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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

2016

Open to Public Inspection

A For the 2016 calendar year, or tax year beginning 10-01-2016 , and ending 09-30-2017

B Check if applicable
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
399 REVOLUTION DRIVE NO 645

City or town, state or province, country, and ZIP or foreign postal code
SOMERVILLE, MA 02145

D Employer identification number
90-0656139

E Telephone number
(857) 282-0747

G Gross receipts $ 12,716,490,778

F Name and address of principal officer
DAVID F TORCHIANA MD
800 BOYLSTON STREET
BOSTON, MA 02199

H(a) Is this a group return for subordinates? ☑ Yes ☐ No

H(b) Are all subordinates included? ☑ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶ 5803

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

J Website: ▶ WWW PARTNERS ORG

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation

M State of legal domicile

Part I Summary

1 Briefly describe the organization's mission or most significant activities
PATIENT CARE, RESEARCH, EDUCATION AND SERVICE TO THE COMMUNITY LOCALLY AND GLOBALLY

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	610
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	375
5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	**5**	71,167
6	Total number of volunteers (estimate if necessary)	**6**	5,000
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	33,641,171
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	2,007,186

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	2,365,428,359	2,967,780,415
9	Program service revenue (Part VIII, line 2g)	8,722,419,906	9,247,897,369
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	13,960,667	260,033,262
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	195,192,793	236,519,698
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	11,297,001,725	12,712,230,744
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	734,828,336	1,192,132,923
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	6,193,732,206	6,488,080,545
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶66,748,730		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	4,308,978,284	4,704,106,027
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	11,237,538,826	12,384,319,495
19	Revenue less expenses Subtract line 18 from line 12	59,462,899	327,911,249

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	15,693,513,301	16,695,511,153
21	Total liabilities (Part X, line 26)	7,830,077,629	6,981,438,398
22	Net assets or fund balances Subtract line 21 from line 20	7,863,435,672	9,714,072,755

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

****** 2018-08-13
Signature of officer Date

PETER K MARKELL EXEC VP, CFO & TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
Firm's name ▶			Firm's EIN ▶	
Firm's address ▶			Phone no	

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

PARTNERS HEALTHCARE SYSTEM, INC IS DEVELOPING AN INTEGRATED HEALTH CARE DELIVERY SYSTEM THROUGHOUT THE REGION THAT OFFERS PATIENTS A CONTINUUM OF COORDINATED, HIGH-QUALITY CARE

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 11,190,133,883 including grants of $ 1,192,132,923) (Revenue $ 9,257,534,345)

See Additional Data

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

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

4d Other program services (Describe in Schedule O)

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

4e **Total program service expenses** ▶ 11,190,133,883

Part IV Checklist of Required Schedules

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

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

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	**20a**	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	**20b**	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**	Yes	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**	Yes	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**	Yes	
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**	Yes	
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

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

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	78		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**		Yes	
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**	71,167		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	**2b**		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**		Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**		Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .	**4a**			No
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? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**		Yes	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**		Yes	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**			No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	**7f**			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**			
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .	**9a**			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	**9b**			
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O	**13a**			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	**14b**			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	610		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	375		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**		Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? .	**3**			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	**4**			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .	**5**			No
6	Did the organization have members or stockholders?	**6**		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	**8a**		Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**			No

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed▶ AK , AL , AR , CA , CO , CT , DC , FL , GA , HI , IL , KS , KY , MD , MI , MN , MS , NC , ND , NH , NJ , NM , NY , OH , PA , RI , SC , TN , TX , WA , WV , MA , MT , OK , UT , VA , VT , WI

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

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶PARTNERS FIN-TAX DIRECTOR 399 REVOLUTION DRIVE STE 645 SOMERVILLE, MA 02145 (857) 282-0747

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

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

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

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

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

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

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

(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			
See Additional Data Table										

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			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								110,701,467	15,085,296	12,468,569

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 ▶ 12,685

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

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
SUFFOLK CONSTRUCTION CO 99 CONIFER HILL DRIVE DANVERS, MA 01923	CONSTRUCTION SERVICE	119,052,202
WALSH BROTHERS 210 COMMERCIAL STREET BOSTON, MA 02109	CONSTRUCTION SERVICE	41,230,019
TURNER CONSTRUCTION CO 855 BOYSLTON STREET BOSTON, MA 02114	CONSTRUCTION SERVICE	31,143,085
BLUE CROSS AND BLUE SHIELD OF MA INC 41 PARK DRIVE BOSTON, MA 02215	MEDICAL CLAIMS SVCS	21,168,845
ANGELICA-WORCESTER PO BOX 823283 PHILADELPHIA, PA 191823283	LAUNDRY SERVICE	19,501,092

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 368

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** 29,199,778			
	d Related organizations	**1d** 902,214,232			
	e Government grants (contributions)	**1e** 818,889,000			
	f All other contributions, gifts, grants, and similar amounts not included above	**1f** 1,217,477,405			
	g Noncash contributions included in lines 1a-1f $ _____				
	h Total. Add lines 1a-1f . . . . . ▶	2,967,780,415			
Program Service Revenue		Business Code			
	2a PATIENT CARE REVENUE	622110	8,563,381,779	8,563,381,779	
	b OTHER PROGRAM REVENUE	621999	673,391,784	668,506,143	4,885,641
	c TUITION REVENUE	624410	7,089,970	7,089,970	
	d PARTNERSHIP INCOME	900099	2,543,220	2,543,220	
	e AMBULANCE INCOME	621910	1,490,616	1,490,616	
	f All other program service revenue				
	g Total. Add lines 2a–2f . . . . ▶	9,247,897,369			
	3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶	59,505,930		11,154,754	48,351,176
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties . . . . . ▶	68,842,717			68,842,717
		(i) Real	(ii) Personal		
	6a Gross rents	62,961,624			
	b Less rental expenses	0			
	c Rental income or (loss)	62,961,624			
	d Net rental income or (loss) . . . . . ▶	62,961,624		17,600,776	45,360,848
		(i) Securities	(ii) Other		
	7a Gross amount from sales of assets other than inventory	200,527,332			
	b Less cost or other basis and sales expenses	0			
	c Gain or (loss)	200,527,332			
	d Net gain or (loss) . . . . . ▶	200,527,332			200,527,332
Other Revenue	**8a** Gross income from fundraising events (not including $ 29,199,778 of contributions reported on line 1c) See Part IV, line 18 . . . . **a**	1,961,613			
	b Less direct expenses . . . **b**	4,260,034			
	c Net income or (loss) from fundraising events . . ▶	-2,298,421			-2,298,421
	9a Gross income from gaming activities See Part IV, line 19 . . . **a**				
	b Less direct expenses . . . **b**				
	c Net income or (loss) from gaming activities . . ▶				
	10a Gross sales of inventory, less returns and allowances . . **a**				
	b Less cost of goods sold . . **b**				
	c Net income or (loss) from sales of inventory . . ▶				
	Miscellaneous Revenue	Business Code			
	11a PARKING INCOME	812930	58,843,003		58,843,003
	b CAFETERIA INCOME	722310	33,648,158		33,648,158
	c CONSULTING REVENUE	621500	14,354,205	14,354,205	
	d All other revenue		168,412	168,412	
	e Total. Add lines 11a–11d . . . . . ▶		107,013,778		
	12 Total revenue. See Instructions . . . . . ▶		12,712,230,744	9,257,534,345	33,641,171	453,274,813

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	1,175,622,735	1,175,622,735		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	16,510,188	16,510,188		
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	109,114,799		109,114,799	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	4,897,421,554	4,471,420,279	387,770,974	38,230,301
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	423,020,858	386,346,891	36,277,090	396,877
9 Other employee benefits	809,746,419	718,186,540	79,384,916	12,174,963
10 Payroll taxes	248,776,915	222,352,257	26,424,658	
11 Fees for services (non-employees)				
a Management				
b Legal	8,094,989	7,049,972	978,239	66,778
c Accounting	162,277	138,814	23,463	
d Lobbying	56,450	2,806	53,644	
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,051,310,772	935,719,718	107,933,603	7,657,451
12 Advertising and promotion	21,823,662	18,427,375	3,175,163	221,124
13 Office expenses	1,457,963,176	1,311,207,515	143,979,786	2,775,875
14 Information technology	40,644,159	35,988,868	4,629,518	25,773
15 Royalties . .				
16 Occupancy	379,467,348	340,593,929	36,347,817	2,525,602
17 Travel	35,843,852	31,968,461	3,359,883	515,508
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .				
19 Conferences, conventions, and meetings	9,404,812	8,625,486	718,927	60,399
20 Interest	146,726,850	126,708,063	20,018,787	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization . .	535,587,392	481,888,366	53,699,026	
23 Insurance . . .	86,000,750	78,275,379	7,725,371	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a OTHER RESEARCH EXPENSES	334,397,953	307,028,930	27,368,683	340
b PROGRAM SUPPORT/SUBSIDY	288,071,411	255,641,993	32,429,418	
c HSN/MEDICAID TAX	151,413,835	136,314,285	15,099,550	
d MISCELLANEOUS EXPENSES	93,503,302	70,316,610	22,795,964	390,728
e All other expenses	63,633,037	53,798,423	8,127,603	1,707,011
25 **Total functional expenses.** Add lines 1 through 24e	12,384,319,495	11,190,133,883	1,127,436,882	66,748,730
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		1	
	2	Savings and temporary cash investments	502,362,883	2	420,181,232
	3	Pledges and grants receivable, net	408,930,100	3	412,456,322
	4	Accounts receivable, net	1,011,175,285	4	1,093,243,145
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net	5,360,058	7	6,808,730
	8	Inventories for sale or use	55,076,079	8	54,223,457
	9	Prepaid expenses and deferred charges	55,328,323	9	51,051,779
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 9,500,846,489			
	b	Less accumulated depreciation — 10b: 4,169,213,176	5,217,014,779	10c	5,331,633,313
	11	Investments—publicly traded securities		11	
	12	Investments—other securities See Part IV, line 11	6,603,540,236	12	7,288,730,767
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets See Part IV, line 11	1,834,725,558	15	2,037,182,408
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	15,693,513,301	16	16,695,511,153
Liabilities	17	Accounts payable and accrued expenses	3,489,716,887	17	2,652,330,942
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	4,340,360,742	25	4,329,107,456
	26	**Total liabilities.** Add lines 17 through 25	7,830,077,629	26	6,981,438,398
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	5,325,311,553	27	6,846,713,269
	28	Temporarily restricted net assets	1,502,209,482	28	1,701,331,080
	29	Permanently restricted net assets	1,035,914,637	29	1,166,028,406
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	7,863,435,672	33	9,714,072,755
	34	Total liabilities and net assets/fund balances	15,693,513,301	34	16,695,511,153

Part XI Reconcilliation 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	12,712,230,744
2	Total expenses (must equal Part IX, column (A), line 25)	2	12,384,319,495
3	Revenue less expenses Subtract line 2 from line 1	3	327,911,249
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	7,863,435,672
5	Net unrealized gains (losses) on investments	5	844,182
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 in Schedule O)	9	1,521,881,652
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	9,714,072,755

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	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?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in 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?	3a	Yes	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990, Part III, Line 4a:

SEE SCHEDULE O

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DALE ADLER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						552,479	0	54,794
JOAN M ARCHER SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				250,449	0	55,379
STANLEY W ASHLEY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						603,956	0	66,742
MAUREEN BANKS SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				526,814	0	53,173
ROBERT L BARBIERI MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						526,580	0	61,223
JANIS P BELLACK PHD RN FAAN SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				419,299	0	50,660
JOAN M BENGTSON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						257,077	0	53,660
CHRISTINE A BLASKI MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						264,217	0	25,589
MICHAEL L BLUTE SR MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						946,177	0	57,495
SALLY MASON BOEMER SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				762,424	0	72,076

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GILES W BOLAND MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						595,743	0	78,978
CHRISTOPHER M BONO MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						489,375	0	57,446
O'NEIL BRITTON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						733,848	0	161,720
DAVID F BROWN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						755,967	0	59,869
CALVIN A BROWN III MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						337,870	0	52,470
DEBRA A BURKE MSN MBA RN SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						241,897	0	59,250
BRUCE A CHABNER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						256,258	0	53,566
ENNIO A CHIOCCA MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						1,827,804	0	62,063
CHRISTOPHER MARK COBURN SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				834,713	0	71,053
CHRISTOPHER M COLEY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						340,753	0	57,014

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
RAYMOND F CONWAY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						1,200	0	2,821
ERNESTO DASILVA MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						326,359	0	35,672
GERARD M DOHERTY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						868,409	0	58,057
TERENCE P DOORLY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						756,076	0	30,746
BRANDON E EARP MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						1,146,534	0	55,028
JEFFREY L ECKER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						756,345	0	58,104
JONATHAN M FALLON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						620,781	0	38,293
JOHN FANIKOS SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						208,176	0	52,620
THOMAS L FAZIO MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						681,901	0	30,908
CARLOS FERNANDEZ-DEL CASTILLO MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						887,953	0	62,745

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TIMOTHY G FERRIS MD SEE SCHEDULE O - O & T TITLE	0 00 50 00	X						0	881,421	60,057
CHRISTOPHER R FORTIER SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						245,539	0	53,697
LAWRENCE S FRIEDMAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						476,267	0	39,840
TERRY J GARFINKLE MD SEE SCHEDULE O - O & T TITLE	0 00 50 00	X						0	477,026	61,992
LINA GILLIES SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						86,924	0	14,364
DAVID F GITLIN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						259,105	0	54,077
RICHARD S GITOMER MD MBA SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						111,701	0	19,308
JEFFREY A GOLDEN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						909,180	0	70,400
TERRI E GORMAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						376,545	0	40,859
PETER A GRAPE MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						608,636	0	55,565

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
PETER T GREENSPAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						362,362	0	56,823
MICHAEL L GUSTAFSON MD MBA SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				533,815	0	51,458
DAPHNE ADELE HAAS-KOGANMD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						866,999	0	54,960
ROBERT HANDIN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						274,323	0	55,133
MITCHEL B HARRIS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						609,398	0	57,507
MARGOT K HARTMANN MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				346,950	0	22,323
THEODORE S HONG MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						779,794	0	56,870
TERRIE E INDER MBCHB SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						607,959	0	59,806
MICHAEL R JAFF DO SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				858,891	0	59,045
ALAN ANTHONY JAMES SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						462,615	0	44,586

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STEPHEN R JENNEY SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				302,810	0	59,610
MARK D JOHNSON MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						511,369	0	57,288
WILLIAM C JOHNSTON SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				544,189	0	58,605
JAMES D KANG MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						1,410,767	0	61,927
STEVEN E KAPFHAMMER SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				313,069	0	51,840
BARRETT KITCH MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						324,195	0	30,534
RONALD E KLEINMAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						663,973	0	57,800
ANNE KLIBANSKI MD SEE SCHEDULE O - O & T TITLE	0 00 50 00	X						0	902,041	56,986
THOMAS S KUPPER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						575,121	0	57,827
JAY LOEFFLER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						899,023	0	37,919

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOSEPH LOSCALZO MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				711,322	0	60,471
DAVID N LOUIS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						747,312	0	57,375
EVERETT T LYN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						499,054	0	55,531
THOMAS LYNCH JR MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				1,474,248	0	57,507
PETER K MARKELL SEE SCHEDULE O - O & T TITLE	0 00 50 00	X		X				0	1,877,294	615,792
NAVNEET MARWAHA MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						331,717	0	39,314
MAURY E MCGOUGH MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						650,722	0	66,281
GREGG S MEYER MD SEE SCHEDULE O - O & T TITLE	0 00 50 00	X		X				0	1,224,916	666,127
RAYMOND R MONTO MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						876,569	0	46,500
FRANCIS D MOORE MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						751,502	0	60,805

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ELIZABETH A MORT CALCAGNI MD MP SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						645,449	0	58,123
STUART B MUSHLIN MDFACP SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						210,939	0	48,714
ELIZABETH G NABEL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				3,332,922	0	316,162
ALBERT NAMIAS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						486,908	0	34,313
ANDREA NG MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						445,011	0	54,701
ROBERT G NORTON SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				1,171,769	0	64,620
NAWAL M NOUR MD MPH SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						471,599	0	58,099
JOHANNA M O'CONNOR MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						551,952	0	63,656
COURTNEY A O'NEILL SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						155,510	0	15,539
TIMOTHY PARSONS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						365,648	0	34,215

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GREGORY J PAULY SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				748,779	0	67,272
STEVEN B PESTKA MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						347,484	0	35,164
PIETER PIL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						645,288	0	45,348
NANCY S PITTMAN SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				150,871	0	3,653
DAVID S PLADZIEWICZ MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						582,481	0	31,484
BOHDAN POMAHAC MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						908,130	0	57,360
ALLYSON L PRESTON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						399,520	0	35,392
JAMES P RATHMELL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						708,994	0	58,581
DAVID W RATTNER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						869,788	0	62,468
SCOTT L RAUCH MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				720,844	0	69,960

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MITCHELL S REIN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						608,323	0	58,603
DAVID J ROBERTS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				280,691	0	31,755
ALLAN H ROPPER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						279,461	0	54,604
JERROLD F ROSENBAUM MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						517,939	0	56,667
MITCHELL H RUBENSTEIN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						553,639	0	55,488
MARC S RUBIN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						912,249	0	63,997
ROXANNE C RUPPEL SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						296,383	0	66,455
ALI SALIM MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						550,102	0	57,464
MARTIN A SAMUELS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						604,819	0	57,892
JOAN A SAPIR SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						528,063	0	71,296

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARK A SCHECHTER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						354,758	0	33,049
ELLEN W SEELY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						305,656	0	57,861
A ALAN SEMINE MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						72,055	0	23,324
STANTON K SHERNAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						584,449	0	59,763
DAVID SILBERSWEIG MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						649,694	0	58,682
ANEESH B SINGHAL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						434,090	0	55,702
PETER L SLAVIN MD MBA SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				3,258,414	0	371,201
ALLEN L SMITH MD MS SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				781,556	0	210,426
JOHN W STAKES III MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						233,518	0	41,987
LYNN MALLOY STOFER SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				693,891	0	120,663

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID E STORTO SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				1,647,681	0	71,958
THORALF M SUNDT MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						706,774	0	64,925
KHALID SYED MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						370,647	0	33,971
ELIZABETH S TAYLOR SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				253,479	0	46,665
DAVID F TORCHIANA MD SEE SCHEDULE O - O & T TITLE	0 00 50 00	X		X				0	4,649,309	74,538
MICHAEL J VANROOYEN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						664,917	0	57,924
TIMOTHY J WALSH SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				315,980	0	15,199
ANDREW L WARSHAW MD SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						1,098,054	0	62,003
JOSEPH L WOODIN SEE SCHEDULE O - O & T TITLE	50 00 0 00	X		X				243,560	0	29,402
ROSS D ZAFONTE DO SEE SCHEDULE O - O & T TITLE	50 00 0 00	X						607,175	0	138,875

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID ABELMAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RICHARD C BANE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM S BARKER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DAVID S BARLOW SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
JOAN M BARRETT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CAROLYN A BECKEDORFF SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JUDITH G BELASH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
SANFORD ADAMS BELDEN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
MARK R BELSKY MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
SIBEL BESSIM MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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JEANNE E BLAKE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EDWARD B BLOOM SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KENNETH RICHARD BORDEWIECK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JEANINE M BORTHWICK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KEVIN T BOTTOMLEY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DEBRA K BREDE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MARY R BROWN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
JOHN J BURKE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM R CAMP JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
JOHN C CANNISTRARO SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARC N CASPER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM REED CHISHOLM II SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EUGENE H CLAPP SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PHILLIP L CLAY PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JAMES P COHEN MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EARL M COLLIER JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
DHARMA E CORTES PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM MAURICE COWAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SUSAN C CRAMPTON SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MONICA S CURHAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KAREN DOLAN CURRAN MBA CFP SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RICHARD L CURTIS MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BRUCE DANZIGER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ROBERT A DANZIGER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JAMES L DEMETROULAKOS MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
LINDA DERENZO ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHARLES FRANK DESMOND SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOHN M DEUTCH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOANNE HONEY DIBONA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JAMES MANNING DONNELLY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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JOHN P DRISLANE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DEBORAH DUNSIRE MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM R ELFERS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KHAMA D ENNIS MD MPH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DEBORAH C ENOS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ARTHUR J EPSTEIN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
LAURIE FENLASON SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOANNE J FINCK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANNE M FINUCANE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOHN F FISH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JENNIFER COFER FLANAGAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
NANCY S FOSTER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BRUCE FREEDMAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
LAUREN A GEDDES WIRTH MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHARLES K GIFFORD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
THOMAS P GLYNN PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ARTHUR L GOLDSTEIN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BENJAMIN A GOMEZ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
THOMAS H GRAPE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ERWIN L GREENBERG SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SALLY GRIGGS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MAUREEN O HACKETT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
ALEXANDER A HANNENBERG MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOSEPH HARRINGTON MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BRENDA E HAYNES MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANNEMARIE HEATH CNM SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JENNIFER HELZBERG SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BRENT L HENRY ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00	X						0	904,802	64,590
KEVIN F HICKEY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
SUSAN J HOCKFIELD PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
RICHARD E HOLBROOK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
ALBERT A HOLMAN III SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
H ROBERT HORVITZ PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANN INGRAM SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DAVID W IVES SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RONALD J JACKSON SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MELISSA WEINER JANFAZA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DANIEL G JONES SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANNE KALTER MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JAMES L KAPLAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KAREN T KAPLAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
STEPHEN R KARP SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
STEVEN M KAYE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RICHARD M KELLEHER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHRISTOPHER J KELLY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JAMES KIRCHHOFFER MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANTHONY A KLEIN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WENDELL J KNOX SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ADAM M KOPPEL SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JONATHAN A KRAFT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOSHUA M KRAFT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ELIZA B LAKE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KEVIN LISTER LAKE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
RENE M LANDERS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EDWARD P LAWRENCE ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
JEFFREY M LEIDEN MD PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
TIMOTHY J LEPORE MD FACS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BEN S LEVITAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DAVID H LONG SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
STACEY LUCCHINO SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STANLEY J LUKOWSKI SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
HEATHER COLMORE MACK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
PAULINE MARNEY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JULIE A MARRIOTT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CARL J MARTIGNETTI SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
J BRIAN MCCARTHY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
TERENCE A MCGINNIS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
KATINA MCKINNEY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CAROL C MCMULLEN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOSEPH C MCNAY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ANN MERRIFIELD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EDWARD F MILLER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BARRY MILLS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CATHY E MINEHAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
LAURA BARKER MORSE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MICHAEL J MUEHE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PHILIP A NARDONE JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EMILY A NEILL SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
NITIN NOHRIA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOHN N NUNNELLY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARK NUNNELLY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MICHAEL F O'CONNELL ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ROBERT L PAGLIA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MARIE-LOUISE PALANDJIAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KRISHNA PALEPU SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM M PARIZEAU SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DIANE B PATRICK ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RICHARD A PENN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ADELENE Q PERKINS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DONALD M PERRIN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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H BRADLEE PERRY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SUSAN P PETERS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PATRICIA P PETRAGLIA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ROBERT W PIERCE JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MATTHEW MARTIN PITONIAK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JENNIFER L PORTER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MARY G PUMA SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PHILLIP T RAGON SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RONALD H RAPPAPORT ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
EARLE A RAY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0

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ARTHUR I READE JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PAMELA D A REEVE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
NANCY R REEVES SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
LAURA REYNOLDS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
AUGUSTE E RIMPEL JR PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CARMICHAEL S ROBERTS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MICHAEL AF ROBERTS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WILLIAM J ROMAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
HENRY W ROSENBERG SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOSEPH F RYAN ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MELANIE R SABELHAUS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ELISABETH SCHADAE PERCELAY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOHN H SCHAEFER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ERIC D SCHLAGER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SCOTT A SCHOEN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
SCOTT SCHUSTER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
MARK SCHWARTZ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
J DALE SHERRATT SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JEFFREY N SHRIBMAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RICKEL SHUSTER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
RICHARD N SILVERMAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SHIRLEY SINGLETON SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
RONALD L SKATES SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
BARRY R SLOANE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
LAUREN A SMITH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SHARON L SMITH SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JONATHAN SNIDER MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
W LLOYD SNYDER III SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOSIAH A SPAULDING JR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WARREN J SPECTOR SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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PAULA NESS SPEERS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
SCOTT M SPERLING SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
GARY A SPIESS ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHARLES PHILIP STAELIN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
KATHLEEN M STANSKY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ANNE E STEER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
DAVID PIERPONT STEVENS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ELLEN S STORY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
KUMBLE R SUBBASWAMY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
STEPHEN G SULLIVAN SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TIMOTHY D SWEET SEE SCHEDULE O - O & T TITLE	1 00 0 00	X		X				0	0	0
JAMES D TAICLET SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
WALTER TELLER ESQ SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
HENRI A TERMEER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JEFFREY S THOMAS SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ALEXANDER L THORNDIKE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CAROL A VALLONE SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
JOAN M VITELLO-CICCIU RN PHD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CATHERINE S WARD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
PETER WEITZMAN MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0

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BENAREE P WILEY SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
ELIZABETH WINSHIP SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
R JOHN WRIGHT MD SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHARLES F WU SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
GWILL YORK SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
GEOFFREY MARC ZUCKER SEE SCHEDULE O - O & T TITLE	1 00 0 00	X						0	0	0
CHARLES E ADAMS SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				218,007	0	52,054
SARAH ARNHOLZ ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	243,605	61,605
MELISSA P BRENNAN ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	144,792	49,478
EFFIE J CHAN ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	191,735	36,723

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JULIE C CHATTOPADHYAY ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	186,949	44,927
DAVID P CONNOLLY SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				327,761	0	67,027
PAUL G CUSHING ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	276,150	70,461
JEFFREY P DION SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				333,174	0	69,186
CHRISTOPHER DUNLEAVY SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				595,695	0	7,241
STEVEN A GILGEN SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				71,767	0	245
KEVIN T GIORDANO SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				250,081	0	50,072
MICHELE L GOUGEON MSC SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				410,601	0	69,462
ROSEMARY B GUILTINAN ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	126,012	14,713
GERARD F HADLEY SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				253,832	0	29,955

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JAMES L HEFFERNAN SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				633,010	0	74,406
JOHN R HIGHAM ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	303,034	64,642
LAURA STEPHENS KHOSHBIN ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	196,513	28,872
KATHERINE M KNEELAND ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	284,939	42,137
DAVID A LAGASSE SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				358,091	0	65,760
LAURIE LAMOUREUX SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				292,457	0	20,995
LAUREN B LELE SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				117,687	0	30,388
JOANNE MARQUSEE SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				531,363	0	32,900
ELLEN MOLONEY SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				537,746	0	50,580
GILBERT H MUDGE JR MD SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	572,197	57,124

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EDWARD OLIVIER SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				266,488	0	39,121
ANDREA G RE SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	149,673	22,668
MARY E SHAUGHNESSY SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				383,190	0	59,954
REYNOLD G SPADONI SEE SCHEDULE O - O & T TITLE	50 00 0 00			X				454,080	0	67,149
TRACY A SYKES ESQ SEE SCHEDULE O - O & T TITLE	0 00 50 00			X				0	203,783	48,002
DAVID JOSEPH BURKE SEE SCHEDULE O - O & T TITLE	1 00 0 00			X				0	0	0
PAUL ANDERSON MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			594,066	0	60,138
KATRINA ARMSTRONG MD MSCE SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			887,923	0	59,960
KATHERINE BECHTOLD MHA BSN RN SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			315,761	0	25,336
ARTHUR J BOWES SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			303,261	0	53,915

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KENNETH CHISHOLM SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			249,918	0	51,808
SUSAN DEMPSEY SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			319,637	0	62,912
KEREN DIAMOND SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			255,799	0	49,671
MARGARET M DUGGAN MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			565,155	0	60,550
TIMOTHY E FOSTER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			872,480	0	35,052
JOANNE M FUCILE SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			232,522	0	39,533
MARY JO GAGNON SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			270,986	0	47,355
JOSEPH GOLD MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			431,176	0	69,739
GEORGE GOUGIAN SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			159,855	0	35,737
JUDY HAYES SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			311,324	0	49,140

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
PAULA M HEREAU SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			185,200	0	38,565
MICHAEL J HESSION MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			355,796	0	56,366
JEANETTE IVES ERICKSON RN DNP SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			665,444	0	56,731
LOUIS JENIS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			958,050	0	62,374
PARDON R KENNEY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			510,212	0	58,179
CHRISTOPHER J KWOLEK MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			900,812	0	65,042
JANET LARSON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			392,186	0	35,592
KEITH D LILLEMOE MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			940,764	0	62,500
EDWARD LISTON-KRAFT PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			259,428	0	39,044
ROBERT T MCCALL SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			219,719	0	49,859

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CHERYL MERRILL RN MSN NEA- SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			302,947	0	38,260
STEPHANIE N NADOLNY SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			179,359	0	28,030
BRITAIN W NICHOLSON MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			844,139	0	56,995
DOST ONGUR MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			256,966	0	60,040
CHRISTINE REILLY SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			159,207	0	8,589
A KIM SAAL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			540,040	0	37,402
JOHN SARRO SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			352,821	0	27,377
SCOTT L SCHISSEL MD PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			311,972	0	54,609
NANCY D SCHMIDT SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			291,332	0	60,555
ANTHONY J SCIBELLI MS MBA SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			288,978	0	24,797

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JULIA R SINCLAIR MBA SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			464,500	0	70,578
ALAMJIT S VIRK MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			297,392	0	36,562
RON M WALLS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			4,991,749	0	69,099
ROBERT D WELCH SEE SCHEDULE O - O & T TITLE	50 00 0 00				X			203,502	0	54,630
WILLIAM G AUSTEN JR MD SEE SCHEDULE O - O & T TITLE	50 00 0 00					X		1,529,508	0	60,871
CHRISTOPHER W DIGIOVANNI MD SEE SCHEDULE O - O & T TITLE	50 00					X		1,523,320	0	59,288
THOMAS F HOLOVACS MD SEE SCHEDULE O - O & T TITLE	50 00 0 00					X		1,788,775	0	58,928
AMAN B PATEL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00					X		1,645,047	0	62,659
JON P WARNER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00					X		1,988,658	0	58,927
DANIEL J GROSS SEE SCHEDULE O - O & T TITLE	0 00 50 00						X	0	480,938	69,129

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MICHAEL S JELLINEK MD SEE SCHEDULE O - O & T TITLE	0 00 50 00						X	0	292,309	0
KERRY R WATSON SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	664,223	0	0
THOMAS H ARETZ MD SEE SCHEDULE O - O & T TITLE	0 00 50 00						X	0	515,858	61,303
DENNIS AUSIELLO MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	420,188	0	56,833
BARBARA E BIERER MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	345,226	0	57,265
STEVEN D BROWELL MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	441,264	0	31,807
MAUREEN N CHESLEY SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	189,761	0	45,343
MARY BETH DIFILIPPO SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	201,161	0	38,986
GARY W GARBERG SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	173,303	0	41,934
MARK NOVOTNY MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	437,843	0	33,396

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
HARRY W ORF PHD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	663,208	0	56,934
SHEILA K PARTRIDGE MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	861,171	0	36,996
BEATRICE THIBEDEAU SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	287,080	0	0
JEFFREY R ZACK MD SEE SCHEDULE O - O & T TITLE	50 00 0 00						X	395,021	0	41,826

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SCHEDULE A (Form 990 or 990EZ)

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.**

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

f Enter the number of supported organizations 10

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
See Additional Data Table						
Total 10					0	0

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2015 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2016.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2015.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2015.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2016** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2015** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2016.** 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—2015.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

- a ☐ The organization satisfied the Activities Test Complete **line 2** below
- b ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- c ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

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

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

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov 20, 1970 **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)	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI)			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by 035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

Section C - Distributable Amount

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

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

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2016**	**(iii) Distributable Amount for 2016**
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2017.** Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013.			
c Excess from 2014.			
d Excess from 2015.			
e Excess from 2016.			

Part VI **Supplemental Information.**

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

Facts And Circumstances Test

990 Schedule A, Supplemental Information

Return Reference	Explanation
ORGANIZATIONS SUPPORTED	ENTITY PARTNERS MEDICAL INTERNATIONAL, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZAT ION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) O RGANIZED IN THE US YES ENTITY THE MGH HEALTH SERVICES CORPORATION (I) NAME OF SUPPORTED ORGANIZATION THE MASSACHUSETTS GENERAL HOSPITAL (II) EIN 04-1564655 (III) TYPE OF ORGANI ZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY NANTUCKET COTTAGE HOSPITAL FOUNDA TION, INC (I) NAME OF SUPPORTED ORGANIZATION NANTUCKET COTTAGE HOSPITAL (II) EIN 04-210 3823 (III) TYPE OF ORGANIZATION 03 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY PARTNERS MEDICAL INTERNATIONAL, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTE M, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GO VERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY MCLEAN HEALTHCARE, INC (I)NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTH CARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LI STED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZ ED IN THE US YES ENTITY BIOSCIENCES RESEARCH FOUNDATION, INC (I) NAME OF SUPPORTED ORGA NIZATION BRIGHAM AND WOMEN'S HEALTH CARE, INC (II) EIN 04-2921338 (III) TYPE OF ORGANIZ ATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY BWH RESEARCH, INC (I) NAME OF SUP PORTED ORGANIZATION BRIGHAM AND WOMEN'S HEALTH CARE, INC (II) EIN 04-2921338 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGAN IZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY BRIGHAM PATHOLOGY RESEA RCH AND EDUCATION FOUNDATION, INC (I) NAME OF SUPPORTED ORGANIZATION BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC (II) EIN 04-3466314 (III) TYPE OF ORGANIZATION 09 (IV) OR GANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY BRIGHAM MEDICAL RESEARCH AND EDUCATION FOUNDATION, INC (I) NAME OF SUPPORTED ORGANIZATION BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC (II) EIN 04-3466314 (III) TYPE OF ORGANIZATION 09 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY PARTNERS CONTINUING CARE, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALT HCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION L ISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANI ZED IN THE US YES ENTITY NOR

990 Schedule A, Supplemental Information

Return Reference	Explanation
ORGANIZATIONS SUPPORTED	TH SHORE PHYSICIANS GROUP, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SY STEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN T HE US YES ENTITY NEWTON-WELLESLEY HEALTH CARE SYSTEM, INC (I) NAME OF SUPPORTED ORGANIZ ATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 0 7 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUP PORT YES (VI) ORGANIZED IN THE US YES ENTITY NEWTON-WELLESLEY AMBULATORY SERVICES, INC (I) NAME OF SUPPORTED ORGANIZATION NEWTON-WELLESLEY HOSPITAL (II) EIN 04-2103611 (III) T YPE OF ORGANIZATION 03 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY OR GANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY NSMC HEALTHCARE, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-323003 5 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY COOLEY DICK INSON HEALTH CARE CORPORATION (I) NAME OF SUPPORTED ORGANIZATION COOLEY DICKINSON HOSPITA L, INC (II) EIN 22-2617175 (III) TYPE OF ORGANIZATION 03 (IV) ORGANIZATION LISTED IN GO VERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES

Additional Data

Software ID:
Software Version:
EIN: 90-0656139
Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990, Sch A, Part I, Line 12g - Provide the following information about the supported organization(s).

(i)Name of supported organization	(ii)EIN	(iii) Type of organization (described on lines 1- 9 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) PARTNERS HEALTHCARE SYSTEM INC	043230035	3	Yes		0	0
(A) PARTNERS HEALTHCARE SYSTEM INC	043230035	3	Yes		0	0
(A) THE MASSACHUSETTS GENERAL HOSPITAL	041564655	3	Yes		0	0
(A) THE MASSACHUSETTS GENERAL HOSPITAL	041564655	3	Yes		0	0
(B) NANTUCKET COTTAGE HOSPITAL INC	042103823	3	Yes		0	0
(B) NANTUCKET COTTAGE HOSPITAL INC	042103823	3	Yes		0	0
(C) BRIGHAM AND WOMEN'S HEALTH CARE INC	042921338	3	Yes		0	0
(C) BRIGHAM AND WOMEN'S HEALTH CARE INC	042921338	3	Yes		0	0
(D) BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	043466314	3	Yes		0	0
(D) BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	043466314	3	Yes		0	0
(E) THE BRIGHAM AND WOMEN'S HOSPITAL INC	042312909	3	Yes		0	0
(E) THE BRIGHAM AND WOMEN'S HOSPITAL INC	042312909	3	Yes		0	0
(F) BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC	042768256	3	Yes		0	0
(F) BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC	042768256	3	Yes		0	0
(G) NEWTON-WELLESLEY HOSPITAL INC	042103611	3	Yes		0	0
(G) NEWTON-WELLESLEY HOSPITAL INC	042103611	3	Yes		0	0
(H) CD PRACTICE ASSOCIATES INC	043194547	3	Yes		0	0
(H) CD PRACTICE ASSOCIATES INC	043194547	3	Yes		0	0
(I) VNA & HOSPICE OF COOLEY DICKINSON INC	042104788	3	Yes		0	0
(I) VNA & HOSPICE OF COOLEY DICKINSON INC	042104788	3	Yes		0	0

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

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If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization	Employer identification number
PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN	90-0656139

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV
2 Political expenditures ▶ $
3 Volunteer hours

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-
2				
3				
4				
5				
6				

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
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-		

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

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2013	**(b)** 2014	**(c)** 2015	**(d)** 2016	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?	Yes		
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		415,444
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total Add lines 1c through 1i			415,444
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

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

Return Reference	Explanation
LOBBYING EXPENSES	THE CORPORATION MAY ON OCCASION REVIEW PROPOSED LEGISLATION FOR THE PURPOSE OF DETERMINING THE EFFECT UPON ITS TAX-EXEMPT PURPOSES THE CORPORATION MAY ON OCCASION ALSO APPEAR BEFORE A LEGISLATIVE COMMITTEE, CONFER WITH LEGISLATORS OR OTHERWISE ATTEMPT TO INFLUENCE LEGISLATION HOWEVER, IT WILL NOT PARTICIPATE, IN ANY WAY, IN POLITICAL CAMPAIGNS THE CORPORATION'S INVOLVEMENT IN LEGISLATIVE ACTIVITIES CONSTITUTES AN INSUBSTANTIAL PART OF ITS ACTIVITIES IN ADDITION, NELSON MULLINS RILEY & SCARBOROUGH LLP ("NELSON MULLINS") IS PROVIDING STRATEGIC COUNSELING AND PUBLIC POLICY REPRESENTATION TO THE HOME BASE PROGRAM ON A PRO BONO BASIS NELSON MULLINS WILL ADVOCATE FOR THE HOME BASE PROGRAM BEFORE SELECTED MEMBERS OF CONGRESS AS WELL AS HELPING THE HOME BASE PROGRAM BUILD RELATIONSHIPS IN THE DEFENSE INDUSTRY THE MAJORITY OF THE FUNDS EXPENDED FOR LOBBYING ACTIVITIES WERE FOR PAYMENTS MADE TO THE MASSACHUSETTS HOSPITAL ASSOCIATION, WHICH DETERMINED THAT DURING FISCAL YEAR 2017 18 94% OF ITS MEMBERSHIP DUES WERE USED FOR LOBBYING PURPOSES

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or education) ☐ Preservation of an historically important land area
☐ Protection of natural habitat ☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

		Held at the End of the Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

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

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

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	3,023,915,930	1,980,532,089	2,017,884,170	1,879,867,173	1,743,211,839
b Contributions	133,195,286	108,124,301	117,220,932	63,279,981	37,627,277
c Net investment earnings, gains, and losses	405,602,632	137,625,554	-71,620,457	165,579,197	173,355,610
d Grants or scholarships					
e Other expenditures for facilities and programs	117,629,018	91,920,278	82,952,557	90,842,181	77,206,484
f Administrative expenses	0	120,543			
g End of year balance	3,445,084,830	2,134,241,123	1,980,532,088	2,017,884,170	1,876,988,242

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

- a Board designated or quasi-endowment ▶ 33 000 %
- b Permanent endowment ▶ 67 000 %
- c Temporarily restricted endowment ▶ 0 %

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c)Accumulated depreciation	(d)Book value
1a Land	19,013,253	140,451,902		159,465,155
b Buildings	10,415,160	6,458,638,274	3,188,972,146	3,280,081,288
c Leasehold improvements		283,275,778	157,894,534	125,381,244
d Equipment		2,229,161,007	809,282,665	1,419,878,342
e Other		359,891,115	13,063,831	346,827,284
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				5,331,633,313

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) INV IN PARTNERS POOLED ACCTS	6,900,764,293	F
(B) INVESTED CASH EQUIVALENTS	63,494,868	F
(C) EQUITIES	230,398,209	F
(D) US GOVT & OTHER FIXED INC SEC	63,978,997	F
(E) PRIVATE PARTNERSHIPS & OTHER	30,094,400	F
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶	7,288,730,767	

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) DUE FROM AFFILIATES	231,201,366
(2) INV IN NET ASSETS OF AFFIL	1,183,554,048
(3) OTHER ASSETS	564,662,872
(4) INTER-ENTITY NOTE RECEIVABLE	57,764,122
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	2,037,182,408

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	
DUE TO AFFILIATES	413,991,436
PARTNERS HEALTHCARE SYSTEM CAP	3,607,655,296
DUE TO 3RD PARTY PAYORS	7,914,155
CURRENT PORTION OF SETTLEMENT	34,249,913
UNEXPENDED FUNDS ON RESEARCH GRANTS	265,296,656
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	4,329,107,456

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Supplemental Information

Return Reference	Explanation
COLLECTIONS OF ART, HISTORICAL TREASURES OR OTHER SIMILAR	ASSETS THE ORGANIZATION MAINTAINS COLLECTIONS OF ART, HISTORICAL TREASURES OR OTHER SIMIL AR ASSETS THE COLLECTIONS ARE COMPRISED PRINCIPALLY OF MEDICAL ARTIFACTS AND ANTIQUITIES INCLUDING SURGICAL EQUIPMENT THE COLLECTIONS ALSO INCLUDE WORKS OF ART INCLUDING SCULPTUR ES, PICTURES, PORTRAITS AND PLAQUES THESE ITEMS WERE OBTAINED BY THE ORGANIZATION OVER MA NY YEARS PRIMARILY THROUGH DONATIONS THE VALUE OF THESE ITEMS IS NOT CONSIDERED MATERIAL TO THE FINANCIAL STATEMENTS OF THE ORGANIZATION

Supplemental Information

Return Reference	Explanation
COLLECTIONS OF ART, HISTORICAL TREASURES OR OTHER SIMILAR	ASSETS THE ORGANIZATION'S COLLECTION EXPLORES THE EVOLUTION OF HEALTHCARE AND MEDICINE AT MASSACHUSETTS GENERAL HOSPITAL (MGH) EXHIBITS AND PROGRAMS ALLOW VISITORS TO FOLLOW MGH' S HISTORY OF RESEARCH, PATIENT CARE AND MEDICAL DISCOVERY ACROSS THREE CENTURIES AND ARE I N FURTHERANCE OF THE ORGANIZATIONS TEACHING MISSION

Supplemental Information

Return Reference	Explanation
INTENDED USE OF ENDOWMENTS	THE ENDOWMENT FUNDS OF PARTNERS HEALTHCARE SYSTEM, INC AND AFFILIATES ARE USED IN FURTHER ANCE OF ITS TAX-EXEMPT MISSIONS OF PATIENT CARE, RESEARCH AND EDUCATION

Supplemental Information

Return Reference	Explanation
FIN 48(ASC 740) FOOTNOTE	THERE IS NO FIN 48 FOOTNOTE DISCLOSURE IN THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF PARTNERS HEALTHCARE SYSTEM, INC AND AFFILIATES

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.

► Attach to Form 990. ► See separate instructions.

► Information about Schedule F (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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

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

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

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) See Add'l Data					
(2)					
(3)					
(4)					
(5)					
3a Sub-total	0	1			115,501,595
b Total from continuation sheets to Part I	0	41			28,973,347
c **Totals** (add lines 3a and 3b)	0	42			144,474,942

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

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

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

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

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

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

Part IV Foreign Forms

1	Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes,"the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☑ Yes	☐ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)*	☑ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*	☑ Yes	☐ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☑ Yes	☐ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713)*	☑ Yes	☐ No

Part V **Supplemental Information**

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

Return Reference	Explanation
ACCOUNTING METHOD	THE ORGANIZATION USES THE BOOK VALUE METHOD TO REPORT FOREIGN EXPENDITURES TO BE CONSISTENT WITH THE REPORTING USED FOR THE FINANCIAL STATEMENTS

Return Reference	Explanation
MONITORING OF FUNDS	RESEARCH GRANTS PROVIDED TO FOREIGN ORGANIZATIONS IN THE FORM OF A STANDARD SUBCONTRACT AGREEMENT CONVEY THE AWARD TERMS AND CONDITIONS INCLUDING REPORTING REQUIREMENTS OF THE ORIGINATING FEDERAL, FOUNDATION OR INDUSTRY SPONSOR AS SUCH, THE FOREIGN ORGANIZATION IS REQUIRED TO FULLY COMPLY WITH THE TERMS OF THE SUBCONTRACT AS A CONDITION OF INITIAL AND ON-GOING PARTICIPATION IN THE RESEARCH PROGRAM NEW FOREIGN ORGANIZATIONS ARE REQUIRED TO DEMONSTRATE ADMINISTRATIVE, FINANCIAL, AND PROGRAMMATIC CAPACITY TO MANAGE SUBCONTRACT TERMS PRIOR TO EXECUTING AGREEMENTS PARTNERS HEALTHCARE ROUTINELY MONITORS SUBCONTRACTS ISSUED TO FOREIGN ORGANIZATIONS AND CONVENES AN ANNUAL MEETING TO REPORT RESULTS TO PARTNERS HEALTHCARE RESEARCH MANAGEMENT AND COMPLIANCE LEADERSHIP

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
CENTRAL AMERICA & THE CARRIBEAN		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	362,620
CENTRAL AMERICA & THE CARRIBEAN		0	PROGRAM SERVICES	JOINTLY OWNED FOR INS	100,771,780
EAST ASIA AND THE PACIFIC		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	1,676,152

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
EAST ASIA AND THE PACIFIC		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	629,140
EUROPE		1	PROGRAM SERVICES	PAT CARE, RES & EDUC	7,046,448
EUROPE		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	4,797,169

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
MIDDLE EAST AND NORTH AFRICA		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	193,241
MIDDLE EAST AND NORTH AFRICA		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	25,045
NORTH AMERICA		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	7,580,942

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
NORTH AMERICA		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	278,981
RUSSIA AND NEWLY INDEPENDENT STATES		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	39,158
RUSSIA AND NEWLY INDEPENDENT STATES		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	6,280

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
SOUTH AMERICA		0	PROGRAM SERVICES	PAT CARE, RES & EDUC	1,631,801
SOUTH AMERICA		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	1,265,767
SOUTH ASIA		2	PROGRAM SERVICES	PAT CARE, RES & EDUC	1,814,883

Form 990 Schedule F Part I - Activities Outside The United States

(a) Region	(b) Number of offices in the region	(c) Number of employees or agents in region	(d) Activities conducted in region (by type) (i e , fundraising, program services, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for region
SOUTH ASIA		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	948,345
SUB-SAHARAN AFRICA		39	PROGRAM SERVICES	PAT CARE, RES & EDUC	6,847,730
SUB-SAHARAN AFRICA		0	PROGRAM SERVICES	INTERNATIONAL GRANTS	8,559,460

Form 990 Schedule F Part II - Grants or Entities Outside The United States

(a) Name of organization	(b) IRS code section and EIN(if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
		EAST ASIA AND THE PACIFIC	RESEARCH	527,073	WIRE TRANSFER			
		EUROPE	RESEARCH	4,712,933	WIRE TRANSFER			

Form 990 Schedule F Part II - Grants or Entities Outside The United States

(a) Name of organization	(b) IRS code section and EIN(if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
		MIDDLE EAST AND NORTH AFRICA	RESEARCH	25,045	WIRE TRANSFER			
		NORTH AMERICA	RESEARCH	242,181	WIRE TRANSFER			

Form 990 Schedule F Part II - Grants or Entities Outside The United States

(a) Name of organization	(b) IRS code section and EIN(if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
		SOUTH AMERICA	RESEARCH	1,240,167	WIRE TRANSFER			
		SOUTH ASIA	RESEARCH	948,345	WIRE TRANSFER			

Form 990 Schedule F Part II - Grants or Entities Outside The United States

(a) Name of organization	(b) IRS code section and EIN(if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
		SUB-SAHARAN AFRICA	RESEARCH	8,559,460	WIRE TRANSFER			

Form 990 Schedule F Part III - Grants and Assistance to Individuals Outside The U S

(a) Type of grant or assistance	(b) Region	(c)Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
MEDICAL RESEARCH	EAST ASIA AND THE PACIFIC - AUSTRALIA, BRUNEI, BURMA, CAMBODIA,	6	102,068	WIRE TRANSFER			
MEDICAL RESEARCH	EUROPE (INCLUDING ICELAND & GREENLAND) - ALBANIA, ANDORRA, AUSTRIA, BELGIU	14	84,236	WIRE TRANSFER			

Form 990 Schedule F Part III - Grants and Assistance to Individuals Outside The U S

(a) Type of grant or assistance	(b) Region	(c)Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
MEDICAL RESEARCH	NORTH AMERICA - CANADA AND MEXICO, BUT NOT THE UNITED STATES	3	36,800	WIRE TRANSFER			
MEDICAL RESEARCH	RUSSIA AND NEIGHBORING STATES	2	6,280	WIRE TRANSFER			

Form 990 Schedule F Part III - Grants and Assistance to Individuals Outside The U S

(a) Type of grant or assistance	(b) Region	(c)Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
MEDICAL RESEARCH	SOUTH AMERICA - ARGENTINA, BOLIVIA, BRAZIL, CHILE, COLUMBIA, ECUADOR,	3	25,600	WIRE TRANSFER			

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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

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

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

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

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

	(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
1	AMY DOHERTY EVENTS 100 CAMBRIDGE ST BOSTON, MA 02114	FUNDRAISING STRATEGY		No	44,530	33,750	10,780
2	MARTS & LUNDY 1200 WALL ST W LYNDHURST, NJ 07071	FUNDRAISING STRATEGY		No	0	75,000	-75,000
3	MARTS & LUNDY 1200 WALL ST W LYNDHURST, NJ 07071	FUNDRAISING STRATEGY		No	0	95,500	-95,500
4	CCS CONSULTING SERVICES 155 FEDERAL STREET SUITE 306 BOSTON, MA 02110	FUNDRAISING STRATEGY		No	0	67,500	-67,500
5							
6							
7							
8							
9							
10							
Total				▶	44,530	271,750	-227,220

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

AK, AL, AR, CA, CO, CT, DC, FL, GA, HI, IL, KS, KY, MA, MD, MI, MN, MS, NC, ND, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV, MT, WI

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

Revenue		(a) Event #1 2017 POPS (event type)	(b) Event #2 2016 MGH GALA (event type)	(c) Other events 239 (total number)	(d) Total events (add col (a) through col (c))
	1 Gross receipts	3,661,959	2,530,318	24,969,114	31,161,391
	2 Less Contributions	3,257,499	2,304,278	23,638,001	29,199,778
	3 Gross income (line 1 minus line 2)	404,460	226,040	1,331,113	1,961,613
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	25,000		174,569	199,569
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	1,427,630		2,632,835	4,060,465
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				4,260,034
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				-2,298,421

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

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

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

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

b If "No," explain _____

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

b If "Yes," explain _____

11 Does the organization conduct gaming activities with nonmembers? ☐ Yes ☐ No

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

13 Indicate the percentage of gaming activity conducted in

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶

----

16 Gaming manager information

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

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

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

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

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			103,940,216	32,814,420	71,125,796	0 570 %
b Medicaid (from Worksheet 3, column a)			1,179,412,727	742,192,483	437,220,244	3 530 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			1,283,352,943	775,006,903	508,346,040	4 100 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			48,200,178	6,837,856	41,362,322	0 330 %
f Health professions education (from Worksheet 5)			221,576,171	64,706,030	156,870,141	1 270 %
g Subsidized health services (from Worksheet 6)			10,000,000		10,000,000	0 080 %
h Research (from Worksheet 7)			1,641,111,128	1,404,192,090	236,919,038	1 910 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,135,301		2,135,301	0 020 %
j **Total.** Other Benefits			1,923,022,778	1,475,735,976	447,286,802	3 610 %
k **Total.** Add lines 7d and 7j			3,206,375,721	2,250,742,879	955,632,842	7 710 %

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 Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	46,066,293		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	1,936,894,590
6	Enter Medicare allowable costs of care relating to payments on line 5	6	2,550,295,308
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-613,400,718
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☑ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
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? **13**

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
See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group THE GENERAL HOSPITAL CORPORATION

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

THE GENERAL HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

THE GENERAL HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THE GENERAL HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

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

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 THE BRIGHAM AND WOMEN'S HOSPITAL INC

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

THE BRIGHAM AND WOMEN'S HOSPITAL INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

THE BRIGHAM AND WOMEN'S HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THE BRIGHAM AND WOMEN'S HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

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 NORTH SHORE MEDICAL CENTER INC

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 3

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
a			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

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

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 NEWTON-WELLESLEY HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
a			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

NEWTON-WELLESLEY HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

NEWTON-WELLESLEY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

NEWTON-WELLESLEY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 5

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑	Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b ☑	Income level other than FPG (describe in Section C)			
c ☑	Asset level			
d ☑	Medical indigency			
e ☑	Insurance status			
f ☑	Underinsurance discount			
g ☑	Residency			
h ☐	Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15	Explained the method for applying for financial assistance?	**15**	Yes	
	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 ☑	Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑	Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑	Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐	Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	**16**	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑	The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☑	The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c ☑	A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d ☑	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑	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 ☑	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 ☑	Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐	Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 THE MCLEAN HOSPITAL CORPORATION

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 6

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

THE MCLEAN HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

THE MCLEAN HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THE MCLEAN HOSPITAL CORPORATION

Name of hospital facility or letter of facility reporting group

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

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 THE SPAULDING REHABILITATION HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 7

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**		No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

THE SPAULDING REHABILITATION HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b ☑ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☑ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

THE SPAULDING REHABILITATION HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THE SPAULDING REHABILITATION HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 REHABILITATION HOSPITAL OF THE CAPE

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 8

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

REHABILITATION HOSPITAL OF THE CAPE

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

REHABILITATION HOSPITAL OF THE CAPE

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

REHABILITATION HOSPITAL OF THE CAPE

Name of hospital facility or letter of facility reporting group

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

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 SPAULDING HOSPITAL - CAMBRIDGE INC

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 9

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**		No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

SPAULDING HOSPITAL - CAMBRIDGE INC

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b ☑ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☑ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

SPAULDING HOSPITAL - CAMBRIDGE INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

SPAULDING HOSPITAL - CAMBRIDGE INC

Name of hospital facility or letter of facility reporting group

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

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 NANTUCKET COTTAGE HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 10

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**		No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

NANTUCKET COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b ☑ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☑ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

NANTUCKET COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

NANTUCKET COTTAGE HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 MARTHA'S VINEYARD HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 11

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

MARTHA'S VINEYARD HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b ☑ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☑ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

MARTHA'S VINEYARD HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

MARTHA'S VINEYARD HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 NORTH SHORE MEDICAL CENTER INC

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 12

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
a			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

NORTH SHORE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

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

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 COOLEY DICKINSON HOSPITAL INC

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 13

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

COOLEY DICKINSON HOSPITAL INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
b	☑ The FAP application form was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
c	☑ A plain language summary of the FAP was widely available on a website (list url) SEE SCHEDULE H SUPPLEMENTAL INFO			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

COOLEY DICKINSON HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

COOLEY DICKINSON HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

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, 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.

Form and Line Reference	Explanation
See Add'l Data	

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? **81**

Name and address	Type of Facility (describe)
1 See Additional Data Table	
2	
3	
4	
5	
6	
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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H - PART I - SUPPLEMENTAL INFORMATION	PART I, LINE 3C PARTNERS HEALTHCARE AFFILIATED ENTITIES ARE TAX-EXEMPT ENTITIES, WHOSE UNDERLYING MISSION IS TO PROVIDE SERVICES TO ALL IN NEED OF MEDICAL CARE PATIENTS REQUIRING URGENT OR EMERGENT SERVICES SHALL NOT BE DENIED THOSE SERVICES BASED ON THEIR INABILITY TO PAY PARTNERS POST-ACUTE CARE AND BEHAVIORAL HEALTH HOSPITALS WILL WORK WITH PATIENTS WHO HAVE A DEMONSTRATED FINANCIAL NEED TO PROVIDE FINANCIAL ASSISTANCE TO THOSE PATIENTS SEEKING CARE IN THOSE SETTINGS
PART I, LINE 7	THE AMOUNTS REPORTED ON THE CHARITY CARE AND OTHER COMMUNITY BENEFITS TABLE ARE CALCULATED USING THE BEST AVAILABLE DATA USING A COST ACCOUNTING SYSTEM OR A COST TO CHARGE RATIO IN MOST CASES, A COST ACCOUNTING SYSTEM WAS USED AND THE SYSTEM ADDRESSES ALL PATIENT SEGMENTS AND DIRECTLY ASSIGNS COSTS TO INDIVIDUAL SERVICES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II COMMUNITY BUILDING ACTIVITIES	PARTNERS' HOSPITALS ARE WORKING TO DEVELOP A PROCESS TO QUANTIFY THE EXPENDITURES ASSOCIATED WITH THE VARIOUS COMMUNITY BUILDING ACTIVITIES TO BE REPORTED IN PART II BELOW IS A DESCRIPTION OF SOME OF THESE ACTIVITIES THAT TOOK PLACE DURING THE REPORTING PERIOD BUILDING A STRONG HEALTH CARE WORKFORCEPARTNERS HEALTHCARE'S COMMITMENT TO PROVIDING ACCESS TO JOBS WITH FAMILY-SUSTAINING WAGES, EXCELLENT BENEFITS, AND OPPORTUNITIES FOR ADVANCEMENT IS A FOUNDATIONAL PRINCIPLE FOR PARTNERS' WORKFORCE DEVELOPMENT PROGRAMS THROUGH CAREER PIPELINES FOR YOUTH, ADULT COMMUNITY RESIDENTS, AND CURRENT WORKERS, PARTNERS CREATES EMPLOYMENT, TRAINING, AND EDUCATIONAL OPPORTUNITIES FOR INDIVIDUALS AND CONTRIBUTES TO THE ECONOMIC HEALTH OF COMMUNITIES IN WHICH THEY LIVE --THOUSANDS OF PARTNERS EMPLOYEES HAVE PARTICIPATED IN INTERNAL SKILL DEVELOPMENT OPPORTUNITIES --MORE THAN 600 ADULT COMMUNITY RESIDENTS HAVE GRADUATED FROM OUR HEALTH CARE TRAINING AND EDUCATION PROGRAM OVER THE PAST 14 YEARS --MORE THAN 400 STUDENTS EACH YEAR ARE EMPLOYED BY BRIGHAM AND WOMEN'S HOSPITAL (BWH), BRIGHAM AND WOMEN'S FAULKNER HOSPITAL (BWFH), MASSACHUSETTS GENERAL HOSPITAL (MGH), AND NORTH SHORE MEDICAL CENTER (NSMC) DURING THE SUMMER PARTNERS OFFERS MENTORING, ACADEMIC TUTORING, CAREER EXPOSURE, AND SCHOLARSHIP PROGRAMS TO AREA HIGH SCHOOL STUDENTSSUSTAINABLE INITIATIVES AT PARTNERSAS A HEALTH CARE LEADER IN THE BOSTON AREA, PARTNERS RECOGNIZES ITS RESPONSIBILITY TO LEAD BY EXAMPLE AND BECAUSE OF THAT HAS LAUNCHED A SUSTAINABILITY INITIATIVE TO REDUCE OUR IMPACT ON THE ENVIRONMENT THE SUSTAINABILITY PROGRAM OPERATES ON TWO LEVELS THE FIRST, COOPERATION WITH PEER HOSPITALS ACROSS THE COUNTRY THE SECOND IS IMPLEMENTATION OF PROJECTS AT THE LOCAL LEVEL THESE PROJECTS ARE INITIATIVES THAT OFTEN COME FROM EMPLOYEE IDEAS-EVERYTHING FROM RECYCLING BLUE WRAP, THE MATERIALS THAT WRAP SURGICAL INSTRUMENTS FOR OPERATING ROOMS, TO REPLACING BOTTLED WATER WITH FILTERED TAP WATER ON PATIENT FLOORS-AND DISSEMINATING THESE IDEAS THROUGHOUT THE PARTNERS SYSTEM
PART III, LINE 2	THE PATIENT LIABILITY IS REDUCED BY ALL PAYMENTS AND INSURANCE CONTRACTUAL ADJUSTMENTS PREVIOUSLY APPLIED PATIENT DISCOUNTS ARE REVERSED PRIOR TO PLACEMENT IN BAD DEBT IF THE PATIENT DOES NOT PAY AFTER THE PRESCRIBED COLLECTION PROCESS OR IF THE PATIENT RENEGES ON A PREVIOUSLY AGREED PAYMENT SCHEDULE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	TEXT OF BAD DEBT FOOTNOTE FROM AFS (IN THOUSANDS OF DOLLARS)IN ADDITION TO CHARITY CARE AND INADEQUATE FUNDING FROM THE MEDICAID AND MEDICARE PROGRAMS, THERE ARE SIGNIFICANT LOSSES RELATED TO SELF-PAY PATIENTS WHO FAIL TO MAKE PAYMENT FOR SERVICES RENDERED OR INSURED PATIENTS WHO FAIL TO REMIT CO-PAYMENTS AND DEDUCTIBLES AS REQUIRED UNDER THE APPLICABLE HEALTH INSURANCE ARRANGEMENT THE PROVISION FOR BAD DEBTS REPRESENTS CHARGES FOR SERVICES PROVIDED THAT ARE DEEMED TO BE UNCOLLECTIBLE AND WAS $139,554 AND $127,798 IN 2017 AND 2016, RESPECTIVELY THE ESTIMATED COST OF PROVIDING THESE SERVICES WAS APPROXIMATELY $49,501 AND$44,959 FOR 2017 AND 2016, RESPECTIVELY
PART III, LINE 8	ALL COSTS REPORTED ON THE MEDICARE COST REPORT HAVE BEEN DETERMINED IN ACCORDANCE WITH MEDICARE COST-FINDING PRINCIPLES COSTS ALLOCABLE TO MEDICARE PATIENTS ARE LIMITED TO CERTAIN SERVICES AND DERIVED IN A NUMBER OF WAYS, INCLUDING AVERAGE COST PER DAY TIMES MEDICARE DAYS AND RATIO OF COST TO CHARGES APPLIED TO CHARGES FOR ANCILLARY SERVICES PROVIDED TO MEDICARE BENEFICIARIES THE DETERMINATION OF ALLOWABLE COSTS VIA THE MEDICARE COST REPORT EXCLUDES THE COST AND REVENUE ASSOCIATED WITH CERTAIN SERVICES, LIMITS THE COSTS RECOGNIZED FOR OTHER SERVICES AND EXCLUDES CERTAIN COSTS OF DOING BUSINESS IN ADDITION, THE MEDICARE COST REPORT METHODOLOGY DOES NOT ALLOCATE COSTS TO MEDICARE BENEFICIARIES AS PRECISELY AS COST ACCOUNTING SYSTEMS, WHICH, FOR EXAMPLE, ACCOUNT FOR THE MORE INTENSIVE NURSING CARE MEDICARE BENEFICIARIES OFTEN REQUIRE LOSSES ON THE PROVISION OF CARE TO MEDICARE PATIENTS SHOULD BE CONSIDERED COMMUNITY BENEFIT BECAUSE THEY REPRESENT A DIRECT SUBSIDY TO THE FEDERAL GOVERNMENT BY HOSPITALS TO COVER THE COST OF CARE IN EXCESS OF MEDICARE REIMBURSEMENT PROVIDING CARE FOR THE ELDERLY AND DISABLED, AND SERVING MEDICARE PATIENTS IS AN ESSENTIAL PART OF THE COMMUNITY BENEFIT STANDARD BECAUSE ACCESS TO CARE IS ONE OF THE MOST IMPORTANT WAYS WE CAN SERVE OUR COMMUNITIES THIS SUBSIDY HELPS TO MAKE THAT ACCESS POSSIBLE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	THE HOSPITAL WILL TAKE REASONABLE STEPS TO ENSURE THAT NO COLLECTION ACTIONS, INCLUDING TELEPHONE CALLS, STATEMENTS OR LETTERS, ARE INITIATED FOR THOSE PATIENT BALANCES THAT MAY BE EXEMPT FROM COLLECTION ACTION BY REGULATION, INCLUDING PATIENTS DETERMINED TO BE A LOW INCOME PATIENT BY THE OFFICE OF MEDICAID (EXCEPT FOR DENTAL-ONLY LOW INCOME PATIENTS), OR ENROLLED IN MASSHEALTH, CHILDREN'S MEDICAL SECURITY PLAN (CMSP) WITH A MAGI FAMILY INCOME EQUAL TO OR LESS THAN 300% OF THE FPG, EMERGENCY AID TO THE ELDERLY, DISABLED, AND CHILDREN (EAEDC), AND HEALTH SAFETY NET (FULL OR PARTIAL) EXCEPTING DEDUCTIBLES AND CO-PAYMENTS DETERMINED BY THOSE PROGRAMS TO BE A PATIENT RESPONSIBILITY, AND COPAYMENTS FROM ANY THIRD-PARTY PAYER EXCEPT MEDICARE IF IT IS DETERMINED THAT A PATIENT WAS ENROLLED IN ONE OF THOSE CATEGORIES, THEN ALL COLLECTION ACTIONS (EXCEPT APPLICABLE CO-PAYMENTS AND HSN DEDUCTIBLES) WITH THE PATIENT WILL BE CLOSED FOR SERVICES THAT OCCURRED DURING THE PATIENT'S PERIOD OF ELIGIBILITY COLLECTION ACTIONS WILL ALSO CEASE FOR AS LONG AS THE PATIENT IS DETERMINED TO BE LOW INCOME IF THE BALANCE IS FROM A PERIOD WHEN THE PATIENT WAS NOT ENROLLED IN A QUALIFYING PROGRAM THE HOSPITAL MAY CONTINUE TO SEND LETTERS REQUESTING INFORMATION OR ACTION BY THE PATIENT TO RESOLVE COVERAGE AND/OR ELIGIBILITY ISSUES WITH A PRIMARY PAYER, WORKERS COMPENSATION PROGRAM OR TO OBTAIN ANY THIRD PARTY LIABILITY OR MVA CARRIER INFORMATION
PART VI, LINE 2	PARTNERS HEALTHCARE IS COMMITTED TO WORKING WITH COMMUNITY RESIDENTS AND ORGANIZATIONS TO MAKE SIGNIFICANT, MEASURABLE AND SUSTAINABLE PROGRESS TOWARDS IMPROVING THE HEALTH AND WELL-BEING OF LOW INCOME, VULNERABLE PEOPLE AND POPULATIONS IN THE COMMUNITIES SERVED COMMUNITY BENEFIT PRIORITIES ARE DETERMINED THROUGH A COMMUNITY NEEDS ASSESSMENT PROCESS A SYNTHESIS OF COMMUNITY PARTICIPATION AND PUBLICLY AVAILABLE DATA EXTENSIVE DATA FOR NEIGHBORHOODS, TOWNS, AND CITIES, FOCUSING ON BOTH THE SOCIAL AND BIOLOGICAL DETERMINANTS OF HEALTH, INFORMS PARTNERS HEALTHCARE'S DECISION-MAKING AND IS AVAILABLE FOR USE BY COMMUNITY ORGANIZATIONS, MUNICIPALITIES, AND THE GENERAL PUBLIC PARTNERS COMMUNITY HEALTH HAS COMPILED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN COLLABORATION WITH HEALTH RESOURCES IN ACTION THAT SUMMARIZES THE RESULTS AND FINDINGS OF THE RESPECTIVE CHNAS OF OUR MEMBER INSTITUTIONS IN ADDITION, ALL OF PARTNERS' MEMBER INSTITUTIONS CONDUCT CHNAS OF THEIR OWN, AT MINIMUM, EVERY 3 YEARS SEE CHNAS FOR EACH HOSPITAL FACILITY AS REPORTED ON SCHEDULE H, PART V AS WELL AS THE FY'17 COMMUNITY BENEFIT REPORTS THAT WERE FILED WITH THE MASSACHUSETTS ATTORNEY GENERAL FOUND AT HTTP //WWW CBSYS AGO STATE MA US/CBPUBLIC/PUBLIC/BROWSE_REPORTS ASPX?SECTION=0

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	THE HOSPITAL WILL SEEK TO IDENTIFY PATIENTS WHO MAY BE UNINSURED OR INADEQUATELY INSURED IN ORDER TO PROVIDE COUNSELING AND ASSISTANCE THE HOSPITAL WILL PROVIDE FINANCIAL COUNSELING TO THESE PATIENTSAND THEIR FAMILIES, INCLUDING SCREENING FOR ELIGIBILITY FOR OTHER SOURCES OF COVERAGE, SUCH AS STATE PROGRAMS AND OTHER GOVERNMENT PROGRAMS (INCLUDING TO THE EXTENT POSSIBLE, MEDICAID PROGRAMS IN STATES OTHER THAN MASSACHUSETTS), AND PROVIDING INFORMATION REGARDING ALL ACCEPTABLE METHODS OF PAYMENT OF THE HOSPITAL BILL THE HOSPITAL WILL ENCOURAGE PATIENTS WHO ARE POTENTIALLY ELIGIBLE FOR COVERAGE FROM STATE PROGRAMS OR OTHER GOVERNMENT PROGRAMS TO APPLY FOR COVERAGE AND SHALL ASSIST THE PATIENT IN APPLYING FOR BENEFITS PATIENTS MAY ALSO APPLY FOR AND BE APPROVED FOR COVERAGE BY THE HSN FOR CO-INSURANCE OR DEDUCTIBLES NOT COVERED BY THEIR PRIMARY INSURANCE PLAN THE HOSPITAL WILL POST A NOTICE (SIGNS) OF THE AVAILABILITY OF FINANCIAL ASSISTANCE PROGRAMS AND DESCRIBE WHERE TO GO TO FOR ASSISTANCE IN THE FOLLOWING LOCATIONS 1 INPATIENT, CLINIC, EMERGENCY DEPARTMENT, AND COMMUNITY HEALTH CENTER ADMISSION AND/OR REGISTRATION AREAS,2 FINANCIAL COUNSELING WAITING AREAS3 CENTRAL ADMISSION/REGISTRATION AREAS THAT ARE OPEN TO PATIENTS4 BUSINESS OFFICE WAITING AREAS THAT ARE OPEN TO PATIENTSSIGNS WILL BE TRANSLATED INTO OTHER LANGUAGES TO THE EXTENT THAT THE LANGUAGE IS THE PRIMARY LANGUAGE OF MORE THAN 10% OF RESIDENTS IN THE HOSPITAL'S SERVICE SIGNS WILL GENERALLY BE POSTED IN ENGLISHAND SPANISH POSTED SIGNS WILL BE CLEARLY VISIBLE AND LEGIBLE TO PATIENTS VISITING THESE AREAS SIGNAGE WILL ALSO INCLUDE INSTRUCTIONS ON ACCESS TO TRANSLATION SERVICES FOR PATIENTS WHO HAVE OTHERLANGUAGE NEEDS STANDARD NOTICES WILL BE PROVIDED TO ALL PATIENTS AT THE TIME OF THEIR INITIAL REGISTRATION WITH PARTNERS HEALTHCARE THESE NOTICES WILL ALSO BE MADE WIDELY AVAILABLE THROUGHOUT ALL HOSPITALS AND HEALTHCENTERS AND ROUTINELY OFFERED TO EXISTING PATIENTS WHENEVER THEY ARE EXPECTED TO HAVE AN OUT-OF-POCKET LIABILITY COMPLETE COPIES OF THIS POLICY AND THE PHS FINANCIAL ASSISTANCE POLICY AND PHS UNINSURED PATIENT DISCOUNT POLICY WILL ALSO BE MADE AVAILABLE TO PATIENTS AS REQUIRED BOTH POLICIES WILL ALSO BE POSTED ON THE INTERNET AT WWW PARTNERS ORG/PATIENTBILLING WITH LINKS TO THE HOMEPAGES OF ALL HOSPITAL ENTITIES IN READILY IDENTIFIABLE LOCATIONS
PART VI, LINE 4	PLEASE GO TO THE PARTNERS HEALTHCARE COMMUNITY HEALTH BROCHURE FOR MORE INFORMATION HTTP //PARTNERSHEALTHCARE UBERFLIP COM/I/302694-PARTNERS-COMMUNITY-HEALTH-BROCHUREPARTNERS HEALTHCARE IS COMMITTED TO WORKING WITH COMMUNITY RESIDENTS AND ORGANIZATIONS TO MAKE MEASURABLE, SUSTAINABLE IMPROVEMENTS IN THE HEALTH STATUS OF UNDERSERVED POPULATIONS AS A SYSTEM, PARTNERS HEALTHCARE MAKES A SIGNIFICANT COMMITMENT TO COMMUNITY HEALTH IN FY17, THIS INCLUDED A TOTAL OF $200 MILLION INVESTED IN CARING FOR LOW-INCOME PATIENTS AND WORKING TO IMPROVE THE HEALTH OF LOW-INCOME, VULNERABLE PEOPLE IN THE COMMUNITIES WE SERVE THIS REPRESENTED 3 6% OF OUR TOTAL PATIENT CARE-RELATED EXPENSES BELOW ARE SOME OF THE COMMUNITIES AND TARGET POPULATIONS SERVED BOSTON RESIDENTS EXPERIENCING HEALTH DISPARITIESMEDICALLY UNDERSERVED AND/OR LOW INCOME WOMEN AND OTHER RESIDENTS IN PRIORITY COMMUNITIES LIKE MISSION HILL, ROXBURY, JAMAICA PLAIN, DORCHESTER AND MATTAPANVICTIMS OF DOMESTIC VIOLENCEINDIVIDUALS WHO ARE HIV POSITIVE (OR AT RISK OF HIV)RESIDENTS WITH DISPROPORTIONATELY LOWER RATES OF COLORECTAL CANCER SCREENING - WITH A FOCUS ON HISPANIC/LATINO RESIDENTSRESIDENTS AT GREATEST RISK OF AND THOSE LIVING WITH HEART DISEASENATIVE AMERICANSBOSTON YOUTH AND OTHER SPECIAL POPULATIONS SUCH AS THE ELDERLY, HOMELESS, IMMIGRANTS, AND REFUGEESCHARLESTOWN - AN INDEPENDENT-MINDED AND GEOGRAPHICALLY ISOLATED COMMUNITY, CHARLESTOWN IS THE SECOND SMALLEST NEIGHBORHOOD IN BOSTON, AND HAS BOTH THE WEALTHIEST AND POOREST RESIDENTS IN THE CITY OF BOSTON WITHIN IT DESPITE THE DISPARITIES, THE CHARLESTOWN COMMUNITY CONTINUES TO MAKE GAINS IN PREVENTING AND TREATING SUBSTANCE ABUSE - THE COMMUNITY'S KEY GOAL CHELSEA - HOME TO A LARGE POPULATION OF IMMIGRANTS AND REFUGEES, CHELSEA SEEKS TO IMPROVE ACCESS TO AND REDUCE DISPARITIES IN HEALTH CARE REVERE - REVERE IS A CLOSE-KNIT COASTAL CITY LOCATED FIVE MILES NORTH OF BOSTON COMMUNITY GOALS INCLUDE REDUCING SUBSTANCE ABUSE AND VIOLENCE, AND IMPROVING HEALTHY LIVING LOW-INCOME INDIVIDUALS LIVING ON THE NORTH SHORE (LYNN, SALEM AND SURROUNDING COMMUNITIES)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	THE HOSPITALS INCLUDED IN THE PARTNERS HEALTH CARE SYSTEM HAVE GOVERNING BODIES THAT ARE COMPRISED OF COMMUNITY LEADERS WHO ARE GUIDED BY THE MISSION TO DELIVER EXCELLENCE IN PATIENT CARE, ADVANCE THAT CARE THROUGH INNOVATIVE RESEARCH AND EDUCATION AND IMPROVE THE HEALTH AND WELL-BEING OF THE DIVERSE COMMUNITIES SERVED SURPLUS FUNDS ARE USED TO FURTHER THE ORGANIZATION'S TAX EXEMPT MISSIONS OF PATIENT CARE, EDUCATION AND RESEARCH
PART VI, LINE 6	PARTNERS HEALTHCARE IS ONE OF THE LARGEST CHARITABLE DIVERSIFIED HEALTH CARE SERVICES ORGANIZATIONS IN THE UNITED STATES PHS WAS ESTABLISHED IN 1994 BY AN AFFILIATION BETWEEN THE BRIGHAM MEDICAL CENTER, INC , NOW KNOWN AS BRIGHAM AND WOMEN'S HEALTH CARE, INC , AND THE MASSACHUSETTS GENERAL HOSPITAL, IN ORDER TO CREATE AN INTEGRATED HEALTH CARE DELIVERY SYSTEM PARTNERS HEALTHCARE CURRENTLY OPERATES TWO TERTIARY AND SEVEN COMMUNITY ACUTE CARE HOSPITALS THAT COMPRISE THE LARGEST ACUTE HEALTH CARE SYSTEM IN EASTERN MASSACHUSETTS, ONE HOSPITAL PROVIDING INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES AND FOUR HOSPITALS PROVIDING INPATIENT AND OUTPATIENT SERVICES IN REHABILITATION MEDICINE THE TERTIARY HOSPITALS ARE BRIGHAM AND WOMEN'S HOSPITAL AND THE GENERAL HOSPITAL CORPORATION, COMMONLY KNOWN AS MASSACHUSETTS GENERAL HOSPITAL THE COMMUNITY ACUTE CARE HOSPITALS ARE COOLEY DICKINSON HOSPITAL, FAULKNER HOSPITAL, NEWTON-WELLESLEY HOSPITAL, SALEM HOSPITAL, UNION HOSPITAL, MARTHA'S VINEYARD HOSPITAL AND NANTUCKET COTTAGE HOSPITAL MCLEAN HOSPITAL PROVIDES INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES, WHILE SPAULDING REHABILITATION HOSPITAL, SPAULDING HOSPITAL-CAMBRIDGE, AND REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS PROVIDE INPATIENT AND OUTPATIENT SERVICES IN REHABILITATION MEDICINE PARTNERS CONTINUING CARE OVERSEES THE MANAGEMENT, DELIVERY AND INTEGRATION OF NON-ACUTE SERVICES IN THE PARTNERS HEALTHCARE SYSTEM PARTNERS HEALTHCARE PROVIDES PATIENT ACCESS, TRAINING AND ADVISORY SERVICES TO PUBLIC AND PRIVATE ORGANIZATIONS ABROAD THROUGH PARTNERS HEALTHCARE INTERNATIONAL AND PARTNERS MEDICAL INTERNATIONAL PARTNERS HEALTHCARE HAS THE LARGEST NON-UNIVERSITY-BASED NON-PROFIT PRIVATE MEDICAL RESEARCH ENTERPRISE IN THE UNITED STATES AND IS A PRINCIPAL TEACHING AFFILIATE OF THE MEDICAL AND DENTAL SCHOOLS OF HARVARD UNIVERSITY PARTNERS HEALTHCARE ALSO OPERATES A PHYSICIAN NETWORK OF APPROXIMATELY 6,420 PRIMARY CARE PHYSICIANS (PCPS) AND SPECIALISTS PARTNERS HEALTHCARE ALSO OPERATES NEIGHBORHOOD HEALTH PLAN, A LICENSED, NON-PROFIT MANAGED CARE ORGANIZATION THAT PROVIDES HEALTH INSURANCE PRODUCTS TO THE MEDICAID, MASSACHUSETTS HEALTH CONNECTOR AND COMMERCIAL POPULATIONS WITH APPROXIMATELY 45,500 FULL-TIME EQUIVALENT EMPLOYEES (FTES), PARTNERS HEALTHCARE IS ONE OF THE LARGEST PRIVATE EMPLOYERS IN THE COMMONWEALTH OF MASSACHUSETTS (THE COMMONWEALTH) PHS, AS THE PARENT CORPORATION OF PARTNERS HEALTHCARE, PROVIDES A NUMBER OF SERVICES FOR ITS AFFILIATES, INCLUDING CLINICAL AFFAIRS, COMMUNITY BENEFITS, FINANCE, HUMAN RESOURCES, INFORMATION SYSTEMS, INTERNAL AUDIT, INVESTMENTS, LEGAL, MARKETING, MATERIALS MANAGEMENT, REAL ESTATE, RESEARCH ADMINISTRATION AND TREASURY THE FINANCE COMMITTEE OF THE PHS BOARD OF DIRECTORS SERVES ALL OF PARTNERS HEALTHCARE'S CONSTITUENTS AND OVERSEES A CENTRALIZED OPERATING AND CAPITAL BUDGET AND BUSINESS PLANNING PROCESS PARTNERS HEALTHCARE'S CASH AND INVESTMENTS ARE MANAGED CENTRALLY UNDER POLICIES DEVELOPED BY THE INVESTMENT COMMITTEE OF THE PHS BOARD OF DIRECTORS AND REVIEWED BY THE FINANCE COMMITTEE PHS ALSO COORDINATES THE RESEARCH AND MEDICAL EDUCATION PROGRAMS OF ITS AFFILIATES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2 NEEDS ASSESSMENT	PARTNERS HEALTHCARE IS COMMITTED TO WORKING WITH COMMUNITY RESIDENTS AND ORGANIZATIONS TO MAKE SIGNIFICANT, MEASURABLE AND SUSTAINABLE PROGRESS TOWARDS IMPROVING THE HEALTH AND WELL-BEING OF LOW INCOME, VULNERABLE PEOPLE AND POPULATIONS IN THE COMMUNITIES SERVED COMMUNITY BENEFIT PRIORITIES ARE DETERMINED THROUGH A COMMUNITY NEEDS ASSESSMENT PROCESS A SYNTHESIS OF COMMUNITY PARTICIPATION AND PUBLICLY AVAILABLE DATA EXTENSIVE DATA FOR NEIGHBORHOODS, TOWNS, AND CITIES, FOCUSING ON BOTH THE SOCIAL AND BIOLOGICAL DETERMINANTS OF HEALTH, INFORMS PARTNERS HEALTHCARE'S DECISION-MAKING AND IS AVAILABLE FOR USE BY COMMUNITY ORGANIZATIONS, MUNICIPALITIES, AND THE GENERAL PUBLIC PARTNERS COMMUNITY HEALTH HAS COMPILED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN COLLABORATION WITH HEALTH RESOURCES IN ACTION THAT SUMMARIZES THE RESULTS AND FINDINGS OF THE RESPECTIVE CHNAS OF OUR MEMBER INSTITUTIONS IN ADDITION, ALL OF PARTNERS' MEMBER INSTITUTIONS CONDUCT CHNAS OF THEIR OWN, AT MINIMUM, EVERY 3 YEARS SEE CHNAS FOR EACH HOSPITAL FACILITY AS REPORTED ON SCHEDULE H, PART V AS WELL AS THE FY'17 COMMUNITY BENEFIT REPORTS THAT WERE FILED WITH THE MASSACHUSETTS ATTORNEY GENERAL FOUND AT HTTP //WWW CBSYS AGO STATE MA US/CBPUBLIC/PUBLIC/BROWSE_REPORTS ASPX?SECTION=0
PART VI, LINE 7 STATE OF FILING COMMUNITY BENEFIT REPORT	EACH OF THE HOSPITALS THAT COMPRISE THE PARTNERS NETWORK HAS A COMMUNITY BENEFIT PLANNING AND SERVICE DELIVERY STRUCTURE EACH OF THESE ENTITIES (EXCEPT THE THREE REHABILITATION FACILITIES LISTED IN PART V, SECTION A) HAS FILED A SEPARATE COMMUNITY BENEFIT REPORT WITH ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS COORDINATING ACTIVITIES ON A SYSTEM-WIDE BASIS IS MATT FISHMAN, VICE PRESIDENT FOR COMMUNITY HEALTH FOR PARTNERS HEALTHCARE

Additional Data

Software ID:

Software Version:

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Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

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

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? **13** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	THE GENERAL HOSPITAL CORPORATION 55 FRUIT STREET BOSTON, MA 02114 WWW MASSGENERAL ORG 04-2697983	X	X	X	X		X	X			
2	THE BRIGHAM AND WOMEN'S HOSPITAL INC 75 FRANCIS STREET BOSTON, MA 02115 WWW BRIGHAMANDWOMENS ORG 04-2312909	X	X	X	X		X	X			
3	NORTH SHORE MEDICAL CENTER INC 81 HIGHLAND AVENUE SALEM, MA 01970 WWW NSMC PARTNERS ORG 04-3399616	X	X	X	X		X	X			
4	NEWTON-WELLESLEY HOSPITAL 2014 WASHINGTON STREET NEWTON, MA 02462 WWW NWH ORG 04-2103611	X	X	X	X		X	X			
5	BRIGHAM AND WOMEN'S FAULKNER HOSPITAL 1153 CENTRE STREET BOSTON, MA 02130 WWW BRIGHAMANDWOMENSFAULKNER ORG 04-2768256	X	X		X		X	X			

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

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? **13** Name, address, primary website address, and state license number		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**
6	THE MCLEAN HOSPITAL CORPORATION 115 MILL STREET BELMONT, MA 02478 WWW MCLEANHOSPITAL ORG 04-2697981	X			X		X				
7	THE SPAULDING REHABILITATION HOSPITAL 300 FIRST AVENUE CHARLESTOWN, MA 02129 WWW SPAULDINGNETWORK ORG 04-2551124	X								REHAB FACILITY	
8	REHABILITATION HOSPITAL OF THE CAPE 311 SERVICE ROAD EAST SANDWICH, MA 02537 WWW SPAULDINGNETWORK ORG 04-3071419	X								REHAB FACILITY	
9	SPAULDING HOSPITAL - CAMBRIDGE INC 1575 CAMBRIDGE STREET CAMBRIDGE, MA 02138 WWW SPAULDINGNETWORK ORG 27-0273715	X								REHAB FACILITY	
10	NANTUCKET COTTAGE HOSPITAL 57 PROSPECT STREET NANTUCKET, MA 02554 WWW NANTUCKETHOSPITAL ORG 04-2103823	X						X			

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

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? **13** Name, address, primary website address, and state license number		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**
11	MARTHA'S VINEYARD HOSPITAL LINTON LANE PO BOX 1477 OAK BLUFFS, MA 02557 WWW MVHOSPITAL COM 04-2104691	X				X		X			
12	NORTH SHORE MEDICAL CENTER INC 500 LYNNFIELD STREET LYNN, MA 01904 WWW NSMC PARTNERS ORG 04-3399616	X	X	X	X		X	X			
13	COOLEY DICKINSON HOSPITAL INC 30 LOCUST STREET NORTHHAMPTON, MA 01060 WWW COOLEY-DICKINSON ORG 22-2617175	X	X					X			

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

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

Form and Line Reference	Explanation
THE GENERAL HOSPITAL CORPORATION	PART V, SECTION B, LINE 5 BEGINNING FEBRUARY, 2016, MGH CCHI WORKED WITH ITS MULTI? SECTOR COMMUNITY COALITIONS TO REVIEW AND ANALYZE QUANTITATIVE DATA MGH CCHI THEN CONDUCTED INTERVIEWS AND FOCUS GROUPS WITH OVER 200 YOUTH, MENTAL HEALTH EXPERTS, AND THOSE WORKING WITH YOUTH TO PROVIDE INSIGHT INTO THE ISSUES WE BROUGHT THAT DATA BACK TO THE COALITIONS AND RESEARCHED THE FACTORS IN THE PUBLIC HEALTH LITERATURE THAT CREATE RISK OR PROTECTION FOR OR AGAINST SUBSTANCE USE AND DEPRESSION WE THEN ASKED THE COMMUNITIES OVER THE COURSE OF TWO MEETINGS TO PRIORITIZE THE FACTORS MOST RELEVANT IN THEIR COMMUNITIES BASED ON THOSE FACTORS, THE COALITIONS DEVELOPED STRATEGIES TO EITHER STRENGTHEN THE PROTECTIVE FACTORS OR REDUCE THE RISK FACTORS

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

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

Form and Line Reference	Explanation
THE BRIGHAM AND WOMEN'S HOSPITAL, INC	PART V, SECTION B, LINE 5 IN 2016, BRIGHAM AND WOMEN'S HOSPITAL (BWH) EMBARKED ON A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION PLANNING PROCESS TO INFORM COMMUNITY-BASED EFFORTS AS WELL AS TO ADHERE TO REQUIREMENTS SET BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE ACT) THIS WORK BUILDS UPON THE FOUNDATION OF PAST ASSESSMENT WORK AND CURRENT INVESTMENTS IN ADVANCING HEALTH IN THE BWH PRIORITY NEIGHBORHOODS (DORCHESTER, JAMAICA PLAIN, MATTAPAN, MISSION HILL AND ROXBURY) THESE NEIGHBORHOODS ARE CITED IN THE HOSPITAL'S COMMUNITY BENEFIT MISSION AS A FOCUS FOR EFFORT WITH RESIDENTS WHO EXPERIENCE DISPROPORTIONATELY HIGH RATES OF POVERTY, UNEMPLOYMENT AND CHRONIC DISEASE BWH HAS A LONG-STANDING COMMITMENT TO PROMOTING HEALTH EQUITY AND REDUCING HEALTH DISPARITIES FOR PATIENTS, FAMILIES, EMPLOYEES, AND VULNERABLE MEMBERS OF THE COMMUNITY AS PART OF THIS COMMITMENT, THE BWH CENTER FOR COMMUNITY HEALTH AND HEALTH EQUITY (CCHHE) WAS ESTABLISHED IN 1991 TO SERVE AS THE COORDINATING DEPARTMENT FOR COMMUNITY HEALTH PROGRAMS AND TO ACT AS A LIAISON FOR COMMUNITY-BASED ORGANIZATIONS AND THE HOSPITAL THE CENTER WORKS IN PARTNERSHIP WITH OTHER HOSPITAL DEPARTMENTS AND WITH COMMUNITY HEALTH CENTERS, SCHOOLS, AND COMMUNITY-BASED ORGANIZATIONS TO IDENTIFY BARRIERS TO HEALTH AND RELATED SERVICES TO ADDRESS THE SOCIAL FACTORS CONTRIBUTING TO HEALTH AND WELL-BEING THE CENTER'S PROGRAMS HAVE EVOLVED OVER THE PAST TWO DECADES AND INCLUDE EFFORTS AIMED AT ELIMINATING INEQUITIES IN INFANT MORTALITY, AND CANCER, PROMOTING YOUTH DEVELOPMENT AND EMPLOYMENT THROUGH EDUCATION AND CAREER OPPORTUNITIES, CURBING THE CYCLE OF VIOLENCE IN OUR COMMUNITIES AND IMPROVING KNOWLEDGE OF HEALTHY HABITS AND BEHAVIORS

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

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

Form and Line Reference	Explanation
NORTH SHORE MEDICAL CENTER, INC	PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT UTILIZED A PARTICIPATORY, 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 TO DELVE DEEPER INTO BEHAVIORAL HEALTH ISSUES, WHICH WERE IDENTIFIED AS A PRIORITY NEED IN NSMC'S PREVIOUS (2012) CHNA, QUALITATIVE DATA WAS COLLECTED THROUGH INTERVIEWS WITH TWELVE STAKEHOLDERS FROM THE HEALTH CARE, EDUCATION AND SOCIAL SERVICE SECTORS AS WELL AS ONE FOCUS GROUP CONDUCTED WITH COMMUNITY RESIDENTS WHO HAD LIVED EXPERIENCES WITH BEHAVIORAL HEALTH ISSUES

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

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

Form and Line Reference	Explanation
NEWTON-WELLESLEY HOSPITAL	PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT UTILIZED A PARTICIPATORY, 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 FIVE FOCUS GROUPS CONDUCTED WITH COMMUNITY RESIDENTS AND LEADERS, AND TWELVE INTERVIEWS WITH COMMUNITY STAKEHOLDERS FOCUS GROUPS AND KEY INFORMANT INTERVIEWS WERE CONDUCTED WITH INDIVIDUALS FROM ACROSS THE SIX MUNICIPALITIES THAT COMPRISE THE NEWTON-WELLESLEY HOSPITAL SERVICE AREA, AND WITH A RANGE OF PARTICIPANTS REPRESENTING DIFFERENT AUDIENCES, INCLUDING LEADERS IN EDUCATION, HEALTH CARE, AND SOCIAL SERVICE ORGANIZATIONS ULTIMATELY, THE QUALITATIVE RESEARCH ENGAGED APPROXIMATELY 40 PARTICIPANTS

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

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

Form and Line Reference	Explanation
BRIGHAM AND WOMEN'S FAULKNER HOSPITAL	PART V, SECTION B, LINE 5 BRIGHAM AND WOMEN'S FAULKNER HOSPITAL'S 2016 COMMUNITY HEALTH ASSESSMENT (CHA) VALUES ALL THE FACTORS WITHIN ITS COMMUNITIES THAT INFLUENCE HEALTH IT IS IMPORTANT TO INCORPORATE THE SOCIAL, ECONOMIC, AND ENVIRONMENTAL INFLUENCES ON HEALTH OUTCOMES DATA COLLECTION FOR THIS CHA INVOLVED BOTH QUANTITATIVE AND QUALITATIVE DATA TO HELP IDENTIFY ALL ASPECTS OF THE COMMUNITY THAT IMPACT THE HEALTH OF ITS PRIORITY COMMUNITIES DURING THE COLLECTION OF BOTH QUALITATIVE AND QUANTITATIVE DATA, SOCIAL DETERMINANTS OF HEALTH WERE LARGE AREAS OF FOCUS QUANTITATIVE DATA THE BWFH CHA USES SEVERAL SECONDARY DATA SOURCES TO PULL INFORMATION ON HEALTH INDICATORS, AS WELL AS SOCIAL, ECONOMIC, AND ENVIRONMENTAL FACTORS IN THE COMMUNITY THE PRIMARY SOURCE OF THE QUANTITATIVE DATA IS A NEIGHBORHOOD LEVEL DATA ANALYSIS FROM THE BOSTON PUBLIC HEALTH COMMISSION AS WELL AS RACE LEVEL DATA OBTAINED FROM THE 2014-15 HEALTH OF BOSTON REPORT THE BOSTON PUBLIC HEALTH COMMISSION EXTRACTS ITS INFORMATION FROM VARIOUS SOURCES INCLUDING BUT NOT LIMITED TO U S CENSUS, BOSTON BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY 2013, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, HOSPITAL UTILIZATION DATA QUALITATIVE DATA IN THE FALL OF 2015, BWFH CONDUCTED A QUALITY OF LIFE SURVEY (2016 BWFH QOL SURVEY) SEE APPENDIX 1 OVER A 4-WEEK PERIOD, THE SURVEY WAS DISTRIBUTED AT VARIOUS COMMUNITY EVENTS IN BWFH'S 4 PRIORITY COMMUNITIES A TOTAL OF 158 SURVEYS WERE COMPLETED THE DATA WERE ANALYZED IN THE SPRING OF 2016 USING SPSS VERSION 24 0 ADDITIONALLY, BOTH NEIGHBORHOOD FOCUS GROUPS AND ONE-ON-ONE KEY INFORMANT INTERVIEWS WERE HELD TO SPARK THOUGHTFUL AND INSIGHTFUL CONVERSATION TO DISCUSS STRENGTHS AND CHALLENGES OF SUB-SETS OF THE COMMUNITY FOCUS GROUPS WERE COMPROMISED OF 6-15 PARTICIPANTS THESE GROUPS WERE GIVEN A BASIC BACKGROUND TO THE ASSESSMENT PROCESS AND ASKED A SERIES OF QUESTIONS KEY INFORMANT PARTICIPANTS HAVE INCREASED KNOWLEDGE OF A SPECIFIC SUBSET OF THE COMMUNITY OR ASPECT OF THE COMMUNITY BASED ON THEIR ROLE, EXPERIENCE OR INSIGHT (SEE APPENDIX 3) IN ONE-ON-ONE KEY INFORMANT INTERVIEWS, THE AVERAGE INTERVIEW WAS 50 MINUTES WITH A SERIES OF QUESTIONS

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

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

Form and Line Reference	Explanation
THE MCLEAN HOSPITAL CORPORATION	PART V, SECTION B, LINE 5 DUE TO MCLEAN'S HIGHLY SPECIALIZED MISSION AND SERVICES, WE RELY PRIMARILY ON COMMUNITY, REGIONAL AND STATE-WIDE PUBLIC HEALTH AND COMMUNITY NEEDS ASSESSMENTS AS WELL AS FEEDBACK FROM CHNA 17 AND MIDDLEBOROUGH TOWN OFFICIALS NEEDS ASSESSMENTS INCLUDE COMMUNITY / REGIONALO MOUNT AUBURN HOSPITAL COMMUNITY NEEDS ASSESSMENT (SEPTEMBER 2015) HTTP //WWW MOUNTAUBURNHOSPITAL ORG/APP/FILES/PUBLIC/746/MOUNT-AUBURN-HOSPITALCOMMUNITY-HEALTH-NEEDS-ASSESSMENT-2015 PDF AND CHNA 17'S FOLLOW-UP PLANNING DOCUMENT THAT LEVERAGES AND EXTENDS THE MOUNT AUBURN HOSPITAL COMMUNITY NEEDS ASSESSMENT AND INCLUDES STAKEHOLDER INTERVIEWS WE HAVE ALSO HAD IN-DEPTH DISCUSSIONS WITH CHNA 17 LEADERSHIP ABOUT THEIR COMMUNITY INPUT AND PLANNING PROCESSES AND THEIR FINANCIAL SUPPORT OF PROGRAMS THAT ADDRESS MENTAL HEALTH NEEDS O NEWTON WELLESLEY HOSPITAL 2014 COMMUNITY HEALTH NEEDS ASSESSMENT (JANUARY 21, 2015) HTTP //WWW NWH ORG/GEDOWNLOAD /NWH%20DRAFT%20CHNA%20REPORT_1%2021%2015%20TM% 20FINAL PDF?ITEM_ID=47540384&VERSION_ID=47540385STATEO COMMONWEALTH OF MASSACHUSETTS ACTION PLAN TO ADDRESS THE OPIOID EPIDEMIC IN THECOMMONWEALTH (JUNE 22, 2015) AND UPDATE (JANUARY 8, 2016) HTTP //WWW MASS GOV/EOHHS/DOCS/DPH/STOP-ADDICTION/OPIOID-EPIDEMIC-ACTION-PLAN PDFHTTP //WWW MASS GOV/EOHHS/DOCS/DPH/STOP-ADDICTION/ACTION-PLAN-UPDATE PDFO MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH OPIOID-RELATED OVERDOSE DATAHTTP //WWW MASS GOV/EOHHS/GOV/DEPARTMENTS/DPH/STOP-ADDICTION/CURRENT-STATISTICS HTMLO TASK FORCE ON BEHAVIORAL HEALTH DATA POLICIES AND LONG TERM STAYS FINAL REPORT TO THEHEALTH POLICY COMMISSION, THE JOINT COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE AND THE JOINT COMMITTEE ON HEALTH CARE FINANCING (JUNE 2015)WWW CHIAMASS GOV/ASSETS/UPLOADS/BHTF-FINAL-REPORT-2015-6-29 DOCXO MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH STATE HEALTH PLAN BEHAVIORAL HEALTH(DECEMBER 2014) HTTP //WWW MASS GOV/EOHHS/DOCS/DPH/HEALTH-PLANNING/HPC/DELIVERABLE/BEHAVIORAL-HEALTHSTATE- HEALTH-PLAN PDFO MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH ISSUE BRIEFS MASSACHUSETTS BEHAVIORAL HEALTH ANALYSIS (SEPTEMBER 22, 2014) HTTP //WWW MASS GOV/EOHHS/DOCS/DPH/HEALTH-PLANNING/HPC/2014/ISSUE-BRIEFS-SEPT-22 PDFO BEHAVIORAL HEALTH INTEGRATION TASK FORCE REPORT TO THE LEGISLATURE AND HEALTH POLICYCOMMISSION (JULY 2013)HTTP //WWW MASS GOV/ANF/DOCS/HPC/QUIPP/BEHAVIORAL-HEALTH-INTEGRATION-TASK-FORCE-FINALREPORT- AND-RECOMMENDATIONS-JULY-2013 PDFO MCLEAN REVIEWED THE NEED FOR INPATIENT PSYCHIATRIC BEDS IN 2012-2013 WITH THE DECREASE IN STATE-FUNDED INPATIENT BEDS FROM 836 TO 658, AND INCREASING BACKUPS AND WAITING TIMES FOR PATIENTS IN EMERGENCY ROOMS, IT WAS VERY CLEAR THAT ADDITIONAL CAPACITY WAS NEEDED

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

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

Form and Line Reference	Explanation
THE SPAULDING REHABILITATION HOSPITAL	PART V, SECTION B, LINE 5 THE 2015 CHNA IS THE SECOND ASSESSMENT SINCE THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 REQUIRED HOSPITALS TO CONDUCT CHNA'S EVERY THREE YEARS THE GUIDELINES REQUIRE DIVERSE COMMUNITY PARTICIPATION TO IDENTIFY HEALTH PRIORITIES AND DEVELOP STRATEGIC IMPLEMENTATION PLANS SPAULDING PARTNERED WITH THE MGH CENTER FOR COMMUNITY HEALTH IMPROVEMENT (CCHI) IN 2012 TO CONDUCT AN ASSESSMENT IN THE CHARLESTOWN AND USED A PLANNING PROCESS CALLED MAPP, MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS THIS INTENSIVE PROCESS INCLUDED SEVERAL PHASES WITH EXTENSIVE COMMUNITY OUTREACH AND ENGAGEMENT AND PRIMARY DATA COLLECTION THE WORK OF THE COMMUNITY ASSESSMENT COMMITTEES IN 2012 PROVIDED THE STRONG FOUNDATION FOR 2015 THE 2015 CHNA INCLUDED ENGAGING NEW AND EXISTING COMMUNITY PARTNERS WHO COLLECTED AND REVIEWED PRIMARY AND SECONDARY DATA THESE INCLUDED 1) QUALITY OF LIFE SURVEY AVAILABLE IN ENGLISH , SPANISH, ARABIC & CHINESE - 391-428 RESPONSES 2) PUBLIC HEALTH DATA DEPARTMENT OF PUBLIC HEALTH, MGH PATIENT DATA, POLICE DATA & SCHOOL 3) FOCUS GROUPS 4 FOCUS GROUPS INCLUDING 42 PARTICIPANTS FROM CHARLESTOWN THE GOALS OF THE 2015 CHNA WERE TO 1) IDENTIFY THE HEALTH NEEDS, ASSETS AND FORCES OF CHANGE IN CHARLESTOWN 2) ENGAGE COMMUNITY MEMBERS THROUGH THE PROCESS 3) GAUGE THE COMMUNITIES' PROGRESS ON ADDRESSING THE 2012 CHNA PRIORITIES 4) DETERMINE 2015 PRIORITIES AND IMPLEMENTATION STRATEGY

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

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

Form and Line Reference	Explanation
REHABILITATION HOSPITAL OF THE CAPE	PART V, SECTION B, LINE 5 QUANTITATIVE DATA THE SCC CHA USES SEVERAL SECONDARY DATA SOURCES TO PULL INFORMATION ON HEALTH INDICATORS, AS WELL AS SOCIAL, ECONOMIC, AND ENVIRONMENTAL FACTORS IN THE COMMUNITY THE MAJOR SOURCES OF QUANTITATIVE DATA USED IN THE SHC CHA ARE THE AMERICAN COMMUNITY SURVEY (2010-14), THE 2010 CENSUS, THE BUREAU OF LABOR STATISTICS AND THE MASSACHUSETTS BUREAU OF SUBSTANCE ABUSE SERVICES (BSAS), MASSACHUSETTS HOSPITAL INPATIENT DISCHARGES (UHDDS), MASSACHUSETTS HOSPITAL EMERGENCY VISIT DISCHARGES, MASSACHUSETTS VITAL RECORDS MORTALITY, MASSACHUSETTS COMMUNICABLE DISEASE PROGRAM EPIDEMIOLOGY PROGRAM, MA BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM AND THE MA HEALTHY AGING DATABASE A LITERATURE REVIEW OF PUBLISHED ARTICLES AND RESEARCH WAS ALSO CONDUCTED AS A PART OF THIS ASSESSMENT CAPE COD HEALTHCARE IS CONDUCTING ITS OWN EXTENSIVE 2016-2018 COMMUNITY HEALTH ASSESSMENT FOR BARNSTABLE COUNTY AND HAS GENEROUSLY SHARED THE SECONDARY DATA IT COLLECTED WITH SCC FOR THE PURPOSES OF THE SCC CHA WHEREVER POSSIBLE, THIS REPORT WILL INDICATE WHICH DATA POINTS WERE COLLECTED BY CCHC SCC AND CAPE COD HEALTHCARE ARE WORKING TO IDENTIFY COMMON GOALS TO ADDRESS JOINTLY AND/OR WITH OTHER COMMUNITY PARTNERS QUALITATIVE DATA IN THE SPRING OF 2016, SCC DEVELOPED AND CONDUCTED A QUALITY OF LIFE SURVEY (2016 SCC QOL SURVEY) WITH THE ASSISTANCE OF PARTNERS COMMUNITY HEALTH THE SURVEY WAS DESIGNED TO OBTAIN INFORMATION ABOUT COMMUNITY PERCEPTIONS OF THE QUALITY OF LIFE ON CAPE COD AND TO ENHANCE SPAULDING'S UNDERSTANDING OF THE SPECIFIC BARRIERS TO HEALTH AND WELLNESS THAT OLDER PERSONS, CAREGIVERS AND PERSONS WITH DISABILITIES FACE FOR 2 MONTHS, THE SURVEY WAS AVAILABLE ONLINE AND HARD COPIES WERE MADE AVAILABLE THROUGHOUT THE HOSPITAL, AT SCC'S OUTPATIENT CENTERS, AND AT LOCAL EVENTS THE SURVEY WAS DISTRIBUTED BY EMAIL TO SUPPORT GROUPS, SCC'S CONTACTS, AND ASSOCIATED GROUPS LOCATED IN SCC'S PRIORITY COMMUNITIES A TOTAL OF 357 SURVEYS WERE COMPLETED ADDITIONALLY, SPAULDING AND JSI CONDUCTED THREE PROVIDER/COMMUNITY FOCUS GROUPS, TO SPARK THOUGHTFUL AND INSIGHTFUL CONVERSATION ABOUT THE NEEDS AND CHALLENGES OF RESIDENTS LIVING ACROSS THE CAPE THE TEAM ALSO CONDUCTED INTERVIEWS WITH KEY STAKEHOLDERS REPRESENTING UNDERSERVED POPULATIONS AND/OR SERVICES WITH SIGNIFICANT HEALTH IMPACTS FINDINGS FROM ALL THESE FORUMS AND INTERVIEWS WERE COMBINED INTO A SINGLE REPORT BY JSI AND INCORPORATED INTO THIS REPORT

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

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

Form and Line Reference	Explanation
SPAULDING HOSPITAL - CAMBRIDGE, INC	PART V, SECTION B, LINE 5 QUANTITATIVE DATA THE SHC CHA USES SEVERAL SECONDARY DATA SOURCES TO PULL INFORMATION ON HEALTH INDICATORS, AS WELL AS SOCIAL, ECONOMIC, AND ENVIRONMENTAL FACTORS IN THE COMMUNITY THE MAIN SOURCES OF QUANTITATIVE DATA ARE THE AMERICAN COMMUNITY SURVEY (2009-13), THE 2010 CENSUS, THE BUREAU OF LABOR STATISTICS AND THE CRIME IN THE UNITED STATES 2012 REPORT AND MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH MASSCHIP "HEALTH STATUS INDICATORS REPORTS" THE COMMUNITY COMMONS HEALTH INDICATORS REPORTING TOOL WAS UTILIZED IN THE CREATION OF THIS REPORT QUALITATIVE DATA IN THE SPRING OF 2016, SHC DEVELOPED AND CONDUCTED A QUALITY OF LIFE SURVEY (2016 SHC QOL SURVEY) WITH THE ASSISTANCE OF PARTNERS COMMUNITY HEALTH THE SURVEY WAS DESIGNED TO PROVIDE INFORMATION ABOUT COMMUNITY PERCEPTIONS OF TOP COMMUNITY HEALTH ISSUES AND TO BETTER UNDERSTANDING THE SPECIFIC BARRIERS TO HEALTH AND WELLNESS THAT PERSONS WITH DISABILITIES FACE OVER A 6-WEEK PERIOD, INDIVIDUALS WHO EITHER LIVE OR WORK IN THE SHC PRIORITY TOWNS WERE SURVEYED THE SURVEY WAS AVAILABLE ONLINE AND PROMOTED THROUGH SHC'S SOCIAL MEDIA PROFILE AND DISTRIBUTED IN EMAIL BLASTS TO SHC'S CONTACTS AND ASSOCIATED GROUPS LOCATED IN SHC'S PRIORITY COMMUNITIES A TOTAL OF 81 SURVEYS WERE COMPLETED ADDITIONALLY, KEY INFORMANT INTERVIEWS AND FOCUS GROUPS WERE HELD TO SPARK THOUGHTFUL AND INSIGHTFUL CONVERSATION ABOUT THE STRENGTHS OF AND CHALLENGES IN THE COMMUNITY IN PARTICULAR, THE CAMBRIDGE PUBLIC HEALTH DEPARTMENT WAS CONSULTED AS A PART OF THIS PROCESS ALTHOUGH THEIR 2014 COMMUNITY HEALTH NEEDS ASSESSMENT DID NOT FOCUS ON THE SPECIFIC NEEDS OF DISABLED PERSONS, THEY CONFIRMED THAT THE NEEDS IDENTIFIED BY THE ASSESSMENT (SEE PAST COMMUNITY HEALTH ASSESSMENTS ABOVE) WERE TRULY ISSUES THAT CUT ACROSS EVERY DEMOGRAPHIC AND SOCIAL SECTOR OF CAMBRIDGE RESIDENTS SHC AND THE CAMBRIDGE PUBLIC HEALTH DEPARTMENT HOPE TO WORK MORE COLLABORATIVELY ON FUTURE NEEDS ASSESSMENTS

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

Form and Line Reference	Explanation
NANTUCKET COTTAGE HOSPITAL	PART V, SECTION B, LINE 5 QUANTITATIVE DATA - REVIEWING EXISTING SECONDARY DATA TO DESCRI BE THE SOCIO ECONOMIC AND HEALTH STATUS OF THE NANTUCKET COTTAGE HOSPITAL SERVICE AREA POP ULATION, THIS REPORT DRAWS FROM AUTHORITATIVE SECONDARY DATA SOURCES AT THE COUNTY AND CIT Y LEVEL SOURCES OF DATA INCLUDED, BUT WERE NOT LIMITED TO, COMMUNITY COMMONS, THE U S CE NSUS, CENTERS FOR DISEASE CONTROL AND PREVENTION, COUNTY HEALTH RANKINGS, MASSACHUSETTS DE PARTMENT OF PUBLIC HEALTH, HOUSING NANTUCKET, NATIONAL LOW INCOME HOUSING COALITION, AND T HE F B I UNIFORM CRIME REPORTS SOME OF THE DATA WERE EXTRACTED FROM THE COMMUNITY COMMONS WEBSITE, AND OTHERS WERE ACCESSED DIRECTLY OTHER TYPES OF DATA INCLUDED A SELF REPORT OF HEALTH BEHAVIORS FROM LARGE, POPULATION BASED SURVEYS SUCH AS THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS), AS WELL AS VITAL STATISTICS BASED ON BIRTH AND DEATH RECORDS WHEN POSSIBLE, SECONDARY DATA ARE COMPARED TO STATE AVERAGES QUALITATIVE DATA - FOCUS GR OUPS AND SURVEYS IN MAY 2015, NANTUCKET COTTAGE HOSPITAL ORGANIZED TWO FOCUS GROUPS WITH C OMMUNITY HEALTH AGENCIES AND ORGANIZATIONS, AS WELL AS A CROSS SECTION OF NANTUCKET RESIDE NTS, TO SOLICIT INPUT ON THE ISLAND'S MOST PRESSING HEALTH NEEDS, COMMUNITY ASSETS, CHALLE NGES, AND SOLUTIONS THE FIRST FOCUS GROUP WAS HELD AT A REGULAR MEETING OF THE NANTUCKET HEALTHY COMMUNITY COLLABORATIVE, WHICH INCLUDES REPRESENTATION FROM A WIDE RANGE OF COMMUN ITY STAKEHOLDERS - BOTH PUBLIC AGENCIES AND PRIVATE ORGANIZATIONS - THAT ARE COMMITTED TO ADDRESSING NANTUCKET'S HUMAN SERVICES NEEDS THE SECOND FOCUS GROUP WAS CONDUCTED DURING A SPECIAL MEETING OF NANTUCKET COTTAGE HOSPITAL'S PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) THE PFAC, A STANDING COMMITTEE OF NCH, SEEKS THE COMMUNITY'S FEEDBACK AND INVOLVEMENT T O IMPROVE CARE AT NCH, AND HELPS THE HOSPITAL FULFILL ITS MISSION TO MEET THE NEEDS OF AN INCREASINGLY DIVERSE AND EXPANDING NANTUCKET COMMUNITY A SEMI STRUCTURED GUIDE WAS USED D URING BOTH FOCUS GROUP SESSIONS TO ENSURE CONSISTENCY IN THE TOPICS COVERED THE SESSIONS WERE FACILITATED BY A MODERATOR, AND DETAILED NOTES WERE TAKEN DURING CONVERSATIONS THE 2 015 NANTUCKET QUALITY OF LIFE SURVEY WAS DISTRIBUTED THROUGHOUT ALL PATIENT WAITING AREAS WITHIN NANTUCKET COTTAGE HOSPITAL DURING THE MONTH OF MAY 2015 AND THE FIRST TWO WEEKS OF JUNE, AS WELL AS DURING THE ANNUAL NCH HEALTH FAIR ON MAY 2 THE START OF THE SURVEY PERIO D WAS ANNOUNCED IN THE ISLAND NEWSPAPER, THE INQUIRER AND MIRROR, AND POSTED ON A LOCAL ME DIA WEBSITE, THE NANTUCKET CHRONICLE AN ELECTRONIC VERSION OF THE SURVEY WAS POSTED ON TH E NCH WEB SITE DURING MAY AND JUNE, AS WELL AS THE TOWN OF NANTUCKET'S WEB SITE, AND THE T OWN OF NANTUCKET BOARD OF HEALTH'S WEB SITE THE ELECTRONIC VERSION WAS ALSO SENT TO ISLAN D RESIDENTS VIA E-NEWSLETTERS FROM NCH AND THE TOWN OF NANTUCKET PHYSICAL COPIES OF THE S URVEY WERE DISTRIBUTED AT SEVERAL OTHER LOCATIONS AROUND THE ISLAND, INCLUDING THE SALTMAR SH SENIOR CENTER, THE NANTUCKE

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

Form and Line Reference	Explanation
NANTUCKET COTTAGE HOSPITAL	T COMMUNITY SCHOOL, AND ST MARY'S CHURCH, AND COLLECTED BY NCH STAFF FOLLOWING THE CLOSE OF THE SURVEY PERIOD

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

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

Form and Line Reference	Explanation
MARTHA'S VINEYARD HOSPITAL	PART V, SECTION B, LINE 5 MARTHA'S VINEYARD HOSPITAL'S 2016 COMMUNITY HEALTH ASSESSMENT (MVH CHA) INCORPORATES MANY FACTORS OF COMMUNITY HEALTH THAT ARE OUTSIDE OF CLASSIFIED HEALTH OUTCOMES THERE IS IMPORTANCE IN RECOGNIZING SOCIAL, ECONOMIC, AND ENVIRONMENTAL INFLUENCES ON HEALTH OUTCOMES THIS CHA'S DATA COLLECTION METHODS USE QUANTITATIVE AND QUALITATIVE DATA TO IDENTIFY ALL ASPECTS OF THE COMMUNITY THAT INFLUENCE THE HEALTH OF ITS RESIDENTS QUANTITATIVE DATA REVIEWING SECONDARY DATA THE MVH CHA USES SEVERAL SECONDARY DATA SOURCES TO PULL INFORMATION ON HEALTH INDICATORS, AS WELL AS SOCIAL, ECONOMIC, AND ENVIRONMENTAL FACTORS IN THE COMMUNITY THE PRIMARY SOURCE OF THE QUANTITATIVE DATA IS THE DUKES COUNTY HEALTH INDICATOR REPORT FROM THE COMMUNITY COMMONS CHNA TOOL, WHICH PROVIDES COUNTY AND STATE LEVEL INFORMATION THE COMMUNITY COMMONS EXTRACTS ITS INFORMATION FROM VARIOUS OTHERS SOURCES INCLUDING BUT NOT LIMITED TO THE U S CENSUS, THE NATIONAL CENTER FOR ECONOMIC STATISTICS, THE CENTERS FOR DISEASE CONTROL AND PREVENTION, ETC IN ADDITION, SPECIFIC DATA ON SUBSTANCE ABUSE WAS OBTAINED THROUGH THE STATE WEBSITE'S MASSCHIP DUKES COUNTY HEALTH INDICATOR REPORT QUALITATIVE DATA QUALITY OF LIFE (QOL) SURVEY AND COMMUNITY INTERVIEWS THE 2016 MVH QOL SURVEY WAS CONDUCTED IN FEBRUARY AND MARCH OF 2016 THE SURVEY WAS DISTRIBUTED IN ENGLISH AND PORTUGUESE AND MADE AVAILABLE ONLINE AND IN HARD COPY IN ALL SIX LIBRARIES ON THE ISLAND IN ADDITION, ENGLISH VERSIONS WERE PLACED AS FULL PAGES IN THE MARTHA'S VINEYARD TIMES AND THE VINEYARD GAZETTE A TOTAL OF 319 SURVEYS WERE COLLECTED IN ADDITION TO THE 2016 MVH QOL SURVEY TELEPHONE INTERVIEWS WITH APPROXIMATELY ONE DOZEN MEMBERS OF THE MARTHA'S VINEYARD COMMUNITY WERE CONDUCTED INTERVIEWS WERE CONDUCTED DURING NOVEMBER AND DECEMBER, 2015 AND EACH WAS GENERALLY 30-60 MINUTES IN DURATION COMMUNITY MEMBERS WERE SELECTED BY THE BOARD BASED ON VARIOUS FACTORS, INCLUDING THEIR CONNECTION TO THE HEALTHCARE COMMUNITY ON THE ISLAND, THEIR HISTORIC LEVEL OF INVOLVEMENT WITH THE HOSPITAL, AND THE SENSE THAT THEIR OPINION LIKELY MIRRORED THOSE OF OTHER ISLAND RESIDENTS

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

Form and Line Reference	Explanation
COOLEY DICKINSON HOSPITAL, INC	PART V, SECTION B, LINE 5 THE INPUT OF THE COMMUNITY AND OTHER IMPORTANT REGIONAL STAKEHO LDERS WAS PRIORITIZED BY THE COALITION AS AN IMPORTANT PART OF THE 2016 CHNA PROCESS BELO W ARE THE PRIMARY MECHANISMS FOR COOLEY DICKINSON HEALTH CARE COMMUNITY HEALTH NEEDS ASSES SMENT 2016 5 COMMUNITY AND STAKEHOLDER ENGAGEMENT " A CHNA STEERING COMMITTEE WAS FORMED THAT INCLUDED REPRESENTATIVES FROM EACH HOSPITAL/INSURER COALITION MEMBER AS WELL AS PUBLI C HEALTH AND COMMUNITY STAKEHOLDERS FROM EACH HOSPITAL SERVICE AREA STAKEHOLDERS ON THE S TEERING COMMITTEE INCLUDED LOCAL AND REGIONAL PUBLIC HEALTH AND HEALTH DEPARTMENT REPRESEN TATIVES, REPRESENTATIVES FROM LOCAL AND REGIONAL ORGANIZATIONS SERVING OR REPRESENTING MED ICALLY UNDERSERVED, LOW-INCOME OR MINORITY POPULATIONS, AND INDIVIDUALS FROM ORGANIZATIONS THAT REPRESENTED THE BROAD INTERESTS OF THE COMMUNITY WHEN IDENTIFYING COMMUNITY AND PUB LIC HEALTH REPRESENTATIVES TO PARTICIPATE, A STAKEHOLDER ANALYSIS WAS CONDUCTED BY THE COA LITION AND CONSULTANTS TO ENSURE GEOGRAPHIC, SECTOR (E G SCHOOLS, COMMUNITY SERVICE ORGAN IZATIONS, HEALTHCARE PROVIDERS, PUBLIC HEALTH, AND HOUSING) AND RACIAL/ETHNIC DIVERSITY OF COMMUNITY REPRESENTATIVES BY INCLUDING THESE STAKEHOLDERS ON THE STEERING COMMITTEE, THE COMMUNITY AND PUBLIC HEALTH REPRESENTATIVES HAD INPUT ON THE CHNA PROCESS USED TO IDENTIF Y AND PRIORITIZE COMMUNITY HEALTH NEEDS, CHNA FINDINGS, AND DISSEMINATION OF INFORMATION ASSESSMENT METHODS AND FINDINGS WERE MODIFIED BASED ON STEERING COMMITTEE FEEDBACK THE ST EERING COMMITTEE MET MONTHLY FROM OCTOBER 2015 - JULY 2016 " KEY INFORMANT INTERVIEWS AND FOCUS GROUPS WERE CONDUCTED TO BOTH GATHER INFORMATION THAT WAS UTILIZED TO IDENTIFY PRIO RITY HEALTH NEEDS AND ENGAGE THE COMMUNITY KEY INFORMANT INTERVIEWS WERE CONDUCTED WITH H EALTH CARE PROVIDERS, HEALTH CARE ADMINISTRATORS, LOCAL AND REGIONAL PUBLIC HEALTH OFFICIA LS, AND LOCAL ORGANIZATIONAL LEADERS THAT REPRESENT THE BROAD INTERESTS OF THE COMMUNITY O R THAT SERVE MEDICALLY UNDERSERVED, LOW-INCOME OR COMMUNITIES OF COLOR POPULATIONS IN THE SERVICE AREA INTERVIEWS WITH THE LOCAL AND REGIONAL PUBLIC HEALTH OFFICIALS WERE USED TO IDENTIFY CURRENT AND EMERGING HIGH PRIORITY HEALTH AREAS AND HEALTHCARE AND COMMUNITY FACT ORS THAT CONTRIBUTE TO HEALTH NEEDS FOCUS GROUP PARTICIPANTS INCLUDED INDIVIDUALS REPRESE NTING THE BROAD INTERESTS OF THE COMMUNITY, INCLUDING COMMUNITY ORGANIZATIONAL REPRESENTAT IVES, VULNERABLE POPULATION COMMUNITY MEMBERS (E G LOW-INCOME, PEOPLE OF COLOR), AND OTHE R COMMUNITY STAKEHOLDERS TOPICS INCLUDED HEALTH NEEDS FOR TRANSGENDER AND LESBIAN POPULA TIONS, VETERANS AND MILITARY FAMILIES, MATERNAL AND INFANT/CHILD HEALTH, AND FOR INDIVIDUA LS WITH MENTAL HEALTH AND SUBSTANCE USE CONDITIONS KEY INFORMANT INTERVIEWS AND FOCUS GRO UPS WERE CONDUCTED FROM FEBRUARY 2016 - APRIL 2016 " A PRELIMINARY CHNA FINDINGS REVIEW M EETING WAS HELD WITH HOSPITAL AND COMMUNITY REPRESENTATIVES TO VET FINDINGS AND OBTAIN INP UT ON WHETHER FINDINGS RESONAT

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

Form and Line Reference	Explanation
COOLEY DICKINSON HOSPITAL, INC	ED WITH THEIR UNDERSTANDING OF THE COMMUNITY AND WHETHER ANY IMPORTANT AREAS WERE MISSING PRIORITIZED HEALTH NEEDS AND PRESENTATION OF DATA WERE REVISED BASED ON FEEDBACK FROM THI S MEETING " A COMMUNITY LISTENING SESSION WAS HELD TO VET THE REVISED LIST OF PRIORITIZED HEALTH NEEDS WITH COMMUNITY MEMBERS AND MODIFICATIONS WERE MADE BASED ON FINDINGS FROM TH IS SESSION AT THIS SESSION, ATTENDEES ALSO PROVIDED INFORMATION ON EXISTING RESOURCES IN THE COMMUNITY TO ADDRESS PRIORITIZED HEALTH NEEDS

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

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

Form and Line Reference	Explanation
COOLEY DICKINSON HOSPITAL, INC	PART V, SECTION B, LINE 6A COOLEY DICKINSON HEALTH CARE IS A MEMBER OF THE COALITION OF WESTERN MASSACHUSETTS HOSPITALS (COALITION) THE COALITION IS A PARTNERSHIP BETWEEN TEN NON-PROFIT HOSPITALS/HEALTH PLAN IN WESTERN MASSACHUSETTS BAYSTATE MEDICAL CENTER, BAYSTATE FRANKLIN MEDICAL CENTER, BAYSTATE MARY LANE HOSPITAL, BAYSTATE NOBLE HOSPITAL, BAYSTATE WING HOSPITAL, COOLEY DICKINSON HEALTH CARE, HOLYOKE MEDICAL CENTER, MERCY MEDICAL CENTER (A MEMBER OF SISTERS OF PROVIDENCE HEALTH SYSTEM), SHRINERS HOSPITALS FOR CHILDREN - SPRINGFIELD, AND HEALTH NEW ENGLAND, A LOCAL HEALTH INSURER WHOSE SERVICE AREAS COVERS THE FOUR COUNTIES OF WESTERN MASSACHUSETTS THE COALITION FORMED IN 2012 WHEN SEVEN WESTERN MASSACHUSETTS HOSPITALS JOINED TOGETHER TO SHARE RESOURCES AND WORK IN PARTNERSHIP TO CONDUCT THEIR COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNA) AND ADDRESS REGIONAL NEEDS THE COALITION HAS SINCE EXPANDED TO TEN MEMBERS AND IS CURRENTLY CONDUCTING COLLABORATIVE WORK TO ADDRESS MENTAL HEALTH NEEDS IN THE REGION CDHC HAS BEEN PART OF THE COALITION SINCE 2012 AND WORKED COLLABORATIVELY WITH THE COALITION ON SELECT ASPECTS OF THE 2013 CHNA PROCESS THIS CHNA WAS CONDUCTED IN COLLABORATION WITH THE OTHER COALITION HOSPITALS/INSURERS INTEGRAL TO THIS NEEDS ASSESSMENT WAS THE PARTICIPATION AND SUPPORT OF COMMUNITY LEADERS AND REPRESENTATIVES WHO PROVIDED INPUT THROUGH STEERING COMMITTEE PARTICIPATION, STAKEHOLDER INTERVIEWS AND FOCUS GROUPS, A PRELIMINARY FINDINGS REVIEW MEETING, AND A COMMUNITY LISTENING SESSION

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

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

Form and Line Reference	Explanation
PART V, SECTION B - LINES 7 AND 10	HOSPITAL FACILITY CHNA AND IMPLEMENTATION STRATEGY WEBSITES THE GENERAL HOSPITAL CORPORATIONHTTP //WWW MASSGENERAL ORG/CCHI/THE BRIGHAM AND WOMEN'S HOSPITAL, INC HTTP //WWW BRIGHAMANDWOMENS ORG/ABOUT_BWH/COMMUNITYPROGRAMS/CHNAREPORTS ASPXNORTH SHORE MEDICAL CENTER, INC HTTP //NSMC PARTNERS ORG/ABOUT_NSMC/COMMITMENT_TO_COMMUNITYNEWTON-WELLESLEY HOSPITALHTTPS //WWW NWH ORG/ABOUT-US/COMMUNITY-HEALTH-ASSESSMENTBRIGHAM AND WOMEN'S/FAULKNER HOSPITALHTTP //WWW BRIGHAMANDWOMENSFAULKNER ORG/ABOUT-US/GENERAL-INFORMATION/COMMUNITY-HEALTH-AND-WELLNESS/DEFAULT ASPX?SUB=0# VRO5KDIRLCSTHE MCLEAN HOSPITAL CORPORATIONHTTP //WWW MCLEANHOSPITAL ORG/NEWS/PUBLICATIONS?TAB=COMMUNITY-BENEFITS-REPORTSPAULDING REHABILITATION HOSPITAL CORPORATIONHTTP //SPAULDINGREHAB ORG/ABOUT/COMMUNITY-INVOLVEMENTREHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATIONHTTP //SPAULDINGREHAB ORG/ABOUT/COMMUNITY-INVOLVEMENTSPAULDING HOSPITAL - CAMBRIDGE, INC HTTP //SPAULDINGREHAB ORG/ABOUT/COMMUNITY-INVOLVEMENTNANTUCKET COTTAGE HOSPITALHTTP //NANTUCKETHOSPITAL ORG/2015-NANTUCKET-COMMUNITY-HEALTH-NEEDS-ASSESSMENT/MARTHA'S VINEYARD HOSPITALHTTPS //WWW MVHOSPITAL COM/ABOUT/2016-COMMUNITY-HEALTH-NEEDS-ASSESSMENTCOOLEY DICKINSON HOSPITAL, INC HTTPS //WWW COOLEYDICKINSON ORG/ABOUT-US/COMMITMENT-TO-COMMUNITY/BENEFITING-OUR-COMMUNITY/

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	PLEASE SEE THE CHNAS AND IMPLEMENTATION STRATEGIES FOR EACH OF THE HOSPITAL FACILITIES AT THE APPLICABLE URL LISTED IN PART V, SECTION B FOLLOWING ARE SOME EXAMPLES OF HOW THE PAR TNERS HOSPITALS ARE ADDRESSING THE HEALTH NEEDS IDENTIFIED THE GENERAL HOSPITAL CORPORATIO NCHNA SUB GOAL PREVENT AND REDUCE ADOLESCENT SUBSTANCE USE AND MENTAL HEALTH ISSUESOBJECT IVE 1 DECREASE THE NUMBER OF YOUTH FEELING SAD OR DOWN IN THE LAST TWO WEEKS BY 5%OBJECTI VE 2 REDUCE ADOLESCENT SUBSTANCE, PARTICULARLY MARIJUANA USE, AND INCREASE PERCEPTION OF HARM FROM SUBSTANCES BY 10% STRATEGY 1 INCREASE JOB SHADOW-SHIP PROGRAMS AND YOUTH JOBS-- CONNECT SCHOOLS AND ORGANIZATIONS WITH PROFESSIONALS TO EXPOSE YOUTH TO CAREERS AND EDUCAT IONAL OPPORTUNITIES THROUGHOUT THE COMMUNITIES--WORK WITH MGH YOUTH PROGRAMS TO SUPPORT SU MMER JOBS FOR YOUTH FROM CHELSEA, REVERE, CHARLESTOWN, AND E BOSTONSTRATEGY 2 ENHANCE AD ULT CAPACITIES FOR INFORMAL AND FORMAL MENTORSHIPS AND COMMUNICATION WITH YOUTH --EDUCATE PARENT/GUARDIAN ON SUBSTANCES AND USE AS WELL AS THEIR SKILLS IN COMMUNICATING WITH THEIR CHILD(REN) ABOUT THE DANGERS OF SUBSTANCES, AND SETTING EXPECTATIONS AND RULES--USE EXISTI NG GROUPS AS A PLACE TO BUILD BONDS WITH ADULTS (CHARLESTOWN 02129 YOUTH GROUP, BOYS AND G IRLS CLUBS, AFTER SCHOOL PROGRAMS)STRATEGY 3 COLLABORATE WITH ORGANIZATIONS TO ADVOCATE F OR AGE APPROPRIATE YOUTH ACTIVITIES IN EACH COMMUNITY--SUPPORT THE EXPANSION OF AFTER SCHO OL PROGRAMMING AND ACTIVITIES TO PROVIDE YOUTH WITH HEALTHY ACTIVITIES THAT DEVELOP PRO SO CIAL SKILLS, RESILIENCE, AND OTHER CORE DEVELOPMENTAL ASSETS--PARTNER TO ORGANIZE ACTIVITI ES FOR YOUTH, DESIGNED BY YOUTHSTRATEGY 4 ENGAGE YOUTH AS PART OF EACH COMMUNITY COALITIO N--SUPPORT STRONG YOUTH GROUPS FOR EACH COALITION--PRESENT ASSESSMENT FINDINGS TO YOUTH TO PRIORITIZE ACTIVITIES--SUPPORT YOUTH GROUP TO CREATE SOCIAL MEDIA CAMPAIGN IN EACH COMMUN ITY (SEE BELOW)--SUPPORT AND GUIDE YOUTH TO MAKE POSITIVE DIFFERENCES IN THEIR COMMUNITIES STRATEGY 5 INCREASE COPING SKILLS OF YOUTH AND ADULTS TO POSITIVELY MANAGE AND REDUCE STR ESS--SUPPORT SCHOOLS TO OFFER STRESS?MANAGEMENT SKILL BUILDING TO STUDENTS--SUPPORT COALIT ION YOUTH GROUP TO CREATE STRESS MANAGEMENT OPPORTUNITIES WITH THEIR PEERS STRATEGY 6 IMP LEMENT SOCIAL MARKETING CAMPAIGN TO INCREASE PERCEPTION OF HARM OF ADOLESCENT MARIJUANA US E--DEVELOP AND IMPLEMENT ORIGINAL MEDIA CAMPAIGN ABOUT LOCAL YOUTH SUBSTANCE USE ISSUES, I NCLUDING LOCAL YRBS DATA, EDUCATION ON RECREATIONAL MARIJUANA, INCREASING AWARENESS OF MAR IJUANA USE AND ITS EFFECTS ON THE DEVELOPING TEEN BRAIN--CREATE AND MAINTAIN SOCIAL MEDIA ACCOUNTS TO PROMOTE YOUTH CAMPAIGN AND OTHER YOUTH RELATED COMMUNITY & COALITION ACTIVITIE S (INSTAGRAM, FACEBOOK, TWITTER)STRATEGY 7 COLLABORATE WITH SCHOOLS AND ORGANIZATIONS TO INCORPORATE A CURRICULUM THAT ADDRESSES SUBSTANCE USE AND MENTAL WELL BEING--INVESTIGATE C URRENT HEALTH PREVENTION CURRICULA IN SCHOOLS & COMMUNITY, COMMUNICATE RESULTS TO ALL STAK EHOLDERS--IDENTIFY OPPORTUNITI

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	ES TO STRENGTHEN/INCREASE IMPLEMENTATION OF EVIDENCE BASED PREVENTION CURRICULA AND HEALTH EDUCATION IN SCHOOLS, AFTER SCHOOL PROGRAMS, AND COMMUNITY ORGANIZATIONS THE BRIGHAM AND WOMEN'S HOSPITAL, INC OBJECTIVE PROVIDE AN INTEGRATED AND EFFECTIVE RESPONSE TO THOSE EXPE RIENCING INTERPERSONAL VIOLENCE AND BUILD SYSTEM CAPACITY TO PROVIDE TRAUMA INFORMED CARE 1 1 1 INTERPERSONAL VIOLENCE--PROVIDE ADVOCACY, SAFETY PLANNING AND SUPPORTIVE COUNSELING FOR PATIENTS WHO EXPERIENCE INTERPERSONAL VIOLENCE (DOMESTIC VIOLENCE AND COMMUNITY VIOLEN CE)--OFFER FREE AND CONFIDENTIAL ADVOCACY SERVICES TO THE WIDER COMMUNITY THROUGH A DOMEST IC VIOLENCE ADVOCATE BASED AT A COMMUNITY SITE --PROVIDE DIRECT INTERVENTION TO PATIENTS W HO ARE IMPACTED BY SEXUAL VIOLENCE AND HUMAN TRAFFICKING --COLLABORATE WITH KEY COMMUNITY PARTNERS TO OFFER SUPPORTIVE VIOLENCE PREVENTION EDUCATION TO YOUNG PEOPLE IN HIGH RISK EN VIRONMENTS --COORDINATE AND COLLABORATE WITH THE CITY OF BOSTON AND LOCAL HOSPITALS ON ISS UES OF INTERPERSONAL VIOLENCE PREVENTION AND INTERVENTION--DEVELOP AND IMPLEMENT STRATEGIE S TO FURTHER INTEGRATE THE BWH RESPONSE WITH THE CITY OF BOSTON STREET-WORKER PROGRAM --DE VELOP AND IMPLEMENT A HOSPITAL WIDE POLICY ON INTERPERSONAL VIOLENCE INCLUSIVE OF DOMESTIC , SEXUAL, COMMUNITY VIOLENCE AND HUMAN TRAFFICKING 1 1 2 TRAUMA INFORMED CARE (TIC)--IN CO LLABORATION WITH THE PARTNERS TIC NETWORK, PROVIDE LEARNING OPPORTUNITIES FOR BWHC STAFF T O DEVELOP AWARENESS, SKILLS AND CONFIDENCE IN PROVIDING TRAUMA INFORMED CARE --DEVELOP AND IMPLEMENT AN EFFECTIVE HOSPITAL-WIDE POLICY ON THE PROVISION OF TRAUMA INFORMED CARE PRIO RITY 2 ACCESS TO HEALTHCARE STRENGTHEN ACCESS FOR COMMUNITY MEMBERS TO ENABLE IMPROVED HEA LTH OUTCOMES OBJECTIVE ADDRESS THE BARRIERS THAT HINDER ACCESS TO CARE FOR LOW INCOME PATI ENTS AND COMMUNITY MEMBERS NORTH SHORE MEDICAL CENTER, INC - BOTH NSMC FACILITIESGOAL E NSURE ACCESS TO CARE BY ENGAGING PATIENTS IN PRIMARY AND SPECIALTY CARE, PROVIDING PATIENT NAVIGATION SERVICES AND OTHER SUPPORTS FOR VULNERABLE AND/OR HIGH RISK PATIENTS, AND COOR DINATING PATIENT HEALTH INSURANCE COVERAGESTRATEGIES --PRIMARY CARE CONNECTION ENSURE THA T PATIENTS WITHOUT PRIMARY CARE PHYSICIANS (PCPS) WHO PRESENT AT THE EMERGENCY DEPARTMENT (ED) ARE PROVIDED WITH A PROMPT FOLLOW-UP APPOINTMENT AT THE APPROPRIATE COMMUNITY HEALTH CENTER (CHC) --NSMC'S CACS PROVIDE INFORMATION ABOUT THE FULL RANGE OF INSURANCE PROGRAMS OFFERED BY EOHHS AND THE HEALTH CONNECTOR OUR CACS HELP INDIVIDUALS COMPLETE AN APPLICATI ON OR RENEWAL, WORK WITH THE INDIVIDUAL TO PROVIDE REQUIRED DOCUMENTATION, SUBMIT APPLICAT IONS AND RENEWALS FOR THE INSURANCE PROGRAMS, INTERACT WITH EOHHS AND THE HEALTH CONNECTOR ON THE STATUS OF SUCH APPLICATIONS AND RENEWALS, AND HELP FACILITATE ENROLLMENT OF APPLIC ANTS OR BENEFICIARIES IN INSURANCE PROGRAMS -- SPECIALTY ACCESS PROGRAM PROVIDE SPECIALTY CARE TO ALL WHO NEED IT, ESPECIALLY HEALTH SAFETY NET, MEDICAID/MASSHEALTH, AND COMMONWEAL TH CARE PATIENTS IN ADDITION T

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	O THE UNINSURED AND UN-ENROLLED PATIENTS (VIA CONNECTING WITH THE APPROPRIATE STATE INSURA NCE PLAN) --HEALTH CARE TRANSPORTATION ASSISTANCE PROGRAM--COMPLEX CARE MANAGEMENT INITIAT IVE ("CCMI") PROJECT PROVIDE HIGH RISK PATIENTS WITH A SPECIALLY DESIGNED TEAM MODEL OF C ARE WHICH USES THE SERVICES OF SPECIALLY TRAINED COMMUNITY HEALTH WORKERS ACTION STATUS -- ASSIGNED A FULL TIME HIGHLY EXPERIENCES PATIENT NAVIGATOR TO THE NSMC ED TO IDENTIFY AND C ONNECT WITH HIGH UTILIZERS AND OTHERS WHO USE THE ED UNNECESSARILY BECAUSE OF LACK OF EDUC ATION OR ACCESS TO APPROPRIATE PRIMARY CARE --IN FY15, THERE WERE 9 5 NORTH SHORE MEDICAL CENTER CACS THAT SERVED AN ESTIMATED 3,473 INDIVIDUALS --IN FY15 WE CONTINUED TO WORK WITH NORTH SHORE CARDIOVASCULAR ASSOCIATES (AN AVERAGE OF 13 PATIENTS PER MONTH) AND THE UROLO GY PRACTICE (AN AVERAGE OF 15 PATIENTS PER MONTH) TO PROVIDE CARE TO PATIENTS THROUGH THIS DELIVERY MODEL --MORE THAN 3000 TAXI VOUCHERS AND 500 T PASSES WERE PROVIDED DURING FY 20 15 --DEMONSTRATION PROJECT PERIOD CAME TO AN END COMPARISON OF PRE AND POST ENROLLMENT DA TA SHOWED STATISTICALLY SIGNIFICANT DECREASES IN THE MEAN NUMBER OF ED VISITS AND INPATIEN T DAYS AND A STATISTICALLY SIGNIFICANT INCREASE IN PATIENTS WITH NO INPATIENT ADMISSIONS N EWTON-WELLESLEY HOSPITALWALTHAM, IN GENERAL OBJECTIVE WALTHAM IS A UNIQUE COMMUNITY IN TH E NWH SERVICE AREA WHILE THE OTHER CITIES AND TOWNS IN THE SERVICE AREA TEND TO HAVE SIMI LAR DEMOGRAPHIC PROFILES, WALTHAM LOOKS SOMEWHAT DIFFERENT WALTHAM HAS A MORE AFFORDABLE COST OF LIVING AND HAS MORE RACIAL AND ETHNIC DIVERSITY HOWEVER, WALTHAM RESIDENTS HAVE L OWER MEDIAN HOUSEHOLD INCOMES AND EDUCATIONAL ATTAINMENT WALTHAM ALSO EXPERIENCES DISPROP ORTIONATELY WORSE HEALTH OUTCOMES COMPARED TO THE OTHER CITIES AND TOWNS IN THE AREA BEIN G IDENTIFIED AS THE COMMUNITY IN NEED OF THE GREATEST NUMBER OF RESOURCES, NWH WILL SEEK T O ENGAGE WITH THE CITY OF WALTHAM THROUGH A VARIETY OF HIGH-IMPACT INITIATIVES THAT WILL A DDRESS THE AFOREMENTIONED NEEDS STRATEGIES --CREATE THE WALTHAM WELLNESS COLLABORATIVE I N PARTNERSHIP WITH HEALTHY WALTHAM --PROVIDE SCREENING MAMMOGRAMS FOR WOMEN AT THE HOME SU ITES INN --PROVIDE SCHOOL PHYSICALS FOR UNDERPRIVILEGED YOUTH --CONDUCT MENTAL WELLNESS SE MINARS FOR PARENTS AT THE HOME SUITES INN --CONDUCT HEALTHCARE RELATED SEMINARS FOR THE HO MELESS --PROVIDE TAXI VOUCHERS TO HOMELESS SHELTERS SUBSTANCE ABUSE OBJECTIVE SUBSTANCE A BUSE WAS RAISED CONSISTENTLY DURING THE CHNA PROCESS DRUG USE CUTS ACROSS ALL SOCIOECONOM IC AND GEOGRAPHIC BOUNDARIES STRATEGIES --NWH WILL PROVIDE NASAL NALOXONE KITS (NARCAN) FOR USE BY FIRST RESPONDERS INCLUDING POLICE AND FIRE PERSONNEL AS WELL AS DEPARTMENTS OF HEALTH --NWH WILL PROVIDE OR ARRANGE ANY NECESSARY/APPROPRIATE TRAINING FOR USE OF THE KI TS

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	--SPONSOR HIGH SCHOOL-BASED ON-SITE EVENT AS A MEANS FOR AN ALTERNATIVE SOCIAL OUTLET --S PONSOR ON-LINE ALCOHOL EDUCATION PROGRAM FOR 9TH GRADE STUDENTS AND PARENTS BRIGHAM AND W OMEN'S FAULKNER HOSPITAL OBJECTIVE BY SEPTEMBER 2019, INCREASE AWARENESS OF CHRONIC DISEA SE MANAGEMENT AND PREVENTION THROUGH EDUCATION AND SCREENINGS STROKE--EDUCATE THE COMMUNIT Y ON STROKE SIGNS AND SYMPTOMS AND THE IMPORTANCE OF GETTING TO THE HOSPITAL --PROVIDE A S TROKE SUPPORT GROUP FOR STROKE SURVIVORS AND OR THEIR CAREGIVERS --MAINTAIN AN ACTIVE HOSP ITAL BASED STROKE COMMITTEE TO ENSURE THE HIGHEST LEVEL OF CARE FOR STROKE PATIENTS CARDI OVASCULAR DISEASE --EDUCATE THE COMMUNITY ABOUT HEART DISEASE AND DIABETES --PROVIDE SCREE NING PROGRAMS TO HELP RESIDENTS IDENTIFY AND OR MONITOR RISK FACTORS SUCH AS CHOLESTEROL L EVELS, GLUCOSE AND BLOOD PRESSURE --PARTICIPATE IN AWARENESS AND EDUCATION CAMPAIGNS --MAI NTAIN A COLLABORATIVE CORE MEASURE IMPROVEMENT TEAM FOR THE PREVENTION OF CHF READMISSION DIABETES--DEVELOP AND IMPLEMENT A DIABETES EDUCATION PROGRAM BASED ON THE AADE7 SELF-CARE BEHAVIORS --HEALTHY EATING MAKING HEALTHY FOOD CHOICES, UNDERSTANDING PORTION SIZES, LEA RNING THE BEST TIMES TO EAT, LEARNING THE EFFECT FOOD HAS ON BLOOD GLUCOSE, READING LABELS , PLANNING AND PREPARING FOODS, UNDERSTANDING AND COPING WITH BARRIERS AND TRIGGERS, ETC --BEING ACTIVE REGULAR ACTIVITY FOR OVERALL FITNESS, WEIGHT MANAGEMENT, BLOOD GLUCOSE CON TROL, IMPROVE BMI, ENHANCE WEIGHT LOSS, CONTROL LIPIDS, BLOOD PRESSURE AND REDUCE STRESS --MONITORING DAILY SELF-MONITORING OF BLOOD GLUCOSE TO HELP ASSESS HOW FOOD, PHYSICAL ACT IVITY AND MEDICATION AFFECT LEVELS MCLEAN HOSPITAL CORPORATION IMPLEMENTATION STRATEGIES --EXPAND PSYCHIATRIC SERVICES TO MEET COMMUNITY NEEDS --IMPROVE COMMUNITY MENTAL HEALTH TH ROUGH INNOVATIVE PROGRAMS --CARE FOR UNINSURED AND UNDERINSURED --STRENGTHEN MENTAL HEALTH THROUGH EDUCATION FOR PROFESSIONALS, CONSUMERS AND THEIR FAMILIES, AND THE PUBLIC --PROVI DE COMMUNITY SUPPORT AND CONTRIBUTIONS ACTIONS --WORK WITH CHNA 17 AND OTHER CHNAS WITHIN MASSACHUSETTS TO FUND MENTAL AND BEHAVIORAL HEALTH PROJECTS IN RESPONSE TO CRITICAL COMMUN ITY NEEDS --EXPAND INPATIENT DETOXIFICATION AND ADDICTION TREATMENT SERVICES --DMH APPROVA L TO OPEN 4 NEW INPATIENT BEDS FOR TREATMENT OF SUBSTANCE USE AND CO-OCCURRING PSYCHIATRIC DISORDERS (WINTER 2017) --OPEN DBT PSYCHO-EDUCATIONAL RESIDENTIAL PROGRAM FOR BOYS AND YO UNG MEN (WINTER 2017) --PILOT EMBEDDING PRIMARY CARE NURSE PRACTITIONERS IN BEHAVIORAL HEA LTH OUTPATIENT CLINICS --COORDINATE AND PROVIDE TIMELY MENTAL HEALTH CONSULTATIONS TO PEDI ATRICIANS AND SCHOOL NURSES IN EASTERN MA AS THEY ADDRESS NEEDS OF PEDIATRIC AND ADOLESCEN T PATIENTS WITH MENTAL HEALTH CHALLENGES --PROVIDE CLINICAL AND PREVENTION SERVICES WITHIN THE BOSTON PUBLIC SCHOOL SYSTEM --HELP COLLEGE STUDENTS WITH MENTAL ILLNESS AND ADJUSTMEN T ISSUES LIVE MORE PRODUCTIVE LIVES SPAULDING REHABILITATION HOSPITAL CORPORATION STRATEGI ES CCHI AND SPAULDING LAUNCHED

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	A PROCESS IN 2014 TO FUND COLLABORATIVE COMMUNITY INITIATIVES THAT SPECIFICALLY ADDRESSED THE NEEDS IDENTIFIED BY THE COMMUNITY THE BUILDING A HEALTHIER CHARLESTOWN GRANT PROGRAM WAS DESIGNED TO REQUIRE MULTIPLE CHARLESTOWN ORGANIZATIONS TO APPLY TOGETHER DEMONSTRATIN G A MEASURABLE IMPACT ON SOCIAL DETERMINANTS OF HEALTH USING EVIDENCE-BASED APPROACHES TO TWO INITIATIVES HAVE EMERGED FROM THIS PROCESS AND EACH ARE IN THE SECOND YEAR OF FUNDING , SUPPORTED BY CCHI AND SPAULDING 1) CANCER / HEALTHY LIVING HEALTHIER LIVING THROUGH GO OD FOOD AND EXERCISE LOCAL CHARLESTOWN ORGANIZATIONS THE KENNEDY CENTER, CAPE (CANCER AWA RENESS PREVENTION & EDUCATION)/ART OF HEALTHY EATING, WHOLE FOODS OF CHARLESTOWN, KIDS COO KING GREEN, AND THE CHARLESTOWN YMCA HAVE PARTNERED TOGETHER TO ADDRESS HEALTHY LIVING AND NUTRITION THROUGH CHILDREN AND PARENT FOCUSED NUTRITION AND EXERCISE CLASSES THE FOCUS I S TO WORK TOGETHER TO PROMOTE AND IMPROVE HEALTH, FITNESS AND QUALITY OF LIFE AND REDUCE C HRONIC DISEASE RISK THROUGH CONSUMPTION OF HEALTHFUL DIETS AND DAILY PHYSICAL ACTIVITY AND ACHIEVEMENT AND MAINTENANCE OF HEALTHY BODY WEIGHTS THE PROGRAM OFFERS MONTHLY ART OF HE ALTHY EATING CLASSES TO OVER 100 CHILDREN AT THE KENNEDY CENTER AS WELL AS SEVERAL PARENT FOCUSED NUTRITION CLASSES, ALONG WITH EXERCISE AND FITNESS COURSES AT THE CHARLESTOWN YMCA 2) EDUCATION CHARLESTOWN EDUCATION COLLABORATIVE BOSTON HOUSING AUTHORITY FOR THE CHAR LESTOWN ADULT EDUCATION PROGRAM (CAEP), BHA CHARLESTOWN ADULT EDUCATION (CAEP), MISHAWUM & CHARLESNEWTOWN HOUSING, SMART FROM THE START AND THE CHARLESTOWN SUBSTANCE ABUSE COALITIO N HAVE PARTNERED TOGETHER WITH THE GOAL TO DEVELOP A CULTURE OF LIFE-LONG LEARNING IN CHAR LESTOWN BY PROVIDING HIGH QUALITY HIGH SCHOOL EQUIVALENCY PREPARATION AND ESOL CLASSES AND FACILITATING HIGH LEVEL COLLEGE AND CAREER READINESS SKILLS IN 2015, 19 OUT OF 25 STUDEN TS IN OUR FAST TRACK CLASS, PASSED THEIR HISET EXAMS (LAST 6 HAVE ONE TEST LEFT), 8 STUDEN TS OBTAINED EMPLOYMENT, 80% OF ESOL STUDENTS ENROLLED IN THE PROGRAM MOVED TO THE NEXT COU RSE LEVEL THIS INITIATIVE HAS ALSO BEEN SUCCESSFUL IN BRINGING IN ADDITIONAL COMMUNITY SU PPORT THROUGH PARTNERSHIPS AND FUNDING SOURCES TO BROADEN THEIR PROGRAMMING AND PLAN FOR L ONG-TERM SUSTAINABILITY REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION PRIOR ITY 1 ACCESS TO SPECIALTY REHABILITATION CARE GOAL 1 IDENTIFY AND REDUCE BARRIERS TO CAR E STRATEGY 1 ADDRESS FINANCIAL BARRIERS TO ACCESSING CARE ACTIONS --CONTINUE TO ASSIST P ATIENTS WITH APPLYING FOR STATE-FUNDED INSURANCE PROGRAMS (I E MASSHEALTH, COMMONHEALTH, CONNECTOR CARE, ETC) --CONTINUE TO ASSIST PATIENTS WITH APPLYING FOR FINANCIAL ASSISTANCE THROUGH THE PARTNERS FINANCIAL ASSISTANCE POLICY STRATEGY 2 ADDRESS TRANSPORTATION BARR IERS TO ACCESSING CARE ACTIONS --EXPLORE OPTIONS TO REMOVE TRANSPORTATION AS A BARRIER TO ACCESSING CARE IN BARNSTABLE COUNTY OPTIONS TO EXPLORE INCLUDE ---COLLABORATION WITH CC RTA/OTHER PROVIDERS --WHERE VI

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	ABLE OPTIONS ARE IDENTIFIED, SCC WILL PARTNER WITH APPROPRIATE ENTITIES TO BRING SUCH ITEM S TO FRUITION --EXPLORE THE FEASIBILITY OF ADOPTING MODELS OF CARE THAT ENABLE DELIVERING TARGETED SERVICES OFF-SITE FOR POPULATIONS AT RISK SPAULDING HOSPITAL - CAMBRIDGE PRIORI TY 2 DISABILITY/ELDER SUPPORT GOAL 1 PROVIDE AND PROMOTE ACTIVITIES THAT PROMOTE SOCIAL INTERACTION AND FITNESS STRATEGY 1 CONNECT ELDER AND DISABLED PATIENTS/RESIDENTS TO COMM UNITY EVENTS ACTIONS --PROMOTE DISABILITY REFRAMED FILM SERIES HOSTED AT SHC TO THE BROAD ER COMMUNITY --MAXIMIZE MARKETING IN LINE WITH DISABILITY AWARENESS MONTH (OCTOBER) --CO NTINUE TO OFFER GROUP MUSIC THERAPY TO PATIENTS WITH NEUROLOGICAL INJURIES AND DISEASES FR EE OF CHARGE FOR SHC'S INPATIENT RESIDENTS --CONTINUE TO INCLUDE RESIDENTS OF YOUVILLE HO USE AS A PART OF MUSIC ON SUNDAY'S PROGRAM HOSTED AT SHC STRATEGY 2 OFFER PROGRAMS FOR D ISABLED RESIDENTS TO ENGAGE IN FITNESS ACTIVITIES ACTIONS --CONTINUE EXPD ROWING PROGRAM TO PROVIDE PARALYZED PERSONS WITH AN OPPORTUNITY TO IMPROVE THEIR CARDIOVASCULAR HEALTH AN D MUSCULAR STRENGTH --CONTINUE TO OFFER ADAPTIVE SPORTS RECREATIONAL PROGRAM TO FOSTER FI TNESS, WELL-BEING, SOCIAL INTERACTION AND ENGAGEMENT WITH THE COMMUNITY --EXPAND COMMUNIC ATION EFFORTS TO PROMOTE ADAPTIVE SPORTS PROGRAMS --EXPLORE OPPORTUNITIES TO CONNECT ADAP TIVE SPORTS PROGRAM TO OTHER ACTIVE DISABLED GROUPS (E G ADAPTIVE CLIMBING GROUP AT BROOK LYN BOULDERS) --CONTINUE HOSTING THE ANNUAL YOUTH WITH DISABILITIES SOCCER CLINIC IN PARTN ERSHIP WITH THE NEW ENGLAND REVOLUTION NANTUCKET COTTAGE HOSPITAL ALCOHOL AND SUBSTANCE U SE DISORDERS TO ADDRESS THE ALCOHOL AND SUBSTANCE USE DISORDERS ISSUE IN THE NANTUCKET COM MUNITY, IDENTIFY GAPS IN SERVICES FOR THOSE IN NEED, AND SUPPORT THE EFFORTS OF THE NANTUC KET BEHAVIORAL HEALTH TASK FORCE AND OTHER COMMUNITY EFFORTS IN THESE AREAS ACCESS TO HOU SING PLAY A PROACTIVE ROLE IN HELPING TO ADDRESS THE ISLAND'S AFFORDABLE HOUSING CRISIS, A ND USE NCH'S POSITION AS ONE OF THE LARGEST PRIVATE EMPLOYERS ON THE ISLAND TO ADVOCATE FO R AND IMPLEMENT SOLUTIONS MENTAL HEALTH DISORDERS CONTINUE TO SERVE AS THE ACUTE SAFETY N ET FOR ISLAND PATIENTS REQUIRING PSYCHIATRIC EVALUATION, STABILIZATION, OBSERVATION, AND/O R TRANSFER OFF ISLAND IDENTIFY GAPS IN SERVICES AND SUPPORT THE WORK OF THE BEHAVIORAL HE ALTH TASK FORCE TO FILL THEM AND COLLABORATE WITH OTHER COMMUNITY AGENCIES AND INITIATIVES CANCER TO PROVIDE CANCER SCREENINGS AND EDUCATION TO THE NANTUCKET COMMUNITY, WHILE SUST AINING THE GROWTH IN NCH'S CANCER CARE PROGRAM TO PROVIDE MORE ON ISLAND SERVICES TO CANCE R PATIENTS

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	MARTHA'S VINEYARD HOSPITAL, INC OUTLINE FOR STRATEGY AND IMPLEMENTATION ACCESS TO HEALTHC ARE GOAL TO ADDRESS THE ISSUE OF ACCESS TO HEALTHCARE --TIMELINE 1 YEAR PARTNERS MVH P HYSICIAN GROUP, ADMINISTRATION STRATEGY ENHANCE ACCESS TO HEALTHCARE ACTION RECRUIT HEAL THCARE PROVIDERS CONTINUE TO WORK TO ENSURE HEALTHCARE COVERAGE THROUGH OUR FINANCIAL COU NSELORS/CERTIFIED APPLICATION COUNSELORS (CACS) ACTION STATUS IN THE PROCESS OF ACTIVELY EXPANDING OUR PRIMARY CARE PRACTICES TO IMPROVE ACCESS TO CARE BY AGGRESSIVELY RECRUITING PRIMARY CARE PHYSICIANS AND INCREASING OUR EMPLOYMENT OF MID-LEVEL PROVIDERS IN THE PRIMA RY CARE ARENA IN ADDITION, EVALUATING THE NEED FOR ACCESS TO SPECIALTY CARE AND EXPANDING OUR ORTHOPEDIC PRACTICE AND PAIN MANAGEMENT SERVICES AS WELL AS ACCESS TO OUR ONCOLOGY PA RTNERSHIP WITH THE MASSACHUSETTS GENERAL HOSPITAL HOUSING GOAL TO PLAY A PROACTIVE ROLE IN HELPING TO ADDRESS THE ISLAND'S SHORTAGE OF AFFORDABLE HOUSING BY USING OUR POSITION AS ONE OF THE LARGEST EMPLOYERS ON THE ISLAND TO ADVOCATE FOR SOLUTIONS --TIMELINE 3 YEARS PARTNERS ADMINISTRATION STRATEGY DEVELOP A MASTER FACILITY PLAN (MFP) INCREASE THE STO CK OF HOSPITAL-OWNED HOUSING TO DECREASE PRESSURE ON THE ISLAND HOUSING RENTAL POOL PROVI DE ASSISTANCE TO STAFF TO OBTAIN OWNED HOUSING WHICH LIKEWISE DECREASES PRESSURE ON THE IS LAND HOUSING RENTAL POOL ACTION INITIAL MFP COMMITTEE MEETING AUGUST 24 DEVELOP AN EMPL OYEE HOUSING PLAN THAT INCLUDES HOUSING PURCHASES AND A HOMEOWNER ASSISTANCE PLAN ACTION STATUS WE HAVE BEGUN WORK ON THE MASTER FACILITY PLAN AND HAVE PURCHASED PROPERTY THAT IS BEING CONVERTED INTO STAFF HOUSING WE HAVE HELPED EMPLOYEES WITH LOANS TO HELP OBTAIN PE RMANENT HOUSING COOLEY DICKINSON HOSPITAL, INC A NUMBER OF SOCIAL, ECONOMIC AND COMMUNITY LEVEL FACTORS WERE IDENTIFIED AS PRIORITIZED COMMUNITY HEALTH NEEDS IN CDHC'S 2011 CHNA AN D CONTINUE TO IMPACT THE HEALTH OF THE POPULATION IN THE CDHC SERVICE AREA SOCIAL, ECONOM IC, AND COMMUNITY LEVEL NEEDS IDENTIFIED IN THIS CHNA INCLUDE --LACK OF RESOURCES TO MEET BASIC NEEDS - THE CDHC SERVICE AREA HAS HIGHER RATES OF POVERTY THAN THE STATE, WITH THE H IGHEST RATES FOUND IN AMHERST AND NORTHAMPTON TWENTY-SIX PERCENT OF CHILDREN LIVING IN TH E CDHC SERVICE AREA QUALIFY FOR FREE OR REDUCED LUNCH ALTHOUGH THE MEDIAN FAMILY INCOME I N HAMPSHIRE COUNTY IS COMPARABLE TO THE STATE, A NUMBER OF COMMUNITIES FALL BELOW THIS AMO UNT THE LOWEST MEDIAN FAMILY INCOMES WERE FOUND IN PARTS OF NORTHAMPTON AND EASTHAMPTON IN THE COMMUNITIES OF EASTHAMPTON AND NORTHAMPTON, 8% OF ELIGIBLE INDIVIDUALS DO NOT HAVE A HIGH SCHOOL DIPLOMA WHICH CONTRIBUTES TO UNEMPLOYMENT AND THE ABILITY TO EARN A LIVABLE WAGE --HOUSING NEEDS - A LACK OF AFFORDABLE HOUSING IS A NEED THAT IMPACTS CDHC SERVICE AR EA RESIDENTS OVER A THIRD OF THE POPULATION IN CDH'S SERVICE AREA IS HOUSING COST BURDENE D HOMELESSNESS ALSO IMPACTS THE HEALTH OF RESIDENTS IN WESTERN MASSACHUSETTS, AND SOME IN DIVIDUALS IN THE CDHC SERVICE

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	AREA INCREASED SERVICES FOR HOMELESS INDIVIDUALS WERE IDENTIFIED AS A NEED POOR HOUSING CONDITIONS ALSO IMPACT THE HEALTH OF RESIDENTS OLDER HOUSING COMBINED WITH LIMITED RESOUR CES TO MAINTAIN THE HOUSING LEADS TO CONDITIONS THAT CAN AFFECT ASTHMA, OTHER RESPIRATORY CONDITIONS AND SAFETY

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

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

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

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

Name and address	Type of Facility (describe)
1 - MGH HEALTH CENTER CHELSEA 100 EVERETT AVENUE 1ST FLOOR 16C CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
2 - MGH CHARLESTOWN HEALTHCARE CENTER 73 HIGH STREET CHARLESTOWN, MA 02129	OUTPATIENT CLINIC & HEALTHCARE CENTER
3 - MGH CHELSEA HEALTHCARE CENTER 151 EVERETT AVENUE FLOORS 1-4 CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
4 - MGH EVERETT FAMILY CARE 19-23 NORWOOD STREET EVERETT, MA 02149	OUTPATIENT CLINIC & HEALTHCARE CENTER
5 - STUDENT HEALTH CENTER AT CHELSEA HIGH S 299 EVERETT AVENUE CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
6 - EMERSON HOSPITAL MGH-RADIATION ONCOLOGY ROUTE 2 CUMMINGS BUILDING CONCORD, MA 01742	OUTPATIENT CLINIC & HEALTHCARE CENTER
7 - MGH ROCA YOUTH HEALTH CENTER 101 PARK STREET 1ST FLOOR CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
8 - MGH REVERE HEALTHCARE CENTER 300 OCEAN AVENUE 3RD FLOOR REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
9 - MGH BACK BAY HEALTHCARE CENTER 388 COMMONWEALTH AVENUE BOSTON, MA 02115	OUTPATIENT CLINIC & HEALTHCARE CENTER
10 - MGH WEST 40 SECOND AVENUE SUITE 200 360 400 WALTHAM, MA 02154	OUTPATIENT CLINIC & HEALTHCARE CENTER
11 - MGH REVERE SCHOOL BASED HEALTH CENTER 101 SCHOOL STREET REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
12 - LABORATORY FOR MOLECULAR MEDICINE 65 LANSDOWNE STREET 3RD FLOOR CAMBRIDGE, MA 02139	OUTPATIENT DIAGNOSTIC LABORATORY
13 - MGH VOICE DISORDER PROGRAM ONE BOWDOIN SQUARE 11TH FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
14 - MGH CARDIOVASCULAR DISEASE PREVENTION CE 25 NEW CHARDON STREET SUITE 301 BOSTON, MA 02114	OUTPATIENT CLINIC & HEALTHCARE CENTER
15 - YAWKEY CENTER FOR OUTPATIENT CARE 32 FRUIT STREET BOSTON, MA 02114	OUTPATIENT CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
16 - MGH CHARLES RIVER PLAZA 165 CAMBRIDGE STREET BOSTON, MA 02114	OUTPATIENT CLINIC
17 - MGH VASCULAR CENTER 52 SECOND AVENUE 2ND FLOOR WALTHAM, MA 02451	OUTPATIENT CLINIC
18 - MGH SPORTS MEDICINE CENTER 175 CAMBRIDGE STREET 4TH FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
19 - MGH SLEEP DISORDERS TESTING UNIT 5 BLOSSOM STREET 2ND FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
20 - MGH OUTPATIENT CARE 275 CAMBRIDGE STREET 3RD FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
21 - MGH CHARLESTOWN MONUMENT STREET COUNSEL 76 MONUMENT STREET 1ST FLOOR CHARLESTOWN, MA 02129	OUTPATIENT CLINIC
22 - MASS GENERALNORTH SHORE CENTER FOR OUT 102 ENDICOTT STREET 1ST AND 2ND FLOORS DANVERS, MA 02129	OUTPATIENT CLINIC & HEALTHCARE CENTER
23 - MGH REVERE BROADWAY HEALTH CENTER 300 BROADWAY REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
24 - MGH RADIATION ONCOLOGY AT NWH 2014 WASHINGTON STREET SOUTH WING NEWTON, MA 02462	OUTPATIENT CLINIC
25 - BROOKSIDE COMMUNITY HEALTH CENTER 3297 WASHINGTON STREET BOSTON, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
26 - SOUTHERN JAMAICA PLAIN HEALTH CENTER 640 CENTRE STREET JAMAICA PLAIN, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
27 - PARTNERS MULTIPLE SCLEROSIS CENTER ONE BROOKLINE PLACE SUITE 227 BROOKLINE, MA 02445	OUTPATIENT CLINIC
28 - TEEN HEALTH CENTER AT ENGLISH HIGH SCH 144 MCBRIDGE STREET 2ND FLOOR BOSTON, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
29 - BRIGHAM AND WOMEN'S AMBULATORY CARE CTR 850 BOYLSTON STREET CHESTNUT HILL, MA 02467	OUTPATIENT CLINIC & HEALTHCARE CENTER
30 - BRIGHAM AND WOMEN'S BEHAVIORAL NEUROLOGY 221 LONGWOOD AVENUE RFB MEZZANINE BOSTON, MA 02115	OUTPATIENT CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
31 - BRIGHAM AND WOMEN'S HOSPITAL OUTP PSY 221 LONGWOOD AVENUE BL BUILDING BOSTON, MA 02115	OUTPATIENT CLINIC
32 - BRIGHAM DERMATOLOGY ASSOCIATES 221 LONGWOOD AVENUE 1ST FLOOR BOSTON, MA 02115	OUTPATIENT CLINIC
33 - BRIGHAM AND WOMEN'S HOSPITAL CARE CENTER 1153 CENTRE STREET 1ST FLOOR BOSTON, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
34 - BRIGHAM MRI RESEARCH CENTER 221 LONGWOOD AVENUE GROUND LEVEL BOSTON, MA 02115	OUTPATIENT CLINIC
35 - BRIGHAM AND WOMEN'S HOSPITAL MOHS AND D 1153 CENTRE STREET SUITE 4349 BOSTON, MA 02130	OUTPATIENT CLINIC
36 - OUTPATIENT ENDOCRINOLOGY AND METABOLIC 221 LONGWOOD AVENUE 2ND FLOOR BOSTON, MA 02115	OUTPATIENT CLINIC
37 - BRIGHAM AND WOMEN'S HOSPITAL MRI AT S 1 COMPASS WAY SUITE 108 EAST BRIDGEWATER, MA 02333	OUTPATIENT CLINIC
38 - BRIGHAM AND WOMEN'SMASS GENERAL HEALTH 20 PATRIOTS PLACE FOXBORO, MA 02035	OUTPATIENT CLINIC & HEALTHCARE CENTER
39 - BRIGHAM AND WOMEN'S HOSPITAL ADVANCED P 301 SOUTH HUNTINGTON AVENUE JAMAICA PLAIN, MA 02115	OUTPATIENT CLINIC
40 - BRIGHAM AND WOMEN'S HOSPITAL IMMUNOLOGY 221 LONGWOOD AVENUE BL-059 BOSTON, MA 02115	CLINICAL LABORATORY
41 - KRAFT FAMILY BLOOD DONOR CTR AT DFCI 35 BINNEY STREET 1ST FLOOR BOSTON, MA 02115	BLOOD DONOR CENTER
42 - WOMEN'S HEALTH CARE CENTER OF THE NORTH 1 HUTCHINSON DRIVE 1ST FLOOR DANVERS, MA 01923	OUTPATIENT CLINIC
43 - NSMC PROFESSIONAL SERVICES 55 HIGHLAND AVENUE SALEM, MA 01923	OUTPATIENT CLINIC
44 - NORTH SHORE MEDICAL CENTER OUTP 490 LYNNFIELD STREET LYNN, MA 01904	OUTPATIENT CLINIC
45 - RADIOLOGY SERVICES AT LYNN COMMUNITY H 269 UNION STREET LYNN, MA 01901	OUTPATIENT CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
46 - NSMC MAGNETIC IMAGING 4 CENTENNIAL DRIVE SUITE 104 PEABODY, MA 01960	OUTPATIENT CLINIC
47 - NORTH SHORE MEDICAL CENTER OUTPATIENT I 1 BLACKBURN CIRCLE LEVEL 1 SUITE 2 GLOUCESTER, MA 01930	OUTPATIENT CLINIC
48 - NEWTON-WELLESLEY FAMILY MEDICINE 111 NORFOLK AVENUE 1ST FLOOR WALPOLE, MA 02081	OUTPATIENT CLINIC
49 - NEWTON-WELLESLEY URGENT CARE DEVINCENT BUILDING 9 HOPE AVENUE WALTHAM, MA 02453	OUTPATIENT CLINIC
50 - NEWTON-WELLESLY HOSPITAL HAND THERAPY 830 BOYLSTON STREET SUITE 212 CHESTNUT HILL, MA 02467	OUTPATIENT CLINIC
51 - NEWTON-WELLESLEY AMBULATORY CARE CENTER 307 WEST CENTRAL STREET 1ST FLOOR NATICK, MA 01760	OUTPATIENT CLINIC
52 - NEWTON-WELLESLEY SLEEP CENTER AT NEWTON 2345 COMMONWEALTH AVENUE BUILDING C NEWTON, MA 02446	OUTPATIENT CLINIC
53 - NEWTON-WELLESLEY HOSPITAL REMOTE RADIOL 2000 WASHINGTON STREET NEWTON, MA 02462	OUTPATIENT CLINIC
54 - NEWTON-WELLESLEY OUTPATIENT SURGERY CTR 25 WASHINGTON STREET WELLESLEY, MA 02481	OUTPATIENT CLINIC
55 - NEWTON-WELLESLEY AMBULATORY CARE CENTER 159 WELLS AVENUE NEWTON, MA 02459	OUTPATIENT CLINIC
56 - MCLEAN SOUTHEAST DEPARTMENT OF VETERANS 940 BELMONT STREET BUILDING 7 BROCKTON, MA 02301	OUTPATIENT CLINIC
57 - SPAULDING OUTPATIENT CENTER - BRIGHTON 20 GUEST STREET SUITE 150 BOSTON, MA 02135	OUTPATIENT CLINIC
58 - SPAULDING OUTPATIENT CENTER - FRAMINGHAM 570 WORCESTER ROAD FRAMINGHAM, MA 01702	OUTPATIENT CLINIC
59 - SPAULDING OUTPATIENT CENTER - MEDFORD 101 MAIN STREET SUITE 101 AND 118-119 MEDFORD, MA 02155	OUTPATIENT CLINIC
60 - SPAULDING OUTPATIENT CENTER - WELLESLEY 65 WALNUT STREET WELLESLEY, MA 02181	OUTPATIENT CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
61 - SPAULDING OUTPATIENT CENTER - BRAINTREE 300 GRANITE STREET 1ST FLOOR BRAINTREE, MA 02184	OUTPATIENT CLINIC
62 - SPAULDING OUTPATIENT CENTER - DOWNTOWN 294 WASHINGTON STREET SUITE 215 BOSTON, MA 02114	OUTPATIENT CLINIC
63 - SPAULDING OUTPATIENT CENTER - CAMBRIDGE 1575 CAMBRIDGE STREET 1ST FLOOR CAMBRIDGE, MA 02138	OUTPATIENT CLINIC
64 - SPAULDING OUTPATIENT CENTER FOR CHILDREN 1 MAGUIRE ROAD 1ST FLOOR LEXINGTON, MA 02421	OUTPATIENT CLINIC
65 - SPAULDING OUTPATIENT CENTER - LYNN 583 CHESTNUT STREET SUITES 3 AND 4 LYNN, MA 01904	OUTPATIENT CLINIC
66 - SPAULDING OUTPATIENT CENTER - MARBLEHEAD 4 COMMUNITY ROAD 2ND FLOOR MARBLEHEAD, MA 01945	OUTPATIENT CLINIC
67 - SPAULDING OUTPATIENT CENTER - MIDDLETON 147 SOUTH MAIN STREET SUITE 300 MIDDLETON, MA 01949	OUTPATIENT CLINIC
68 - SPAULDING OUTPATIENT CENTER - PEABODY 4 CENTENNIAL DRIVE SUITE 101 PEABODY, MA 01960	OUTPATIENT CLINIC
69 - SPAULDING OUTPATIENT CENTER AT LYNCH 40 LEGGIS HILL ROAD 1ST FLOOR SUITE 4D MARBLEHEAD, MA 01945	OUTPATIENT CLINIC
70 - SPAULDING OUTPATIENT CENTER AT BRIGHTV 50 ENDICOTT STREET 2ND FLOOR DANVERS, MA 01923	OUTPATIENT CLINIC
71 - SPAULDING OUTPATIENT CENTER - CAPE ANN 1 BLACKBURN CIRCLE SUITE 2 GLOUCESTER, MA 01930	OUTPATIENT CLINIC
72 - SPAULDING OUTPATIENT CENTER - ORLEANS 65 OLD COLONY WAY SUITE 2 ORLEANS, MA 02653	OUTPATIENT CLINIC
73 - SPAULDING OUTPATIENT CENTER - YARMOUTH 130 ANSEL HALLET ROAD WEST YARMOUTH, MA 02675	OUTPATIENT CLINIC
74 - SPAULDING EILEEN M WARD OUTPATIENT CTR 280-D ROUTE 130 SUITE 7 FORESTDALE, MA 02644	OUTPATIENT CLINIC
75 - SPAULDING AQUATICS PROGRAM - YARMOUTH 579 BUCK ISLAND ROAD WEST YARMOUTH, MA 02673	OUTPATIENT CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
76 - SPAULDING OUTPATIENT CENTER - PLYMOUTH 1 SCOBEE CIRCLE PLYMOUTH, MA 02360	OUTPATIENT CLINIC
77 - COOLEY DICKINSON SOUTH DEERFIELD CENTER 21 B ELM STREET 1ST FLOOR SOUTH DEERFIELD, MA 01373	OUTPATIENT CLINIC
78 - COOLEY DICKINSON HOSPITAL 170 UNIVERSITY DRIVE AMHERST, MA 01002	OUTPATIENT CLINIC
79 - THE COOLEY DICKINSON HOSPITAL OUTPATIENT 10 COLLEGE HIGHWAY SOUTHAMPTON, MA 01073	OUTPATIENT CLINIC
80 - COOLEY DICKINSON HOSPITAL REHAB SERV 58 OLD NORTH ROAD SUITE 1 WORTHINGTON, MA 01098	OUTPATIENT REHAB CLINIC
81 - COOLEY DICKINSON HOSPITAL REHAB SERV 380 RUSSELL STREET 1ST FLOOR HADLEY, MA 01035	OUTPATIENT REHAB CLINIC

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I General Information on Grants and Assistance

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

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 276

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 2

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

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

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

Return Reference	Explanation
USE OF GRANTS/DONATIONS	PARTNERS HEALTHCARE SYSTEM, INC AND AFFILIATES MAKE DONATIONS TO VARIOUS TAX-EXEMPT ORGANIZATIONS THESE DONATIONS CAN BE USED BY THE RECIPIENT ONLY IN FURTHERANCE OF THEIR TAX-EXEMPT MISSION

Additional Data

Software ID:
Software Version:
EIN: 90-0656139
Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE MASSACHUSETTS GENERAL HOSPITAL 55 FRUIT STREET BOSTON, MA 02114	04-1564655	501(C)(3)	155,188,227				TO SUPPORT TAX EXEMPT AFFLILIATE
NEWTON-WELLESLEY HOSPITAL 2014 WASHINGTON STREET NEWTON, MA 02462	04-2103611	501(C)(3)	14,810,913				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE BRIGHAM AND WOMEN'S HOSPITAL INC 75 FRANCIS STREET BOSTON, MA 02115	04-2312909	501(C)(3)	80,654,429				TO SUPPORT TAX EXEMPT AFFLILIATE
THE SPAULDING REHABILITATION HOSPITAL CORP 300 FIRST AVENUE CHARLESTOWN, MA 02129	04-2551124	501(C)(3)	19,642,909				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE GENERAL HOSPITAL CORPORATION 55 FRUIT STREET BOSTON, MA 02114	04-2697983	501(C)(3)	12,875,599				TO SUPPORT TAX EXEMPT AFFLILIATE
BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC 1153 CENTRE STREET BOSTON, MA 02130	04-2768256	501(C)(3)	35,000				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASSACHUSETTS GENERAL PHYSICIANS ORGANIZ 55 FRUIT STREET BOSTON, MA 02114	04-2807148	501(C)(3)	3,757				TO SUPPORT TAX EXEMPT AFFLILIATE
BRIGHAM AND WOMEN'S HEALTH CARE INC 75 FRANCIS STREET BOSTON, MA 02115	04-2921338	501(C)(3)	29,334,339				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PARTNERS HEALTHCARE SYSTEM INC 800 BOYLSTON STREET BOSTON, MA 02199	04-3230035	501(C)(3)	231,204,894				TO SUPPORT TAX EXEMPT AFFLILIATE
NORTH SHORE MEDICAL CENTER INC 81 HIGHLAND AVENUE SALEM, MA 01970	04-3399616	501(C)(3)	23,408,036				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION 75 FRANCIS STREET BOSTON, MA 02115	04-3466314	501(C)(3)	12,668,136				TO SUPPORT TAX EXEMPT AFFLILIATE
MCLEAN HEALTHCARE INC 115 MILL STREET BELMONT, MA 02478	20-4572876	501(C)(3)	24,019,828				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FRC INC 101 MERRIMAC STREET BOSTON, MA 02114	22-2632121	501(C)(3)	4,292,725				TO SUPPORT TAX EXEMPT AFFLILIATE
PARTNERS CONTINUING CARE INC 800 BOYLSTON STREET BOSTON, MA 02199	26-0003495	501(C)(3)	3,449,363				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NEWTON-WELLESLEY HOSPITAL CHARITABLE FOUNDATION 2014 WASHINGTON STREET NEWTON, MA 02462	04-3455952	501(C)(3)	116,613				TO SUPPORT TAX EXEMPT AFFLILIATE
THE MCLEAN HOSPITAL CORPORATION 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-2697981	501(C)(3)	5,000,000				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COOLEY DICKINSON HEALTH CARE CORPORATION 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-2103561	501(C)(3)	45,475,954				TO SUPPORT TAX EXEMPT AFFLILIATE
SPAULDING HOSPITAL CAMBRIDGE 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	27-0273715	501(C)(3)	14,053,725				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3071419	501(C)(3)	4,775,452				TO SUPPORT TAX EXEMPT AFFLILIATE
NORTH SHORE PHYSICIANS GROUP INC 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3080484	501(C)(3)	13,092,744				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SHAUGHNESSY-KAPLAN REHABILITATION HOSPITAL INC 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3067082	501(C)(3)	1,595,559				TO SUPPORT TAX EXEMPT AFFLILIATE
WNR INC 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3419920	501(C)(3)	550,000				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CD PRACTICE ASSOCIATES INC 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3194547	501(C)(3)	10,070,882				TO SUPPORT TAX EXEMPT AFFLILIATE
SOUTH SHORE ENDOSCOPY CENTER INC 399 REVOLUTION DRIVE NO 645 SOMERVILLE, MA 02145	04-3306443	501(C)(3)	700,000				TO SUPPORT TAX EXEMPT AFFLILIATE

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	8,800,000				COMMUNITY BENEFIT PROGRAM
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	4,155,392				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
LYNN COMMUNITY HEALTH CENTER 269 UNION STREET LYNN, MA 01901	04-2525066	501(C)(3)	3,687,223				COMMUNITY BENEFIT PROGRAM
RIZE MASSACHUSETTS 101 HUNTINGTON AVE SUITE 1300 BOSTON, MA 02199	04-2261109	501(C)(3)	3,333,333				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	3,136,404				COMMUNITY BENEFIT PROGRAM
EAST BOSTON (PLS FUNDS) 10 GOVE ST BOSTON, MA 02128	23-7425849	501(C)(3)	1,459,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	1,112,153				COMMUNITY BENEFIT PROGRAM
LYNN COMMUNITY HEALTH CENTER 269 UNION STREET LYNN, MA 01901	04-2525066	501(C)(3)	806,364				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NORTH SHORE COMMUNITY HEALTH 27 CONGRESS STREET SALEM, MA 01970	04-2610447	501(C)(3)	733,570				COMMUNITY BENEFIT PROGRAM
BRIDGEWELL 10 DEARBORN ROAD PEABODY, MA 01960	04-2477820	501(C)(3)	637,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASS LEAGUE OF COMMUNITY HEALTH CENTERS 40 COURT STREET 10TH FL BOSTON, MA 02108	04-2507409	501(C)(3)	537,923				COMMUNITY BENEFIT PROGRAM
MASS LEAGUE OF COMM HEALTH CENTERS 40 COURT STREET 10TH FLOOR BOSTON, MA 02108	04-2507409	501(C)(3)	523,337				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ROXBURY TENANTS OF HARVARD ASSOCIATION 11 NEW WHITNEY STREET BOSTON, MA 02115	04-2555987	501(C)(3)	467,352				COMMUNITY BENEFIT PROGRAM
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	286,597				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HEALTH CARE FOR ALL ONE FEDERAL STREET 5TH FLOOR BOSTON, MA 02110	04-3071598	501(C)(3)	250,271				COMMUNITY BENEFIT PROGRAM
BOYS AND GIRLS CLUBS OF BOSTON (PLS FUNDING) 50 CONGRESS ST STE 730 BOSTON, MA 02109	04-2103922	501(C)(3)	233,614				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UPHAM'S CORNER HEALTH CENTER 500 COLOMBIA RD DORCHESTER, MA 02125	04-2708670	501(C)(3)	225,000				COMMUNITY BENEFIT PROGRAM
BOSTON HEALTH CARE FOR THE HOMELESS 729 MASSACHUSETTS AVENUE BOSTON, MA 02118	04-3160480	501(C)(3)	221,013				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM 780 ALBANY STREET BOSTON, MA 02118	04-3160480	501(C)(3)	221,013				COMMUNITY BENEFIT PROGRAM
MISSION HILL NEIGHBORHOOD HOUSING SERVICES 1620 TREMONT STREET BOSTON, MA 02120	23-7428011	501(C)(3)	202,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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MATTAPAN COMMUNITY HEALTH CENTER 1425 BLUE HILL AVENUE MATTAPAN, MA 02126	04-2544151	501(C)(3)	182,500				COMMUNITY BENEFIT PROGRAM
CHILDREN'S FRIEND AND FAMILY SERVICES 110 BOSTON ST SALEM, MA 01970	04-2526357	501(C)(3)	174,928				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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SCHOLAR ATHLETE PROGRAM 57 MAGAZINE ST BOSTON, MA 02119	27-3987854	501(C)(3)	125,000				COMMUNITY BENEFIT PROGRAM
JAMAICA PLAIN NEIGHBORHOOD DEVELOPMENT COOPERATION 31 GERMANIA STREET JAMAICA PLAIN, MA 02130	04-2652919	501(C)(3)	102,095				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CAMP HARBORVIEW FOUNDATION 200 CLARENDON STREET 60TH FLOOR BOSTON, MA 02117	75-3235491	501(C)(3)	100,000				COMMUNITY BENEFIT PROGRAM
COLLEGE BOUND DORCHESTER 18 SAMOSET STREET DORCHESTER, MA 02124	04-2383512	501(C)(3)	100,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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MAURICE J TOBIN K-8 SCHOOL 40 SMITH STREET ROXBURY, MA 02120	04-6001138	501(C)(3)	92,000				COMMUNITY BENEFIT PROGRAM
LEGAL SERVICES CENTER OF HARVARD LAW SCHOOL 122 BOYLSTON STREET JAMAICA PLAIN, MA 02130	04-2103580	501(C)(3)	90,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BPHC 1010 MASS AVE BOSTON, MA 02118	04-3316655	501(C)(3)	71,489				COMMUNITY BENEFIT PROGRAM
WHITTIER STREET HEALTH CENTER 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	501(C)(3)	71,354				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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BOSTON HOUSING AUTHORITY 52 CHAUNCY ST BOSTON, MA 02111	04-3576423	501(C)(3)	69,813				COMMUNITY BENEFIT PROGRAM
JF KENNEDY FAMILY SERVICES CENTER INC 23A MOULTON ST CHARLESTOWN, MA 02129	04-2373976	501(C)(3)	68,980				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MISSIONSAFE 18 JOHN ELIOT SQUARE ROXBURY, MA 02119	04-3457195	501(C)(3)	65,000				COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS COALITION FOR THE HOMELESS INC 15 BUBIER ST LYNN, MA 01901	22-2599662	501(C)(3)	62,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY SERVICE CARE INC PO BOX 300040 JAMAICA PLAIN, MA 02130	04-2754281	501(C)(3)	61,362				COMMUNITY BENEFIT PROGRAM
EDWARD M KENNEDY ACADEMY 360 HUNTINGTON AVE - 102CA BOSTON, MA 02115	04-3418167	501(C)(3)	60,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MOTHERS FOR JUSTICE AND EQUALITY 184 DUDLEY ST SUITE 109 LL ROXBURY, MA 02119	45-3741482	501(C)(3)	60,000				COMMUNITY BENEFIT PROGRAM
URBAN LEAGUE OF EASTERN MA 88 WARREN STREET ROXBURY, MA 02119	23-7349132	501(C)(3)	60,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CCHERS (FOR HEART CONSORTIUM) 716 COLUMBUS AVE BOSTON, MA 02120	04-3112225	501(C)(3)	56,666				COMMUNITY BENEFIT PROGRAM
BOSTON PRIVATE INDUSTRY COUNCIL 2 OLIVER STREET 7TH FLOOR BOSTON, MA 02109	04-2676661	501(C)(3)	55,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MATTAPAN COMMUNITY HEALTH CENTER 1575 BLUE HILL AVENUE BOSTON, MA 02126	04-2544151	501(C)(3)	55,000				COMMUNITY BENEFIT PROGRAM
SOUTH BOSTON COMMUNITY HEALTH CENTER 409 WEST BROADWAY STREET SOUTH BOSTON, MA 02127	04-2682152	501(C)(3)	55,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNIVERSITY OF MASS DONOHUE INSTITUTE 100 VENTURE WAY SUITE 9 HADLEY, MA 01035	04-3167352	501(C)(3)	53,544				COMMUNITY BENEFIT PROGRAM
SOUTH END COMMUNITY HEALTH CENTER 1601 WASHINGTON STREET BOSTON, MA 02118	04-2456134	501(C)(3)	51,812				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ALL DORCHESTER SPORTS LEAGUE 1565 DORCHESTER AVE DORCHESTER, MA 01211	22-2827346	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
BOSTON PUBLIC HEALTH COMMISSION 1010 MASS AVE BOSTON, MA 02118		501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON SCHOLAR ATHLETES PROGRAM 65 ALLERTON STREET BOSTON, MA 02119	27-3987854	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
BOYS AND GIRLS CLUB OF BOSTON 50 CONGRESS ST STE 730 BOSTON, MA 02109	04-2103922	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
C3 SUMMIT LLC 38 EAST 37TH STREET NEW YORK, NY 10016	45-5047215	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
CAMP HARBOR VIEW (CO THE CONNORS FAMILY OFFICE) 200 CLARENDON STREET 60TH FLOOR BOSTON, MA 02117	75-3235491	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HARVARD UNIVERSITY 1033 MASSACHUSETTS AVE STE 3 CAMBRIDGE, MA 02138	04-2103580	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
HEALTH NETWORK 33 RIVER STREET CHAGRIN FALLS, OH 44022	04-3804600	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LYNN POLICE DEPT 300 WASHINGTON ST LYNN, MA 01902	04-6001397	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
YOUTH AND FAMILY ENRICHMENT SERVICES INC 1234 HYDE PARK AVE SUITE 104 HYDE PARK, MA 02136	05-0588064	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HAWC (HEALING ABUSE WORKING FOR CHANGE) 27 CONGRESS STREET SALEM, MA 01970	04-2655367	501(C)(3)	46,895				COMMUNITY BENEFIT PROGRAM
CLINICAL & SUPPORT OPTIONS 8 ATWOOD DRIVE NORTHAMPTON, MA 01060	04-2206041	501(C)(3)	45,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DIMOCK 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	43,333				COMMUNITY BENEFIT PROGRAM
PROJECT BREAD 145 BORDER STREET EAST BOSTON, MA 02128	04-2931195	501(C)(3)	41,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HEALTH LAW ADVOCATES ONE FEDERAL STREET 5TH FL BOSTON, MA 02110	04-3298116	501(C)(3)	40,000				COMMUNITY BENEFIT PROGRAM
GREATER LYNN SENIOR SERVICES INC 8 SILSBEE ST LYNN, MA 01901	04-2581129	501(C)(3)	39,757				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
A B C D PARKER HILL FENWAY NEIGHBORHOOD 714 PARKER STREET ROXBURY, MA 02120	04-2304133	501(C)(3)	39,000				COMMUNITY BENEFIT PROGRAM
HEALTH RESOURCES IN ACTION (HRIA) 95 BERKELEY ST BOSTON, MA 02116	04-2229839	501(C)(3)	37,492				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TOWN OF MIDDLEBORO FAMILY RESOURCE CENTER AND COUNCIL ON AGING 41 MAYFLOWER AVE MIDDLEBORO, MA 02346	04-6001221	501(C)(3)	35,035				COMMUNITY BENEFIT PROGRAM
IGLESIA LA LUZ DE CRISTO INC 738 BROADWAY CHELSEA, MA 02150		501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BLACK PHILANTHROPY FUND (FUND 4635) C/O THE BOSTON FOUNDATION 75 ARLINGTON ST 10TH FL BOSTON, MA 02116	46-1721740	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM
BOSTON COMMUNITY CAPITAL INC 10 MALCOLM X BOULEVARD BOSTON, MA 02119	04-3246555	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SOCIEDAD LATINA 1530 TREMONT STREET ROXBURY, MA 02120	04-2678255	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM
SPAN INC 105 CHAUNCY ST 6TH FLOOR BOSTON, MA 02111	04-2594873	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UU URBAN MINISTRIES 10 PUTMAN STREET ROXBURY, MA 02119	04-2105897	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM
ROXBURY PRESBYTERIAN CHURCH SOCIAL IMPACT CENTER 328 WARREN STREET ROXBURY, MA 02119	04-3506648	501(C)(3)	34,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE DIMOCK CENTER 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	33,333				COMMUNITY BENEFIT PROGRAM
DIMOCK COMMUNITY HEALTH CENTER INC 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	33,333				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
E INC (AN ENVIRONMENT SCIENCE LEARNING & ACTION CENTER) 114 16TH ST ROOM 1030 BOSTON, MA 02129	02-0580037	501(C)(3)	33,000				COMMUNITY BENEFIT PROGRAM
ORTHOPAEDIC RESEARCH AND EDUCATION FOUND 9400 WEST HIGGINS ROAD SUITE 215 ROSEMONT, IL 60018	36-6009467	501(C)(3)	33,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
REVERE ON THE MOVE -CITY OF REVERE 45 SCHOOL STREET BOSTON, MA 02108	22-3061699	501(C)(3)	33,000				COMMUNITY BENEFIT PROGRAM
GIRLS INCORPORATED OF LYNN 50 HIGH STREET LYNN, MA 01902	04-2104250	501(C)(3)	32,608				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HOMESTART INC 552 MASS AVE SUITE 208A CAMBRIDGE, MA 02139	04-3311270	501(C)(3)	31,213				COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH 130 BOWDOIN STREET SUITE 309 BOSTON, MA 02108	04-2104711	501(C)(3)	30,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ALTERNATIVE FOR COMMUNITY AND ENVIRONMENT 2201 WASHINGTON ST SUITE 302 ROXBURY, MA 02119	04-3228509	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BARAKA COMMUNITY WELLNESS 122 ELM HILL AVE UNIT 200 BOSTON, MA 02121	46-2584139	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM
DIMOCK CHC 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ST STEPHEN'S YOUTH PROGRAM 31 LENOX STREET BOSTON, MA 02118	26-1749602	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM
THE FOUNDATION FOR BOSTON CENTERS FOR YOUTH AND FAMILIES 885 WASHINGTON ST BOSTON, MA 02111	04-2602576	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UROLOGY ASSOCIATES 400 HIGHLAND AVENUE SALEM, MA 01970	04-2498460	501(C)(3)	28,040				COMMUNITY BENEFIT PROGRAM
MV COMMUNITY SERVICES 111 EDGARTOWN RD VINEYARD HAVEN, MA 02568	04-2301598	501(C)(3)	25,830				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
GREATER BOSTON CHAMBER OF COMMERCE 265 FRANKLIN STREET 12TH FLOOR BOSTON, MA 02110	04-1103090	501(C)(3)	25,650				COMMUNITY BENEFIT PROGRAM
AMERICAN CANCER SOCIETY 30 SPEEN STREET FRAMINGHAM, MA 01701	13-1788491	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON PRIVATE INDUSTRY COUNCIL 2 OLIVER STREET 7TH FLOOR BOSTON, MA 02109	04-2676661	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
EAST BOSTON 10 GOVE STREET EAST BOSTON, MA 02128	23-7425849	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EDWARD M KENNEDY INSTITUTE FOR THE UNITED STATES SENATE 210 MORRISSEY BOULEVARD COLUMBIA POINT, MA 02125	27-0963869	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
LAWRENCE GENERAL HOSPITAL 1 GENERAL STREET LAWRENCE, MA 01842	04-2103586	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASSACHUSETTS PUBLIC HEALTH ASSOCIATION 101 TREMONT STREET SUITE 1011 BOSTON, MA 02108	04-2326503	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
PROJECT PLACE 1145 WASHINGTON ST BOSTON, MA 02118	34-2026629	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ROXBURY PRESBYTERIAN CHURCH 328 WARREN STREET ROXBURY, MA 02119	04-3506648	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
THE SCHWARTZ CENTER FOR COMPASSIONATE HEALTHCARE 205 PORTLAND STREET 6TH FLOOR BOSTON, MA 02114	04-1564655	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

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UNITED SOUTH END SETTLEMENTS 566 COLUMBIS AVE BOSTON, MA 02118	04-2104280	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
WAGE PROJECT INC 1443 BEACON ST APT 809 BROOKLINE, MA 02446	02-0703030	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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COLLABORATIVE FOR EDUCATIONAL SERVICES 97 HAWLEY STREET NORTHAMPTON, MA 01060	04-2562893	501(C)(3)	24,280				COMMUNITY BENEFIT PROGRAM
WALTHAM PARTNERSHIP FOR YOUTH 510 MOODY ST WALTHAM, MA 02453	04-3399437	501(C)(3)	23,361				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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VETERANS TAXI 224 CALVARY ST WALTHAM, MA 02453	83-0504026	501(C)(3)	22,440				COMMUNITY BENEFIT PROGRAM
HEALTH CAREERS CONNECTION 300 FRANK OGAWA PLAZA STE 243 OAKLAND, CA 94612	25-1904312	501(C)(3)	20,300				COMMUNITY BENEFIT PROGRAM

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ABCD 178 TREMONT STREET 2ND FLOOR BOSTON, MA 02111	04-2304133	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
COMMUNITY CATALYST ONE FEDERAL ST 5TH FL BOSTON, MA 02110	04-3355127	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM
MACHW 35 HARVARD ST STE 300 WORCESTER, MA 01609	04-2775264	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ST MARY - ST CATHERINE OF SIENA PARISH FOR HARVEST ON THE VINE 46 WINTHROP ST CHARLESTOWN, MA 02129	33-1136053	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM
ALPFA 801 S GRAND AVE SUITE 400 LOS ANGELES, CA 90017	32-0178401	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ARTHRITIS FOUNDATION 1355 PEACHTREE STREET SUITE 600 ATLANTA, GA 30309	58-1341679	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
BIG SISTER ASSOCIATION 161 MASSACHUSETTS AVENUE BOSTON, MA 02115	04-2150651	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CATHOLIC SCHOOLS FOUNDATION INC 260 FRANKLIN STREET SUITE 630 BOSTON, MA 02110	22-2485502	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
HEALTH AND EDUCATION SERVICES (HES) ZERO CENTENNIAL DRIVE PEABODY, MA 01960	04-2777145	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
INTERNATIONAL OCD FOUNDATION CONFERENCE PO BOX 961029 BOSTON, MA 02196	22-2894564	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
JOHN F KENNEDY LIBRARY FOUNDATION COLUMBIA POINT BOSTON, MA 02125	04-6113130	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MASSACHUSETTS BUDGET AND POLICY CENTER 15 COURT SQUARE SUITE 700 BOSTON, MA 02108	04-2967537	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
NATIONAL ASSOCIATION OF CORPORATE DIRECTORS 2001 PENNSYLVANIA AVE NW SUITE 500 WASHINGTON, DC 20006	52-2314113	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ROCA 101 PARK STREET CHELSEA, MA 02150	22-3223641	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
SPECIAL TOWNIES 336 MAIN ST CHARLESTOWN, MA 02129	04-2696004	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE BOSTON FOUNDATION 75 ARLINGTON STREET 10TH FLOOR BOSTON, MA 02116	04-2104021	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
THE NEW ENGLAND COUNCIL 98 NORTH WASHINGTON STREET SUITE 201 BOSTON, MA 02114	04-1661090	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
URBAN IMPROV 8 ST JOHN STREET JAMAICA PLAIN, MA 02130	04-2789576	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
NORTH SHORE CARDIOVASCULAR ASSOCIATES 80 HIGHLAND AVE SALEM, MA 01970	04-2499010	501(C)(3)	14,456				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHARLESTOWN BOYS AND GIRLS CLUB 15 GREEN STREET CHARLESTOWN, MA 02129	04-2103922	501(C)(3)	14,334				COMMUNITY BENEFIT PROGRAM
BOYS & GIRLS CLUB OF BOSTON CHARLESTOWN CLUB 15 GREEN ST CHARLESTOWN, MA 02129	04-2103922	501(C)(3)	13,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
JANE DOE INC 14 BEACON STREET SUITE 507 BOSTON, MA 02108	04-2676138	501(C)(3)	13,000				COMMUNITY BENEFIT PROGRAM
HARVARD MEDICAL SCHOOL 25 SHATTUCK ST BOSTON, MA 02115	04-2103580	501(C)(3)	12,503				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON CENTER FOR INDEPENDENT LIVING 60 TEMPLE PLACE 5TH FLOOR BOSTON, MA 02111	04-2546595	501(C)(3)	12,500				COMMUNITY BENEFIT PROGRAM
CITY OF NORTHAMPTON 210 MAIN ST RM 18 NORTHAMPTON, MA 01060		501(C)(3)	12,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GLAD 30 WINTER STREET SUITE 800 BOSTON, MA 02108	04-2660498	501(C)(3)	12,500				COMMUNITY BENEFIT PROGRAM
UNITED WAY OF HAMPSHIRE COUNTY 71 KING STREET NORTHAMPTON, MA 01060	04-2104792	501(C)(3)	12,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WALTHAM WEST SUBURBAN CHAMBER 84 SOUTH ST WALTHAM, MA 02453	04-1944360	501(C)(3)	11,830				COMMUNITY BENEFIT PROGRAM
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) SCHRAFFTS CENTER 529 MAIN STREET SUITE 1M17 BOSTON, MA 02129	04-2777012	501(C)(3)	11,250				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY 31 SPEEN STREET FRAMINGHAM, MA 01701	13-1788491	501(C)(3)	11,000				COMMUNITY BENEFIT PROGRAM
THE PARTNERSHIP 155 SEAPORT BOULEVARD 13TH FLOOR BOSTON, MA 02210	04-2879910	501(C)(3)	11,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN CONGRESS OF REHABILITATION MEDICINE 11654 PLAZA AMERICA DRIVE SUITE 535 RESTON, VA 20190	36-2170784	501(C)(3)	10,984				COMMUNITY BENEFIT PROGRAM
SPECIAL TOWNIES 336 MAIN ST CHARLESTOWN, MA 02129	04-2696004	501(C)(3)	10,250				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ALZHEIMERS ASSOCIATION OF MANH CHAPTER 480 PLEASANT STREET WATERTOWN, MA 02472	04-2731194	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
ANTI-DEFAMATION LEAGUE 40 COURT STREET FLOOR 12 BOSTON, MA 02108	13-2887439	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ARTHRITIS FOUNDATION 29 CRAFTS STREET NEWTON, MA 02458	58-1341679	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
BOSTON PUBLIC HOUSING CORPORATION 76 MONUMENT ST 2ND FLOOR CHARLESTOWN, MA 02129	04-3576423	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTONCANSHARE 1 CITY HALL SQUARE ROOM 603 BOSTON, MA 02201		501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
CASA LATINA 140 PINE STREET ROOM 6 FLORENCE, MA 01062	22-2477843	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EASTHAMPTON PUBLIC SCHOOLS 50 PAYSON AVE EASTHAMPTON, MA 01027		501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
ENVIRONMENTAL LEAGUE OF MA 14 BEACON STREET SUITE 714 BOSTON, MA 02108	04-2760271	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
FOUNDATION FOR BCYF CAMP JOY THE 1483 TREMONT STREET BOSTON, MA 02120	04-2602576	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
FOUNDATION FOR BCYF CAMP JOYTHE 1483 TREMONT ST BOSTON, MA 02120	04-2602576	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MARCH OF DIMES 1275 MAMARONECK AVE WHITE PLAINS, NY 10605	13-1846366	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
MASS BLACK LAWYERS ASSOCIATION 16 BEACON STREET BOSTON, MA 02108	04-3021895	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MASS HEALTH COUNCIL 200 RESERVOIR ST STE 101 NEEDHAM, MA 02494	04-2296739	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
MASS WOMEN'S POLITICAL CAUCUS EDUCATION FUND 89 SOUTH ST 603 BOSTON, MA 02111	04-2738443	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASSACHUSETTS BUSINESS ALLIANCE FOR EDUCATION 400 ATLANTIC AVENUE BOSTON, MA 02110	04-3274599	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS HOUSING INVESTMENT CORPORATION ON BEHALF OF THE HILLTOWN COMM 70 FEDERAL ST 6TH FLOOR BOSTON, MA 02110	04-3094550	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MULTISERVICE EATING DISORDER ASSOCIATION 92 PEARL STREET NEWTON, MA 02458	04-3224394	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
NEUROSURGERY RESEARCH AND EDUCATION FOUNDATION (NREF) 5550 MEADOWBROOK DRIVE ROLLING MEADOWS, IL 60008	46-2905743	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE BOSTON EDUCATION DEVELOPMENT FOUNDATION INC 50 BUNKER HILL STREET CHARLESTOWN, MA 02129	22-2514422	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
THE BOSTON EDUCATIONAL DEVELOPMENT FOUNDATION FOR THE WARREN PRESCOTT SCHOO 50 SCHOOL ST CHARLESTOWN, MA 02129	22-2514422	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE IMPOSSIBLE DREAM 50 W 47TH ST SUITE 2113 NEW YORK, NY 10036	80-0969365	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
UNITED WAY OF MASS BAY INC 51 SLEEPER ST BOSTON, MA 02210	04-2382233	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED WAY OF MASSACHUSETTS BAY PO BOX 51381 BOSTON, MA 02205	04-2382233	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
URBAN LAND INSTITUTE 2001L STREET NW 200 WASHINGTON, DC 20036	23-7349132	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
URBAN LEAGUE OF BOSTON 88 WARREN STREET ROXBURY, MA 02119	53-0159845	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
URBAN LEAGUE OF EASTERN MASS INC 88 WARREN STREET ROXBURY, MA 02119	23-7349132	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
VICTORY PROGRAMS 965 MASSACHUSETTS AVENUE BOSTON, MA 02118	04-2575322	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
WHITTIER STREET HC 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HARVEST ON VINE FOOD PANTRY 46 WINTHROP STREET CHARLESTOWN, MA 02129	33-1136053	501(C)(3)	9,850				COMMUNITY BENEFIT PROGRAM
GREATER NORTHAMPTON CHAMBER OF COMMERCE 99 PLEASANT STREET NORTHAMPTON, MA 01060	04-1679420	501(C)(3)	9,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WALTHAM PARTNERSHIP FOR YOUTH INC 510 MOODY ST WALTHAM, MA 02453	04-3399437	501(C)(3)	9,245				COMMUNITY BENEFIT PROGRAM
DORCHESTER EAGLES POP WARNER FOOTBALL 145 HOLLINGSWORTH STREET HYDE PARK, MA 02136	04-3237502	501(C)(3)	9,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
KENT CHARLESTOWN COMMUNITY SCHOOL COUNCIL INC 255 MEDFORD STREET SOMERVILLE, MA 02143	04-2760660	501(C)(3)	9,000				COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS ASSN FOR MENTAL HEALTH INC 50 FEDERAL STREET 6TH FLOOR BOSTON, MA 02110	04-2104711	501(C)(3)	9,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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WEST COAST SYMPOSIUM ON ADDICTIVE DISORDERS (C4 RECOVERY) 414 RIDGE ST ALGONQUIN, IL 60102	31-1789558	501(C)(3)	9,000				COMMUNITY BENEFIT PROGRAM
COMMUNITY SERVINGS INC 18 MARBURY TERRACE JAMAICA PLAIN, MA 02130	22-3154028	501(C)(3)	8,334				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JEWISH VOCATIONAL SERVICES 75 FEDERAL STREET 3RD FLOOR BOSTON, MA 02110	04-2104357	501(C)(3)	8,334				COMMUNITY BENEFIT PROGRAM
NEWTON-NEEDHAM CHAMBER COMMERCE 281 NEEDHAM ST NEWTON, MA 02464	04-1670500	501(C)(3)	8,025				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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CHARLESTOWN LACROSSE & LEARNING CENTER 14 GREEN ST CHARLESTOWN, MA 02129	04-3484770	501(C)(3)	8,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN LITTLE LEAGUE POBOX 290642 CHARLESTOWN, MA 02129	37-1513586	501(C)(3)	8,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
GAVIN FOUNDATION INC 675 EAST 4TH STREET BOSTON, MA 02127	04-3220123	501(C)(3)	8,000				COMMUNITY BENEFIT PROGRAM
MISSION GRAMMAR SCHOOL 94 ST ALPHONUS STREET ROXBURY, MA 02120	04-2106198	501(C)(3)	8,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WOMENS LUNCH PLACE 67 NEWBURY STREET BOSTON, MA 02116	22-2514148	501(C)(3)	8,000				COMMUNITY BENEFIT PROGRAM
FRESH TRUCK 196 QUINCY ST BOSTON, MA 02125	46-2848535	501(C)(3)	7,786				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BLACK MINISTERIAL ALLIANCE 7 PALMER STREET 3RD FLOOR ROXBURY, MA 02119	04-3499852	501(C)(3)	7,500				COMMUNITY BENEFIT PROGRAM
RESEARCH AMERICA 1101 KING STREET SUITE 520 ALEXANDRIA, VA 22314	52-1609875	501(C)(3)	7,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PHYSICIAN HEALTH SERVICES 860 WINTER ST WALTHAM, MA 02451	22-3234975	501(C)(3)	7,100				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN YOUTH FOOTBALL AND CHEERING INC 134 OLD ORPMSODES WAY CHARLESTOWN, MA 02129	35-2339457	501(C)(3)	7,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHARLESTOWN YOUTH HOCKEY 9 SHORT ST CHARLESTOWN, MA 02129	04-3040076	501(C)(3)	7,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN YOUTH SOCCER ASSOCIATION PO BOX 290021 CHARLESTOWN, MA 02129	26-0428613	501(C)(3)	7,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CCHERS 360 HUNTINGTON AVE 222 YMCA BOSTON, MA 02115	04-3286409	501(C)(3)	6,668				COMMUNITY BENEFIT PROGRAM
C C H E R S INC 360 HUNTINGTON AVENUE 222 YMCA BOSTON, MA 02115	04-3286409	501(C)(3)	6,666				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EPILEPSY FOUNDATION 335 MAIN STREET WILMINGTON, MA 01887	22-2505819	501(C)(3)	6,000				COMMUNITY BENEFIT PROGRAM
HARBOR HEALTH SERVICES INC 1135 MORTON STREET MATTAPAN, MA 02126	23-7100550	501(C)(3)	6,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SPRINGWELL AREA AGENCY ON AGING 125 WALNUT ST WATERTOWN, MA 02472	04-2616064	501(C)(3)	6,000				COMMUNITY BENEFIT PROGRAM
GRANTMAKERS IN HEALTH 1100 CONNECTICUT AVE NW WASHINGTON, DC 20036	13-3206571	501(C)(3)	5,750				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NATIONAL BRAIN TUMOR SOCIETY 55 CHAPEL STREET SUITE 200 NEWTON, MA 02458	04-3068130	501(C)(3)	5,575				COMMUNITY BENEFIT PROGRAM
DORCHESTER HOUSE MULTI-SERVICE CENTER 1353 DORCHESTER AVE DORCHESTER, MA 02122	23-7125970	501(C)(3)	5,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WHITTIER STREET HEALTH CENTER 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	501(C)(3)	5,500				COMMUNITY BENEFIT PROGRAM
SAFE PASSAGE 43 CENTER ST NORTHAMPTON, MA 01060	04-2690131	501(C)(3)	5,250				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
A BETTER CITY 33 BROAD STREET SUITE 300 BOSTON, MA 02109	04-3036987	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
AIDS ACTION COMMITTEE 75 AMORY STREET ROXBURY, MA 02119	22-2707246	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN OSTEOPATHIC FOUNDATION 142 E ONTARIO ST CHICAGO, IL 60611	36-2170786	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION ANNUAL MEETING 39 MARION RD MONTCLAIR, NJ 07043	13-6215578	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BIG SISTER ASSOCIATION OF GREATER BOSTON 20 PARK PLAZA 1420 BOSTON, MA 02116	04-2150651	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BIG SISTER ASSOCIATION OF GREATER BOSTON 20 PARK PLAZA 1420 BOSTON, MA 02116	04-2150651	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BIOMEDICAL SCIENCE CAREERS PROGRAM 164 LONGWOOD AVENUE 2ND FLOOR BOSTON, MA 02115	04-3241307	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BIOMEDICAL SCIENCE CAREERS PROGRAM 164 LONGWOOD AVENUE 2ND FLOOR BOSTON, MA 02115	04-3241307	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BOCH CENTER (J SPAULDING) 270 TREMONT ST BOSTON, MA 02116	51-0197209	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BOSTON AREA RAPE CRISIS 99 BISHOP ALLEN DRIVE CAMBRIDGE, MA 02139	04-2974983	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BOSTON BRANCH NAACP 330 MLK JR BLVD ROXBURY, MA 02119	04-3574060	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BOSTON BRANCH NAACP PO BOX 300159 BOSTON, MA 02130	04-3574060	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON HEALTHCARE FOR THE HOMELESS PROGRAM 780 ALBANY STREET BOSTON, MA 02118	04-3160480	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BOSTON NAACP PO BOX 301779 BOSTON, MA 02130	04-6188955	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOSTON NORTH CANCER CENTER PO BOX 3153 PEABODY, MA 01960	23-7174582	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BOYS AND GIRLS CLUBS OF BOSTON 50 CONGRESS ST STE 730 BOSTON, MA 02109	04-2103922	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BUNKER HILL COMMUNITY COLLEGE FOUNDATION 250 NEW RUTHERFORD AVENUE SUITE C-304 BOSTON, MA 02129	22-2757389	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CARE 2 COMMUNITIES INC 1320 CENTER STREET SUITE 202 NEWTON CENTER, MA 02459	26-4369180	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CAREER COLLABORATIVE 77 SUMMER ST BOSTON, MA 02111	04-3402682	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN EMERGENCY FUND C/O SAINT FRANCES DE SALES PARISH 303 BUNKER HILL STREET CHARLESTOWN, MA 02129	04-3264650	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHARLESTOWN GIRLS' SOFTBALL 20 TIBBETTS TOWN WAY CHARLESTOWN, MA 02129	81-4989970	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN LACROSSE & LEARNING CENTER INC 14 GREEN ST CHARLESTOWN, MA 02129	04-3484770	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHARLESTOWN LITTLE LEAGUE INC POBOX 290642 CHARLESTOWN, MA 02129	37-1513586	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN NURSERY SCHOOL 124 MAIN STREET CHARLESTOWN, MA 02129	20-8277040	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHARLESTOWN WORKING THEATER 442 BUNKER HILL ST CHARLESTOWN, MA 02129	04-2575578	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN WORKING THEATRE INC 442 BUNKER HILL ST CHARLESTOWN, MA 02129	04-2575578	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHARLESTOWN YOUTH FOOTBALL AND CHEERLEADING LEAGUE 134 OLD ORPMSODES WAY CHARLESTOWN, MA 02129	35-2339457	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN YOUTH HOCKEY ASSOCIATION PO BOX 712 CHARLESTOWN, MA 02129	04-3040076	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHARLESTOWN YOUTH SOCCER ASSOCIATION PO BOX 290021 CHARLESTOWN, MA 02129	26-0428613	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
CODMAN SQUARE HEALTH CENTER 637 WASHINGTON STREET DORCHESTER, MA 02124	04-2678774	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY WORKS 25 WEST STREET BOSTON, MA 02111	04-2762623	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
DORCHESTER HOUSE MULTI-SERVICE CENTER 1353 DORCHESTER AVE DORCHESTER, MA 02122	23-7125970	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EASTER SEALS MA 89 SOUTH ST BOSTON, MA 02111	04-2103867	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
FOOD ALLERGY RESEARCH EDUCATION 7925 JONES BRANCH DRIVE SUITE 1100 MCLEAN, VA 22102	13-3905508	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FOUNDATION OF MASS EYE AND EAR INC 243 CHARLES STREET BOSTON, MA 02114	04-2785453	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
FRIENDS OF THE CHARLESTOWN LIBRARY LTD 179 MAIN STREET CHARLESTOWN, MA 02129	04-3330182	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
GOSNOLD INC 200 TER HEUN DRIVE FALMOUTH, MA 02540	04-2502970	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
GREATER BOSTON PFLAG PO BOX 541619 WALTHAM, MA 02454	04-3272394	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
HEALTH EXEC INSTITUTE 1 BROADWAY CAMBRIDGE, MA 02142	20-4034018	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
HEBREW SENIOR LIFE 1200 CENTRE ST ROSLINDALE, MA 02131	90-0183119	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HYDE SQUARE TASK FORCE 375 CENTER STREET JAMAICA PLAIN, MA 02130	04-3118543	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
JOHN F KENNEDY FAMILY SERVICE CENTER 23A MOULTON ST CHARLESTOWN, MA 02129	04-2373978	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JOHN F KENNEDY LIBRARY & MUSEUM COLUMBIA POINT BOSTON, MA 02125	04-6113130	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
JOHN F KENNEDY LIBRARY AND MUSEUM COLUMBIA POINT BOSTON, MA 02125	04-6113130	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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LINKS FOUNDATION 1200 MASS AVE NW WASHINGTON, DC 20005	52-1170830	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
MASS EYE & EAR ASSOCIATES INC 243 CHARLES STREET BOSTON, MA 02114	22-2658209	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MASS INC 11 BEACON STREET SUITE 500 BOSTON, MA 02108	68-0480736	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
MASS INSIGHT 18 TREMONT STREET SUITE 1010 BOSTON, MA 02108	04-3369687	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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MASSACHUSETTS COMMUNITIES ACTION NETWORK 150 MOUNT VERNON STREET SUITE 200E DORCHESTER, MA 02125	04-2863903	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
MASSACHUSETTS PUBLIC HEALTH ASSOCIATION 101 TREMONT STREET SUITE 1011 BOSTON, MA 02108	04-2326503	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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MIRA 105 CHAUNCY STREET SUITE 901 BOSTON, MA 02111	22-3115048	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
NATIONAL ASSOCIATION OF CORPORATE DIRECTORS 10 BACK RIVER RD AMESBURY, MA 01913	04-3370584	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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NEWTON COMMUNITY PRIDE 492 WALTHAM S NEWTON, MA 02465	22-2793743	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
NORTH END WATERFRONT HEALTH 332 HANOVER STREET BOSTON, MA 02113	23-7089746	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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PROJECT HOPE 550 DUDLEY STREET ROXBURY, MA 00211	04-2748880	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
RAISING A READER 9B HAMILTON PLACE BOSTON, MA 02108	80-0297898	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
RETREAT AND REFRESH STROKE CAMP 2000 W PIONEER PKWY STE 16 PEORIA, IL 61615	64-0954851	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
ROAD RUNNERS CLUB OF AMERICA 84 WASHINGTON STREET CHARLESTOWN, MA 02129	46-1177785	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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ROCA INC 101 PARK STREET CHELSEA, MA 02150	22-3223641	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
ROGERSON COMMUNITIES 1 FLORENCE STREET ROSLINDALE, MA 02131	04-2104319	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
RON BURTON TRAINING VILLAGE PO BOX 2 HUBBARDSTON, MA 01452	22-2570218	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
SERVICENET 131 KING STREET NORTHAMPTON, MA 01060	04-2526194	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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SOUTH END CHC 1601 WASHINGTON STREET BOSTON, MA 02118	04-2456134	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
ST CYPRIAN'S EPISCOPAL CHURCH 1073 TREMONT STREET BOSTON, MA 02120		501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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TEMPLE REYIM 1860 WASHINGTON ST AUBURNDALE, MA 02466	04-2104413	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
THE DIGNITY INSTITUTE 73 CHELSEA ST SUITE 308 CHARLESTOWN, MA 02129	46-4480924	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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THE GOOD PARTY - MORGAN MEMORIAL GOODWILL INDUSTRIES 1010 HARRISON AVE BOSTON, MA 02119	04-2106765	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
TOWN TRACK CLUB INC 84 WASHINGTON STREET 1 CHARLESTOWN, MA 02129	46-1177785	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

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UMASS FINE ARTS CENTER 151 PRESIDENTS DRIVE AMHERST, MA 01003	54-2084125	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
UNITED WAY OF MASS BAY INC 51 SLEEPER STREET BOSTON, MA 02210	04-2382233	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WARREN- PRESCOTT FOUNDATION 50 WEST SCHOOL STREET CHARLESTOWN, MA 02129	20-1745447	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
Y W C A OF BOSTON INC 316 HUNTINGTON AVENUE BOSTON, MA 02115	04-2103551	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM

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(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YEAR UP INC 45 MILK STREET 9TH FLOOR BOSTON, MA 02109	04-3534407	501(C)(3)	5,000				COMMUNITY BENEFIT PROGRAM
BOYS AND GIRLS CLUB OF GREATER SALEM PO BOX 24 SALEM, MA 01970	04-2104912	501(C)(3)	1,500				COMMUNITY BENEFIT PROGRAM

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SALEM PARTNERSHIP 265 ESSEX ST 304 SALEM, MA 01970	04-2996598	501(C)(3)	1,000				COMMUNITY BENEFIT PROGRAM

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493227015888

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.**

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III ☐ Compensation committee ☐ Written employment contract ☐ Independent compensation consultant ☐ Compensation survey or study ☐ Form 990 of other organizations ☐ Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	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 non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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 are not listed on Form 990, Part VII

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

(A) Name and Title	**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation in column(B) reported as deferred on prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
See Additional Data	

Additional Data

Software ID:
Software Version:
EIN: 90-0656139
Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINE 1A	FIRST CLASS TRAVEL WAS PROVIDED TO A TRUSTEE/EMPLOYEE LISTED ON FORM 990, PART VII THIS BENEFIT WAS PROVIDED PURSUANT TO A WRITTEN POLICY AND TREATED AS NON-TAXABLE BUSINESS EXPENSE THE BENEFIT WAS REVIEWED AND APPROVED BY THE PARTNERS HEALTHCARE COMPENSATION COMMITTEE

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINE 7	CERTAIN EMPLOYEES RECEIVED INCENTIVE COMPENSATION BASED ON ACHEIVEMENT OF ORGANIZATIONAL AND INDIVIDUAL GOALS THE COMPENSATION COMMITTEE OF PARTNERS HEALTHCARE OR THE COMEPNSATION COMMITTEES OF PARTNERS SUBRODINATE ENTITIES HAVE THE FINAL AUTHORITY FOR SUCH PAYMENTS

Part III, Supplemental Information

Return Reference	Explanation
PAYMENT OR REIMBURSEMENT OF EXPENSES	TRAVEL FOR COMPANIONS WAS PROVIDED TO CERTAIN OFFICERS LISTED ON FORM 990, PART VII AS THE COMPANIONS ATTENDANCE WAS REQUIRED TO FULFILL A BONA FIDE BUSINESS PURPOSE THESE PAYMENTS WERE PROVIDED PURSUANT TO A WRITTEN POLICY AND WERE TREATED AS NON-TAXABLE BUSINESS EXPENSES HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES WERE PROVIDED TO CERTAIN OFFICERS AND OTHER EMPLOYEES LISTED ON FORM 990, PART VII THESE BENEFITS WERE PROVIDED PURSUANT TO A WRITTEN POLICY THE HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES WERE TREATED AS TAXABLE INCOME

Part III, Supplemental Information

Return Reference	Explanation
TRUSTEE COMPENSATION	TRUSTEES RECEIVE NO COMPENSATION OR CONTRIBUTIONS TO EMPLOYEE BENEFIT PLANS FOR SERVICE ON THE BOARD OR ITS COMMITTEES BOARD MEMBERS WHO ARE ALSO EMPLOYED BY THE CORPORATION OR A PARTNERS AFFILIATE RECEIVE COMPENSATION ONLY FOR THEIR SERVICES AS EMPLOYEES

Part III, Supplemental Information

Return Reference	Explanation
ESTABLISHING CEO COMPENSATION	THE CHIEF EXECUTIVE OFFICER'S COMPENSATION WAS ESTABLISHED USING THE FOLLOWING - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - COMPENSATION SURVEY OR STUDY - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

Part III, Supplemental Information

Return Reference	Explanation
CHIEF EXECUTIVE OFFICER'S COMPENSATION	THE FOLLOWING CHIEF EXECUTIVE OFFICER'S COMPENSATION WAS DETERMINED BY THE PARTNERS HEALTHCARE SYSTEM, INC COMPENSATION COMMITTEE PARTNERS HEALTHCARE SYSTEM, INC IS AN AFFILIATED TAX-EXEMPT ORGANIZATION MICHAEL R JAFF, D O GILBERT MUDGE, M D ELIZABETH NABEL, M D ROBERT NORTON SCOTT RAUCH, M D DAVID J ROBERTS, M D PETER SLAVIN, M D ,M B A DAVID STORTO LYNN MALLOY STOFER

Part III, Supplemental Information

Return Reference	Explanation
RECEIPT OF SEVERANCE PAYMENTS	SUSAN M BEAUSOLIEL - $47,636 MICHAEL S JELLINEK, M D - $243,500 GILBERT H MUDGE, JR , M D - $124,209 MARK NOVOTNY, M D - $270,700 JEANNE M RYAN - $62,115 BEATRICE THIBEDEAU - $287,080 KERRY R WATSON - $647,700

Part III, Supplemental Information

Return Reference	Explanation
NONQUALIFIED RETIREMENT PLAN	PARTICIPATION IN A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN THESE AMOUNTS ARE ALREADY INCLUDED IN THE COMPENSATION DISCLOSED ON SCHEDULE J, PART II KATHERINE BECHTOLD, MHA, BSN, RN - $13,772 MICHAEL S JELLINEK, M D - $46,865 LAURIE LAMOUREUX - $24,548 PETER K MARKELL - $370,063 JOANNE MARQUSEE - $22,959 ELIZABETH G NABEL, M D - $475,528 ROBERT G NORTON - $97,759 A KIM SAAL, M D - $23,895 ANTHONY J SCIBELLI, MS, MBA - $12,820 PETER L SLAVIN, M D , M B A - $51,245 DAVID E STORTO - $957,391 DAVID F TORCHIANA, M D - $1,845,586 RON M WALLS, M D - $3,556,990

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
1 DALE ADLER MD SEE SCHEDULE O - O & T TITLE	(I) (II)	482,048 0	23,294 0	47,137 0	36,475 0	18,319 0	607,273 0	0 0
1 JOAN M ARCHER SEE SCHEDULE O - O & T TITLE	(I) (II)	204,117 0	350 0	45,982 0	33,461 0	21,918 0	305,828 0	0 0
2 STANLEY W ASHLEY MD SEE SCHEDULE O - O & T TITLE	(I) (II)	488,781 0	55,900 0	59,275 0	36,478 0	30,264 0	670,698 0	0 0
3 MAUREEN BANKS SEE SCHEDULE O - O & T TITLE	(I) (II)	436,193 0	24,067 0	66,554 0	36,479 0	16,694 0	579,987 0	0 0
4 ROBERT L BARBIERI MD SEE SCHEDULE O - O & T TITLE	(I) (II)	422,729 0	70,674 0	33,177 0	36,478 0	24,745 0	587,803 0	0 0
JANIS P BELLACK PHD RN **5** FAAN SEE SCHEDULE O - O & T TITLE	(I) (II)	349,718 0	350 0	69,231 0	36,478 0	14,182 0	469,959 0	0 0
6 JOAN M BENGTSON MD SEE SCHEDULE O - O & T TITLE	(I) (II)	172,812 0	25,775 0	58,490 0	32,173 0	21,487 0	310,737 0	0 0
7 CHRISTINE A BLASKI MD SEE SCHEDULE O - O & T TITLE	(I) (II)	251,423 0	0 0	12,794 0	0 0	25,589 0	289,806 0	0 0
8 MICHAEL L BLUTE SR MD SEE SCHEDULE O - O & T TITLE	(I) (II)	718,475 0	113,250 0	114,452 0	36,841 0	20,654 0	1,003,672 0	0 0
9 SALLY MASON BOEMER SEE SCHEDULE O - O & T TITLE	(I) (II)	608,727 0	96,350 0	57,347 0	36,477 0	35,599 0	834,500 0	0 0
10 GILES W BOLAND MD SEE SCHEDULE O - O & T TITLE	(I) (II)	487,221 0	73,606 0	34,916 0	53,000 0	25,978 0	674,721 0	0 0
11 CHRISTOPHER M BONO MD SEE SCHEDULE O - O & T TITLE	(I) (II)	475,000 0	11,990 0	2,385 0	36,476 0	20,970 0	546,821 0	0 0
12 O'NEIL BRITTON MD SEE SCHEDULE O - O & T TITLE	(I) (II)	505,891 0	181,900 0	46,057 0	122,775 0	38,945 0	895,568 0	0 0
13 DAVID F BROWN MD SEE SCHEDULE O - O & T TITLE	(I) (II)	531,750 0	137,050 0	87,167 0	36,840 0	23,029 0	815,836 0	0 0
14 CALVIN A BROWN III MD SEE SCHEDULE O - O & T TITLE	(I) (II)	270,042 0	53,028 0	14,800 0	31,500 0	20,970 0	390,340 0	0 0
DEBRA A BURKE MSN MBA **15** RN SEE SCHEDULE O - O & T TITLE	(I) (II)	207,325 0	12,250 0	22,322 0	37,694 0	21,556 0	301,147 0	0 0
16 BRUCE A CHABNER MD SEE SCHEDULE O - O & T TITLE	(I) (II)	215,159 0	6,493 0	34,606 0	33,646 0	19,920 0	309,824 0	0 0
17 ENNIO A CHIOCCA MD PHD SEE SCHEDULE O - O & T TITLE	(I) (II)	1,348,850 0	338,351 0	140,603 0	36,478 0	25,585 0	1,889,867 0	0 0
CHRISTOPHER MARK **18** COBURN SEE SCHEDULE O - O & T TITLE	(I) (II)	592,870 0	181,990 0	59,853 0	36,479 0	34,574 0	905,766 0	0 0
19 CHRISTOPHER M COLEY MD SEE SCHEDULE O - O & T TITLE	(I) (II)	304,807 0	6,375 0	29,571 0	36,845 0	20,169 0	397,767 0	0 0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
21 ERNESTO DASILVA MD SEE SCHEDULE O - O & T TITLE	(I)	245,673	64,791	15,895	4,762	30,909	362,030	0
	(II)	0	0	0	0	0	0	0
1 GERARD M DOHERTY MD SEE SCHEDULE O - O & T TITLE	(I)	295,500	567,948	4,961	36,479	21,578	926,466	0
	(II)	0	0	0	0	0	0	0
2 TERENCE P DOORLY MD SEE SCHEDULE O - O & T TITLE	(I)	391,500	331,488	33,088	2,456	28,290	786,822	0
	(II)	0	0	0	0	0	0	0
3 BRANDON E EARP MD SEE SCHEDULE O - O & T TITLE	(I)	566,375	544,134	36,025	36,481	18,547	1,201,562	0
	(II)	0	0	0	0	0	0	0
4 JEFFREY L ECKER MD SEE SCHEDULE O - O & T TITLE	(I)	585,000	90,900	80,445	36,840	21,264	814,449	0
	(II)	0	0	0	0	0	0	0
5 JONATHAN M FALLON MD SEE SCHEDULE O - O & T TITLE	(I)	610,773	0	10,008	2,821	35,472	659,074	0
	(II)	0	0	0	0	0	0	0
6 JOHN FANIKOS SEE SCHEDULE O - O & T TITLE	(I)	193,765	2,500	11,911	23,367	29,252	260,795	0
	(II)	0	0	0	0	0	0	0
7 THOMAS L FAZIO MD SEE SCHEDULE O - O & T TITLE	(I)	433,093	225,596	23,212	0	30,908	712,809	0
	(II)	0	0	0	0	0	0	0
CARLOS FERNANDEZ-DEL **8** CASTILLO MD SEE SCHEDULE O - O & T TITLE	(I)	569,475	45,882	272,596	36,843	25,902	950,698	0
	(II)	0	0	0	0	0	0	0
9 TIMOTHY G FERRIS MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	600,285	184,500	96,636	36,843	23,214	941,478	0
10 CHRISTOPHER R FORTIER SEE SCHEDULE O - O & T TITLE	(I)	239,021	12,700	-6,182	19,289	34,408	299,236	0
	(II)	0	0	0	0	0	0	0
11 LAWRENCE S FRIEDMAN MD SEE SCHEDULE O - O & T TITLE	(I)	436,544	0	39,723	13,250	26,590	516,107	0
	(II)	0	0	0	0	0	0	0
12 TERRY J GARFINKLE MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	386,603	21,600	68,823	36,478	25,514	539,018	0
13 DAVID F GITLIN MD SEE SCHEDULE O - O & T TITLE	(I)	215,421	19,000	24,684	34,749	19,328	313,182	0
	(II)	0	0	0	0	0	0	0
14 JEFFREY A GOLDEN MD SEE SCHEDULE O - O & T TITLE	(I)	720,775	75,750	112,655	36,476	33,924	979,580	0
	(II)	0	0	0	0	0	0	0
15 TERRI E GORMAN MD SEE SCHEDULE O - O & T TITLE	(I)	267,000	28,875	80,670	18,737	22,122	417,404	0
	(II)	0	0	0	0	0	0	0
16 PETER A GRAPE MD SEE SCHEDULE O - O & T TITLE	(I)	471,839	79,143	57,654	36,478	19,087	664,201	0
	(II)	0	0	0	0	0	0	0
17 PETER T GREENSPAN MD SEE SCHEDULE O - O & T TITLE	(I)	312,105	22,344	27,913	36,845	19,978	419,185	0
	(II)	0	0	0	0	0	0	0
18 MICHAEL L GUSTAFSON MD MBA SEE SCHEDULE O - O & T TITLE	(I)	420,778	45,900	67,137	36,477	14,981	585,273	0
	(II)	0	0	0	0	0	0	0
DAPHNE ADELE HAAS-**19** KOGANMD SEE SCHEDULE O - O & T TITLE	(I)	641,056	80,172	145,771	36,477	18,483	921,959	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
41 ROBERT HANDIN MD SEE SCHEDULE O - O & T TITLE	(I)	258,194	12,451	3,678	36,268	18,865	329,456	0
	(II)	0	0	0	0	0	0	0
1 MITCHEL B HARRIS MD SEE SCHEDULE O - O & T TITLE	(I)	501,771	63,490	44,137	36,478	21,029	666,905	0
	(II)	0	0	0	0	0	0	0
MARGOT K HARTMANN MD **2** PHD SEE SCHEDULE O - O & T TITLE	(I)	301,249	24,090	21,611	5,985	16,338	369,273	0
	(II)	0	0	0	0	0	0	0
3 THEODORE S HONG MD SEE SCHEDULE O - O & T TITLE	(I)	626,738	52,583	100,473	36,477	20,393	836,664	0
	(II)	0	0	0	0	0	0	0
4 TERRIE E INDER MBCHB SEE SCHEDULE O - O & T TITLE	(I)	467,438	48,195	92,326	36,476	23,330	667,765	0
	(II)	0	0	0	0	0	0	0
5 MICHAEL R JAFF DO SEE SCHEDULE O - O & T TITLE	(I)	677,477	82,271	99,143	36,477	22,568	917,936	0
	(II)	0	0	0	0	0	0	0
6 ALAN ANTHONY JAMES SEE SCHEDULE O - O & T TITLE	(I)	345,167	56,700	60,748	30,514	14,072	507,201	0
	(II)	0	0	0	0	0	0	0
7 STEPHEN R JENNEY SEE SCHEDULE O - O & T TITLE	(I)	228,112	40,606	34,092	36,482	23,128	362,420	0
	(II)	0	0	0	0	0	0	0
8 MARK D JOHNSON MD PHD SEE SCHEDULE O - O & T TITLE	(I)	313,578	184,616	13,175	36,479	20,809	568,657	0
	(II)	0	0	0	0	0	0	0
9 WILLIAM C JOHNSTON SEE SCHEDULE O - O & T TITLE	(I)	464,401	48,450	31,338	36,480	22,125	602,794	0
	(II)	0	0	0	0	0	0	0
10 JAMES D KANG MD SEE SCHEDULE O - O & T TITLE	(I)	1,189,600	125,800	95,367	36,475	25,452	1,472,694	0
	(II)	0	0	0	0	0	0	0
11 STEVEN E KAPFHAMMER SEE SCHEDULE O - O & T TITLE	(I)	254,160	14,712	44,197	36,481	15,359	364,909	0
	(II)	0	0	0	0	0	0	0
12 BARRETT KITCH MD SEE SCHEDULE O - O & T TITLE	(I)	267,311	15,100	41,784	5,266	25,269	354,730	0
	(II)	0	0	0	0	0	0	0
13 RONALD E KLEINMAN MD SEE SCHEDULE O - O & T TITLE	(I)	482,225	78,000	103,748	36,478	21,322	721,773	0
	(II)	0	0	0	0	0	0	0
14 ANNE KLIBANSKI MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	683,647	104,482	113,912	36,479	20,507	959,027	0
15 THOMAS S KUPPER MD SEE SCHEDULE O - O & T TITLE	(I)	460,070	100,470	14,581	36,479	21,348	632,948	0
	(II)	0	0	0	0	0	0	0
16 JAY LOEFFLER MD SEE SCHEDULE O - O & T TITLE	(I)	647,081	135,759	116,183	36,477	1,442	936,942	0
	(II)	0	0	0	0	0	0	0
17 JOSEPH LOSCALZO MD PHD SEE SCHEDULE O - O & T TITLE	(I)	613,241	72,099	25,982	36,478	23,993	771,793	0
	(II)	0	0	0	0	0	0	0
18 DAVID N LOUIS MD SEE SCHEDULE O - O & T TITLE	(I)	532,475	106,715	108,122	36,477	20,898	804,687	0
	(II)	0	0	0	0	0	0	0
19 EVERETT T LYN MD SEE SCHEDULE O - O & T TITLE	(I)	434,827	23,649	40,578	36,478	19,053	554,585	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
61THOMAS LYNCH JR MD SEE SCHEDULE O - O & T TITLE	(I)	1,159,475	190,000	124,773	36,843	20,664	1,531,755	0
	(II)	0	0	0	0	0	0	0
1PETER K MARKELL SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	1,283,461	156,290	437,543	586,476	29,316	2,493,086	0
2NAVNEET MARWAHA MD SEE SCHEDULE O - O & T TITLE	(I)	335,093	105	-3,481	5,191	34,123	371,031	0
	(II)	0	0	0	0	0	0	0
3MAURY E MCGOUGH MD SEE SCHEDULE O - O & T TITLE	(I)	521,860	63,480	65,382	36,479	29,802	717,003	0
	(II)	0	0	0	0	0	0	0
4GREGG S MEYER MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	1,022,862	124,958	77,096	629,444	36,683	1,891,043	0
5RAYMOND R MONTO MD SEE SCHEDULE O - O & T TITLE	(I)	749,426	0	127,143	4,000	42,500	923,069	0
	(II)	0	0	0	0	0	0	0
6FRANCIS D MOORE MD SEE SCHEDULE O - O & T TITLE	(I)	540,520	201,249	9,733	36,477	24,328	812,307	0
	(II)	0	0	0	0	0	0	0
ELIZABETH A MORT **7**CALCAGNI MD MP SEE SCHEDULE O - O & T TITLE	(I)	469,225	76,405	99,819	36,477	21,646	703,572	0
	(II)	0	0	0	0	0	0	0
8 STUART B MUSHLIN MDFACP SEE SCHEDULE O - O & T TITLE	(I)	207,934	6,162	-3,157	27,348	21,366	259,653	0
	(II)	0	0	0	0	0	0	0
9ELIZABETH G NABEL MD SEE SCHEDULE O - O & T TITLE	(I)	1,265,336	147,713	1,919,873	301,476	14,686	3,649,084	0
	(II)	0	0	0	0	0	0	0
10ALBERT NAMIAS MD SEE SCHEDULE O - O & T TITLE	(I)	459,233	0	27,675	5,268	29,045	521,221	0
	(II)	0	0	0	0	0	0	0
11ANDREA NG MD SEE SCHEDULE O - O & T TITLE	(I)	382,084	63,893	-966	36,481	18,220	499,712	0
	(II)	0	0	0	0	0	0	0
12ROBERT G NORTON SEE SCHEDULE O - O & T TITLE	(I)	724,171	266,773	180,825	36,477	28,143	1,236,389	0
	(II)	0	0	0	0	0	0	0
13NAWAL M NOUR MD MPH SEE SCHEDULE O - O & T TITLE	(I)	324,005	103,550	44,044	36,478	21,621	529,698	0
	(II)	0	0	0	0	0	0	0
14 JOHANNA M O'CONNOR MD SEE SCHEDULE O - O & T TITLE	(I)	418,660	97,433	35,859	36,480	27,176	615,608	0
	(II)	0	0	0	0	0	0	0
15COURTNEY A O'NEILL SEE SCHEDULE O - O & T TITLE	(I)	145,107	0	10,403	3,920	11,619	171,049	0
	(II)	0	0	0	0	0	0	0
16TIMOTHY PARSONS MD SEE SCHEDULE O - O & T TITLE	(I)	214,400	119,550	31,698	5,008	29,207	399,863	0
	(II)	0	0	0	0	0	0	0
17GREGORY J PAULY SEE SCHEDULE O - O & T TITLE	(I)	492,750	178,900	77,129	35,814	31,458	816,051	0
	(II)	0	0	0	0	0	0	0
18STEVEN B PESTKA MD SEE SCHEDULE O - O & T TITLE	(I)	351,625	0	-4,141	9,262	25,902	382,648	0
	(II)	0	0	0	0	0	0	0
19PIETER PIL MD SEE SCHEDULE O - O & T TITLE	(I)	533,476	60,000	51,812	8,501	36,847	690,636	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
81 NANCY S PITTMAN SEE SCHEDULE O - O & T TITLE	(I)	131,413	7,396	12,062	0	3,653	154,524	0
	(II)	0	0	0	0	0	0	0
1 DAVID S PLADZIEWICZ MD SEE SCHEDULE O - O & T TITLE	(I)	519,897	41,075	21,509	0	31,484	613,965	0
	(II)	0	0	0	0	0	0	0
2 BOHDAN POMAHAC MD SEE SCHEDULE O - O & T TITLE	(I)	378,450	434,788	94,892	36,477	20,883	965,490	0
	(II)	0	0	0	0	0	0	0
3 ALLYSON L PRESTON MD SEE SCHEDULE O - O & T TITLE	(I)	356,241	8,785	34,494	5,311	30,081	434,912	0
	(II)	0	0	0	0	0	0	0
4 JAMES P RATHMELL MD SEE SCHEDULE O - O & T TITLE	(I)	594,745	62,720	51,529	36,476	22,105	767,575	0
	(II)	0	0	0	0	0	0	0
5 DAVID W RATTNER MD SEE SCHEDULE O - O & T TITLE	(I)	677,710	81,800	110,278	36,478	25,990	932,256	0
	(II)	0	0	0	0	0	0	0
6 SCOTT L RAUCH MD SEE SCHEDULE O - O & T TITLE	(I)	574,525	79,910	66,409	36,475	33,485	790,804	0
	(II)	0	0	0	0	0	0	0
7 MITCHELL S REIN MD SEE SCHEDULE O - O & T TITLE	(I)	497,074	32,426	78,823	36,478	22,125	666,926	0
	(II)	0	0	0	0	0	0	0
8 DAVID J ROBERTS MD SEE SCHEDULE O - O & T TITLE	(I)	234,729	13,214	32,748	5,332	26,424	312,447	0
	(II)	0	0	0	0	0	0	0
9 ALLAN H ROPPER MD SEE SCHEDULE O - O & T TITLE	(I)	267,601	4,589	7,271	36,478	18,126	334,065	0
	(II)	0	0	0	0	0	0	0
10 JERROLD F ROSENBAUM MD SEE SCHEDULE O - O & T TITLE	(I)	386,061	78,950	52,928	36,477	20,190	574,606	0
	(II)	0	0	0	0	0	0	0
11 MITCHELL H RUBENSTEIN MD SEE SCHEDULE O - O & T TITLE	(I)	382,638	127,225	43,776	36,480	19,008	609,127	0
	(II)	0	0	0	0	0	0	0
12 MARC S RUBIN MD SEE SCHEDULE O - O & T TITLE	(I)	748,400	52,767	111,082	36,478	27,519	976,246	0
	(II)	0	0	0	0	0	0	0
13 ROXANNE C RUPPEL SEE SCHEDULE O - O & T TITLE	(I)	264,197	14,316	17,870	36,483	29,972	362,838	0
	(II)	0	0	0	0	0	0	0
14 ALI SALIM MD SEE SCHEDULE O - O & T TITLE	(I)	476,197	13,071	60,834	36,478	20,986	607,566	0
	(II)	0	0	0	0	0	0	0
15 MARTIN A SAMUELS MD SEE SCHEDULE O - O & T TITLE	(I)	492,725	56,060	56,034	36,477	21,415	662,711	0
	(II)	0	0	0	0	0	0	0
16 JOAN A SAPIR SEE SCHEDULE O - O & T TITLE	(I)	390,000	63,900	74,163	41,114	30,182	599,359	0
	(II)	0	0	0	0	0	0	0
17 MARK A SCHECHTER MD SEE SCHEDULE O - O & T TITLE	(I)	305,269	16,680	32,809	3,109	29,940	387,807	0
	(II)	0	0	0	0	0	0	0
18 ELLEN W SEELY MD SEE SCHEDULE O - O & T TITLE	(I)	259,788	25,690	20,178	36,479	21,382	363,517	0
	(II)	0	0	0	0	0	0	0
19 STANTON K SHERNAN MD SEE SCHEDULE O - O & T TITLE	(I)	345,540	198,239	40,670	36,479	23,284	644,212	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
101 DAVID SILBERSWEIG MD SEE SCHEDULE O - O & T TITLE	(I)	561,175	57,630	30,889	36,476	22,206	708,376	0
	(II)	0	0	0	0	0	0	0
1 ANEESH B SINGHAL MD SEE SCHEDULE O - O & T TITLE	(I)	310,782	67,777	55,531	36,480	19,222	489,792	0
	(II)	0	0	0	0	0	0	0
2 PETER L SLAVIN MD MBA SEE SCHEDULE O - O & T TITLE	(I)	1,428,548	163,633	1,666,233	334,677	36,524	3,629,615	0
	(II)	0	0	0	0	0	0	0
3 ALLEN L SMITH MD MS SEE SCHEDULE O - O & T TITLE	(I)	659,244	68,300	54,012	190,550	19,876	991,982	0
	(II)	0	0	0	0	0	0	0
4 JOHN W STAKES III MD SEE SCHEDULE O - O & T TITLE	(I)	149,576	51,476	32,466	40,005	1,982	275,505	0
	(II)	0	0	0	0	0	0	0
5 LYNN MALLOY STOFER SEE SCHEDULE O - O & T TITLE	(I)	555,611	71,784	66,496	86,478	34,185	814,554	0
	(II)	0	0	0	0	0	0	0
6 DAVID E STORTO SEE SCHEDULE O - O & T TITLE	(I)	567,802	53,900	1,025,979	36,477	35,481	1,719,639	0
	(II)	0	0	0	0	0	0	0
7 THORALF M SUNDT MD SEE SCHEDULE O - O & T TITLE	(I)	567,076	46,250	93,448	36,477	28,448	771,699	0
	(II)	0	0	0	0	0	0	0
8 KHALID SYED MD SEE SCHEDULE O - O & T TITLE	(I)	294,524	19,733	56,390	4,616	29,355	404,618	0
	(II)	0	0	0	0	0	0	0
9 ELIZABETH S TAYLOR SEE SCHEDULE O - O & T TITLE	(I)	208,043	350	45,086	34,088	12,577	300,144	0
	(II)	0	0	0	0	0	0	0
10 DAVID F TORCHIANA MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	2,125,250	600,350	1,923,709	36,475	-38,063	4,723,847	0
11 MICHAEL J VANROOYEN MD SEE SCHEDULE O - O & T TITLE	(I)	535,479	82,093	47,345	36,478	21,446	722,841	0
	(II)	0	0	0	0	0	0	0
12 TIMOTHY J WALSH SEE SCHEDULE O - O & T TITLE	(I)	182,374	120,400	13,206	0	15,199	331,179	0
	(II)	0	0	0	0	0	0	0
13 ANDREW L WARSHAW MD SEE SCHEDULE O - O & T TITLE	(I)	462,819	81,500	553,735	36,478	25,525	1,160,057	0
	(II)	0	0	0	0	0	0	0
14 JOSEPH L WOODIN SEE SCHEDULE O - O & T TITLE	(I)	221,137	0	22,423	0	29,402	272,962	0
	(II)	0	0	0	0	0	0	0
15 ROSS D ZAFONTE DO SEE SCHEDULE O - O & T TITLE	(I)	498,485	27,129	81,561	118,116	20,759	746,050	0
	(II)	0	0	0	0	0	0	0
16 BRENT L HENRY ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	716,612	56,063	132,127	36,477	-28,113	969,392	0
17 CHARLES E ADAMS SEE SCHEDULE O - O & T TITLE	(I)	191,628	3,326	23,053	21,730	30,324	270,061	0
	(II)	0	0	0	0	0	0	0
18 SARAH ARNHOLZ ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	227,064	11,777	4,764	31,500	-30,105	305,210	0
19 MELISSA P BRENNAN ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	128,827	5,421	10,544	8,387	-41,091	194,270	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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121 EFFIE J CHAN ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	172,781	1,850	17,104	10,447	-26,275	-228,457	0
JULIE C CHATTOPADHYAY **1** ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	169,346	5,350	12,253	10,304	-34,623	-231,876	0
2 DAVID P CONNOLLY SEE SCHEDULE O - O & T TITLE	(I)	271,926	15,447	40,388	36,478	30,549	394,788	0
	(II)	0	0	0	0	-0	-0	0
3 PAUL G CUSHING ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	226,083	13,355	36,712	36,479	-33,982	-346,611	0
4 JEFFREY P DION SEE SCHEDULE O - O & T TITLE	(I)	263,589	350	69,235	36,479	32,707	402,360	0
	(II)	0	0	0	0	-0	-0	0
5 CHRISTOPHER DUNLEAVY SEE SCHEDULE O - O & T TITLE	(I)	474,382	80,975	40,338	0	7,241	602,936	0
	(II)	0	0	0	0	-0	-0	0
6 KEVIN T GIORDANO SEE SCHEDULE O - O & T TITLE	(I)	220,063	24,141	5,877	11,808	38,263	300,152	0
	(II)	0	0	0	0	-0	-0	0
7 MICHELE L GOUGEON MSC SEE SCHEDULE O - O & T TITLE	(I)	353,908	37,754	18,939	41,114	28,347	480,062	0
	(II)	0	0	0	0	-0	-0	0
8 GERARD F HADLEY SEE SCHEDULE O - O & T TITLE	(I)	201,804	13,183	38,845	0	29,955	283,787	0
	(II)	0	0	0	0	-0	-0	0
9 JAMES L HEFFERNAN SEE SCHEDULE O - O & T TITLE	(I)	456,000	75,950	101,060	41,114	33,292	707,416	0
	(II)	0	0	0	0	-0	-0	0
10 JOHN R HIGHAM ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	286,584	14,359	2,091	36,480	-28,162	-367,676	0
11 LAURA STEPHENS KHOSHBIN ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	189,472	4,779	2,262	20,842	-8,030	-225,385	0
KATHERINE M KNEELAND **12** ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	227,078	13,355	44,506	36,480	-5,657	-327,076	0
13 DAVID A LAGASSE SEE SCHEDULE O - O & T TITLE	(I)	260,014	30,413	67,664	29,150	36,610	423,851	0
	(II)	0	0	0	0	-0	-0	0
14 LAURIE LAMOUREUX SEE SCHEDULE O - O & T TITLE	(I)	211,678	18,750	62,029	7,538	13,457	313,452	0
	(II)	0	0	0	0	-0	-0	0
15 JOANNE MARQUSEE SEE SCHEDULE O - O & T TITLE	(I)	430,499	35,114	65,750	5,206	27,695	564,264	0
	(II)	0	0	0	0	-0	-0	0
16 ELLEN MOLONEY SEE SCHEDULE O - O & T TITLE	(I)	379,852	107,450	50,444	36,475	14,105	588,326	0
	(II)	0	0	0	0	-0	-0	0
17 GILBERT H MUDGE JR MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	342,237	39,763	190,197	36,479	-20,645	-629,321	0
18 EDWARD OLIVIER SEE SCHEDULE O - O & T TITLE	(I)	193,733	40,000	32,755	23,677	15,444	305,609	0
	(II)	0	0	0	0	-0	-0	0
19 ANDREA G RE SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	133,577	1,350	14,746	12,126	-10,542	-172,341	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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141 MARY E SHAUGHNESSY SEE SCHEDULE O - O & T TITLE	(I)	305,201	17,550	60,439	36,480	23,474	443,144	0
	(II)	0	0	0	0	0	0	0
1 REYNOLD G SPADONI SEE SCHEDULE O - O & T TITLE	(I)	369,578	39,421	45,081	36,477	30,672	521,229	0
	(II)	0	0	0	0	0	0	0
2 TRACY A SYKES ESQ SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	181,275	1,350	21,158	16,304	31,698	251,785	0
3 PAUL ANDERSON MD PHD SEE SCHEDULE O - O & T TITLE	(I)	488,853	52,250	52,963	36,477	23,661	654,204	0
	(II)	0	0	0	0	0	0	0
KATRINA ARMSTRONG MD **4** MSCE SEE SCHEDULE O - O & T TITLE	(I)	683,225	107,491	97,207	36,841	23,119	947,883	0
	(II)	0	0	0	0	0	0	0
KATHERINE BECHTOLD MHA **5** BSN RN SEE SCHEDULE O - O & T TITLE	(I)	263,903	21,038	30,820	11,915	13,422	341,098	0
	(II)	0	0	0	0	0	0	0
6 ARTHUR J BOWES SEE SCHEDULE O - O & T TITLE	(I)	280,419	14,301	8,541	31,283	22,632	357,176	0
	(II)	0	0	0	0	0	0	0
7 KENNETH CHISHOLM SEE SCHEDULE O - O & T TITLE	(I)	211,160	0	38,758	20,996	30,812	301,726	0
	(II)	0	0	0	0	0	0	0
8 SUSAN DEMPSEY SEE SCHEDULE O - O & T TITLE	(I)	263,490	28,460	27,687	36,480	26,432	382,549	0
	(II)	0	0	0	0	0	0	0
9 KEREN DIAMOND SEE SCHEDULE O - O & T TITLE	(I)	193,864	22,676	39,259	21,228	28,443	305,470	0
	(II)	0	0	0	0	0	0	0
10 MARGARET M DUGGAN MD SEE SCHEDULE O - O & T TITLE	(I)	215,445	295,708	54,002	36,476	24,074	625,705	0
	(II)	0	0	0	0	0	0	0
11 TIMOTHY E FOSTER MD SEE SCHEDULE O - O & T TITLE	(I)	857,000	0	15,480	7,574	27,478	907,532	0
	(II)	0	0	0	0	0	0	0
12 JOANNE M FUCILE SEE SCHEDULE O - O & T TITLE	(I)	207,040	11,327	14,155	26,886	12,647	272,055	0
	(II)	0	0	0	0	0	0	0
13 MARY JO GAGNON SEE SCHEDULE O - O & T TITLE	(I)	211,430	12,958	46,598	34,630	12,725	318,341	0
	(II)	0	0	0	0	0	0	0
14 JOSEPH GOLD MD SEE SCHEDULE O - O & T TITLE	(I)	395,527	39,606	-3,957	41,114	28,625	500,915	0
	(II)	0	0	0	0	0	0	0
15 GEORGE GOUGIAN SEE SCHEDULE O - O & T TITLE	(I)	126,931	22,210	10,714	8,749	26,987	195,591	0
	(II)	0	0	0	0	0	0	0
16 JUDY HAYES SEE SCHEDULE O - O & T TITLE	(I)	257,438	27,750	26,136	36,481	12,659	360,464	0
	(II)	0	0	0	0	0	0	0
17 PAULA M HEREAU SEE SCHEDULE O - O & T TITLE	(I)	150,251	8,916	26,033	23,662	14,903	223,765	0
	(II)	0	0	0	0	0	0	0
18 MICHAEL J HESSION MD SEE SCHEDULE O - O & T TITLE	(I)	247,850	69,785	38,161	36,479	19,887	412,162	0
	(II)	0	0	0	0	0	0	0
JEANETTE IVES ERICKSON **19** RN DNP SEE SCHEDULE O - O & T TITLE	(I)	485,750	78,750	100,944	41,114	15,616	722,174	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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161 LOUIS JENIS MD SEE SCHEDULE O - O & T TITLE	(I)	636,319	125,850	195,881	36,476	25,898	1,020,424	0
	(II)	0	0	0	0	0	0	0
1 PARDON R KENNEY MD SEE SCHEDULE O - O & T TITLE	(I)	416,675	47,738	45,799	36,475	21,704	568,391	0
	(II)	0	0	0	0	0	0	0
2 CHRISTOPHER J KWOLEK MD SEE SCHEDULE O - O & T TITLE	(I)	734,475	26,250	140,087	36,477	28,565	965,854	0
	(II)	0	0	0	0	0	0	0
3 JANET LARSON MD SEE SCHEDULE O - O & T TITLE	(I)	283,217	0	108,969	8,706	26,886	427,778	0
	(II)	0	0	0	0	0	0	0
4 KEITH D LILLEMOE MD SEE SCHEDULE O - O & T TITLE	(I)	653,480	170,600	116,684	36,477	26,023	1,003,264	0
	(II)	0	0	0	0	0	0	0
5 EDWARD LISTON-KRAFT PHD SEE SCHEDULE O - O & T TITLE	(I)	212,556	23,340	23,532	35,488	3,556	298,472	0
	(II)	0	0	0	0	0	0	0
6 ROBERT T MCCALL SEE SCHEDULE O - O & T TITLE	(I)	180,742	10,750	28,227	19,205	30,654	269,578	0
	(II)	0	0	0	0	0	0	0
CHERYL MERRILL RN MSN **7** NEA- SEE SCHEDULE O - O & T TITLE	(I)	248,628	13,600	40,719	33,750	4,510	341,207	0
	(II)	0	0	0	0	0	0	0
8 STEPHANIE N NADOLNY SEE SCHEDULE O - O & T TITLE	(I)	154,982	8,696	15,681	7,394	20,636	207,389	0
	(II)	0	0	0	0	0	0	0
9 BRITAIN W NICHOLSON MD SEE SCHEDULE O - O & T TITLE	(I)	554,475	157,837	131,827	36,478	20,517	901,134	0
	(II)	0	0	0	0	0	0	0
10 DOST ONGUR MD PHD SEE SCHEDULE O - O & T TITLE	(I)	257,504	10,250	-10,788	28,774	31,267	317,007	0
	(II)	0	0	0	0	0	0	0
11 CHRISTINE REILLY SEE SCHEDULE O - O & T TITLE	(I)	130,149	7,785	21,273	7,498	1,091	167,796	0
	(II)	0	0	0	0	0	0	0
12 A KIM SAAL MD SEE SCHEDULE O - O & T TITLE	(I)	425,416	93,998	20,626	12,619	24,783	577,442	0
	(II)	0	0	0	0	0	0	0
13 JOHN SARRO SEE SCHEDULE O - O & T TITLE	(I)	316,238	16,875	19,708	0	27,377	380,198	0
	(II)	0	0	0	0	0	0	0
14 SCOTT L SCHISSEL MD PHD SEE SCHEDULE O - O & T TITLE	(I)	272,930	25,389	13,653	36,479	18,130	366,581	0
	(II)	0	0	0	0	0	0	0
15 NANCY D SCHMIDT SEE SCHEDULE O - O & T TITLE	(I)	233,990	13,741	43,601	36,477	24,078	351,887	0
	(II)	0	0	0	0	0	0	0
16 ANTHONY J SCIBELLI MS MBA SEE SCHEDULE O - O & T TITLE	(I)	244,426	19,584	24,968	2,614	22,183	313,775	0
	(II)	0	0	0	0	0	0	0
17 JULIA R SINCLAIR MBA SEE SCHEDULE O - O & T TITLE	(I)	364,358	64,840	35,302	36,480	34,098	535,078	0
	(II)	0	0	0	0	0	0	0
18 ALAMJIT S VIRK MD SEE SCHEDULE O - O & T TITLE	(I)	303,449	0	-6,057	6,106	30,456	333,954	0
	(II)	0	0	0	0	0	0	0
19 RON M WALLS MD SEE SCHEDULE O - O & T TITLE	(I)	1,189,601	187,040	3,615,108	36,476	32,623	5,060,848	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
181 ROBERT D WELCH SEE SCHEDULE O - O & T TITLE	(I)	168,177	10,000	25,325	24,068	30,562	258,132	0
	(II)	0	0	0	0	0	0	0
1 WILLIAM G AUSTEN JR MD SEE SCHEDULE O - O & T TITLE	(I)	1,190,476	235,100	103,932	36,844	24,027	1,590,379	0
	(II)	0	0	0	0	0	0	0
CHRISTOPHER W **2** DIGIOVANNI MD SEE SCHEDULE O - O & T TITLE	(I)	954,937	460,250	108,133	36,841	22,447	1,582,608	0
	(II)	0	0	0	0	0	0	0
3 THOMAS F HOLOVACS MD SEE SCHEDULE O - O & T TITLE	(I)	1,154,481	533,536	100,758	36,477	22,451	1,847,703	0
	(II)	0	0	0	0	0	0	0
4 AMAN B PATEL MD SEE SCHEDULE O - O & T TITLE	(I)	1,266,951	12,802	365,294	36,476	26,183	1,707,706	0
	(II)	0	0	0	0	0	0	0
5 JON P WARNER MD SEE SCHEDULE O - O & T TITLE	(I)	1,745,193	135,539	107,926	36,476	22,451	2,047,585	0
	(II)	0	0	0	0	0	0	0
6 DANIEL J GROSS SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	386,084	29,074	65,780	36,479	-32,650	550,067	0
7 MICHAEL S JELLINEK MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	0	0	292,309	0	0	292,309	0
8 KERRY R WATSON SEE SCHEDULE O - O & T TITLE	(I)	0	0	664,223	0	0	664,223	0
	(II)	0	0	0	0	0	0	0
9 THOMAS H ARETZ MD SEE SCHEDULE O - O & T TITLE	(I)	0	0	0	0	0	0	0
	(II)	398,724	50,000	67,134	36,478	-24,825	577,161	0
10 DENNIS AUSIELLO MD SEE SCHEDULE O - O & T TITLE	(I)	359,475	500	60,213	36,845	19,988	477,021	0
	(II)	0	0	0	0	0	0	0
11 BARBARA E BIERER MD SEE SCHEDULE O - O & T TITLE	(I)	311,225	0	34,001	33,461	23,804	402,491	0
	(II)	0	0	0	0	0	0	0
12 STEVEN D BROWELL MD SEE SCHEDULE O - O & T TITLE	(I)	386,959	34,852	19,453	4,974	26,832	473,070	0
	(II)	0	0	0	0	0	0	0
13 MAUREEN N CHESLEY SEE SCHEDULE O - O & T TITLE	(I)	152,880	13,311	23,570	15,919	29,424	235,104	0
	(II)	0	0	0	0	0	0	0
14 MARY BETH DIFILIPPO SEE SCHEDULE O - O & T TITLE	(I)	179,633	9,234	12,294	12,183	26,803	240,147	0
	(II)	0	0	0	0	0	0	0
15 GARY W GARBERG SEE SCHEDULE O - O & T TITLE	(I)	143,252	6,396	23,655	13,380	28,554	215,237	0
	(II)	0	0	0	0	0	0	0
16 MARK NOVOTNY MD SEE SCHEDULE O - O & T TITLE	(I)	156,608	1,015	280,220	11,915	21,481	471,239	0
	(II)	0	0	0	0	0	0	0
17 HARRY W ORF PHD SEE SCHEDULE O - O & T TITLE	(I)	479,225	77,550	106,433	36,480	20,454	720,142	0
	(II)	0	0	0	0	0	0	0
18 SHEILA K PARTRIDGE MD SEE SCHEDULE O - O & T TITLE	(I)	721,651	106,849	32,671	11,028	25,968	898,167	0
	(II)	0	0	0	0	0	0	0
19 BEATRICE THIBEDEAU SEE SCHEDULE O - O & T TITLE	(I)	0	0	287,080	0	0	287,080	0
	(II)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
201JEFFREY R ZACK MD SEE SCHEDULE O - O & T TITLE	(I)	372,299	0	22,722	10,158	31,668	436,847	0
	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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) Pool financing	
							Yes	No	Yes	No	Yes	No
A	MASSACHUSETTS HEALTH AND EDUCATION FACILITIES AU	04-2456011		12-23-2008	3,500,000	ENERGY EFFICIENCY EQUIPMENT		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	3,517,762			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	20,847			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	3,374,123			
11	Other spent proceeds	122,792			
12	Other unspent proceeds				
13	Year of substantial completion	2010			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X						
15	Were the bonds issued as part of 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							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
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 ▶								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X						
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?	X							
b	Exception to rebate?		X						
c	No rebate due?		X						
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X						
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?	X							
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X							

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
SCHEDULE K, PART II, LINE 3	THE TOTAL PROCEEDS REPORTED IN PART II, LINE 3, COLUMNS C INCLUDE INVESTMENT EARNINGS OF $17,762 THEREFORE THEY DIFFER FROM THE ISSUE PRICE LISTED IN PART I, COLUMN(E)

Return Reference	Explanation
SCHEDULE K, PART III,LINE 9	COOLEY DICKINSON HOSPITAL HAS PERFORMED AN EXTENSIVE REVIEW OF ALL ACTIVITIES CONDUCTED WITHIN ITS BOND FINANCED FACILITIES UPON REVIEW, THE ORGANIZATION HAS DETERMINED THAT THERE IS NO PRIVATE BUSINESS USE

Return Reference	Explanation
SCHEDULE K, PART V	COOLEY DICKINSON HOSPITAL HAS HISTORICALLY PERFORMED PERIODIC EXTENSIVE REVIEWS OF ALL ACTIVITIES CONDUCTED WITHIN ITS TAX EXEMPT BOND FINANCED FACILITIES EFFECTIVE JULY 24,2013, THE ORGANIZATION FORMALIZED ITS PRACTICE IN A WRITTEN PROCEDURE

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)

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

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

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

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

Part II Loans to and/or From Interested Persons.

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

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

Part III Grants or Assistance Benefiting Interested Persons.

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L PART II LOANS TO AND/OR FROM INTERESTED PERSONS	THE DEFAULT DESIGNATION FOR THE LOAN OUTSTANDING TO JOSEPH WOODIN IS DUE TO ONGOING ARBITRATION

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990, Schedule L, Part II - Loans to and from Interested Persons

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
M JOHNSON MD	DIRECTOR	PHYSICIAN RECRUITMENT		X	85,000	12,312		No		No		No
E A CHIOCCA MD	DIRECTOR	PHYSICIAN RECRUITMENT		X	400,000	70,000		No		No		No
D HAAS-KOGANMD	DIRECTOR	PHYSICIAN RECRUITMENT		X	250,000	133,333		No		No		No
E OLIVIER	OFFICER	RECRUITMENT		X	100,000	80,000		No		No		No
J WOODIN	OFFICER	RECRUITMENT		X	250,000	250,000	Yes			No		No
T GORMAN MD	DIRECTOR	RECRUITMENT		X	150,000	37,500		No		No		No
A SALIM MD	DIRECTOR	RECRUITMENT		X	200,000	33,967		No		No		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
C NABEL	NABEL, TRU AND OFF (FAM)	60,246	SALARY		No
NPP DEVELOPMENT	KRAFT, TRU (FAM)	3,926,719	LEASE		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
SUFFOLK CONSTRUCTION	FISH, TRU	53,390,249	CONSTRUCTION SERVICES		No
B RATTNER	RATTNER, TRU (FAMILY)	201,395	SALARY		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
P HEARON	HIGHAM, OFF (FAMILY)	64,527	SALARY		No
K CASPER	PIL, TRU (FAMILY)	301,960	SALARY		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
C OLIVIER	OLIVER, OFF (FAMILY)	92,121	SALARY		No
J RAY	RAY, TRU (FAMILY)	50,899	SALARY		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
R VANDERHOOP	SWEET, TRU,OFF (FAMILY)	160,377	SALARY		No
J MONTO	MONTO, TR (FAM)	92,541	SALARY		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
E COLLIER	COLLIER, TRU (FAMILY)	94,028	SALARY		No
B MILLER	SPIESS, TRU (FAMILY)	92,753	SALARY		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
CARLON MEDICAL	PITONIAK, TRU	339,882	LEASE		No
VIDOC	WEITZMAN, TRU (FAMILY)	269,477	LEASE		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
NORTH SHORE CARDIOVASCULAR ASSOCIATES INC	ROBERTS, TRU	369,399	SERVICES		No
GCA REAL ESTATE	ZUCKER, TRU	249,471	LEASE		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
NORTH SHORE CARDIOVASCULAR ASSOCIATES INC	ROBERTS, TRU	356,179			No

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art	X	60	864,377	FMV
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications	X		3,211	FMV
5	Clothing and household goods	X		65,614	FMV
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded	X	829	52,260,804	FMV
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles	X	21	33,839	FMV
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ See Additional Data				
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

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

			Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		No
b	If "Yes," describe the arrangement in Part II			
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31	Yes	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		No
b	If "Yes," describe in Part II			
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II			

Part II **Supplemental Information.**

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

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Part I, Lines 25-28

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
Other ▶ (MISCELLANEOUS)	X	512	353,815	FMV
Other ▶ (ADVERTISING)	X	7	148,167	FMV
Other ▶ (GIFT CERTIFICATES)	X	287	126,854	FMV
Other ▶ (MEDICAL EQUIPMENT)	X	17	115,098	FMV
Other ▶ (HOTEL PACKAGES)	X	64	102,444	FMV
Other ▶ (FOOD)	X	87	72,582	FMV
Other ▶ (SPORTING EVENT/THEATER/MUSEUM TICKETS)	X	94	53,817	FMV
Other ▶ (TRAVEL/AIRFARE/TRANSPORTATION)	X	16	44,386	FMV
Other ▶ (ROUNDS OF GOLF)	X	23	33,591	FMV
Other ▶ (JEWLERY)	X	20	26,186	FMV
Other ▶ (COMPUTER EQUIPMENT)	X	5	9,298	FMV
Other ▶ (PORTRAITS)	X	8	6,710	FMV
Other ▶ (STUDIO PARTY/PARTY)	X	7	2,960	FMV

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SCHEDULE N (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Liquidation, Termination, Dissolution, or Significant Disposition of Assets

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 31 or 32; or Form 990-EZ, line 36.
▶ Attach certified copies of any articles of dissolution, resolutions, or plans.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule N (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

Part I **Liquidation, Termination, or Dissolution.** Complete this part if the organization answered "Yes" on Form 990, Part IV, line 31, or Form 990-EZ, line 36. Part I can be duplicated if additional space is needed.

1 (a) Description of asset(s) distributed or transaction expenses paid	(b) Date of distribution	(c) Fair market value of asset(s) distributed or amount of transaction expenses	(d) Method of determining FMV for asset(s) distributed or transaction expenses	(e) EIN of recipient	(f) Name and address of recipient	(g) IRC section of recipient(s) (if tax-exempt) or typeof entity
CASH	09-30-2017	134,494	BOOK VALUE	04-2650246	NEWTON WELLESLEY HOSPITAL 399 REVOLUTION DR SOMERVILLE, MA 02145	501(C)(3)

		Yes	No
2	Did or will any officer, director, trustee, or key employee of the organization		
a	Become a director or trustee of a successor or transferee organization?		No
b	Become an employee of, or independent contractor for, a successor or transferee organization?		No
c	Become a direct or indirect owner of a successor or transferee organization?		No
d	Receive, or become entitled to, compensation or other similar payments as a result of the organization's liquidation, termination, or dissolution?		No
e	If the organization answered "Yes" to any of the questions on lines 2a through 2d, provide the name of the person involved and explain in Part III ▶		

Part I **Liquidation, Termination, or Dissolution** (continued)

Note. If the organization distributed all of its assets during the tax year, then Form 990, Part X, column (B), line 16 (Total assets), and line 26 (Total liabilities), should equal -0-

			Yes	No
3	Did the organization distribute its assets in accordance with its governing instrument(s)? If "No," describe in Part III	3	Yes	
4a	Is the organization required to notify the attorney general or other appropriate state official of its intent to dissolve, liquidate, or terminate?	4a	Yes	
b	If "Yes," did the organization provide such notice?	4b	Yes	
5	Did the organization discharge or pay all of its liabilities in accordance with state laws?	5	Yes	
6a	Did the organization have any tax-exempt bonds outstanding during the year?	6a		No
b	If "Yes" on line 6a, did the organization discharge or defease all of its tax-exempt bond liabilities during the tax year in accordance with the Internal Revenue Code and state laws?	6b		

c If "Yes" on line 6b, describe in Part III how the organization defeased or otherwise settled these liabilities If "No" on line 6b, explain in Part III

Part II **Sale, Exchange, Disposition, or Other Transfer of More Than 25% of the Organization's Assets.**

Complete this part if the organization answered "Yes" on Form 990, Part IV, line 32, or Form 990-EZ, line 36. Part II can be duplicated if additional space is needed.

1	**(a)** Description of asset(s) distributed or transaction expenses paid	**(b)** Date of distribution	**(c)** Fair market value of asset(s) distributed or amount of transaction expenses	**(d)** Method of determining FMV for asset(s) distributed or transaction expenses	**(e)** EIN of recipient	**(f)** Name and address of recipient	**(g)** IRC section of recipient(s) (if tax-exempt) or type of entity

			Yes	No
2	Did or will any officer, director, trustee, or key employee of the organization			
a	Become a director or trustee of a successor or transferee organization?	2a		
b	Become an employee of, or independent contractor for, a successor or transferee organization?	2b		
c	Become a direct or indirect owner of a successor or transferee organization?	2c		
d	Receive, or become entitled to, compensation or other similar payments as a result of the organization's significant disposition of assets?	2d		

e If the organization answered "Yes" to any of the questions on lines 2a through 2d, provide the name of the person involved and explain in Part III ▶

Part III **Supplemental Information.**

Provide the information required by Part I, lines 2e and 6c, and Part II, line 2e. Also complete this part to provide any additional information.

Return Reference	Explanation
MERGER	THE FOLLOWING ORGANIZATION MERGED INTO ITS 501(C)(3) TAX EXEMPT PARENT ORGANIZATION NEWTON-WELLESLEY CHILDREN'S CORNER, INC (EIN 04-2650246) MERGED INTO NEWTON-WELLESLEY HOSPITAL (EIN 04-2103611)

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ **Attach to Form 990 or 990-EZ.**

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number

90-0656139

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	PATIENT CARE FOR MANY YEARS, PARTNERS HEALTHCARE HAS INVESTED IN THE DEVELOPMENT AND IMPL EMENTATION OF PROGRAMS TO IMPROVE PATIENT CARE QUALITY AND OUTCOMES AND MANAGE THE GROWTH IN THE COSTS OF PATIENT CARE BEGINNING IN 2007 WITH A CMS DEMONSTRATION PROJECT FOR MEDIC ARE PATIENTS THESE EFFORTS WERE COORDINATED IN A NUMBER OF SYSTEM-WIDE PATIENT AFFORDABILI TY AND COST MANAGEMENT INITIATIVES THAT RESULTED IN THE ADOPTION ACROSS THE NETWORK OF PRO GRAMS SUCH AS THE INTEGRATED CARE MANAGEMENT PROGRAM (ICMP), THAT USES IMPROVED INFORMATIO N SHARING AND ACTIVE CASE MANAGEMENT TO COORDINATE TREATMENT FOR HIGH-RISK PATIENTS ACROSS THE CONTINUUM OF CARE, AND THE TEAM-BASED PATIENT CENTERED MEDICAL HOME (PCMH) MODEL FOR PARTNERS HEALTHCARE PRIMARY CARE PROVIDERS, THAT INCREASES PATIENT ACCESS TO PREVENTATIVE CARE, REDUCES UTILIZATION OF UNNECESSARY SERVICES AND MOVES LOW ACUITY CARE INTO APPROPRIA TE COMMUNITY SETTINGS THE UPWARD PRESSURE ON HEALTHCARE COSTS HAS CONTINUED BOTH NATIONAL LY AND LOCALLY, AND THE HEALTHCARE INDUSTRY HAS RESPONDED IN A NUMBER OF WAYS, INCLUDING T HE GROWTH OF ALTERNATIVE PAYMENT MODELS, SUCH AS ACCOUNTABLE CARE ORGANIZATIONS (ACOS), TH AT EMPHASIZE COST CONTROL AND QUALITY IMPROVEMENT OVER VOLUME, TIGHTER REFERRAL MANAGEMENT BY PROVIDER NETWORKS THAT ARE PARTICIPATING IN RISK CONTRACTS, AND INCREASED COST AND PRI CE SENSITIVITY ON THE PART OF REGULATORS, CONSUMERS, EMPLOYERS, INSURERS AND PROVIDER GROU PS IN ORDER TO RESPOND TO THESE MARKET FORCES, PARTNERS HEALTHCARE HAS ONCE AGAIN COMMITT ED TO BE A LEADER IN CLINICAL CARE AND SYSTEM INNOVATION AND IN THE SHIFT TO VALUE-DRIVEN HEALTHCARE BY FOCUSING ITS EFFORTS ON THE FOLLOWING STRATEGIC INITIATIVES 1 EXPENSE AND RESOURCE MANAGEMENT (ALSO REFERRED TO AS "PARTNERS 2 0") 2 POPULATION HEALTH MANAGEMENT 3 AMBULATORY SERVICES DEVELOPMENT PARTNERS HEALTHCARE ACUTE CARE SECTOR INCLUDES TWO OF TH E MOST WELL RESPECTED ACADEMIC MEDICAL CENTERS IN THE UNITED STATES, BWH AND THE GENERAL, AND SEVEN ACUTE CARE COMMUNITY HOSPITALS COOLEY, FAULKNER, MVH, NCH, NWH AND NSMC'S SALEM AND UNION HOSPITALS TOGETHER THESE FORM THE LARGEST ACUTE CARE DELIVERY SYSTEM IN EASTER N MASSACHUSETTS BWH AND THE GENERAL ARE RENOWNED FOR THEIR EXCELLENCE IN PATIENT CARE, IN NOVATIVE AND FAR-REACHING RESEARCH EFFORTS AND EDUCATIONAL PROGRAMS BWH AND THE GENERAL S ERVE BOTH AS COMMUNITY HOSPITALS FOR PORTIONS OF METROPOLITAN BOSTON AND AS PROVIDERS OF T ERTIARY AND QUATERNARY SERVICES, PRIMARILY TO EASTERN MASSACHUSETTS AND ADJACENT PORTIONS OF CONTIGUOUS STATES, BUT ALSO TO THE REMAINDER OF MASSACHUSETTS, NEW ENGLAND, OTHER PARTS OF THE UNITED STATES AND OTHER NATIONS SINCE A SIGNIFICANT PART OF THE PRIMARY SERVICE A REAS OF BWH AND THE GENERAL DO NOT OVERLAP, BOTH BWH AND THE GENERAL CONTINUE TO PROVIDE M ANY OF THE SAME TERTIARY AND SECONDARY SERVICES AMONG THE TERTIARY SERVICES THAT PARTNERS HEALTHCARE OFFERS THROUGH BWH AND THE GENERAL ARE ALL FORMS OF ORGAN TRANSPLANTS, INCLUDI NG HEART, LUNG, HEART-LUNG, LI

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	VER, KIDNEY, BONE MARROW, SMALL BOWEL AND PANCREAS TRANSPLANTS THE BURN AND LEVEL I TRAUM A UNITS (FOR TREATMENT OF THE MOST SERIOUS CASES) AT BWH AND THE GENERAL REPRESENT TWO OF ONLY THREE SUCH UNITS IN MASSACHUSETTS AND ARE AMONG THE LARGEST IN NEW ENGLAND BRIGHAM A ND WOMEN'S AND THE GENERAL ARE LEADING ACADEMIC MEDICAL CENTERS ALONG WITH FIVE COMMUNITY HOSPITALS AND FIVE SPECIALTY HOSPITALS, PARTNERS OFFERS HEALTH CARE FOR NEARLY EVERY MEDI CAL NEED PATIENTS CHOOSE TO COME TO PARTNERS HOSPITALS FROM THE BOSTON AREA, BUT ALSO FRO M ACROSS THE COUNTRY AND THROUGHOUT THE WORLD BECAUSE OF GROUND BREAKING ACHIEVEMENTS IN M EDICAL CARE AND THE HIGH DEGREE OF SPECIALIZATION PROVIDED DURING THE FISCAL YEAR 2017, E NDING SEPTEMBER 30, 2017 PARTNERS HEALTHCARE RECORDED 159,238 ADMISSIONS AND 981,977 PATIE NT DAYS AMBULATORY CARE EACH OF PARTNERS HEALTHCARE'S NINE ACUTE CARE HOSPITALS PROVIDES EMERGENCY, AMBULATORY AND OUTPATIENT CARE ACROSS MAJOR SPECIALTIES COMBINED, THEY COMPRI SE THE LARGEST OUTPATIENT NETWORK IN EASTERN MASSACHUSETTS IN 2017, PARTNERS HEALTHCARE A CUTE CARE HOSPITAL BASED AND NON-HOSPITAL BASED AMBULATORY CARE PROGRAMS RESULTED IN APPRO XIMATELY 1,396,000 ROUTINE VISITS, APPROXIMATELY 388,000 EMERGENCY SERVICES VISITS AND APP ROXIMATELY 923,000 HOME HEALTH VISITS BWH IS THE RESULT OF A 1975 MERGER OF THE PETER BEN T BRIGHAM HOSPITAL, THE ROBERT BRECK BRIGHAM HOSPITAL AND THE BOSTON HOSPITAL FOR WOMEN, W HOSE INPATIENT FACILITIES WERE PHYSICALLY CONSOLIDATED IN 1980 IN THE 2017-18 U S NEWS A ND WORLD REPORT, BWH RANKED #2 IN MASSACHUSETTS AND #2 IN BOSTON METRO AREA AND WAS NATION ALLY RECOGNIZED IN ELEVEN ADULT SPECIALTIES AND NINE PROCEDURES AND CONDITIONS, INCLUDING CANCER, CARDIOLOGY AND HEART SURGERY, DIABETES AND ENDOCRINOLOGY, GASTROENTEROLOGY & GI S URGERY, GERIATRICS, GYNECOLOGY, NEPHROLOGY, NEUROLOGY & NEUROSURGERY, ORTHOPEDICS, PULMONO LOGY, AND RHEUMATOLOGY BWH PROVIDES OUTPATIENT SERVICES, INCLUDING PRIMARY CARE, SPECIALT Y CARE, DIAGNOSTICS, IMAGING AND AMBULATORY PROCEDURES AT NUMEROUS AMBULATORY PRACTICES IN VARIOUS LOCATIONS FOUR PRACTICE SITES ON THE BWH DISTRIBUTED MAIN CAMPUS AND THE BRIGHAM AND WOMEN'S AMBULATORY CARE CENTER IN CHESTNUT HILL HOUSE THE MAJORITY OF THESE PRACTICES , AND THE REMAINDER ARE IN SATELLITES LOCATED SOUTHWEST AND SOUTH OF BOSTON, INCLUDING THE BRIGHAM AND WOMEN'S/MASS GENERAL HEALTH CARE CENTER LOCATED AT PATRIOT PLACE IN FOXBOROUG H, MASSACHUSETTS IN ADDITION, BWH OPERATES NEIGHBORHOOD HEALTH CENTERS IN THE JAMAICA PLA IN SECTION OF BOSTON NEAR ITS HOSPITAL FACILITIES AND SERVES AS A REFERRAL FACILITY FOR BO TH HEALTH CENTERS THESE COMMUNITY HEALTH CENTERS PROVIDE COMPREHENSIVE SERVICES SIMILAR T O THOSE OFFERED BY SATELLITE PRACTICES AND INCLUDE PRIMARY CARE, DENTISTRY, PEDIATRICS, PO DIATRY, OBSTETRICS, GYNECOLOGY, MENTAL HEALTH, NUTRITION, OUTPATIENT SUBSTANCE ABUSE COUNS ELING AND SOCIAL SERVICES BWH IS LICENSED BY THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALT H (DPH) TO OPERATE 763 BEDS, A

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	LL OF WHICH WERE STAFFED AS OF SEPTEMBER 30, 2017 PURSUANT TO A JOINT VENTURE IN ADULT ON COLOGY BETWEEN BWH AND DANA FARBER CANCER INSTITUTE, INC (DFCI), THIRTY BEDS THAT ARE ON DFCI'S LICENSE ARE LOCATED ON BWH'S MAIN CAMPUS AND ARE SUPPORTED BY BWH PURSUANT TO SERVI CE CONTRACTS WITH DFCI ORIGINALLY A DIVISION OF MGH, WHICH WAS FOUNDED BY SPECIAL ACT OF THE MASSACHUSETTS LEGISLATURE IN 1811, THE GENERAL WAS SEPARATELY INCORPORATED AS A SUBSID IARY OF MGH IN 1980 THE GENERAL HOSPITAL ADMITTED ITS FIRST PATIENT IN 1821 IT IS THE TH IRD OLDEST GENERAL, NON-MILITARY HOSPITAL IN THE UNITED STATES AND THE OLDEST IN NEW ENGLA ND IN THE 2017-18 U S NEWS AND WORLD REPORT, THE GENERAL RANKED #4 IN THE NATION, #1 IN MASSACHUSETTS AND #1 IN BOSTON BASED ON QUALITY OF CARE, PATIENT SAFETY AND REPUTATION IN SIXTEEN CLINICAL SPECIALTIES, INCLUDING CANCER, CARDIOLOGY & HEART SURGERY, DIABETES & END OCRINOLOGY, EAR, NOSE & THROAT, GASTROENTEROLOGY & GI SURGERY, GERIATRICS, GYNECOLOGY, NEP HROLOGY, NEUROLOGY & NEUROSURGERY, OPHTHALMOLOGY, ORTHOPEDICS, PSYCHIATRY, PULMONOLOGY, RE HABILITATION, RHEUMATOLOGY, AND UROLOGY ADDITIONALLY, THE GENERAL RANKED #2 FOR DIABETES & ENDOCRINOLOGY, EAR, NOSE & THROAT, AND PSYCHIATRY THE GENERAL HOSPITAL IS RECOGNIZED AS A "MAGNET" HOSPITAL BY THE AMERICAN NURSES CREDENTIALING CENTER MAGNET DESIGNATION REPRE SENTS THE HIGHEST HONOR AVAILABLE FOR NURSING EXCELLENCE AND IS ACHIEVED BY FEWER THAN 7% OF HOSPITALS IN THE UNITED STATES THE GENERAL HOSPITAL IS LICENSED BY THE DPH TO OPERATE 1,035 BEDS, 1,011 OF WHICH WERE STAFFED AS OF SEPTEMBER 30, 2017 COMMUNITY HOSPITALS PART NERS HEALTHCARE CURRENTLY OPERATES EIGHT ACUTE CARE COMMUNITY HOSPITALS AS SHOWN IN THE TA BLE BELOW, TWO OF WHICH OPERATE ON NSMC'S LICENSE NSMC IS IN THE PROCESS OF CONSOLIDATING UNION HOSPITAL INPATIENT SERVICES INTO THE SALEM HOSPITAL SITE, WHICH IS CURRENTLY UNDERG OING RENOVATIONS TO ACCOMMODATE THIS CONSOLIDATION AND PLANNED PROGRAMMATIC CHANGES GENER ALLY, EACH OF THE MAINLAND COMMUNITY HOSPITALS OFFER A BROAD RANGE OF INPATIENT AND OUTPAT IENT SERVICES INCLUDING BUT NOT LIMITED TO SOME OR ALL OF THE FOLLOWING, DEPENDING ON THE PARTICULAR HOSPITAL MEDICAL/SURGICAL, ORTHOPEDIC, PEDIATRIC, GERIATRIC, GYNECOLOGICAL, OB STETRICS, EMERGENCY, INTENSIVE CARE, PSYCHIATRIC AND REHABILITATIVE PROGRAMS THE ISLAND H OSPITALS, MVH AND NCH, HAVE A SOMEWHAT MORE LIMITED RANGE OF INPATIENT AND OUTPATIENT SERV ICES, BUT EACH OF THEM HAS LONG-STANDING COLLABORATIONS WITH THE GENERAL IN A VARIETY OF S PECIALTIES AND USES TELEMEDICINE LINKS TO THE GENERAL MOST OF THE COMMUNITY HOSPITALS OFF ER RESIDENCY PROGRAMS IN SELECTED MEDICAL SERVICES AND SPECIALTIES AND SERVE AS TRAINING S ITES FOR STUDENTS IN MEDICINE, NURSING AND OTHER FIELDS THROUGH AFFILIATIONS WITH HARVARD UNIVERSITY'S MEDICAL AND DENTAL SCHOOLS AND THE TUFTS UNIVERSITY SCHOOL OF MEDICINE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1 CONTINUE)	NAME LOCATION LICENSED BEDS AS OF 9/30/17 BWFH JAMAICA PLAIN (BOSTON), MA 162 COOLEY NORTH AMPTON, MA 140 MVH MARTHA'S VINEYARD ISLAND, MA 25 NCH NANTUCKET ISLAND, MA 19 NSMC SALEM, MA/LYNN, MA 396 NWH NEWTON, MA 265 WDH DOVER, NH (NOT IN GROUP) 178 PARTNERS HEALTHCARE C OMMUNITY HOSPITALS ALSO OFFER EXTENSIVE AMBULATORY CARE SERVICES FOR EXAMPLE, BWFH OFFERS AN OUTPATIENT CENTER IN BREAST HEALTH CARE, AND OUTPATIENT SERVICES AT NWH INCLUDE A CANC ER CENTER, SPINE CENTER, WOMEN'S IMAGING CENTER, CARDIOVASCULAR HEALTH CENTER, JOINT RECON STRUCTION CENTER, DIABETES CENTER AND AN AMBULATORY SURGERY CENTER NSMC OFFERS IMAGING SE RVICES, CARDIOLOGY TESTING AND SURGICAL SUITES DESIGNED EXCLUSIVELY FOR OUTPATIENT SURGERY AND DIAGNOSTIC ENDOSCOPIC PROCEDURES PHYSICIAN SECTOR PARTNERS HEALTHCARE HAS AN EXTENSI VE NETWORK OF APPROXIMATELY 6,800 EMPLOYED AND AFFILIATED PHYSICIANS THAT CONSISTS OF APPR OXIMATELY 1,100 COMMUNITY AND ACADEMIC PCPS, APPROXIMATELY 1,650 COMMUNITY SPECIALISTS AND APPROXIMATELY 4,050 ACADEMIC SPECIALISTS INCLUDED WITHIN THESE PHYSICIAN TOTALS ARE APPR OXIMATELY 1,550 PHYSICIANS WHO ARE NOT EMPLOYED BY PARTNERS HEALTHCARE AND THEREFORE THE F INANCIAL RESULTS OF THEIR PRACTICES ARE NOT INCLUDED IN THE FINANCIAL RESULTS OF THE PARTN ERS HEALTHCARE PHYSICIAN SECTOR THE TWO ACADEMIC PHYSICIAN ORGANIZATIONS, BWPO AND MGPO, EMPLOY SUBSTANTIALLY ALL OF THE STAFF PHYSICIANS WHO PROVIDE HEALTHCARE SERVICES TO PATIEN TS AT BWH AND THE GENERAL, RESPECTIVELY THE BWPO AND MGPO PHYSICIANS ALSO SUPERVISE OTHER PROFESSIONAL AND TECHNICAL PERSONNEL AND TEACH MEDICAL STUDENTS AND RESIDENTS AT BWH AND THE GENERAL, RESPECTIVELY REHABILITATION CARE SECTOR PARTNERS CONTINUING CARE OVERSEES TH E MANAGEMENT, DELIVERY AND INTEGRATION OF NON-ACUTE SERVICES IN THE PARTNERS HEALTHCARE SY STEM SPAULDING REHABILITATION NETWORK THE SPAULDING REHABILITATION NETWORK INCLUDES SPAU LDING REHABILITATION HOSPITAL IN CHARLESTOWN, AS WELL AS SPAULDING REHABILITATION HOSPITAL CAPE COD, SPAULDING HOSPITAL CAMBRIDGE AND SPAULDING NURSING AND THERAPY CENTER BRIGHTON, AS WELL AS TWENTY-FIVE OUTPATIENT SITES THROUGHOUT EASTERN MASSACHUSETTS THE NETWORK INV OLVES THREE HOSPITAL FACILITIES AS SHOWN IN THE TABLE BELOW, TWO OF WHICH ARE INPATIENT RE HABILITATION FACILITIES (IRFS) AND ONE OF WHICH IS LICENSED AS A LONG-TERM ACUTE CARE (LTA C) FACILITY SPAULDING BOSTON IS ONE OF THE LARGEST SPECIALTY IRFS IN THE UNITED STATES AN D SERVES AS A REFERRAL HOSPITAL FOR ACUTE CARE HOSPITALS IN THE REGION IN THE 2017-18 U S NEWS AND WORLD REPORT SPAULDING REHABILITATION HOSPITAL RANKED #4 FOR REHABILITATION EA CH OF THE SPAULDING IRFS OPERATES A NUMBER OF OUTPATIENT FACILITIES OFFERING A VARIETY OF THERAPY SERVICES SPAULDING REHABILITATION NETWORK NAME AND LOCATION FACILITY TYPE LICENSE D BEDS SPAULDING BOSTON IRF 132 SPAULDING CAMBRIDGE LTAC 180 SPAULDING CAPE COD IRF 60 (EA ST SANDWICH) SKILLED NURSING PARTNERS HEALTHCARE OWNS FREE-STANDING SKILLED NURSING FACIL ITIES (SNFS) TO ACCOMMODATE BO

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1 CONTINUE)	TH SHORT TERM AND LONGER-TERM PATIENT NEEDS FREE-STANDING SNFS INCLUDE SPAULDING BRIGHTON AND THE CLARK HOUSE THE FORMER SPAULDING NORTH END (140-BED SNF) AND WEST ROXBURY (81-BE D SNF) SITES WERE CONSOLIDATED INTO SPAULDING BRIGHTON, A 123-BED SNF THAT OPENED IN OCTOB ER 2017 THE MGH HEALTH SERVICES CORPORATION IS A GENERAL PARTNER IN FOX HILL VILLAGE PART NERSHIP WHICH OPERATES THE CLARK HOUSE, A 70-BED SNF LOCATED IN WESTWOOD, MASSACHUSETTS ON THE CAMPUS OF THE FOX HILL VILLAGE RETIREMENT COMMUNITY HOME HEALTH HOME HEALTH CARE IS AN ESSENTIAL PART OF THE CONTINUUM OF CARE IT SUPPORTS THE TRANSITION OF PATIENTS BACK I NTO THE COMMUNITY, PROMOTES THEIR INDEPENDENCE, REDUCES THE NEED FOR HOSPITALIZATION AND I NSTITUTIONALIZATION AND IS A COST-EFFECTIVE ALTERNATIVE TO INPATIENT CARE PHH SERVES A GE OGRAPHIC AREA FROM NEWBURYPORT TO THE NORTH OF BOSTON, TO FRAMINGHAM IN THE WEST, AND PLYM OUTH IN THE SOUTH WITH REGIONAL BRANCH OFFICES IN BEVERLY, WALTHAM AND BRAINTREE, PHH EMP LOYS APPROXIMATELY 860 STAFF MEMBERS AND IS ONE OF THE LARGEST HOME HEALTH CARE PROVIDERS IN EASTERN MASSACHUSETTS PHH'S MEDICARE-CERTIFIED DIVISION IS ACCREDITED BY THE JOINT COM MISSION PSYCHIATRIC CARE SECTOR MCLEAN IS A TERTIARY PSYCHIATRIC REFERRAL AND RESEARCH HO SPITAL LICENSED FOR 324 BEDS LOCATED IN BELMONT, MASSACHUSETTS MCLEAN PROVIDES A CONTINUU M OF INPATIENT, ACUTE AND LONG-TERM RESIDENTIAL, PARTIAL HOSPITALIZATION AND TREATMENT-SPE CIFIC OUTPATIENT SERVICES TO CHILDREN, ADOLESCENTS, ADULTS AND GERIATRIC PATIENTS IT ALSO HAS TWO SPECIALIZED SCHOOLS FOR CHILDREN AND ADOLESCENTS THAT OFFER A RANGE OF THERAPEUTI C SERVICES IT IS THE LARGEST PSYCHIATRIC TEACHING AFFILIATE OF HARVARD MEDICAL SCHOOL IN THE 2017-18 U S NEWS AND WORLD REPORT, MCLEAN HOSPITAL RANKED #1 IN THE NATION FOR PSYCH IATRY MCLEAN BENEFITS FROM A WIDE ARRAY OF CLINICAL AND HOSPITAL REFERRAL SOURCES AND ATT RACTS PATIENTS REQUIRING COMPLEX TREATMENT BOTH FROM THE GREATER EASTERN MASSACHUSETTS REG ION AND, TO A DEGREE, NATIONALLY AND INTERNATIONALLY FOR EACH OF THE LAST 20 YEARS, MCLEA N HAS RECEIVED MORE NIH RESEARCH FUNDING THAN ANY PRIVATE PSYCHIATRIC HOSPITAL IN THE COUN TRY MCLEAN'S RESEARCH FOCUS IS ON BASIC BENCHTOP, PRECLINICAL, TRANSLATIONAL AND CLINICAL NEUROSCIENCE ALL OF MCLEAN'S ACTIVE STAFF OF 136 PHYSICIANS AND PSYCHOLOGISTS HOLD HARVA RD MEDICAL SCHOOL APPOINTMENTS MCLEAN, IN CONJUNCTION WITH THE GENERAL, OPERATES TRAINING PROGRAMS FOR RESIDENTS AND OTHERS IN ALL FIELDS OF PSYCHIATRY AND FOR STUDENTS AND FELLOW S IN PSYCHOLOGY, SUBSTANCE ABUSE TREATMENT AND NEUROLOGY MCLEAN OFFERS A NUMBER OF CLINIC AL PROGRAMS, BOTH ON AND OFF CAMPUS THESE INCLUDE, BUT ARE NOT LIMITED TO, SATELLITE PROG RAMS AT NINE SITES IN THE GREATER EASTERN MASSACHUSETTS REGION AND ONE IN MAINE THAT OFFER ONE OR MORE OF INPATIENT, RESIDENTIAL, PARTIAL HOSPITAL, SUBSTANCE ABUSE TREATMENT AND IN TENSIVE EVALUATION AND DIAGNOSTIC SERVICES FOR PATIENTS OF ALL AGES PHYSICIAN SECTOR PART NERS HEALTHCARE PROVIDES EMERG

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1 CONTINUE)	ENCY AND OTHER CARE TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY THE COST OF PROVIDING THAT CARE IS REFLECTED IN THE STATEMENTS OF OPERATIONS SERVICES PROVIDED TO CHARITY CARE PATIENTS, FOR WHICH ACUTE CARE HOSPITALS RECEIVE REIMBURSEMENT THROUGH THE STATEWIDE HEALT H SAFETY NET TRUST FUND (HSN), AND TO PATIENTS COVERED UNDER THE MEDICARE AND MEDICAID PRO GRAMS GENERATE COSTS FOR WHICH PARTNERS HEALTHCARE IS NOT FULLY REIMBURSED SEE "PATIENT C ARE REVENUE TRENDS AND METHODOLOGIES" ABOVE FOR A MORE DETAILED DESCRIPTION OF EACH OF THE SE PROGRAMS FOR CHARITY CARE, MEDICAID AND MEDICARE, THE TOTAL ESTIMATED COST OF SERVICES PROVIDED BY PARTNERS HEALTHCARE EXCEEDED THE NET REIMBURSEMENT RECEIVED UNDER THESE PROGR AMS BY $1,448 3 MILLION IN 2017 THE ESTIMATED COST OF SERVICES PROVIDED IS EITHER OBTAINE D DIRECTLY FROM A COSTING SYSTEM OR IS BASED ON AN ENTITY SPECIFIC RATIO OF COST TO GROSS CHARGES IN THE LATTER CASE, COST IS DERIVED BY APPLYING THIS RATIO TO GROSS CHARGES ASSOC IATED WITH PROVIDING CARE TO CHARITY CARE, MEDICAID AND MEDICARE PATIENTS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 2)	RESEARCH THE CONDUCT OF BIOMEDICAL RESEARCH CONSTITUTES ONE OF PARTNERS HEALTHCARE'S CORE MISSIONS AND ACTIVITIES IT INCLUDES FUNDAMENTAL BENCH RESEARCH IN ALL OF THE LIFE SCIENC ES DISCIPLINES, PATIENT-CENTERED RESEARCH WITHIN THE INPATIENT AND OUTPATIENT SERVICES OF PARTNERS HEALTHCARE HOSPITALS, CLINICAL TRIALS OF NEW DRUGS AND DEVICES, AS WELL AS HEALTH SERVICES AND EPIDEMIOLOGICAL RESEARCH PARTNERS HEALTHCARE HAS THE LARGEST NON-UNIVERSITY -BASED, NON-PROFIT PRIVATE MEDICAL RESEARCH ENTERPRISE IN THE UNITED STATES HOWEVER, EACH PARTNERS HEALTHCARE AFFILIATE WITH MAJOR RESEARCH OPERATIONS - THE GENERAL, BWH, SPAULDIN G BOSTON AND MCLEAN - ACT AS SEPARATE RESEARCH GRANT RECIPIENTS PARTNERS HEALTHCARE'S TOT AL RESEARCH EXPENDITURES IN 2017 WERE $1,654 1 MILLION, OF WHICH APPROXIMATELY $810 2 MILL ION (49%) WAS FUNDED DIRECTLY BY NIH AND OTHER FEDERAL AGENCIES, AND AN ADDITIONAL $179 7 MILLION (11%) WAS FUNDED VIA FEDERAL SUBCONTRACTS, LARGELY THROUGH UNIVERSITY COLLABORATIO NS AS OF SEPTEMBER 30, 2017, PARTNERS HEALTHCARE'S COMMITTED FUTURE RESEARCH FUNDING WAS APPROXIMATELY $3 1 BILLION IN ADDITION, THE DANA FARBER/PARTNERS CANCER CARE, INC (DF/PC C) ONCOLOGY RESEARCH JOINT VENTURE AMONG DFCI, BWH, THE GENERAL AND PHS, RECEIVED $145 MIL LION IN NIH FUNDING IN 2017 ALTHOUGH DFCI IS NOT A MEMBER OF PARTNERS HEALTHCARE, DF/PCC COORDINATES THE CLINICAL CANCER RESEARCH PROGRAMS OF BOTH DFCI AND PARTNERS HEALTHCARE PA RTNERS HEALTHCARE SUPPORTS VARIOUS RESEARCH PROGRAMS TO FACILITATE THE TRANSLATION OF MEDI CAL ADVANCES TO ITS PATIENTS PARTNERS PERSONALIZED MEDICINE (PPM) WAS ESTABLISHED IN 2001 TO REALIZE THE PROMISE OF GENETICS AND GENOMICS IN RESEARCH AND IN MEDICAL PRACTICE ONE OF THE GOALS OF PPM IS TO HELP ENSURE THAT THE KNOWLEDGE GAINED FROM GENETICS AND GENOMICS BECOMES AN INTEGRAL PART OF DIAGNOSIS, PROGNOSIS AND TREATMENT OF DISEASE (INCLUDING THE DETERMINATION OF THE APPROPRIATE DRUGS) FOR INDIVIDUAL PATIENTS SERVED BY THE PARTNERS HEA LTHCARE INSTITUTIONS UNDER THE OVERSIGHT OF PPM, PARTNERS HEALTHCARE ESTABLISHED THE PART NERS BIOBANK - A REPOSITORY OF CONSENTED PATIENT SAMPLES LINKED TO THE ELECTRONIC MEDICAL RECORD AND SUPPLEMENTED WITH HEALTH INFORMATION/FAMILY HISTORY FROM SURVEYS TO DATE OVER 75,000 PATIENTS ARE ENROLLED, AND SAMPLES OF 20,000 PATIENTS HAVE BEEN GENOTYPED BIOBANK DATA AND SAMPLES ARE USED IN RESEARCH TO BETTER UNDERSTAND, PREVENT, AND TREAT MANY DIFFER ENT DISEASES, OVERALL THE BIOBANK HAS SUPPORTED OVER $160 MILLION IN FUNDED RESEARCH STUDI ES AS AN EXAMPLE, THE BIOBANK ENABLED PARTNERS HEALTHCARE TO BE AWARDED TWO GRANTS TOTALI NG $12 MILLION AS PART OF THE NIH ELECTRONIC MEDICAL RECORDS AND GENOMICS NETWORK (EMERGE) THE PRIMARY GOAL OF THE EMERGE NETWORK IS TO DEVELOP, DISSEMINATE, AND APPLY APPROACHES TO RESEARCH THAT COMBINE DNA BIOREPOSITORIES WITH THE ELECTRONIC MEDICAL RECORD SYSTEM FOR LARGE-SCALE, HIGH-THROUGHPUT GENETIC RESEARCH PARTNERS HEALTHCARE IS ABLE TO LEVERAGE IT S INVESTMENT IN ECARE AND THE

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Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 2)	BIOBANK TO IDENTIFY RARE AND COMMON GENE VARIANTS AND EXAMINE HOW THOSE VARIANTS RELATE TO DISEASE RISKS AND TREATMENT EFFECTS ON A NATIONAL SCALE, PARTNERS HEALTHCARE WAS INVOLVE D IN FORMULATING THE PRECISION MEDICINE INITIATIVE - A NATIONAL RESEARCH EFFORT ESTABLISHE D IN 2015 TO REVOLUTIONIZE HEALTH CARE AND THE TREATMENT OF DISEASE THE INITIATIVE AIMS T O GIVE MEDICAL PROFESSIONALS THE RESOURCES THEY NEED TO TARGET SPECIFIC TREATMENTS FOR ILL NESSES AND FURTHER DEVELOP SCIENTIFIC AND MEDICAL RESEARCH, TAKING INTO ACCOUNT INDIVIDUAL DIFFERENCES IN PEOPLE'S GENES, ENVIRONMENTS AND LIFESTYLES PARTNERS HEALTHCARE ALONG WIT H BOSTON MEDICAL CENTER HAVE FORMED THE NEW ENGLAND PRECISION MEDICINE CONSORTIUM, A REGIO NAL RECRUITMENT SITE FOR THE ALL OF US (AOU) BIOMEDICAL RESEARCH PROGRAM THAT IS THE CORNE RSTONE OF THE LARGER PRECISION MEDICINE INITIATIVE AOU IS FUNDED AT $1 5 BILLION OVER THE NEXT 10 YEARS WITH THE GOAL TO RECRUIT ONE MILLION OR MORE VOLUNTEERS TO A NATIONAL BIOBA NK WITH ADVANCES IN BIG DATA ANALYTICS AND MACHINE LEARNING, HEALTH CARE DATA HAS BECOME THE CORNERSTONE OF MANY NEW DISCOVERIES IN THE DIAGNOSIS AND TREATMENT OF DISEASE PARTNER S HEALTHCARE HAS A ROBUST PATIENT DATA ASSET, CREATING TOOLS THAT ALLOW THE COMPLIANT USE OF AND ACCESS TO THIS DATA UNDER THE PURVIEW OF THE PARTNERS RESEARCH INFORMATION SCIENCE AND COMPUTING (RISC) DEPARTMENT LEVERAGING DATA SCIENTISTS, MACHINE LEARNING/ARTIFICIAL I NTELLIGENCE, AND CLINICAL EXPERTISE, RISC DEVELOPS NEW CLINICAL APPLICATIONS FOR CLINICAL CARE AND WITH THE POTENTIAL FOR COMMERCIALIZATION THE PARTNERS BIG DATA COMMONS IS THE FO UNDATION, LAUNCHED IN 2013 TO INTEGRATE DISPARATE ISLANDS OF PATIENT DATA ONTO A COMMON PL ATFORM, IT ALLOWS RESEARCHERS TO ANALYZE DATA FROM MULTIPLE SOURCES SUCH AS RADIOLOGY, THE BIOBANK, AND OTHER CLINICAL OR RESEARCH DATA SOURCES TO BETTER UNDERSTAND PATIENT OUTCOME S AND TREATMENT RESPONSES IN ADDITION, GENERAL ELECTRIC AND PARTNERS HEALTHCARE ESTABLISH ED A TEN-YEAR COLLABORATION FOCUSED ON HEALTHCARE AI IN APRIL 2017 LEVERAGING CO-INVESTME NT BY BWH AND THE GENERAL TO LAUNCH THE CENTER FOR CLINICAL DATA SCIENCE, GE AND PARTNERS HEALTHCARE WILL COLLABORATE TO DEVELOP A LEARNING PLATFORM AND CLINICAL APPLICATIONS TO AD VANCE THE USE OF ARTIFICIAL INTELLIGENCE ACROSS A BROAD RANGE OF DIAGNOSTIC AND TREATMENT PARADIGMS THE IMPLEMENTATION OF ECARE IS ACCELERATING THE TRANSLATION OF NEW DISCOVERIES AND INVENTIONS TO PATIENT CARE THIS INCLUDES ENABLING TARGETED RESEARCH OPPORTUNITIES TO BE INTEGRATED AT THE POINT-OF-CARE USING TOOLS BUILT BY PARTNERS, INTEGRATING INNOVATIVE H EALTHCARE APPS WITH THE CLINICAL WORKFLOW TO GUIDE CLINICAL DECISION MAKING, AND ALLOWING PATIENTS TO DIRECTLY ENGAGE WITH RESEARCHERS THE PARTNERS RESEARCH PATIENT PORTAL IS A CO MPREHENSIVE, LEADING-EDGE PATIENT RESEARCH ENGAGEMENT SOLUTION THAT CONNECTS PATIENTS WITH RESEARCH STUDIES, PROVIDING OPPORTUNITIES FOR PATIENTS AND RESEARCHERS TO ENGAGE AT DIFFE RENT LEVELS OF PARTICIPATION,

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Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 2)	AND FACILITATES RESEARCH-BASED ELECTRONIC DATA COLLECTION IN 2014, BWH, TOGETHER WITH THE GENERAL AND HARVARD MEDICAL SCHOOL, WAS AWARDED A SEVEN-YEAR $16 0 MILLION NIH GRANT AS O NE OF THREE NIH CENTERS FOR ACCELERATED INNOVATION WITH MATCHING INSTITUTIONAL, COMMERCIAL AND OTHER FEDERAL FUNDS TO ESTABLISH THE BOSTON BIOMEDICAL INNOVATION CENTER (B-BIC) B-B IC WAS DESIGNED TO PARTNER WITH INDUSTRY TO ACCELERATE THE DEVELOPMENT OF DIAGNOSTIC PRODU CTS IN THE AREAS OF CARDIAC, PULMONARY, SLEEP AND HEMATOLOGIC DISEASES PARTNERS HEALTHCAR E CONTINUES TO COLLABORATE WITH HARVARD UNIVERSITY, WHICH ESTABLISHED THE HARVARD CATALYST , AN NIH FUNDED ENTERPRISE DEDICATED TO IMPROVING HUMAN HEALTH THAT INCLUDES OTHER HARVARD MEDICAL SCHOOL AFFILIATED EDUCATIONAL AND HEALTHCARE CENTERS IN THE BOSTON AREA HARVARD CATALYST WAS INITIALLY FUNDED IN 2008 AND IN 2013 WAS AWARDED A $121 0 MILLION FIVE-YEAR G RANT FROM NIH

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Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 3)	TEACHING THE PARTNERS HEALTHCARE HOSPITALS HAVE A LONG TRADITION OF EDUCATING PHYSICIANS, OTHER HEALTHCARE PROFESSIONALS AND BIOMEDICAL SCIENTISTS GRADUATE MEDICAL EDUCATION APPROXIMATELY 1,466 RESIDENTS AND 703 CLINICAL FELLOWS IN OVER 285 PROGRAMS IN NEARLY ALL SPECIALTIES AND SUBSPECIALTIES OF MEDICINE ARE APPOINTED TO THE HOSPITALS EACH YEAR MOST OF THESE ARE BASED AT BWH AND/OR THE GENERAL, BUT NWH, NSMC AND SPAULDING BOSTON ALSO SPONSOR GRADUATE MEDICAL EDUCATION PROGRAMS A NUMBER OF TRAINING PROGRAMS ARE INTEGRATED ACROSS TWO OR MORE PARTNERS HEALTHCARE HOSPITALS, AND SEVERAL INVOLVE AFFILIATIONS WITH OTHER HARVARD MEDICAL SCHOOL OR TUFTS UNIVERSITY SCHOOL OF MEDICINE (TUSM) TEACHING HOSPITALS GRADUATE MEDICAL EDUCATION AT PARTNERS HEALTHCARE UTILIZES BOTH INPATIENT AND AMBULATORY SETTINGS, THE PARTNERS HEALTHCARE AFFILIATED COMMUNITY HEALTH CENTERS PLAY AN IMPORTANT ROLE IN TRAINING HEALTHCARE PROFESSIONALS AT PARTNERS HEALTHCARE BWFH, NWH AND NSMC ARE TEACHING AFFILIATES OF TUSM AND ALSO SERVE AS TRAINING SITES FOR RESIDENCY PROGRAMS FROM BWH AND THE GENERAL NWH IS ALSO A TRAINING SITE FOR A TUFTS MEDICAL CENTER INTERNAL MEDICINE RESIDENCY PROGRAM AND MANY MEMBERS OF NWH'S MEDICAL STAFF AND THE CHIEFS OF ITS CLINICAL DEPARTMENTS HOLD TUSM FACULTY APPOINTMENTS MEDICAL AND DENTAL STUDENT EDUCATION BWH AND THE GENERAL ARE MAJOR TEACHING AFFILIATES OF HARVARD MEDICAL SCHOOL AND THE HARVARD SCHOOL OF DENTAL MEDICINE MOST OF THE ACTIVE CLINICAL AND RESEARCH STAFF OF BWH AND THE GENERAL HOLD HARVARD MEDICAL SCHOOL APPOINTMENTS AND ACTIVELY PARTICIPATE IN BOTH THE CLINICAL AND PRE-CLINICAL TRAINING OF MEDICAL STUDENTS MCLEAN AND SPAULDING BOSTON ARE PRINCIPAL CLINICAL TEACHING SITES FOR HARVARD MEDICAL SCHOOL STUDENTS IN PSYCHIATRY AND PHYSIATRY, RESPECTIVELY OTHER EDUCATION AND TRAINING IN ADDITION, THE GENERAL SPONSORS PROGRAMS IN PSYCHOLOGY, MCLEAN SPONSORS PROGRAMS IN PSYCHOLOGY, BWH AND THE GENERAL PROVIDE TRAINING IN GENERAL DENTISTRY, AND BWH AND THE GENERAL EACH OFFER INTERNSHIPS IN DIETETICS AND HOSPITAL ADMINISTRATION FELLOWSHIPS COMPLEMENTING THE DIVERSITY OF CLINICAL TRAINING, THERE ARE APPROXIMATELY 2,000 RESEARCH FELLOWS AT BWH AND THE GENERAL, WITH SOME ADDITIONAL FELLOWS AT THE OTHER INSTITUTIONS THESE PH D OR M D /PH D SCIENTISTS PARTICIPATE IN MENTORED RESEARCH EXPERIENCES MANY ALSO TAKE PART IN ONE OF THE DIDACTIC PROGRAMS AIMED AT BASIC, TRANSLATIONAL, OR CLINICAL AND OUTCOMES RESEARCH THAT ARE OFFERED WITHIN THE PARTNERS HEALTHCARE SYSTEM

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Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 1	THE FOLLOWING ENTITIES HAVE A DIFFERENCE IN VOTING RIGHTS - BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC - NANTUCKET COTTAGE HOSPITAL THE FOLLOWING ENTITIES ALSO HAVE AN EXECUTIVE COMMITTEE - BRIGHAM HEALTH, INC - THE BRIGHAM AND WOMEN'S HOSPITAL, INC - BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC - BRIGHAM & WOMEN'S FAULKNER HOSPITAL, INC - THE SPAULDING REHABILITATION HOSPITAL CORPORATION - PARTNERS HOME CARE, INC - FRC, INC - SPAULDING HOSPITAL - CAMBRIDGE, INC - PARTNERS CONTINUING CARE, INC - REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION - SHAUGHNESSY-KAPLAN REHABILITATION HOSPITAL, INC - NANTUCKET COTTAGE HOSPITAL - MARTHA'S VINEYARD HOSPITAL, INC IN GENERAL, THE EXECUTIVE COMMITTEES HAVE ALL OF THE RESPONSIBILITIES AND AUTHORITY OF THE TRUSTEES BETWEEN MEETINGS OF THE TRUSTEES EXCEPT FOR THE POWERS SPECIFIED IN SECTION 55 OF MASSACHUSETTS GENERAL LAWS, CHAPTER 156B

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Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	SCOTT SPERLING & MARC CASPER - BUSINESS RELATIONSHIP PETER MARKELL & WILLIAM COWAN - BUSINESS RELATIONSHIP JOHN DEUTCH & ARTHUR L GOLDSTEIN - BUSINESS RELATIONSHIP JOHN DEUTCH & RONALD L SKATES - BUSINESS RELATIONSHIP BRUCE DANZINGER & ROBERT A DANZIGER - FAMILY RELATIONSHIP RICHARD HOLBROOK & TERRENCE MCGINNIS & RICHARD C BANE & J BRIAN MCCARTHY - BUSINESS RELATIONSHIP RICHARD HOLBROOK & J BRIAN MCCARTHY & TERRENCE MCGINNIS & CHARLES F DESMOND & JEFFREY SHRIBMAN - BUSINESS RELATIONSHIP JEFFREY SHRIBMAN & ANTHORNY A KLEIN - BUSINESS RELATIONSHIP ANTHONY KLEIN & KEVIN BOTTOMLEY - BUSINESS RELATIONSHIP PAMELA REEVE & DAVID ABELMAN - BUSINESS RELATIONSHIP STANLEY J LUKOWSKI & WENDELL J KNOX - BUSINESS RELATIONSHIP PAULA NESS SPEERS & MARY SHAUHGNESSY - BUSINESS RELATIONSHIP

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Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	PARTNERS HEALTHCARE SYSTEM, INC , A MASSACHUSETTS NONPROFIT CORPORATION, IS EITHER DIRECTLY OR INDIRECTLY THE SOLE MEMBER OF ALL THE SUBORDINATES INCLUDED IN THE PARTNERS HEALTHCARE SYSTEM, INC GROUP RETURN EXCEPT FOR THE FOLLOWING SUBORDINATES (WHICH DO NOT HAVE MEMBERS) BRIGHAM MEDICAL RESEARCH & EDUCATION FOUNDATION

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Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE SOLE MEMBER OF EACH ORGANIZATION HAS AUTHORITIES AS SPECIFICALLY ENUMERATED IN EACH ORGANIZATION'S CORPORATE BY-LAWS THESE AUTHORITIES VARY WIDELY BETWEEN EACH ORGANIZATION A FEW EXAMPLES OF THE TYPE OF AUTHORITIES GRANTED BY MANY, BUT NOT NECESSARILY ALL, CORPORATE BY-LAWS INCLUDE - APPOINT A FIRM OF PUBLIC ACCOUNTANTS ANNUALLY TO CONDUCT AN INDEPENDENT AUDIT OF THE CORPORATION'S FINANCIAL AFFAIRS DURING THE FISCAL YEAR LAST ENDED, - REVIEW AND APPROVE ALL PROPOSED CAPITAL AND OPERATING BUDGETS OF THE CORPORATION AND ALL PROPOSED TRANSACTIONS BY THE CORPORATION WHICH INVOLVE AN EXPENDITURE IN EXCESS OF $2,000,000, WHEN SUCH EXPENDITURE HAS NOT BEEN INCLUDED IN A BUDGET PREVIOUSLY APPROVED BY THE MEMBER, - REVIEW AND APPROVE EACH TRANSACTION PROPOSED BY THE CORPORATION WHICH WOULD INVOLVE THE CORPORATION INCURRING DEBT THROUGH LENDER FINANCING, - THE MEMBER MAY ADOPT, AMEND OR REPEAL ANY BYLAW, INCLUDING ANY BYLAWS ADOPTED BY THE TRUSTEES - THE MEMBER MAY ELECT THE OFFICERS AND TRUSTEES OF THE CORPORATION - THE MEMBER OR THE TRUSTEES, EACH BY MAJORITY VOTE OF THEIR NUMBER THEN IN OFFICE, MAY SUSPEND OR REMOVE FOR CAUSE ANY TRUSTEE - THE MEMBER SHALL ENACT, AND FROM TIME TO TIME MAY AMEND A CODE OF CONDUCT AND A POLICY ON CONFLICTS OF INTEREST PURSUANT TO THE LAWS OF MASSACHUSETTS, THE AUTHORITY FOR THE FOLLOWING ACTIONS IS RESERVED TO THE MEMBER OF THE ORGANIZATION A AMEND OR RESTATE THE ARTICLES OF ORGANIZATION B CONSOLIDATION OR MERGER C SALE, LEASE, EXCHANGE OR DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ORGANIZATIONS PROPERTY OR ASSETS

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Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	EXPLANATION IS INCLUDED IN LINE 7A

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Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 WAS PREPARED AND REVIEWED BY THE PARTNERS HEALTHCARE SYSTEM, INC (PHS) TAX DEPARTMENT CERTAIN KEY SECTIONS WERE ALSO REVIEWED BY THE PHS EXECUTIVE VICE PRESIDENT OF ADMINISTRATION AND FINANCE, CFO AND TREASURER AND BY THE PHS GENERAL COUNSEL THE EXECUTIVE VICE PRESIDENT OF ADMINISTRATION AND FINANCE, CFO AND TREASURER REVIEWED AND SIGNED THE FORM 990 THE COMPENSATION DISCLOSURES WERE PRESENTED TO AND DISCUSSED WITH THE PHS COMPENSATION COMMITTEE AT THE APRIL 24, 2018 MEETING THE PROCESS FOR PREPARING AND REVIEWING FORM 990 WAS DISCUSSED AT THE MAY 2, 2018 MEETING OF THE AUDIT AND COMPLIANCE COMMITTEE OF THE PHS BOARD OF DIRECTORS THE FINAL FILING VERSION OF THE FORM 990 WAS PROVIDED TO CERTAIN VOTING BOARD MEMBERS PRIOR TO FILING

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Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	FOR PURPOSES OF ITS ANNUAL TAX FILING, PARTNERS HEALTHCARE HAS AN ANNUAL QUESTIONNAIRE PROCESS FOR OBTAINING INFORMATION ON INTERESTS THAT MAY GIVE RISE TO CONFLICTS FROM ALL OFFICERS, DIRECTORS, TRUSTEES AND KEY EMPLOYEES IN ADDITION, IN CONNECTION WITH PARTNERS' CONFLICT OF INTEREST POLICY, THE PARTNERS OFFICE FOR INTERACTIONS WITH INDUSTRY AND THE OFFICE OF THE GENERAL COUNSEL WORK TOGETHER TO PERIODICALLY DISTRIBUTE, COLLECT AND REVIEW DISCLOSURE STATEMENTS FROM THESE INDIVIDUALS THE INFORMATION ON EACH SUCH DISCLOSURE IS REVIEWED BY EACH INDIVIDUAL'S SUPERVISOR (WHO IN THE CASE OF DIRECTORS AND TRUSTEES IS DEEMED TO CONSIST OF THE CHAIRMAN OF THE BOARD AND THE ENTITY'S PRESIDENT/CEO, WHO REVIEW THE DISCLOSURES WITH THE ASSISTANCE OF THE GENERAL COUNSEL OR ATTORNEY REPRESENTATIVES OF HER OFFICE) IN ADDITION, UNDER THE PARTNERS CONFLICT OF INTEREST POLICY, ANY TIME AN OFFICER, DIRECTOR, TRUSTEE, OR KEY EMPLOYEE IS AWARE OF A TRANSACTION IN WHICH HIS/HER INTEREST MAY CREATE A CONFLICT, HE/SHE IS REQUIRED TO PROVIDE FULL DISCLOSURE OF THE INTEREST, AND MAY NOT BE INVOLVED IN THE INSTITUTIONAL DECISION-MAKING ABOUT THE TRANSACTION IN ADDITION, WITH RESPECT TO SUCH TRANSACTIONS, IN APPROPRIATE CIRCUMSTANCES, (I) THE CORPORATION MUST CONSIDER AT LEAST TWO ALTERNATIVE DISINTERESTED COMPETITIVE PROPOSALS, OR MUST DETERMINE THAT TWO SUCH COMPETITIVE PROPOSALS DO NOT EXIST OR THAT IT WOULD BE IMPRACTICAL TO ELICIT OR CONSIDER SUCH COMPETITIVE PROPOSALS, AND (II) THE CORPORATION MUST DETERMINE THAT, NOTWITHSTANDING THE APPARENT CONFLICT, THE TRANSACTION IS FAIR AND REASONABLE TO THE CORPORATION AND IS IN THE BEST INTERESTS OF THE CORPORATION A WRITTEN RECORD MUST BE MADE OF THESE DETERMINATIONS FURTHERMORE, TRANSACTIONS THAT PRESENT PARTICULARLY SIGNIFICANT CONFLICTS ARE REVIEWED BY AN INDEPENDENT COMMITTEE OF THE PARTNERS BOARD FOR APPROPRIATE ACTION, WHICH REVIEW IS ALSO DOCUMENTED

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FORM 990, PART VI, SECTION B, LINE 15	THE ORGANIZATION HAS A BOARD LEVEL COMPENSATION COMMITTEE THAT REVIEWS AND APPROVES THE COMPENSATION FOR OFFICERS (EXCEPT SECRETARIES) AND MOST KEY EMPLOYEES THE COMMITTEE IS COMPRISED OF MEMBERS OF THE BOARD WHO ARE NOT EMPLOYED BY THE ORGANIZATION, AND NO MEMBER MAY PARTICIPATE IN THE REVIEW AND APPROVAL OF COMPENSATION IF THE MEMBER HAS A CONFLICT OF INTEREST WITH RESPECT TO THAT COMPENSATION ARRANGEMENT THE COMMITTEE RELIES ON DATA, PROVIDED BY AN INDEPENDENT COMPENSATION CONSULTANT, WHICH INCLUDES COMPARABLE COMPENSATION FOR SIMILARLY QUALIFIED PERSONS, IN FUNCTIONALLY COMPARABLE POSITIONS, AT SIMILARLY SITUATED ORGANIZATIONS THE DELIBERATIONS AND DECISIONS OF THE COMMITTEE ARE DOCUMENTED IN THE MINUTES OF THE MEETING THIS REVIEW PROCESS OCCURS ON AN ANNUAL BASIS

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Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S GOVERNING DOCUMENTS ARE FILED WITH THE MASSACHUSETTS SECRETARY OF STATE AND THE FINANCIAL STATEMENTS ARE FILED WITH THE MASSACHUSETTS ATTORNEY GENERAL, ALL OF WHICH ARE OPEN TO PUBLIC INSPECTION THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS AVAILABLE ON THE ORGANIZATION'S WEBSITE

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Return Reference	Explanation
FORM 990, PART VII	TITLE KEY TRUSTEE - T OFFICER - O KEY EMPLOYEE - K FORMER - F

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Return Reference	Explanation
FORM 990, PART VII CONTINUE	CHARLES E ADAMS O - NSMC, NSMCHC, NSPG, NSMC ON 9/19/2017, NSMCHC ON 9/19/2017, NSPG ON 9/11/2017 DALE ADLER, M D T - BWPO PAUL ANDERSON, M D , PH D K - BWH JOAN M ARCHER T & O - NWCF, NWCF OFF 3/27/2017 THOMAS H ARETZ, M D F(K) - PMI KATRINA ARMSTRONG, M D , M S C E K - GHC, GHC ON 7/21/2017 SARAH ARNHOLZ, ESQ O - MGPO STANLEY W ASHLEY , M D T - BWPO & MED DENNIS AUSIELLO, M D F(K) - GHC MAUREEN BANKS T & O - FRC, PC C, RHCI, SHC, SKRH ROBERT L BARBIERI, M D T - BWPO SUSAN M BEAUSOLIEL F(K) - PHC KA THERINE BECHTOLD, MHA, BSN, RN K - CDH JANIS P BELLACK, PH D , R N , FAAN T - PMI JOA N M BENGTSON, M D T - BWPO BARBARA E BIERER, M D F (K) - BWH CHRISTINE A BLASKI, M D T - NSPG MICHAEL L BLUTE, SR , M D T - CDH, CDHCC, CDPA, VHCD , CDH OFF 10/24/2 016, CDHCC OFF 10/1/2016 CDPA OFF 12/31/2016, VHCD OFF 10/24/2016 SALLY MASON BOEMER T & O - NSPG, O - GHC, MGH, NSMC, NSMCHC, NSMC OFF 09/19/2017, NSMC HC OFF 09/19/2017, NSPG OFF 09/11/2017, NSPG OFF 06/01/2017 GILES W BOLAND, M D T - BWPO CHRISTOPHER M BONO, M D T - BWPO, BWPO ON 10/16/2017 ARTHUR J BOWES K - NSMC MELISSA P BRENNAN, ESQ O - PCC, SRH, SHC, RHCI, SKRH, FRC, PHC O'NEIL BRITTON, M D T - MVH, WNR, MVH ON 07/21/ 2017, WNR ON 07/21/2017 STEVEN D BROWELL, M D F (K) - NSPG DAVID F BROWN, M D T - BWPO, CDH, CDHCC, VHCD CALVIN A BROWN III, M D T - BWPO, BWPO ON 12/15/2016 DEBRA A B URKE, MSN, MBA, RN T - MVH, WNR BRUCE A CHABNER, M D T - NCH EFFIE J CHAN, ESQ O - BWPO, HMA, SSEC JULIE C CHATTOPADHYAY, ESQ O - NWH,NWHC,NWAS MAUREEN N CHESLEY F (K) - PHC ENNIO A CHIOCCA, M D , PH D T - BWPO KENNETH CHISHOLM K - MVH CHRISTOPHER MARK COBURN T & O - PMI CHRISTOPHER M COLEY, M D T - MGPO DAVID P CONNOLLY O - PC PO RAYMOND F CONWAY, M D T - CDH, CDHCC, VHCD PAUL G CUSHING, ESQ O - NSMC, NSMCHC , NSPG ERNESTO DASILVA, M D T - NSPG SUSAN DEMPSEY K - BWFH KEREN DIAMOND K - PHC M ARY BETH DIFILIPPO F(K) - SKRH JEFFREY P DION O - NWH, NWHC, NWCF, T & O- NWAS, NWCC, NWCC ON 07/24/2017, NWCC OFF 09/30/2017, NWCC OFF 09/30/2017, NWCC OFF 09/30/2017 GERARD M DOHERTY, M D T - BWH TERENCE P DOORLY, M D T - NSPG MARGARET M DUGGAN, M D K - BWFH CHRISTOPHER DUNLEAVY O - BWH, BH BRANDON E EARP, M D T - BWFH, BWH, BH, BH O FF 05/23/2017, BWFH OFF 05/10/2017, BWH OFF 05/10/2017 JEFFREY L ECKER, M D T - CDH, C DHCC, CDPA, VHCD, CDHCC ON 10/01/2016, CDH ON 10/24/2016, CDVNA ON 10/24/2016, CDPA ON 01/ 01/2017 JONATHAN M FALLON, M D T - CDPA JOHN FANIKOS T - PHS SP THOMAS L FAZIO, M D T - PCPO CARLOS FERNANDEZ-DEL CASTILLO, M D T- MGPO CHRISTOPHER R FORTIER T - PH S SP TIMOTHY E FOSTER, M D K - NWH LAWRENCE S FRIEDMAN, M D T - NWH, NWHCS OFF 07/ 01/2017, NWH OFF 07/01/2017 JOANNE M FUCILE K - SHC MARY JO GAGNON K - NSMC GARY W G ARBERG F(K) - PHC TERRY J GARFINKLE, M D T - PCPO STEVEN A GILGEN O - NCH, NPO ON 08/18/2017, NPO ON 08/18/2017

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FORM 990, PART VII CONTINUE	LINA GILLIES T - NPO KEVIN T GIORDANO O - MED DAVID F GITLIN, M D T - BWPO , BWP O OFF 12/15/2016 RICHARD S GITOMER, M D , M B A T - BWPO JOSEPH GOLD, M D K - MCLEA N JEFFREY A GOLDEN, M D T - BWPO TERRI E GORMAN, M D T - BWPO , BWPO ON 12/15/2016 MICHELE L GOUGEON, M SC O - MCLEAN, MCHC GEORGE GOUGIAN K - FRC PETER A GRAPE, M D O & T - HMA, SSEC PETER T GREENSPAN, M D T - MGPO , MGPO OFF 06/16/2017 DANIEL J GROSS F (O) - NWAS, NWCC, NWCF, NWH, NWHC ROSEMARY B GUILTINAN, ESQ O - PMI MICHAEL L GUSTAFSON, M D , M B A T & O - BWFH, T - SSEC DAPHNE ADELE HAAS-KOGAN, M D T - BW PO GERARD F HADLEY O - BWFH ROBERT HANDIN, M D T - MED MITCHEL B HARRIS, M D T - BWPO, BWPO ON 12/15/2016, BWPO OFF 09/30/2017 MARGOT K HARTMANN, M D , PH D T & O - N CH JUDY HAYES K - BWFH JAMES L HEFFERNAN O - MGPO PAULA M HEREAU K - SRH MICHAEL J HESSION, M D K - HMA JOHN R HIGHAM, ESQ O - GHC, MGH THEODORE S HONG, M D T - MGPO, MGPO ON 06/16/2017 TERRIE E INDER, M B CH B T - BWPO JEANETTE IVES ERICKSON, R N , D N P K - GHC MICHAEL R JAFF, D O T & O - NWH, NWHC, NWAS, NWCF, T - MVH, PCPO, WNR, NWH ON 10/01/2016, NWH ON 10/01/2016, NWHCF ON 10/01/2016, NWHCS ON 10/01/2016, NWHC S ON 10/01/2016, PCPO ON 10/01/2016, NWAS ON 12/14/2016, NWAS ON 12/14/2016, NWHCF ON 12/1 4/2016 ALAN ANTHONY JAMES T - MVH, WNR, CDH, CDHCC, VHCD, CDVNA MICHAEL S JELLINEK, M D F (O) - NWAS, NWCC, NWCF, NWH, NWHC LOUIS JENIS, M D K - NWH STEPHEN R JENNEY O - BWPO MARK D JOHNSON, M D , PH D T - BWPO, BWPO OFF 12/15/2016 WILLIAM C JOHNSTON O - BWPO, T & O HMA, SSEC JAMES D KANG, M D T - BWPO STEVEN E KAPFHAMMER T & O - NS PG PARDON R KENNEY, M D K - BWFH LAURA STEPHENS KHOSHBIN, ESQ O - PHS SP BARRETT KI TCH, M D T - NSPG RONALD E KLEINMAN, M D T - MGPO ANNE KLIBANSKI, M D K - PHS, T - PMI, PMI ON 01/20/2017 KATHERINE M KNEELAND, ESQ O - HSC THOMAS S KUPPER, M D T - BWPO CHRISTOPHER J KWOLEK, M D K - NWH DAVID A LAGASSE O - MCLEAN & MCHC LAURIE LAMOUREUX O - CDH JANET LARSON, M D K - NWH LAUREN B LELE O - NWCC KEITH D LILLEM OE, M D K - GHC EDWARD LISTON-KRAFT, PH D K - BWFH JAY LOEFFLER, M D T - MGPO, MG PO OFF 06/16/2017 JOSEPH LOSCALZO, M D , PH D T & O - MED, T - BCP, BWFH, BWH, BH, BWPO DAVID N LOUIS, M D T - MGPO, MGPO ON 06/16/2017 EVERETT T LYN, M D T - NSPG THOMA S LYNCH JR , MD T & O - MGPO, T - MGH, GHC PETER K MARKELL T & O - BCP, HSC, PMI, T - MCLEAN, MCHC, PPIH, O - BWFH, BH, BWH, BRF, BWHR, GHC, MGH, PHS JOANNE MARQUSEE T & O - CDH, CDHCC, VHCD, CDPA NAVNEET MARWAHA, M D T - CDPA ROBERT T MCCALL K - SRH MAURY E MCGOUGH, M D T - NSMC, NSMCHC, NSPG, PHS, PHS OFF 06/30/2017 CRAIG MELIN F (O) - C DH CHERYL MERRILL, R N , M S N , N E A -B C K - NSMC GREGG S MEYER, M D K - PHS, T& O NSMC, NSMCHC, T - NSPG ELLEN MOLONEY O- NWH, NWHC, NWAS, NWCF RAYMOND R MONTO, M D T - NCH FRANCIS D MOORE, M D

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Return Reference	Explanation
FORM 990, PART VII CONTINUE	T - BWPO ELIZABETH A MORT CALCAGNI, M D , M P H T - CDH, CDHCC, VHCD GILBERT H MU DGE, JR , M D O - PMI STUART B MUSHLIN, M D , F A C P T - PMI ELIZABETH G NABEL, M D T & O - BRF, BH, BWH, BWHR, T - BWPO, PMI, PMI ON 01/20/2017 STEPHANIE N NADOLNY K - RHCI ALBERT NAMIAS, M D T - NSPG ANDREA NG, M D T - BWPO, BWPO ON 12/15/2016 BRI TAIN W NICHOLSON, M D K - GHC ROBERT G NORTON T & O - NSMC & NSMC HC, NSMC OFF 12/3 1/2016, NSMC OFF 12/31/2016, NSMC HC OFF 12/31/2016, NSPG OFF 12/31/2016 NAWAL M NOUR, M D , M P H T - BH, BWH, BWFH, BWFH ON 05/10/2017, BWH ON 05/10/2017, BH ON 05/23/2017 MA RK NOVOTNY, M D F (K) - CDH JOHANNA M O'CONNOR, M D T - NSMC, NSMCHC, NSMC ON 10/24 /2017, NSMC HC ON 10/24/2017 EDWARD OLIVIER O - MVH COURTNEY A O'NEILL T - NCH DOST O NGUR, M D , PH D K - MCLEAN HARRY W ORF, PH D F (K) - GHC TIMOTHY PARSONS, M D T - CDH, CDHCC, VHCD SHEILA K PARTRIDGE, M D F(K) - NWH GREGORY J PAULY T&O - MGPO, T - GHC, MGH, NCH, GHC ON 03/16/2017, GHC OFF 08/01/2017, MGH ON 03/16/2017, MGH OFF 08/01 /2017, MGPO ON 03/16/2017, MGPO OFF 08/01/2017 STEVEN B PESTKA, M D T - NWH EDITH PETE R F (K) - CDH PIETER PIL, M D T - MVH NANCY S PITTMAN T & O - NCH, NPO ON 08/18/20 17, NPO ON 08/18/2017 DAVID S PLADZIEWICZ, M D T- PCPO BOHDAN POMAHAC, M D T-BWPO A LLYSON L PRESTON, M D T - NSPG JAMES P RATHMELL, M D T - BWPO DAVID W RATTNER, M D T- MGH, GHC SCOTT L RAUCH, M D T & O - MCLEAN, MCHC CHRISTINE REILLY K - FRC MI TCHELL S REIN, M D T - NSPG, PCPO DAVID J ROBERTS, M D T & O - NSMC, NSMCHC, T - N SPG, NSPG OFF 04/03/2017, NSMC ON 04/03/2017, NSMC HC ON 04/03/2017, NSPG ON 04/03/2017 AL LAN H ROPPER, M D T - BWPO JERROLD F ROSENBAUM, M D T - GHC, MGH, PHS, MGH OFF 06/ 27/2017, GHC OFF 07/21/2017 PRISCILLA M ROSS K-VHCD MITCHELL H RUBENSTEIN, M D T-BW PO, BWPO OFF 12/15/2016 MARC S RUBIN, M D T - NSMC, NSMC HC ROXANNE C RUPPEL T - NS PG JEANNE M RYAN F (K) - VHCD A KIM SAAL, M D K-CDPA , CDH OFF 02/17/2017, CDHCC OF F 02/17/2017, CDPA OFF 02/17/2017, CDVNA OFF 02/17/2017 ALI SALIM, M D T - BH, BWH, BWF H, BWFH ON 05/10/2017, BWH ON 05/10/2017, BH ON 05/23/2017 MARTIN A SAMUELS, M D T - B WPO JOAN A SAPIR T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH JOHN SARRO K - PCPO MARK A SCHECHTER, M D T - NSPG SCOTT L SCHISSEL, M D , PH D K - BWFH NANCY D SCHMIDT K - PCC ANTHONY J SCIBELLI, MS, MBA K - CDH ELLEN W SEELY, M D T - BWFH, BWH, BH, BH OFF 05/23/2017, BWFH OFF 05/10/2017, BWH OFF 05/10/2017 A ALAN SEMINE, M D T - NWH, NW HCS OFF 07/01/2017, NWH OFF 07/01/2017 MARY E SHAUGHNESSY O - FRC, HSC, PCC, PHC, RHCI, SHC, SKRH, SRH & SRHC STANTON K SHERNAN, M D T - BWPO, BWPO OFF 12/15/2016

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FORM 990, PART VII CONTINUE	DAVID SILBERSWEIG, M D T - BWPO, PCC, PCC ON 09/26/2017 JULIA R SINCLAIR, MBA K - BW H ANEESH B SINGHAL, M D T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH PETER L SLAVIN, M D , M B A T & O - MGH, GHC, T - MGPO, CDH, CDHCC, VHCD, PMI ALLEN L SMITH, M D , M S T & O - BCP & BWPO, T - HMA, NWH, NWHCS, PCPO, PMI, PMI OFF 01/15/2017 REYNOLD G SPADONI O - PHC, PHC OFF 08/11/2017 ARTHUR ST GERMAIN K - PHC JOHN W STAKES, III, M D T - N CH, NCH OFF 05/22/2017 LYNN MALLOY STOFER T & O - PCPO DAVID E STORTO T - FRC, HSC, R HCI, SHC, SKRH, T & O - PHC, SRH, O - PCC THORALF M SUNDT, M D T - MGPO KHALID SYED, M D T - NSPG TRACY A SYKES, ESQ O -BCP, BRF, BWHR ELIZABETH S TAYLOR T & O - NWCC BEATRICE THIBEDEAU F (K) - NSMC DAVID F TORCHIANA, M D T&O - PHS, T - PMI MICHAEL J VANROOYEN, M D T - BWPO ALAMJIT S VIRK, M D K - MVH RON M WALLS, M D K - BWH TIMOTHY J WALSH T & O - MVH, MVH ON 06/07/2017, WNR ON 06/07/2017 ANDREW L WARSHAW, M D T - PMI, PMI OFF 01/15/2017 KERRY R WATSON F (O) - NWH, NWHC ROBERT D WELCH K - PCC JOSEPH L WOODIN T & O - MVH, MVH OFF 06/07/2017, WNR OFF 06/07/2017 ROSS D ZAFONT E, D O T - PCC, RHCI, SHC, SKRH, SRH DAVID ABELMAN T - PCPO, PCPO ON 01/10/2017 RICHA RD C BANE T - NSMC, T - NSMC HC WILLIAM S BARKER T - NWHCF DAVID S BARLOW T - MCL EAN, O - MCLEAN, T - MHC, O - MHC JOAN M BARRETT T - NWHCF CAROLYN A BECKEDORFF T - NWH, T - NWHCS, NWHCS OFF 07/01/2017, NWH OFF 07/01/2017 JUDITH G BELASH T - NCH, O - N CH SANFORD ADAMS BELDEN T - CDH, O - CDH, T - CDHCC, O - CDHCC, T - CDPA, O - CDPA, T - CDVNA, O - CDVNA, CDH OFF 10/25/2016, CDHCC OFF 10/25/2016, CDVNA OFF 10/25/2016 MARK R B ELSKY, M D T - NWH, T - NWHCF, O - NWHCF, T - NWHCS SIBEL BESSIM, M D T - NWHCF JEAN NE E BLAKE T - MCLEAN, T - MHC EDWARD B BLOOM T - NWH, T - NWHCS KENNETH RICHARD BOR DEWIECK T - CDH, T - CDHCC, T - CDVNA JEANINE M BORTHWICK T - NCH KEVIN T BOTTOMLEY T - NSMC, T - NSMC HC DEBRA K BREDE T - NWH, T - NWHCS MARY R BROWN T - MVH, O - M VH, T - WNR, O - WNR DAVID JOSEPH BURKE O - NPO, NPO OFF 08/18/2017 JOHN J BURKE T - NCH WILLIAM R CAMP, JR T - NCH, O - NCH JOHN C CANNISTRARO T - NWHCF MARC N CASPER T - BH, T - BWFH, T - BWH WILLIAM REED CHISHOLM II T - NCH EUGENE H CLAPP T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE PHILLIP L CLAY, PH D T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE JAMES P COHE N, M D T - PCPO, PCPO ON 11/01/2016 EARL M COLLIER, JR T - NWAS, O - NWAS, T - NWH, O - NWH, T - NWHCF, T - NWHCS, O - NWHCS, T - PHS DHARMA E CORTES, PH D T - NSMC, T - NSMC HC, NSMC ON 11/01/2016, NSMC HC ON 11/01/2016 WILLIAM MAURICE COWAN T - GHC, T - M GH, T - PHS SUSAN C CRAMPTON T - MVH, T - WNR MONICA S CURHAN T - CDH, T - CDHCC, T - CDVNA, CDH ON 03/03/2017, CDHCC ON 03/03/2017, CDVNA ON 03/03/2017 KAREN DOLAN CURRAN, M B A, C F P T - CDH, T - CD

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FORM 990, PART VII CONTINUE	HCC, T - CDVNA, CDH ON 09/25/2017, CDHCC ON 09/25/2017, CDVNA ON 09/25/2017 RICHARD L CUR TIS, M D T - NWHCF, T - PCPO BRUCE DANZIGER T - NWHCF ROBERT A DANZIGER T - NWHCF JAMES L DEMETROULAKOS, M D T - NSMC, T - NSMC HC LINDA DERENZO, ESQ T - NWH, T - NW HCS, CHARLES FRANK DESMOND T - NSMC, T - NSMC HC JOHN M DEUTCH T - MGPO, T - PMI, PMI OFF 01/15/2017 JOANNE "HONEY" DIBONA T - NWHCF JAMES MANNING DONNELLY T - CDH, T - CD HCC, T - CDVNA JOHN P DRISLANE T - NSMC, T - NSMC HC DEBORAH DUNSIRE, M D T - MGPO, MGPO ON 10/21/2016 WILLIAM R ELFERS T - NWAS, T - NWH, T - NWHCF, T - NWHCS KHAMA D EN NIS, M D , M P H T - CDH, T - CDHCC, T - CDVNA DEBORAH C ENOS T - BH, T - BWFH, T - BWH ARTHUR J EPSTEIN T - NSMC, T - NSMC HC LAURIE FENLASON T - CDH, T - CDHCC, T - CD VNA TIMOTHY G FERRIS, M D T - GHC, T - MGH, T - MGPO, O - MGPO, O - MGPO, T - PCPO, GH C ON 08/01/2017, MGH ON 08/01/2017, MGPO ON 08/01/2017, PCPO ON 09/05/2017 JOANNE J FINCK T - CDH, T - CDHCC, T - CDVNA, CDH ON 11/18/2016, CDHCC ON 11/18/2016, CDVNA ON 11/18/2 016 ANNE M FINUCANE T - BH, T - BWFH, T - BWH, T - PHS JOHN F FISH T - BH, T - BWFH, T - BWH JENNIFER COFER FLANAGAN T - NSMC, T - NSMC HC, T - NSPG, NSMC OFF 09/20/2017, N SMC HC OFF 09/20/2017, NSPG OFF 09/20/2017 NANCY S FOSTER T - NWHCF BRUCE FREEDMAN T - NWH, T - NWHCF, T - NWHCS LAUREN A GEDDES WIRTH, M D T - PCPO CHARLES K GIFFORD T - GHC, T - MGH, T - NCH, T - PHS, MGH OFF 08/01/2017, GHC OFF 08/01/2017, PHS OFF 06/30/2 017 THOMAS P GLYNN, PH D T - MCLEAN, T - MHC MAUREEN GOGGIN O - PHS ARTHUR L GOLDST EIN T - MGPO BENJAMIN A GOMEZ T - NWH, T - NWHCS THOMAS H GRAPE T - NWAS, T - NWH, T - NWHCS ERWIN L GREENBERG T - NCH SALLY GRIGGS T - CDH, T - CDHCC, T - CDVNA MAURE EN O HACKETT O - NCHF, T - NCHF ALEXANDER A HANNENBERG, M D T - NWH, T - NWHCS JOSE PH HARRINGTON, M D T - PCPO, PCPO OFF 07/11/2017 BRENDA E HAYNES, M D T - NWHCF ANN EMARIE HEATH CNM T - CDPA JENNIFER HELZBERG T - NWHCF, NWHCF ON 07/01/2017 BRENT L HE NRY, ESQ T - MVH, T - WNR, MVH OFF 07/21/2017, WNR OFF 07/21/2017 KEVIN F HICKEY T - NCH, O - NCH, T - NCHF SUSAN J HOCKFIELD, PH D T - PHS RICHARD E HOLBROOK T - NSMC , O - NSMC, T - NSMC HC, O - NSMC HC, T - PHS ALBERT A HOLMAN III T - BH, O - BH, O - B WFH, T - BWFH, T - BWH, O - BWH, T - PHS, PHS OFF 06/30/2017 H ROBERT HORVITZ, PH D T - GHC, T - MGH ANN INGRAM T - NWHCF DAVID W IVES T - NSMC, T - NSMC HC RONALD J JACK SON T - MCLEAN, T - MHC MELISSA WEINER JANFAZA T - BH, T - BWFH, T - BWH WILLIAM JOHNS TON O - HMA, T - SSE, O - SSE DANIEL G JONES T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE JAMES L KAPLAN T - NWAS, T - NWH, T - NWHCF, T - NWH CS KAREN T KAPLAN T - BH, T - BWFH, T - BWH STEPHEN R KARP T - NCH STEVEN M KAYE T - BH, T - BWFH, T - BWH RICHARD M KELLEHER T - MCLEAN, T - MHC CHRISTOPHER J KELLY T - NWH, T - NWHCF, T - NWHCS

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FORM 990, PART VII CONTINUE	JAMES KIRCHHOFFER, M D T - CDH, T - CDHCC, T - CDVNA ANTHONY A KLEIN T - NSMC, T - NSMC HC WENDELL J KNOX T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH -CAMBRIDGE ADAM M KOPPEL T - NWH, T - NWHCS JONATHAN A KRAFT T - GHC, T - MGH JOSHUA M KRAFT T - BH, T - BWFH, T - BWH ELIZA B LAKE T - CDH, T - CDHCC, T - CDVNA KEVIN LISTER LAKE T - CDH, O - CDH, T - CDHCC, O - CDHCC, T - CDVNA, O - CDVNA REN E M LANDER S T - GHC, T - MGH, MGH ON 06/27/2017, GHC ON 07/21/2017 EDWARD P LAWRENCE, ESQ T - PHS, O - PHS JEFFREY M LEIDEN, M D , PH D T - BH, T - BWFH, T - BWH TIMOTHY J LEPORE, M D , F A C S T - NCH, NCH ON 10/01/2017 BEN S LEVITAN T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE DAVID H LONG T - GHC, T - MGH STACEY LUC CHINO T - MCLEAN, T - MHC STANLEY J LUKOWSKI T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE, PCC OFF 07/12/2017, FRC OFF 07/12/2017, PHC OFF 07/12/ 2017, SKRH OFF 07/12/2017, SRHC OFF 07/12/2017, SRH-CAMBRIDGE OFF 07/12/2017, RHCI OFF 07/ 12/2017 THOMAS J LYNCH, JR , M D T - CDHCC, T - GHC, T - MGH, T - MGPO, O - MGPO, O - MGPO, T - PCPO, GHC OFF 03/16/2017, MGH OFF 03/16/2017, MGPO OFF 03/16/2017, PCPO OFF 03/1 6/2017, CDHCC OFF 03/16/2017 HEATHER COLMORE MACK T - NWHCF, O - NWHCF, NWHCF ON 03/27/2 017 PAULINE MARNEY T - CDH, T - CDHCC, T - CDVNA, CDH OFF 10/24/2016, CDHCC OFF 10/01/20 16, CDVNA OFF 10/24/2016 JULIE A MARRIOTT T - NWH, T - NWHCF, T - NWHCS, NWH ON 07/01/2 017, NWHCS ON 07/01/2017 CARL J MARTIGNETTI T - GHC, T - MGH, T - PHS, PHS ON 07/01/201 7 J BRIAN MCCARTHY T - NSMC, T - NSMC HC TERENCE A MCGINNIS T - NSMC, T - NSMC HC, T - NSPG, O - NSPG, T - PCPO KATINA MCKINNEY T - NWCC, NWCC ON 07/24/2017, NWCC OFF 09/30 /2017 CAROL C MCMULLEN T - PCPO, PCPO OFF 12/27/2016 JOSEPH C MCNAY T - BWPO ANN MER RIFIELD T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE EDWAR D F MILLER T - MVH, T - WNR BARRY MILLS T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH , T - SRHC, T - SRH-CAMBRIDGE CATHY E MINEHAN T - GHC, O - GHC, T - MGH, O - MGH, T - M GPO, T - PHS LAURA BARKER MORSE T - MGPO MICHAEL J MUEHE T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE PHILIP A NARDONE, JR T - NCH EMILY A NE ILL T - NWHCF NITIN NOHRIA T - GHC, T - MGH JOHN N NUNNELLY T - CDH, O - CDH, O - C DH, T - CDHCC, O - CDHCC, O - CDHCC, T - CDPA, O - CDPA, T - CDVNA, O - CDVNA, O - CDVNA M ARK NUNNELLY T - BH, T - BWFH, T - BWH MICHAEL F O'CONNELL, ESQ T - BWPO ROBERT L P AGLIA T - NWHCF MARIE-LOUISE PALANDJIAN T - NWHCF KRISHNA PALEPU T - PMI, PMI OFF 01 /20/2017 WILLIAM M PARIZEAU T - NWHCF DIANE B PATRICK, ESQ T - GHC, T - MGH, T

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FORM 990, PART VII CONTINUE	RICHARD A PENN T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRID GE ADELENE Q PERKINS T - GHC, T - MGH, MGH ON 06/27/2017, GHC ON 07/21/2017 DONALD M P ERRIN T - NWHCF H BRADLEE PERRY T - NWHCF SUSAN P PETERS T - GHC, T - MGH, MGH ON 02/28/2017, GHC ON 03/03/2017 PATRICIA P PETRAGLIA T - BWPO ROBERT W PIERCE, JR T - MCLEAN, T - MHC MATTHEW MARTIN PITONIAK T - CDPA JENNIFER L PORTER T - MCLEAN, T - M HC MARY G PUMA T - NSMC, T - NSMC HC PHILLIP T RAGON T - GHC, T - MGH RONALD H RAPP APORT, ESQ T - MVH, T - WNR, MVH OFF 07/13/2017, WNR OFF 07/13/2017 EARLE A RAY T - MVH, O - MVH, T - WNR, O - WNR ANDREA GEIGER RE, ESQ O - PCPO ARTHUR I READE, JR T - NPO, NPO OFF 08/18/2017 PAMELA D A REEVE T - MGPO, T - PCPO, O - PCPO, T - PHS, PHS ON 07/01/2017 NANCY R REEVES T - CDH, T - CDHCC, T - CDVNA LAURA REYNOLDS T - NCH AUG USTE E RIMPEL, JR , PH D T - MCLEAN, T - MHC CARMICHAEL S ROBERTS T - MGPO MICHAEL A F ROBERTS T - NCH WILLIAM J ROMAN T - MVH, T - WNR, MVH ON 07/21/2017, WNR ON 07/2 1/2017 HENRY W ROSENBERG T - CDH, T - CDHCC, T - CDVNA, CDH OFF 10/24/2016, CDHCC OFF 1 0/01/2016, CDVNA OFF 10/24/2016 JOSEPH F RYAN, ESQ T - PCC, PCC ON 09/26/2017 MELANIE R SABELHAUS T - NCH ELISABETH SCHADAE PERCELAY T - NCH, NCH ON 10/21/2016 JOHN H SCH AEFER T - MVH, T - WNR ERIC D SCHLAGER T - BH, T - BWFH, T - BWH SCOTT A SCHOEN O - FRC, T - FRC, T - PCC, O - PCC, T - PHC, O - PHC, T - PHS, T - RHCI, O - RHCI, T - SKRH, O - SKRH, T - SRHC, O - SRHC, T - SRH-CAMBRIDGE, O - SRH-CAMBRIDGE SCOTT SCHUSTER T - B H, T - BWFH, T - BWH, T - BWPO MARK SCHWARTZ T - GHC, T - MGH, MGH ON 01/24/2017, GHC ON 03/03/2017 J DALE SHERRATT T - BWPO, T - PMI, PMI OFF 01/20/2017 JEFFREY N SHRIBMAN T - NSMC, T - NSMC HC RICKEL SHUSTER T - NWHCF RICHARD N SILVERMAN T - NWHCF SHIRLEY SINGLETON T - NSMC, T - NSMC HC RONALD L SKATES T - MGPO BARRY R SLOANE T - GHC, T - MGH LAUREN A SMITH T - NWH, T - NWHCS, NWH ON 07/01/2017, NWHCS ON 07/01/2017 SHARO N L SMITH T - PCPO, PCPO OFF 01/10/2017 JONATHAN SNIDER, M D T - NWHCF W LLOYD SNYD ER, III T - MCLEAN, T - MHC JOSIAH A SPAULDING, JR T - FRC, T - PCC, T - PHC, T - RH CI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE WARREN J SPECTOR T - MVH, T - WNR, MVH OFF 07 /21/2017, WNR OFF 07/21/2017 PAULA NESS SPEERS T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE SCOTT M SPERLING T - BH, O - BH, T - BRF, O - BWFH, T - BWFH, T - BWH, O - BWH, T - BWH RESEARCH, T - PHS GARY A SPIESS, ESQ T - NSMC, T - NSMC HC CHARLES PHILIP STAELIN T - CDH, O - CDH, T - CDHCC, O - CDHCC, T - CDVNA, O - CD VNA, CDH ON 10/25/2016, CDHCC ON 10/25/2016, CDVNA ON 10/25/2016 KATHLEEN M STANSKY T - NWHCF ANNE E STEER T - NWHCF DAVID PIERPONT STEVENS T - CDH, T - CDHCC, T - CDVNA, C DH ON 09/25/2017, CDHCC ON 09/25/2017, CDVNA ON 09/25/2017 ELLEN S STORY T - CDH, T - C DHCC, T - CDVNA , CDH ON 03/03

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Return Reference	Explanation
FORM 990, PART VII CONTINUE	/2017, CDHCC ON 03/03/2017, CDVNA ON 03/03/2017 KUMBLE R SUBBASWAMY T - CDH, T - CDHCC, T - CDVNA , CDH OFF 09/25/2017, CDHCC OFF 09/25/2017, CDVNA OFF 09/25/2017 STEPHEN G SUL LIVAN T - NWH, T - NWHCF, T - NWHCS, NWH ON 07/01/2017, NWHCS ON 07/01/2017 TIMOTHY D S WEET T - MVH, O - MVH, T - WNR, O - WNR JAMES D TAICLET T - BH, T - BWFH, T - BWH WAL TER TELLER, ESQ T - MVH, T - WNR HENRI A TERMEER T - GHC, T - MGH, T - PHS , MGH OFF 05/13/2017, GHC OFF 05/13/2017, PHS OFF 05/13/2017 JEFFREY S THOMAS T - NWHCF ALEXANDE R L THORNDIKE T - BH, T - BWFH, T - BWH, T - PHS, PHS ON 07/01/2017 CAROL A VALLONE T - MCLEAN, T - MHC JOAN M VITELLO-CICCIU, RN, PH D T - NWH, T - NWHCS CATHERINE S WA RD T - NCH PETER WEITZMAN, M D T - CDPA BENAREE P WILEY T - FRC, T - PCC, T - PHC, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE , FRC ON 11/02/2016, PHC ON 11/02/2016, R HCI ON 11/02/2016, SKRH ON 11/02/2016, SRHC ON 11/02/2016, SRH-CAMBRIDGE ON 11/02/2016 ELI ZABETH WINSHIP T - NCH R JOHN WRIGHT, M D T - FRC, T - PCC, T - PHC, T - RHCI, T - S KRH, T - SRHC, T - SRH-CAMBRIDGE, PCC OFF 01/31/2017, FRC OFF 01/31/2017, PHC OFF 01/31/20 17, SKRH OFF 01/31/2017, SRHC OFF 01/31/2017, SRH-CAMBRIDGE OFF 01/31/2017, RHCI OFF 01/31 /2017 CHARLES F WU T - NWH, T - NWHCS GWILL YORK T - BH, T - BWFH, T - BWH, T - FRC, T - PCC, T - PHC, T - PHS, T - RHCI, T - SKRH, T - SRHC, T - SRH-CAMBRIDGE GEOFFREY MARC Z UCKER T - CDH, T - CDHCC, T - CDPA, T - CDVNA, CDH OFF 09/25/2017, CDHCC OFF 09/25/2017, CDVNA OFF 09/25/2017

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 24E	CORPORATE ALLOCATIONS PROGRAM SERVICE EXPENSES 21,542,683 MANAGEMENT AND GENERAL EXPENSES 1,804,407 FUNDRAISING EXPENSES 14,318 TOTAL EXPENSES 23,361,408 MEALS PROGRAM SERVICE EXPENSES 16,708,449 MANAGEMENT AND GENERAL EXPENSES 1,288,209 FUNDRAISING EXPENSES 1,718,966 TOTAL EXPENSES 19,715,624 NON CAPITAL EQUIPMENT PROGRAM SERVICE EXPENSES 9,819,851 MANAGEMENT AND GENERAL EXPENSES 1,328,475 FUNDRAISING EXPENSES -26,273 TOTAL EXPENSES 11,122,053 FREE CARE CHARGED TO FUNDS PROGRAM SERVICE EXPENSES 4,712,513 MANAGEMENT AND GENERAL EXPENSES 396,886 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 5,109,399 FUNDRAISING COST PROGRAM SERVICE EXPENSES 791,366 MANAGEMENT AND GENERAL EXPENSES 3,344,601 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 4,135,967 ASSISTANTSHIP - IHP/MB PROGRAM SERVICE EXPENSES 180,894 MANAGEMENT AND GENERAL EXPENSES 15,251 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 196,145 NON-PATIENT BAD DEBT EXPENSE PROGRAM SERVICE EXPENSES 42,667 MANAGEMENT AND GENERAL EXPENSES -50,226 FUNDRAISING EXPENSES 0 TOTAL EXPENSES -7,559

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	EQUITY INVESTMENT ACTIVITY (UNREALIZED G/L ON INVESTMENTS) 606,960,656 CHANGE IN FUNDED STATUS OF DEFINED BENEFIT PLAN 909,990,002 NET ASSET ADDITIONS FROM ADDED GROUP SUBORDINATES 4,930,994

990 Schedule O, Supplemental Information

Return Reference	Explanation
ENTITIES INCLUDED IN THE GROUP RETURN	BELOW IS A LIST OF ORGANIZATIONS INCLUDED IN THIS GROUP RETURN AND THE ACRONYMS USED THROU GHOUT THIS RETURN TO REFERENCE THE ORGANIZATION BIOSCIENCES RESEARCH FOUNDATION, INC (BR F) - EIN 22-2483849 BRIGHAM AND WOMEN'S FAULKNER HOSPITAL, INC (BWFH) - EIN 04-2768256 F/ K/A FAULKNER HOSPITAL, INC BRIGHAM HEALTH, INC (BH) - EIN 04-2921338 BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC (BWPO) - EIN 04-3466314 BRIGHAM COMMUNITY PRACTICES, INC (BCP) - EIN 22-2588069 BRIGHAM MEDICAL RESEARCH & EDUCATIONAL FOUNDATION, INC (MED) - EIN 04-3539249 BWH RESEARCH, INC (BWHR) - EIN 04-3011445 CD PRACTICE ASSOCIATES, INC - EIN 0 4-3194547 COOLEY DICKINSON HEALTH CARE CORPORATION - EIN 04-2103561 COOLEY DICKINSON HOSPI TAL, INC - EIN 22-2617175 FRC, INC (FRC), ALSO REFERRED TO AS SPAULDING NURSING AND THER APY CENTER & SPAULDING NURSING AND THERAPY CENTER - EIN 22-2632121 HARBOR MEDICAL ASSOCIAT ES, INC (HMA) - EIN 04-2702579 MARTHA'S VINEYARD HOSPITAL, INC (MVH) - EIN 04-2104691 MA SSACHUSETTS GENERAL PHYSICIANS ORGANIZATION, INC (MGPO) - EIN 04-2807148 MCLEAN HEALTHCAR E, INC (MHC) - EIN 20-4572876 NANTUCKET COTTAGE HOSPITAL FOUNDATION, INC (NCHF) - EIN 04 -3829745 NANTUCKET COTTAGE HOSPITAL (NCH) - EIN 04-2103823 NANTUCKET PHYSICIAN ORGANIZATIO N, INC (NPO) - EIN 26-4349357 NEWTON-WELLESLEY AMBULATORY SERVICES, INC (NWAS) - EIN 22- 2560501 NEWTON-WELLESLEY CHILDREN'S CORNER, INC (NWCC) - EIN 04-2650246 NEWTON-WELLESLEY HEALTH CARE SYSTEM, INC (NWHC)- EIN 20-4295282 NEWTON-WELLESLEY HOSPITAL (NWH) - EIN 04-2 103611 NEWTON-WELLESLEY HOSPITAL CHARITABLE FOUNDATION, INC (NWCF) - EIN 04-3455952 NORTH SHORE MEDICAL CENTER, INC (NSMC) - EIN 04-3399616 NORTH SHORE PHYSICIANS GROUP, INC (NS PG) - EIN 04-3080484 NSMC HEALTHCARE, INC (NSHC) - EIN 04-3294420 PARTNERS COMMUNITY PHYS ICIANS ORGANIZATION, INC EIN 04-3236175 PARTNERS CONTINUING CARE, INC (PCC) - EIN 26-000 3495 PARTNERS HEALTHCARE SP, INC (PARTNERS SP) - EIN 82-1707493 PARTNERS HOME CARE, INC (PHC), ALSO REFERRED TO AS PARTNERS HEALTHCARE AT HOME - HOME CARE - EIN 04-2918280 PARTNE RS MEDICAL INTERNATIONAL, INC (PMI) - EIN 04-3197711 REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION (RHCI), ALSO REFERRED TO AS SPAULDING REHABILITATION HOSPITAL - CA PE COD - EIN 04-3071419 SHAUGHNESSY-KAPLAN REHABILITATION HOSPITAL, INC (SKRH), ALSO REFE RRED TO AS SPAULDING HOSPITAL FOR CONTINUING MEDICAL CARE - NORTH SHORE - EIN 04-3067082 S OUTH SHORE ENDOSCOPY CENTER, INC (SSEC) EIN 04-3306443 SPAULDING HOSPITAL - CAMBRIDGE, IN C (SHC), ALSO REFERRED TO AS SPAULDING HOSPITAL FOR CONTINUING MEDICAL CARE - CAMBRIDGE - EIN 27-0273715 THE BRIGHAM AND WOMEN'S HOSPITAL, INC (BWH) - EIN 04-2312909 THE GENERAL HOSPITAL CORPORATION (THE GENERAL OR GHC) - EIN 04-2697983 THE MASSACHUSETTS GENERAL HOSPI TAL (MGH) - EIN 04-1564655 THE MCLEAN HOSPITAL CORPORATION (MCL)- EIN 04-2697981 THE MGH H EALTH SERVICES CORPORATION (HSC) - EIN 22-2717383 THE SPAULDING REHABILITATION HOSPITAL CO RPORATION (SRH), ALSO REFERRED

990 Schedule O, Supplemental Information

Return Reference	Explanation
ENTITIES INCLUDED IN THE GROUP RETURN	TO AS SPAULDING REHABILITATION HOSPITAL - BOSTON - EIN 04-2551124 VNA & HOSPICE OF COOLEY DICKINSON, INC - EIN 04-2104788 WNR, INC (WNR) - EIN 04-3419920

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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. ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
PARTNERS HEALTHCARE SYSTEM INC &
AFFILIATES GROUP RETURN

Employer identification number
90-0656139

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) PARTNERS HEALTHCARE INTERNATIONAL LLC 800 BOYLSTON STREET BOSTON, MA 02199 20-5281203	GLOBAL HEALTH CARE	MA	7,509,715	15,709,451	PHS
(2) PARTNERS HARVARD MEDICAL INTERNATIONAL GULF FZ LLC 100 CAMBRIDGE ST DUBAI AE	GLOBAL HEALTH CARE	AE	0	0	PHS
(3) PARTNERS PRIVATE CARE LLC 1101 WORCESTER ROAD FRAMINGHAM, MA 01701 26-3871702	HOME HEALTH	MA	10,643,147	3,371,967	PHC
(4) MERRIMACK VALLEY ENDOSCOPY LLC ONE PARKWAY HAVERHILL, MA 01830 04-3578297	MEDICAL SERVICES	MA	1,432,305	0	PCPO
(5) PARTNERS INNOVATION II LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4444790	INVESTMENTS	MA	0	0	PHS
(6) PARTNERS INNOVATION MANAGEMENT COMPANY LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4431654	INVESTMENTS	MA	1,178,337	0	PHS

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.

See Additional Data Table

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

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) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) PHS BAY COLONY FUND 245 PARK AVENUE NY, NY 10167 13-3887448	INVESTMENTS	DE	PPIA	EXCLUDED	384,450	184,773		No			No	93 870 %
(2) WELLINGTON TRUST COMPANY NA CTF QUALITY 280 CONGRESS STREET BOSTON, MA 02210 04-6657593	INVESTMENTS	MA	PPIA	EXCLUDED	606,064			No			No	80 310 %
(3) PARTNERS HEALTHCARE SYSTEM POOLED INVEST 101 MERRIMAC STREET BOSTON, MA 02114 04-3268842	INVESTMENTS	MA	PHS	EXCLUDED	314,205,038	8,236,155,545		No	7,994,476	Yes		100 000 %

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity? Yes	(i) No
(1)NEWTON-WELLESLEY PHYSICIAN HOSPITAL ORG 2014 WASHINGTON STREET NEWTON, MA 02462 04-3209749	HEALTHCARE	MA	NWHC	C	4,675,275	10,113,926	100 000 %		No

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

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

		Yes	No
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or**(iv)** rent from a controlled entity	1a	Yes	
b Gift, grant, or capital contribution to related organization(s)	1b	Yes	
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j		No
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r		No
s Other transfer of cash or property from related organization(s)	1s		No

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

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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) Disproprtionate 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	

Part VII **Supplemental Information**

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

Additional Data

Software ID:

Software Version:

EIN: 90-0656139

Name: PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN

Form 990, Schedule R, Part I - Identification of Disregarded Entities

(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) PARTNERS HEALTHCARE INTERNATIONAL LLC 800 BOYLSTON STREET BOSTON, MA 02199 20-5281203	GLOBAL HEALTH CARE	MA	7,509,715	15,709,451	PHS
(1) PARTNERS HARVARD MEDICAL INTERNATIONAL GULF FZ LLC 100 CAMBRIDGE ST DUBAI AE	GLOBAL HEALTH CARE	AE	0	0	PHS
(2) PARTNERS PRIVATE CARE LLC 1101 WORCESTER ROAD FRAMINGHAM, MA 01701 26-3871702	HOME HEALTH	MA	10,643,147	3,371,967	PHC
(3) MERRIMACK VALLEY ENDOSCOPY LLC ONE PARKWAY HAVERHILL, MA 01830 04-3578297	MEDICAL SERVICES	MA	1,432,305	0	PCPO
(4) PARTNERS INNOVATION II LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4444790	INVESTMENTS	MA	0	0	PHS
(5) PARTNERS INNOVATION MANAGEMENT COMPANY LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4431654	INVESTMENTS	MA	1,178,337	0	PHS

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) 55 FRUIT STREET BOSTON, MA 02114 04-1564655	HEALTHCARE	MA	501(C)(3)	7	PHS	Yes	
(1) 55 FRUIT STREET BOSTON, MA 02114 04-2697983	HOSPITAL	MA	501(C)(3)	3	MGH	Yes	
(2) 55 FRUIT STREET BOSTON, MA 02114 04-2807148	HEALTHCARE	MA	501(C)(3)	9	MGH	Yes	
(3) 55 FRUIT STREET BOSTON, MA 02114 22-2717383	HEALTHCARE	MA	501(C)(3)	11A	MGH	Yes	
(4) 36 FIRST AVENUE CHARLESTOWN, MA 02129 04-2868893	MED EDUCATION	MA	501(C)(3)	2	MGH	Yes	
(5) 115 MILL STREET BELMONT, MA 02478 20-4572876	ADMIN SUPPORT	MA	501(C)(3)	11A	MGH	Yes	
(6) 115 MILL STREET BELMONT, MA 02478 04-2697981	HOSPITAL	MA	501(C)(3)	3	MHC	Yes	
(7) LINTON LANE PO BOX 1477 OAK BLUFFS, MA 02557 04-2104691	HEALTHCARE	MA	501(C)(3)	3	MGH	Yes	
(8) 1 LINTON LANE OAK BLUFFS, MA 02557 04-3419920	NURSING SVCS	MA	501(C)(3)	9	MVH	Yes	
(9) 57 PROSPECT STREET NANTUCKET, MA 02554 04-2103823	HOSPITAL	MA	501(C)(3)	3	MGH	Yes	
(10) 57 PROSPECT STREET NANTUCKET, MA 02554 04-3829745	ADMIN SUPPORT	MA	501(C)(3)	11A	NCH	Yes	
(11) 75 FRANCIS STREET BOSTON, MA 02115 04-2921338	ADMIN SUPPORT	MA	501(C)(3)	7	PHS	Yes	
(12) 75 FRANCIS STREET BOSTON, MA 02115 04-2312909	HOSPITAL	MA	501(C)(3)	3	BH	Yes	
(13) 75 FRANCIS STREET BOSTON, MA 02115 22-2483849	PROMOTE RES	MA	501(C)(3)	11A	BH	Yes	
(14) 75 FRANCIS STREET BOSTON, MA 02115 04-3011445	MED RESEARCH	MA	501(C)(3)	11A	BH	Yes	
(15) 75 FRANCIS STREET BOSTON, MA 02115 22-2588069	HEALTHCARE	MA	501(C)(3)	9	BH	Yes	
(16) 75 FRANCIS STREET BOSTON, MA 02115 04-3466314	HEALTHCARE	MA	501(C)(3)	9	BH	Yes	
(17) 75 FRANCIS STREET BOSTON, MA 02115 04-3539249	MED RES & EDU	MA	501(C)(3)	11A	BWPO	Yes	
(18) 1153 CENTRE STREET BOSTON, MA 02130 04-2768256	HOSPITAL	MA	501(C)(3)	3	BWHC	Yes	
(19) 1153 CENTRE STREET BOSTON, MA 02130 04-2775265	NURSING HOME	MA	501(C)(3)	3	BWFH	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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
(21) PRUDENTIAL TOWER 800 BOYLSTON STREE BOSTON, MA 02199 26-0003495	ADMIN SUPPORT	MA	501(C)(3)	11A	PHS	Yes	
(1) 300 FIRST AVENUE CHARLESTOWN, MA 02129 04-2551124	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
(2) 311 SERVICE ROAD EAST SANDWICH, MA 02537 04-3071419	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
(3) DOVE AVENUE SALEM, MA 01970 04-3067082	HEALTHCARE	MA	501(C)(3)	3	PCC	Yes	
(4) 281 WINTER STREET WALTHAM, MA 02451 04-2918280	HOME HEALTH	MA	501(C)(3)	9	PCC	Yes	
(5) 101 MERRIMAC STREET BOSTON, MA 02114 22-2632121	HEALTHCARE	MA	501(C)(3)	3	PCC	Yes	
(6) 81 HIGHLAND AVENUE SALEM, MA 01970 04-3294420	ADMIN SUPPORT	MA	501(C)(3)	11A	PHS	Yes	
(7) 81 HIGHLAND AVENUE SALEM, MA 01970 04-3399616	HOSPITAL	MA	501(C)(3)	3	NSHC	Yes	
(8) 81 HIGHLAND AVENUE SALEM, MA 01970 04-3080484	HEALTHCARE	MA	501(C)(3)	11A	NSHC	Yes	
(9) 2014 WASHINGTON STREET NEWTON, MA 02462 20-4295282	ADMIN SUPPORT	MA	501(C)(3)	11A	PHS	Yes	
(10) 2014 WASHINGTON STREET NEWTON, MA 02462 04-2103611	HOSPITAL	MA	501(C)(3)	3	NWHC	Yes	
(11) 2014 WASHINGTON STREET NEWTON, MA 02462 22-2560501	HEALTHCARE	MA	501(C)(3)	11A	NWHC	Yes	
(12) 2014 WASHINGTON STREET NEWTON, MA 02462 04-3455952	FUNDRAISING	MA	501(C)(3)	7	NWHC	Yes	
(13) 2014 WASHINGTON STREET NEWTON, MA 02462 04-2650246	CHILD CARE	MA	501(C)(3)	9	NWHC	Yes	
(14) 100 CAMBRIDGE STREET BOSTON, MA 02114 04-3197711	MED TRAINING	MA	501(C)(3)	11A	PHS	Yes	
(15) 1575 CAMBRIDGE STREET CAMBRIDGE, MA 02138 27-0273715	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
(16) 57 PROSPECT STREET NANTUCKET, MA 02554 26-4349357	HEALTHCARE	MA	501(C)(3)	9	MGH	Yes	
(17) 253 SUMMER STREET BOSTON, MA 02210 04-2932021	INSURANCE	MA	501(C)(4)	NONE	PHS	Yes	
(18) 253 SUMMER STREET BOSTON, MA 02210 04-3454185	INSURANCE	MA	501(C)(3)	11A	NHP	Yes	
(19) 30 LOCUST STREET NORTHAMPTON, MA 01060 22-2617175	HOSPITAL	MA	501(C)(3)	3	CDHCC	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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
(41) 168 INDUSTRIAL DRIVE NORTHAMPTON, MA 01060 04-2104788	HOME HEALTH	MA	501(C)(3)	9	CDHCC	Yes	
(1) 30 LOCUST STREET NORTHAMPTON, MA 01060 04-2103561	ADMIN SUPPORT	MA	501(C)(3)	11B	MGH	Yes	
(2) POBOX 911 NORTHAMPTON, MA 01060 04-3194547	HEALTHCARE	MA	501(C)(3)	9	CDHCC	Yes	
(3) 789 CENTRAL AVE DOVER, NH 03820 02-0260334	HOSPITAL	NH	501(C)(3)	3	MGH	Yes	
(4) 789 CENTRAL AVE DOVER, NH 03820 02-0497927	HEALTHCARE	NH	501(C)(3)	3	WDH	Yes	
(5) 789 CENTRAL AVE DOVER, NH 03820 51-0491062	SUPPORT	NH	501(C)(3)	11B	WDH	Yes	

Form 990, Schedule R, Part V - Transactions With Related Organizations

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	BRIGHAM AND WOMEN'S HOSPITAL INC	A	77,526	FMV
(1)	BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC	B	29,334,339	FMV
(2)	PARTNERS CONTINUING CARE INC	B	229,511	FMV
(3)	BRIGHAM AND WOMEN'S HOSPITAL INC	B	63,366,952	FMV
(4)	BRIGHAM AND WOMEN'S HOSPITAL INC	B	14,830,096	FMV
(5)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	B	12,542,324	FMV
(6)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	1,730,187	FMV
(7)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	2,442,301	FMV
(8)	BRIGHAM AND WOMEN'S OBSTETRICS AND GYN	C	1,266,678	FMV
(9)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	109,125	FMV
(10)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	440,676	FMV
(11)	BRIGHAM PATHOLOGY RESEARCH AND EDUCATION FOUN	C	747,805	FMV
(12)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	1,341,109	FMV
(13)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	873,833	FMV
(14)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	1,724,908	FMV
(15)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	343,857	FMV
(16)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	467,173	FMV
(17)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	321,548	FMV
(18)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	468,769	FMV
(19)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	264,356	FMV
(20)	BRIGHAM AND WOMEN'S PHYSICIANS ORG	C	125,813	FMV
(21)	THE MCLEAN HOSPITAL CORPORATION	B	420,027	FMV
(22)	NANTUCKET COTTAGE HOSPITAL	A	113,819	FMV
(23)	MARTHA'S VINEYARD HOSPITAL INC	A	9,646	FMV
(24)	REHABILITATION HOSPITAL OF THE CAPE AND ISL	A	13,896	FMV

Form 990, Schedule R, Part V - Transactions With Related Organizations

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(26)	PARTNERS HEALTHCARE SYSTEM INC	B	25,983,358	FMV
(1)	PARTNERS CONTINUING CARE INC	B	295,660	FMV
(2)	REHABILITATION HOSPITAL OF THE CAPE AND ISL	B	105,115	FMV
(3)	WENTWORTH DOUGLAS HOSPITAL	B	325,908	FMV
(4)	THE GENERAL HOSPITAL CORPORATION	C	149,488,227	FMV
(5)	MASSACHUSETTS GENERAL PHYSICIANS ORG	C	700,000	FMV
(6)	THE GENERAL HOSPITAL CORPORATION	L	440,464	FMV
(7)	MASSACHUSETTS GENERAL PHYSICIANS ORG	L	100,091	FMV
(8)	NORTH SHORE MEDICAL CENTER INC	B	12,551,981	FMV
(9)	SPAULDING HOSPITAL - CAMBRIDGE INC	B	8,203,725	FMV
(10)	SHAUGHNESSY-KAPLAN REHABILITATION HOSPITAL	B	1,595,559	FMV
(11)	THE SPAULDING REHABILITATION HOSPITAL CORP	B	19,538,759	FMV
(12)	FRC INC	B	349,751	FMV
(13)	REHABILITATION HOSPITAL OF THE CAPE AND ISL	B	3,570,948	FMV
(14)	THE MASSACHUSETTS GENERAL HOSPITAL	C	295,660	FMV
(15)	THE MGH HEALTH SERVICES CORPORATION	C	1,003,966	FMV
(16)	BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC	C	229,511	FMV
(17)	NEWTON-WELLESLEY HOSPITAL INC	C	50,044	FMV
(18)	THE SPAULDING REHABILITATION HOSPITAL CORP	L	6,036,000	FMV
(19)	PARTNERS HOME CARE INC	L	6,531,996	FMV
(20)	FRC INC	L	2,370,000	FMV
(21)	SPAULDING HOSPITAL - CAMBRIDGE INC	L	3,714,996	FMV
(22)	REHABILITATION HOSPITAL OF THE CAPE AND ISL	L	2,234,004	FMV
(23)	WNR INC	B	550,000	FMV
(24)	COOLEY DICKINSON HOSPITAL	C	45,475,954	FMV