOM 305	04-3574136 PHILADELPHIA, PA 19104 RETIRE TRUST	PA	501(A)	N/A	TRUSTEES		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512 YES NO
UPENN RETIREE BENEFITS TRUST 3451 WALNUT STREET, ROOM 329	23-2769744 PHILADELPHIA, PA 19104 BENEFITS	PA	501(C)(3)	12, I	TRUSTEES	X
WISSAHICKON HOSPICE OF UPHS 150 MONUMENT ROAD, SUITE 300	23-2152662 BALA CYNWYD, PA 19004 HOSPICE CARE	PA	501(C)(3)	10	TRUSTEES	X
WOMEN'S AND CHILDREN'S HEALTH SERVICES 700 SPRUCE STREET	23-2248956 PHILADELPHIA, PA 19106 HEALTHCARE	PA	501(C)(3)	3	PA HOSPITAL	X
PENN MEDICINE-PMA 5 ATRIUM, 3400 CIVIC CTR BLVD	86-3800365 PHILADELPHIA, PA 19104 HEALTHCARE	PA	501(C)(3)	10	CCA	X