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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

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 10-01-2017 , and ending 09-30-2018

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 $ 13,614,828,285

F Name and address of principal officer
ANNE KLIBANSKI 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

Activities & Governance

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	636
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	410
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5	71,817
6	Total number of volunteers (estimate if necessary)	6	5,271
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	20,452,314
b	Net unrelated business taxable income from Form 990-T, line 34	7b	28,616,078

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	2,967,780,415	2,904,676,699
	9	Program service revenue (Part VIII, line 2g)	9,247,897,369	10,174,737,520
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	260,033,262	340,000,181
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	236,519,698	189,551,941
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	12,712,230,744	13,608,966,341
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,192,132,923	1,146,707,910
	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)	6,488,080,545	6,809,650,881
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	527,501
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶71,776,610		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	4,704,106,027	5,029,490,891
	18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	12,384,319,495	12,986,377,183
	19	Revenue less expenses Subtract line 18 from line 12	327,911,249	622,589,158

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	16,695,511,153	18,199,079,471
	21	Total liabilities (Part X, line 26)	6,981,438,398	6,899,862,627
	22	Net assets or fund balances Subtract line 21 from line 20	9,714,072,755	11,299,216,844

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

****** | 2019-08-14
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 $ 11,692,788,661 including grants of $ 1,146,707,910) (Revenue $ 10,189,122,151)

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 ▶** 11,692,788,661

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	Yes	
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	Yes	
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	297			
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	71,817			
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** 636			
	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** 410			
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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
See Additional Data Table										

	(D)	(E)	(F)
1b Sub-Total ▶			
c Total from continuation sheets to Part VII, Section A ▶			
d Total (add lines 1b and 1c) ▶	90,850,239	37,532,647	10,123,800

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 ▶ 11,792

			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
WALSH BROTHERS 210 COMMERCIAL STREET BOSTON, MA 02109	CONSTRUCTION SERVICE	87,931,386
SUFFOLK CONSTRUCTION CO 99 CONIFER HILL DRIVE DANVERS, MA 01923	CONSTRUCTION SERVICE	54,339,960
AMN HEALTHCARE INC 26 CONNELL STREET QUINCY, MA 02169	STAFFING SERVICES	29,421,357
BLUE CROSS AND BLUE SHIELD OF MA INC 41 PARK DRIVE BOSTON, MA 02215	MEDICAL CLAIMS SERVICES	21,667,457
ANGELICA-WORCESTER PO BOX 823283 PHILADELPHIA, PA 191823283	LAUNDRY SERVICES	20,340,657

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 ▶ 257

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	28,437,499				
d Related organizations	1d	939,907,940				
e Government grants (contributions)	1e	852,617,197				
f All other contributions, gifts, grants, and similar amounts not included above	1f	1,083,714,063				
g Noncash contributions included in lines 1a-1f $ 68,216,517						
h **Total.** Add lines 1a-1f ▶			2,904,676,699			
Program Service Revenue	Business Code					
2a PATIENT CARE REVENUE	622110		9,329,045,016	9,329,045,016		
b OTHER PROGRAM REVENUE	621999		785,055,652	777,938,244	7,117,408	
c TUITION REVENUE	624410		57,484,737	57,484,737		
d AMBULANCE INCOME	621910		1,491,696	1,491,696		
e PARTNERSHIP INCOME	900099		1,490,050	1,490,050		
f All other program service revenue			170,369	170,369		
g **Total.** Add lines 2a–2f ▶			10,174,737,520			

Other Revenue	(i) Real / (i) Securities	(ii) Personal / (ii) Other	(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
3 Investment income (including dividends, interest, and other similar amounts) ▶			84,639,330		3,434,736	81,204,594
4 Income from investment of tax-exempt bond proceeds ▶						
5 Royalties ▶			22,810,949			22,810,949
	(i) Real	(ii) Personal				
6a Gross rents	55,584,653					
b Less rental expenses	0					
c Rental income or (loss)	55,584,653					
d Net rental income or (loss) ▶			55,584,653		9,900,170	45,684,483
	(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory	255,360,851					
b Less cost or other basis and sales expenses	0					
c Gain or (loss)	255,360,851					
d Net gain or (loss) ▶			255,360,851			255,360,851
8a Gross income from fundraising events (not including $ 28,437,499 of contributions reported on line 1c) See Part IV, line 18 . . a		2,249,642				
b Less direct expenses . . b		5,861,278				
c Net income or (loss) from fundraising events ▶			-3,611,636			-3,611,636
9a Gross income from gaming activities See Part IV, line 19 . . a		166,982				
b Less direct expenses . . b		666				
c Net income or (loss) from gaming activities ▶			166,316	166,316		
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	58,755,240			58,755,240
b CAFETERIA INCOME		722514	34,510,696			34,510,696
c CONSULTING REVENUE		621500	14,166,258	14,166,258		
d All other revenue			7,169,465	7,169,465		
e **Total.** Add lines 11a–11d ▶			114,601,659			
12 **Total revenue.** See Instructions ▶			13,608,966,341	10,189,122,151	20,452,314	494,715,177

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	1,106,250,091	1,106,250,091		
2 Grants and other assistance to domestic individuals See Part IV, line 22	6,657,498	6,657,498		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	33,800,321	33,800,321		
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	90,850,239		90,850,239	
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	5,272,687,613	4,784,933,055	446,918,280	40,836,278
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	318,946,865	291,044,694	27,049,407	852,764
9 Other employee benefits	871,701,522	768,644,693	90,463,878	12,592,951
10 Payroll taxes	255,464,642	228,915,488	26,549,154	
11 Fees for services (non-employees)				
a Management				
b Legal	23,953,277	21,759,930	2,165,753	27,594
c Accounting	100,128	84,068	15,980	80
d Lobbying	5,436,324		5,436,324	
e Professional fundraising services See Part IV, line 17	527,501			527,501
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)	1,105,401,361	977,925,992	120,142,838	7,332,531
12 Advertising and promotion	24,622,454	20,385,802	3,942,125	294,527
13 Office expenses	1,596,432,388	1,425,025,934	166,904,621	4,501,833
14 Information technology	46,886,542	40,821,069	6,029,256	36,217
15 Royalties . .	4,966,896	4,637,221	329,675	
16 Occupancy	413,565,854	366,591,297	44,957,026	2,017,531
17 Travel	37,589,265	33,366,931	3,422,508	799,826
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .				
19 Conferences, conventions, and meetings	9,347,476	8,590,495	718,981	38,000
20 Interest	154,034,532	132,497,640	21,536,892	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization . .	589,075,416	526,475,414	62,600,002	
23 Insurance . . .	99,676,800	90,840,823	8,835,977	
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	344,990,775	317,514,402	27,474,395	1,978
b PROGRAM SUPPORT/SUBSIDY	230,810,239	202,124,782	28,685,457	
c HSN/MEDICAID TAX	171,051,037	153,789,509	17,261,528	
d MISCELLANEOUS EXPENSES	98,871,036	85,353,176	13,298,650	219,210
e All other expenses	72,679,091	64,758,336	6,222,966	1,697,789
25 **Total functional expenses.** Add lines 1 through 24e	12,986,377,183	11,692,788,661	1,221,811,912	71,776,610
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		420,181,232	2	334,779,034
	3	Pledges and grants receivable, net		412,456,322	3	467,986,678
	4	Accounts receivable, net		1,093,243,145	4	1,205,904,143
	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		6,808,730	7	5,754,041
	8	Inventories for sale or use		54,223,457	8	65,610,698
	9	Prepaid expenses and deferred charges		51,051,779	9	65,958,289
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 10,068,209,216			
	b	Less accumulated depreciation	10b 4,511,582,915	5,331,633,313	10c	5,556,626,301
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11		7,288,730,767	12	8,369,362,704
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		2,037,182,408	15	2,127,097,583
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		16,695,511,153	16	18,199,079,471
Liabilities	17	Accounts payable and accrued expenses		2,652,330,942	17	2,476,275,693
	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		4,329,107,456	25	4,423,586,934
	26	**Total liabilities.** Add lines 17 through 25		6,981,438,398	26	6,899,862,627
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		6,846,713,269	27	8,218,339,110
	28	Temporarily restricted net assets		1,701,331,080	28	1,792,081,470
	29	Permanently restricted net assets		1,166,028,406	29	1,288,796,264
		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		9,714,072,755	33	11,299,216,844
	34	Total liabilities and net assets/fund balances		16,695,511,153	34	18,199,079,471

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	13,608,966,341
2	Total expenses (must equal Part IX, column (A), line 25)	2	12,986,377,183
3	Revenue less expenses Subtract line 2 from line 1	3	622,589,158
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	9,714,072,755
5	Net unrealized gains (losses) on investments	5	
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	962,554,931
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	11,299,216,844

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 TITLES	50 00	X						542,976	0	56,806
KATRINA ARMSTRONG MD SEE SCHEDULE O - O & T TITLES	50 00	X						902,403	0	58,038
STANLEY W ASHLEY MD SEE SCHEDULE O - O & T TITLES	50 00	X						670,387	0	50,676
MAUREEN BANKS SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	582,955	39,704
ROBERT L BARBIERI MD SEE SCHEDULE O - O & T TITLES	50 00	X						596,492	0	64,970
GREGORY A BIRD SEE SCHEDULE O - O & T TITLES	50 00	X						308,370	0	50,113
CHRISTINE A BLASKI MD SEE SCHEDULE O - O & T TITLES	50 00	X						228,572	0	25,273
SALLY MASON BOEMER SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	1,027,856	52,754
GILES W BOLAND MD SEE SCHEDULE O - O & T TITLES	50 00	X						797,235	0	67,224
CHRISTOPHER M BONO MD SEE SCHEDULE O - O & T TITLES	50 00	X						407,471	0	46,730

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
JAMES A BRINK MD SEE SCHEDULE O - O & T TITLES	50 00	X						916,245	0	59,289
O'NEIL BRITTON MD SEE SCHEDULE O - O & T TITLES	50 00	X						793,713	0	57,972
CALVIN A BROWN III MD SEE SCHEDULE O - O & T TITLES	50 00	X						330,981	0	47,012
DAVID F BROWN MD SEE SCHEDULE O - O & T TITLES	50 00	X						790,174	0	59,974
DEBRA A BURKE MSN SEE SCHEDULE O - O & T TITLES	50 00	X						250,921	0	59,493
ELLEN L CAILLE SEE SCHEDULE O - O & T TITLES	50 00	X						427,397	0	92,138
PAUL R CASS DO SEE SCHEDULE O - O & T TITLES	50 00	X						838,250	0	98,274
BRUCE A CHABNER SEE SCHEDULE O - O & T TITLES	50 00	X						246,153	0	44,531
ENNIO A CHIOCCA MD SEE SCHEDULE O - O & T TITLES	50 00	X						1,981,008	0	65,281
CHRISTOPHER MARK COBURN SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	1,016,771	47,459

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			
CHRISTOPHER M COLEY MD SEE SCHEDULE O - O & T TITLES	50 00	X						369,055	0	57,022
YOLONDA L COLSON MD SEE SCHEDULE O - O & T TITLES	50 00	X						474,925	0	61,881
RAYMOND F CONWAY MD SEE SCHEDULE O - O & T TITLES	50 00	X						150	0	0
WILLIAM S DANFORD SEE SCHEDULE O - O & T TITLES	50 00	X						427,215	0	25,827
ERNESTO DASILVA MD SEE SCHEDULE O - O & T TITLES	50 00	X						336,897	0	34,953
MARCELA DEL CARMEN MD SEE SCHEDULE O - O & T TITLES	50 00	X						707,556	0	46,447
JEFFREY P DION SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	323,792	57,679
GERARD M DOHERTY MD SEE SCHEDULE O - O & T TITLES	50 00	X						1,427,167	0	67,131
TERENCE P DOORLY MD SEE SCHEDULE O - O & T TITLES	50 00	X						704,009	0	35,390
PETER M DOUBILET MD SEE SCHEDULE O - O & T TITLES	50 00	X						551,002	0	61,884

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
SUNIL EAPPEN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	622,959	58,175
JEFFREY L ECKER MD SEE SCHEDULE O - O & T TITLES	50 00	X						759,407	0	58,269
KHAMA D ENNIS-HOLCOMBE SEE SCHEDULE O - O & T TITLES	50 00	X						84,173	0	10,605
JONATHAN M FALLON MD SEE SCHEDULE O - O & T TITLES	50 00	X						639,590	0	25,276
THOMAS L FAZIO MD SEE SCHEDULE O - O & T TITLES	50 00	X						698,959	0	20,488
CARLOS FERNANDEZ-DEL CASTILLO MD SEE SCHEDULE O - O & T TITLES	50 00	X						873,050	0	62,830
TIMOTHY G FERRIS MD SEE SCHEDULE O - O & T TITLES	50 00	X		X				881,971	0	59,327
CRISTINA R FERRONE MD SEE SCHEDULE O - O & T TITLES	50 00	X						487,807	0	68,836
AARON S FISHMAN SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	112,989	13,293
MARY ANN GAGNON SEE SCHEDULE O - O & T TITLES	50 00	X						142,128	0	26,028

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
JOSEPH MICHAEL GARASIC MD SEE SCHEDULE O - O & T TITLES	50 00	X						394,801	0	37,994
TERRY J GARFINKLE MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X						0	507,705	48,275
ROYA GHAZINOURI PT SEE SCHEDULE O - O & T TITLES	50 00	X						125,725	0	33,156
STEVEN A GILGEN SEE SCHEDULE O - O & T TITLES	50 00	X		X				275,698	0	3,400
RICHARD S GITOMER MD SEE SCHEDULE O - O & T TITLES	50 00	X						492,857	0	46,721
MATTHEW J GOLDBERG SEE SCHEDULE O - O & T TITLES	50 00	X						285,468	0	24,637
JEFFREY A GOLDEN MD SEE SCHEDULE O - O & T TITLES	50 00	X						910,314	0	65,178
TERRI E GORMAN MD SEE SCHEDULE O - O & T TITLES	50 00	X						394,002	0	45,704
PETER A GRAPE MD SEE SCHEDULE O - O & T TITLES	50 00	X		X				648,126	0	58,292
MICHAEL L GUSTAFSON MD SEE SCHEDULE O - O & T TITLES	50 00	X		X				575,248	0	38,118

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
DAPHNE ADELE HAAS-KOGANMD SEE SCHEDULE O - O & T TITLES	50 00	X						938,804	0	45,704
ROBERT HANDIN MD SEE SCHEDULE O - O & T TITLES	50 00	X						277,755	0	57,428
MARGOT K HARTMANN MD SEE SCHEDULE O - O & T TITLES	50 00	X		X				348,264	0	18,073
ANNEMARIE HEATH CNM DNP SEE SCHEDULE O - O & T TITLES	50 00	X						139,178	0	21,522
JAMES L HEFFERNAN SEE SCHEDULE O - O & T TITLES	50 00	X		X				690,938	0	62,381
THEODORE S HONG MD SEE SCHEDULE O - O & T TITLES	50 00	X						813,681	0	57,176
TERRIE E INDER MBCHB SEE SCHEDULE O - O & T TITLES	50 00	X						661,682	0	54,992
MICHAEL R JAFF DO SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	919,864	52,539
ALAN ANTHONY JAMES SEE SCHEDULE O - O & T TITLES	50 00	X						503,062	0	42,953
WILLIAM C JOHNSTON SEE SCHEDULE O - O & T TITLES	50 00	X		X				740,663	0	58,394

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
ANNE KALTER SEE SCHEDULE O - O & T TITLES	50 00	X						206,021	0	30,627
JAMES D KANG MD SEE SCHEDULE O - O & T TITLES	50 00	X						1,472,184	0	67,883
STEVEN E KAPFHAMMER SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	337,621	38,796
BARRETT KITCH MD SEE SCHEDULE O - O & T TITLES	50 00	X						354,914	0	18,880
RONALD E KLEINMAN MD SEE SCHEDULE O - O & T TITLES	50 00	X						653,794	0	59,274
ANNE KLIBANSKI MD SEE SCHEDULE O - O & T TITLES	50 00	X						975,365	0	57,401
THOMAS S KUPPER MD SEE SCHEDULE O - O & T TITLES	50 00	X						622,828	0	60,093
PATRICK T LEE MD SEE SCHEDULE O - O & T TITLES	50 00	X						16,490	0	0
JOSEPH LOSCALZO MD SEE SCHEDULE O - O & T TITLES	50 00	X		X				781,460	0	60,757
DAVID N LOUIS MD SEE SCHEDULE O - O & T TITLES	50 00	X						736,680	0	57,493

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HUGH MACDONALD SEE SCHEDULE O - O & T TITLES	50 00	X						299,777	0	40,238
HEATHER COLMORE MACK SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	242,212	29,466
PETER K MARKELL SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	5,293,969	51,722
JOANNE MARQUSEE SEE SCHEDULE O - O & T TITLES	50 00	X		X				578,307	0	18,500
NAVNEET MARWAHA MD SEE SCHEDULE O - O & T TITLES	50 00	X						291,715	0	34,292
DAVID MCCREADY MBA MHA SEE SCHEDULE O - O & T TITLES	50 00	X		X				541,322	0	50,058
MAURY E MCGOUGH MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X						0	655,573	50,914
PAULA MILONE-NUZZO PHD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	271,198	27,281
ELIZABETH A MORT MD SEE SCHEDULE O - O & T TITLES	50 00	X						635,762	0	57,642
ELIZABETH G NABEL MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	2,538,960	40,952

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ALBERT NAMIAS MD SEE SCHEDULE O - O & T TITLES	50 00	X						478,369	0	36,554
ANDREA NG MD SEE SCHEDULE O - O & T TITLES	50 00	X						458,713	0	54,488
NAWAL M NOUR MD MPH SEE SCHEDULE O - O & T TITLES	50 00	X						564,791	0	37,765
JOHN NOVELLO SEE SCHEDULE O - O & T TITLES	50 00	X						330,781	0	33,213
JOHANNA M O'CONNOR MD SEE SCHEDULE O - O & T TITLES	50 00	X						527,192	0	60,615
TIMOTHY PARSONS MD SEE SCHEDULE O - O & T TITLES	50 00	X						9,000	0	33,902
GREGORY J PAULY SEE SCHEDULE O - O & T TITLES	50 00	X						873,913	0	57,671
STEVEN B PESTKA MD SEE SCHEDULE O - O & T TITLES	50 00	X						410,200	0	30,643
PIETER PIL MD SEE SCHEDULE O - O & T TITLES	50 00	X						630,192	0	41,050
NANCY S PITTMAN SEE SCHEDULE O - O & T TITLES	50 00	X		X				148,906	0	4,982

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DAVID S PLADZIEWICZ MD SEE SCHEDULE O - O & T TITLES	50 00	X						580,988	0	21,369
ALLYSON L PRESTON MD SEE SCHEDULE O - O & T TITLES	50 00	X						394,651	0	41,056
JAMES P RATHMELL MD SEE SCHEDULE O - O & T TITLES	50 00	X						811,586	0	55,213
DAVID W RATTNER MD SEE SCHEDULE O - O & T TITLES	50 00	X						953,008	0	62,912
SCOTT L RAUCH MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	754,680	56,030
MITCHELL S REIN MD SEE SCHEDULE O - O & T TITLES	50 00	X						636,119	0	59,039
PHILLIP L RICE JR MD SEE SCHEDULE O - O & T TITLES	50 00	X						481,059	0	38,302
DAVID J ROBERTS MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	556,529	10,007
ALLAN H ROPPER MD SEE SCHEDULE O - O & T TITLES	50 00	X						93,661	0	10,691
MARC S RUBIN MD SEE SCHEDULE O - O & T TITLES	50 00	X						911,655	0	63,908

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ROXANNE C RUPPEL SEE SCHEDULE O - O & T TITLES	1 00 50 00	X						0	311,766	48,570
ALI SALIM MD SEE SCHEDULE O - O & T TITLES	50 00	X						575,147	0	48,629
MARTIN A SAMUELS MD SEE SCHEDULE O - O & T TITLES	50 00	X						641,244	0	59,921
JOAN A SAPIR SEE SCHEDULE O - O & T TITLES	50 00	X						566,013	0	62,891
MARK A SCHECHTER MD SEE SCHEDULE O - O & T TITLES	50 00	X						358,532	0	34,723
FREDERICK J SCHOEN MD SEE SCHEDULE O - O & T TITLES	50 00	X						368,189	0	61,792
DAVID SILBERSWEIG MD SEE SCHEDULE O - O & T TITLES	50 00	X						690,922	0	60,923
ANEESH B SINGHAL MD SEE SCHEDULE O - O & T TITLES	50 00	X						434,667	0	56,047
PETER L SLAVIN MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	2,538,414	57,235
ALLEN L SMITH MD MS SEE SCHEDULE O - O & T TITLES	50 00	X		X				887,624	0	265,969

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LYNN MALLOY STOFER SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	783,937	50,682
DAVID E STORTO SEE SCHEDULE O - O & T TITLES	1 00 50 00	X		X				0	960,173	51,189
THORALF M SUNDT MD SEE SCHEDULE O - O & T TITLES	50 00	X						923,775	0	62,828
KHALID SYED MD SEE SCHEDULE O - O & T TITLES	50 00	X						368,929	0	39,717
DAVID F TORCHIANA MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X						0	6,075,835	52,251
GARY USHER SEE SCHEDULE O - O & T TITLES	50 00	X						329,054	0	18,177
MICHAEL J VANROOYEN MD SEE SCHEDULE O - O & T TITLES	50 00	X						708,605	0	60,181
PETER E WALCEK SEE SCHEDULE O - O & T TITLES	50 00	X		X				478,183	0	93,365
GREGORY J WALKER SEE SCHEDULE O - O & T TITLES	50 00	X		X				857,218	0	150,760
TIMOTHY J WALSH SEE SCHEDULE O - O & T TITLES	50 00	X		X				301,941	0	15,084

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ANDREW L WARSHAW MD SEE SCHEDULE O - O & T TITLES	50 00	X						1,048,224	0	62,482
DEBRA F WEINSTEIN MD SEE SCHEDULE O - O & T TITLES	50 00	X						502,276	0	57,203
ROSS D ZAFONTE DO SEE SCHEDULE O - O & T TITLES	50 00	X						644,229	0	57,770
CAROL BAILEY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD C BANE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM S BARKER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID S BARLOW SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOAN M BARRETT SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
FRASER BENNETT BEEDE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JUDITH G BELASH SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SANFORD ADAMS BELDEN SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
MARK R BELSKY MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SIBEL BESSIM MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JEANNE E BLAKE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
EDWARD B BLOOM SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHAEL BOLDOC ESQ SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
KENNETH R BORDEWIECK SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JEANINE M BORTHWICK SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
KEVIN T BOTTOMLEY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES BRANNEN SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DEBRA K BREDE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARY R BROWN SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
JOHN J BURKE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM R CAMP JR SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
JAMES A CANFIELD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN C CANNISTRARO SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD CARD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHAEL CARELLA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARC N CASPER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM REED CHISHOLM II SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
EUGENE H CLAPP SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PHILLIP L CLAY PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES P COHEN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
EARL M COLLIER JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD CONLEY SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
GARGI B COOPER FNP SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DHARMA E CORTES PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM MAURICE COWAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SUSAN C CRAMPTON SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
MONICA S CURHAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KAREN D CURRAN MBA SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
ROBERT A DANZIGER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BRUCE DANZIGER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PETER A D'ARRIGO JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES L DEMETROULAKOS MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LINDA DERENZO ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHARLES FRANK DESMOND SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN M DEUTCH SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOANNE HONEY DIBONA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PETER DIRKSMEIER MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES MANNING DONNELLY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN P DRISLANE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DEBORAH DUNSIRE MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JACKIE EASTWOOD SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
WILLIAM R ELFERS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DEBORAH C ENOS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ARTHUR J EPSTEIN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN FANIKOS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JULIETTE E FAY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LAURIE FENLASON SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOANNE J FINCK SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ANNE M FINUCANE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN F FISH SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JUDITH A FONG BA RN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHRISTOPHER R FORTIER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
NANCY S FOSTER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BRUCE FREEDMAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
NEIL GARVEY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM GEARY BS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LAUREN A GEDDES WIRTH MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CHARLES K GIFFORD SR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
THOMAS P GLYNN PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ARTHUR L GOLDSTEIN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BENJAMIN A GOMEZ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LISA B GRAIN DDS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
THOMAS H GRAPE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ERWIN L GREENBERG SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SALLY GRIGGS SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
KAREN R HALE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ROGER HAMEL SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ALEXANDER A HANNENBERG MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
NANCY HAWTHORNE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BRENDA E HAYNES MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JENNIFER HELZBERG SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BRENT L HENRY ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
KEVIN F HICKEY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD E HOLBROOK SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ALBERT A HOLMAN III SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
H ROBERT HORVITZ PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ROBERT S HUCKMAN SEE SCHEDULE O - O & T TITLES	1 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 INGRAM SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD IORIO SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID W IVES SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RONALD J JACKSON SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ANNE JAMIESON SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MELISSA WEINER JANFAZA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ROBERT E JOHNSON PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DANIEL G JONES SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ELIZABETH JOYCE BS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHAD KAGELEIRY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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(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 TITLES	1 00	X						0	0	0
JAMES L KAPLAN PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
STEPHEN R KARP SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
STEVEN M KAYE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD M KELLEHER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PAUL G KELLIHER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHRISTOPHER J KELLY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
GERARD J KENEALLY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES KIRCHHOFFER MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ANTHONY A KLEIN SEE SCHEDULE O - O & T TITLES	1 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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
JOHN H KNOWLES JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WENDELL J KNOX SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ADAM M KOPPEL SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSHUA M KRAFT SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JONATHAN A KRAFT SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
VINAY KUMAR MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ELIZA B LAKE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
KEVIN LISTER LAKE SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
RENEE M LANDERS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
THOMAS LAVASSEUR SEE SCHEDULE O - O & T TITLES	1 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			
PAMELA L LAWRENCE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JEFFREY M LEIDEN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
TIMOTHY J LEPORE MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DONNA LEVIN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BEN S LEVITAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAY LEVY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID H LONG SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
IAN K LORING SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
STACEY LUCCHINO SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JULIE A MARRIOTT SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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(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			
CARL J MARTIGNETTI SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
J BRIAN MCCARTHY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
VINCENT T MCDERMOTT SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
TERENCE A MCGINNIS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JEROME T MCMANUS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSEPH C MCNAY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CAROLINE ANN MERRIFIELD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
EDWARD F MILLER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BARRY MILLS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CATHY E MINEHAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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(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			
JAMES F MOONEY III SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHARLES A MORRIS MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LAURA BARKER MORSE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHAEL J MUEHE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PHILIP A NARDONE JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
EMILY A NEILL SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARC A NIVET EDD MBA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
NITIN NOHRIA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN N NUNNELLY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARK NUNNELLY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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(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			
GINA L O'BRIEN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHAEL F O'CONNELL ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAY O'NEILL SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ROBERT L PAGLIA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARIE-LOUISE PALANDJIAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM M PARIZEAU SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DIANE B PATRICK ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD A PENN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ADELENE Q PERKINS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DONALD M PERRIN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
H BRADLEE PERRY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SUSAN P PETERS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ANGELLEEN PETERS-LEWIS PHD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PATRICIA P PETRAGLIA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ROBERT W PIERCE JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JENNIFER L PORTER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARY G PUMA SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID L RABIN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PHILLIP T RAGON SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LARRY RAICHE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
BABU RAMDEV SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
EARLE A RAY SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
PAMELA D A REEVE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
NANCY R REEVES SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
LAURA REYNOLDS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
AUGUSTE E RIMPEL JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
THEODORE RISTAINO SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSE DE JESUS RIVERA JD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CARMICHAEL S ROBERTS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHAEL AF ROBERTS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
INGO ROEMER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WILLIAM J ROMAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSEPH F RYAN ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MELANIE R SABELHAUS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN SALMON SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
ELISABETH SCHADAE PERCELAY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOHN H SCHAEFER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DENISE M SCHEPICI SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
JEROME SCHLACHTER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ERIC D SCHLAGER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SCOTT A SCHOEN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SCOTT SCHUSTER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MARK SCHWARTZ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
S CHRISTOPHER SCOTT SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
JEFFREY N SHRIBMAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICKEL SHUSTER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RICHARD N SILVERMAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SHIRLEY SINGLETON SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
RONALD L SKATES SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
BARRY R SLOANE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
LAUREN A SMITH MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JONATHAN SNIDER MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
W LLOYD SNYDER III SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ALISON SOLLEE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSIAH A SPAULDING JR SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PAULA NESS SPEERS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DENISE SPENCE MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
SCOTT M SPERLING SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
GARY A SPIESS ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHARLES PHILIP STAELIN SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KATHLEEN M STANSKY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ANNE E STEER SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID PIERPONT STEVENS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES STEVENS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ELLEN S STORY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
STEPHEN G SULLIVAN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
TIMOTHY D SWEET SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JAMES D TAICLET SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
WALTER TELLER ESQ SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
GEORGE E THIBAULT MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JEFFREY S THOMAS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ALEXANDER L THORNDIKE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
THOMAS TORR SEE SCHEDULE O - O & T TITLES	1 00	X		X				0	0	0
HEATHER UNRUH SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CAROL A VALLONE SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
DAVID VERNO SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOAN M VITELLO-CICCIU RN SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JOSEF H VON RICKENBACH SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CATHERINE S WARD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
PETER WEITZMAN MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
BENAREE P WILEY SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
MICHELLE A WILLIAMS SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
ELIZABETH WINSHIP SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
AMY M WINSLOW SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
CHARLES F WU SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
GWILL YORK SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
GEOFFREY M ZUCKER MD SEE SCHEDULE O - O & T TITLES	1 00	X						0	0	0
JEANETTE IVES-ERICKSON DNP SEE SCHEDULE O - O & T TITLES	50 00	X						677,798	0	50,978
LOUIS JENIS MD SEE SCHEDULE O - O & T TITLES	1 00 50 00	X						0	658,275	24,750
CHARLES E ADAMS SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	227,471	47,667

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
CINDY L AIENA SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	226,902	43,426
SARAH ARNHOLZ ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	250,299	50,414
MELISSA P BRENNAN ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	167,608	46,706
MICHAEL R CARTER SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	276,963	5,534
EFFIE J CHAN ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	185,793	45,388
JULIE C CHATTOPADHYAY ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	189,982	39,757
DAVID P CONNOLLY SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	365,959	52,740
PAUL G CUSHING ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	288,725	53,295
CHRISTOPHER DUNLEAVY SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	980,109	16,567
ATLAS D EVANS SEE SCHEDULE O - O & T TITLES	50 00			X				276,016	0	59,104

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
KEVIN T GIORDANO SEE SCHEDULE O - O & T TITLES	50 00			X				260,501	0	47,163
MICHELE L GOUGEON MSC SEE SCHEDULE O - O & T TITLES	50 00			X				428,516	0	64,624
JUDI S GREENBERG ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	198,467	50,024
ROSEMARY B GUILTINAN ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	128,328	15,907
GERARD F HADLEY SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	248,482	40,923
JOHN R HIGHAM ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	354,530	45,770
STEPHEN R JENNEY SEE SCHEDULE O - O & T TITLES	50 00			X				413,923	0	60,463
LAURA STEPHENS KHOSHBIN ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	199,129	28,591
KATHERINE M KNEELAND ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	295,207	38,203
DAVID A LAGASSE SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	379,303	60,214

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
LAURIE R LAMOUREUX SEE SCHEDULE O - O & T TITLES	50 00			X				327,987	0	23,135
EDWARD J OLIVIER SEE SCHEDULE O - O & T TITLES	50 00			X				293,504	0	27,496
ANDREA G RE ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	151,502	21,392
MARY E SHAUGHNESSY SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	414,514	48,744
TRACY A SYKES ESQ SEE SCHEDULE O - O & T TITLES	1 00 50 00			X				0	221,793	46,455
DAVID ABELMAN SEE SCHEDULE O - O & T TITLES	1 00			X				0	0	0
RICHARD L CURTIS MD SEE SCHEDULE O - O & T TITLES	1 00			X				0	0	0
PAUL ANDERSON MD PHD SEE SCHEDULE O - O & T TITLES	50 00				X			651,505	0	62,355
SHELLY ANDERSON MPM SEE SCHEDULE O - O & T TITLES	50 00				X			583,860	0	40,316
SUSAN DEMPSEY SEE SCHEDULE O - O & T TITLES	50 00				X			324,508	0	50,449

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
KEREN DIAMOND SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	288,230	42,116
MARGARET M DUGGAN MD SEE SCHEDULE O - O & T TITLES	50 00				X			494,343	0	54,477
LINDA FLAHERTY RN SEE SCHEDULE O - O & T TITLES	50 00				X			238,454	0	52,442
TIMOTHY E FOSTER MD SEE SCHEDULE O - O & T TITLES	50 00				X			928,325	0	36,241
LAWRENCE S FRIEDMAN MD SEE SCHEDULE O - O & T TITLES	50 00				X			509,015	0	34,651
JOANNE M FUCILE SEE SCHEDULE O - O & T TITLES	50 00				X			256,954	0	41,664
MARY JO GAGNON SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	284,147	40,907
JOSEPH GOLD MD SEE SCHEDULE O - O & T TITLES	50 00				X			450,023	0	64,879
GEORGE GOUGIAN SEE SCHEDULE O - O & T TITLES	50 00				X			158,808	0	28,415
ROSEMARY HENCHEY SEE SCHEDULE O - O & T TITLES	50 00				X			190,920	0	19,085

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 J HESSION MD SEE SCHEDULE O - O & T TITLES	50 00				X			347,622	0	59,607
ALEX F JOHNSON SEE SCHEDULE O - O & T TITLES	50 00				X			314,478	0	56,186
PARDON R KENNEY MD SEE SCHEDULE O - O & T TITLES	50 00				X			495,134	0	61,888
CHRISTOPHER J KWOLEK MD SEE SCHEDULE O - O & T TITLES	50 00				X			964,546	0	70,535
JANET LARSON MD SEE SCHEDULE O - O & T TITLES	50 00				X			450,097	0	32,951
PAMELA K LEVANGIE SEE SCHEDULE O - O & T TITLES	50 00				X			197,234	0	21,609
KEITH D LILLEMOE MD SEE SCHEDULE O - O & T TITLES	50 00				X			1,016,691	0	62,941
EDWARD LISTON-KRAFT PHD SEE SCHEDULE O - O & T TITLES	50 00				X			262,636	0	27,623
CORI LOESCHER MM BSN RN SEE SCHEDULE O - O & T TITLES	50 00				X			234,328	0	22,390
ROBERT T MCCALL SEE SCHEDULE O - O & T TITLES	50 00				X			228,664	0	41,504

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 SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	313,317	33,694
ELLEN A MOLONEY SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	704,088	42,078
STEPHANIE N NADOLNY SEE SCHEDULE O - O & T TITLES	50 00				X			189,985	0	25,123
BRITAIN W NICHOLSON MD SEE SCHEDULE O - O & T TITLES	50 00				X			763,728	0	57,446
DOST ONGUR MD PHD SEE SCHEDULE O - O & T TITLES	50 00				X			259,604	0	44,566
JEFFREY C POLLOCK SEE SCHEDULE O - O & T TITLES	50 00				X			281,708	0	52,383
LESLIE PORTNEY SEE SCHEDULE O - O & T TITLES	50 00				X			190,491	0	44,579
ANN L PRESTIPINO SEE SCHEDULE O - O & T TITLES	50 00				X			666,822	0	50,906
CHRISTINE REILLY SEE SCHEDULE O - O & T TITLES	50 00				X			173,395	0	8,100
KERRY J RESSLER MD SEE SCHEDULE O - O & T TITLES	50 00				X			320,030	0	40,186

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
JOHN SARRO SEE SCHEDULE O - O & T TITLES	50 00				X			335,389	0	35,631
SCOTT L SCHISSEL MD SEE SCHEDULE O - O & T TITLES	50 00				X			324,423	0	49,697
NANCY D SCHMIDT SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	375,801	50,960
ANTHONY J SCIBELLI MS SEE SCHEDULE O - O & T TITLES	50 00				X			318,120	0	24,145
ARTHUR ST GERMAIN SEE SCHEDULE O - O & T TITLES	1 00 50 00				X			0	167,587	39,011
DENIS G STRATFORD SEE SCHEDULE O - O & T TITLES	50 00				X			191,268	0	45,392
INEZ TUCK SEE SCHEDULE O - O & T TITLES	50 00				X			240,083	0	37,766
ALAMJIT S VIRK MD SEE SCHEDULE O - O & T TITLES	50 00				X			421,817	0	31,773
RON M WALLS MD SEE SCHEDULE O - O & T TITLES	50 00				X			2,245,909	0	56,585
ROBERT D WELCH SEE SCHEDULE O - O & T TITLES	50 00				X			220,828	0	47,086

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: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
SHEILA M WOOLLEY SEE SCHEDULE O - O & T TITLES	50 00				X			326,859	0	58,083
DAVID C BROOKS MD SEE SCHEDULE O - O & T TITLES	50 00					X		1,566,459	0	49,352
BOB S CARTER MD SEE SCHEDULE O - O & T TITLES	50 00					X		1,769,205	0	72,659
THOMAS F HOLOVACS MD SEE SCHEDULE O - O & T TITLES	50 00					X		1,584,590	0	59,146
AMAN B PATEL MD SEE SCHEDULE O - O & T TITLES	50 00					X		1,658,484	0	62,940
JON P WARNER MD SEE SCHEDULE O - O & T TITLES	50 00					X		1,745,989	0	59,145
JANIS P BELLACK PHD FORMER O - IHP	0 00 50 00						X	0	439,703	36,513
DANIEL J GROSS FORMER O - NWCF, NWH, NWHC, NWMG	0 00 50 00						X	0	509,100	52,513
THOMAS LYNCH JR MD FORMER O - MGPO	50 00						X	247,132	0	28,405
REYNOLD G SPADONI FORMER O - PHC	0 00 50 00						X	0	259,247	35,941

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			
KERRY R WATSON FORMER O - NWH, NWHC	0 00 50 00						X	0	596,520	552
JOSEPH L WOODIN FORMER O - MVH, WNR	50 00						X	364,497	0	27,645
DENNIS AUSIELLO MD FORMER K - GHC	50 00						X	460,285	0	58,681
BARBARA E BIERER MD FORMER K - BWH	50 00						X	351,663	0	63,312
STEVEN D BROWELL MD FORMER K - NSPG	50 00						X	535,019	0	34,445
MAUREEN N CHESLEY FORMER K - PHC	0 00 50 00						X	0	197,731	40,485
KENNETH CHISHOLM FORMER K - MVH	50 00						X	221,092	0	12,447
MARY BETH DIFILIPPO FORMER K - SKRH	50 00						X	195,924	0	42,171
GARY W GARBERG FORMER K - PHC	0 00 50 00						X	0	172,009	40,010
JUDY HAYES FORMER K - BWFH	50 00						X	129,352	0	23,568

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 FORMER K - SRH	50 00						X	183,291	0	32,012
HARRY W ORF PHD FORMER K - GHC	50 00						X	652,563	0	56,353
SHEILA K PARTRIDGE MD FORMER K - NWH	50 00						X	917,786	0	29,971
LESLIE G SELBOVITZ MD FORMER K - NWH	0 00 50 00						X	0	380,068	0
JULIA SINCLAIR MBA FORMER K - BWH	50 00						X	534,737	0	55,358
JEFFREY R ZACK MD FORMER K - MVH	50 00						X	329,072	0	36,568

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

2017

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: 8

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
See Additional Data Table						
Total 8					0	0

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170 (b)(1)(A)(ix)**

(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")	2,656,832,804	2,661,435,392	2,365,428,359	2,967,780,415	2,904,676,698	13,556,153,668
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	2,656,832,804	2,661,435,392	2,365,428,359	2,967,780,415	2,904,676,698	13,556,153,668
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						13,556,153,668

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7 Amounts from line 4	2,656,832,804	2,661,435,392	2,365,428,359	2,967,780,415	2,904,676,698	13,556,153,668
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	156,491,976	156,187,632	150,721,645	162,554,741	149,700,026	775,656,020
9 Net income from unrelated business activities, whether or not the business is regularly carried on	415,225	978,507	1,126,666	2,007,186	28,616,078	33,143,662
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						14,364,953,350

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 2017 (line 6, column (f) divided by line 11, column (f)) | 14 | 94 370 %

15 Public support percentage for 2016 Schedule A, Part II, line 14 | 15 |

16a **33 1/3% support test—2017.** 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—2016.** 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—2017.** 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—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 2017 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2017** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2016** Schedule A, Part III, line 17	18	

19a **331/3% support tests—2017.** 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—2016.** 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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
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**		
b	A family member of a person described in (a) above?	**11b**		
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**		

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**		
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**		

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

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

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	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 2017 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-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 **Excess distributions carryover to 2018.** Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

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
PART I LINE 11G	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 MCLEAN H EALTHCARE, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUM ENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTIT Y BIOSCIENCES RESEARCH FOUNDATION, INC (I) NAME OF SUPPORTED ORGANIZATION BRIGHAM HEALT H, INC (II) EIN 04-2921338 (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 BWH RESEARCH, INC (I) NAME OF SUPPORTED ORGANIZATION BRIGHAM HEALTH, INC (II) EIN 04-2921338 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNIN G DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YE S ENTITY BRIGHAM MEDICAL RESEARCH AND EDUCATION FOUNDATION, INC (I) NAME OF SUPPORTED OR GANIZATION BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC (II) EIN 04-3466314 (III) T YPE OF ORGANIZATION 10 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY OR GANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY PARTNERS CONTINUING CARE, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, 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 THE US YES ENTITY NS MC HEALTHCARE, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING D OCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES E NTITY NORTH SHORE PHYSICIANS GROUP, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEA LTHCARE SYSTEM, 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) ORGA NIZED IN THE US YES ENTITY NEWTON-WELLESLEY HEALTH CARE SYSTEM, INC (I) NAME OF SUPPORT ED ORGANIZATION PARTNERS HEAL

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART I LINE 11G	THCARE SYSTEM, 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) ORGAN IZED IN THE US YES ENTITY NEWTON-WELLESLEY MEDICAL GROUP, INC (I) NAME OF SUPPORTED ORGA NIZATION NEWTON-WELLESLEY HOSPITAL, INC (II) EIN 04-2103611 (III) TYPE OF ORGANIZATION 03 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NOTIFY ORGANIZATION OF YOUR S UPPORT YES (VI) ORGANIZED IN THE US YES ENTITY COOLEY DICKINSON HEALTH CARE CORPORATION (I) NAME OF SUPPORTED ORGANIZATION COOLEY DICKINSON HOSPITAL, INC (II) EIN 22-2617175 (III) TYPE OF ORGANIZATION 03 (IV) ORGANIZATION LISTED IN GOVERNING DOCUMENTS YES (V) NO TIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTITY PARTNERS HEAL THCARE SP, INC (I) NAME OF SUPPORTED ORGANIZATION PARTNERS HEALTHCARE SYSTEM, INC (II) EIN 04-3230035 (III) TYPE OF ORGANIZATION 07 (IV) ORGANIZATION LISTED IN GOVERNING DOCUM ENTS YES (V) NOTIFY ORGANIZATION OF YOUR SUPPORT YES (VI) ORGANIZED IN THE US YES ENTIT Y WENTWORTH-DOUGLASS HOSPITAL & HEALTH FOUNDATION (I) NAME OF SUPPORTED ORGANIZATION WEN TWORTH-DOUGLASS HOSPITAL, INC (II) EIN 02-0260334 (III) TYPE OF ORGANIZATION 03 (IV) OR GANIZATION LISTED IN GOVERNING 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	7	Yes		0	0
(A) THE MASSACHUSETTS GENERAL HOSPITAL	041564655	7	Yes		0	0
(B) NANTUCKET COTTAGE HOSPITAL INC	042103823	3	Yes		0	0
(C) BRIGHAM HEALTH INC	042921338	7	Yes		0	0
(D) BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	043466314	10	Yes		0	0
(E) NEWTON-WELLESLEY HOSPITAL INC	042103611	3	Yes		0	0
(F) COOLEY DICKINSON HOSPITAL INC	222617175	3	Yes		0	0
(G) WENTWORTH-DOUGLASS HOSPITAL INC	020260334	3	Yes		0	0

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

2017

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

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

- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of 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 (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

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

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

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

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

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

If the amount on line 1e, column (a) or (b) is:	**The lobbying nontaxable amount is:**
Not over $500,000	20% of the amount on line 1e
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000
Over $17,000,000	$1,000,000

		(a)	(b)
g	Grassroots nontaxable amount (enter 25% of line 1f)		
h	Subtract line 1g from line 1a If zero or less, enter -0-		
i	Subtract line 1f from line 1c If zero or less, enter -0-		

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

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

Lobbying Expenditures During 4-Year Averaging Period

	Calendar year (or fiscal year beginning in)	**(a)** 2014	**(b)** 2015	**(c)** 2016	**(d)** 2017	**(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)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		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		5,436,324
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total Add lines 1c through 1i			5,436,324
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 2018 90 14% OF ITS MEMBERSHIP DUES WERE USED FOR LOBBYING PURPOSES

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
2017
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	2,532,477,579	3,023,915,930	1,980,532,089	2,017,884,170	1,879,867,173
b Contributions	76,242,054	133,195,286	108,124,301	117,220,932	63,279,981
c Net investment earnings, gains, and losses	165,166,784	405,602,632	137,625,554	-71,620,457	165,579,197
d Grants or scholarships					
e Other expenditures for facilities and programs	-72,883,419	117,629,018	91,920,278	82,952,557	90,842,181
f Administrative expenses			120,543		
g End of year balance	2,701,002,998	3,445,084,830	2,134,241,123	1,980,532,088	2,017,884,170

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

a Board designated or quasi-endowment ▶ 46 000 %

b Permanent endowment ▶ 27 000 %

c Temporarily restricted endowment ▶ 27 000 %

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	147,069,299		166,082,552
b Buildings	753,078	6,673,005,322	3,464,838,690	3,208,919,710
c Leasehold improvements		279,535,229	164,286,813	115,248,416
d Equipment		2,231,178,921	868,339,277	1,362,839,644
e Other		717,654,114	14,118,135	703,535,979
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				5,556,626,301

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) PARTNERS POOLED INVESTMENT HOLDINGS, LLC	8,369,362,704	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶	8,369,362,704	

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	247,631,668
(2) INV IN NET ASSETS OF AFFIL	1,215,626,492
(3) OTHER ASSETS	606,075,301
(4) INTER-ENTITY NOTE RECEIVABLE	57,764,122
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	2,127,097,583

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	397,368,898
PARTNERS HEALTHCARE SYSTEM CAP	3,700,760,907
CURRENT PORTION OF SETTLEMENT	41,399,761
UNEXPENDED FUNDS ON RESEARCH GRANTS	284,057,368
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	4,423,586,934

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 SIMILAR ASSETS THE COLLECTIONS ARE COMPRISED PRINCIPALLY OF MEDICAL ARTIFACTS AND ANTIQUITIES INCLUDING SURGICAL EQUIPMENT THE COLLECTIONS ALSO INCLUDE WORKS OF ART INCLUDING SCULPTURES, PICTURES, PORTRAITS AND PLAQUES THESE ITEMS WERE OBTAINED BY THE ORGANIZATION OVER MANY 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 IN 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

SCHEDULE E (Form 990 or 990-EZ)

Department of the Treasury

Schools

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 13, or Form 990-EZ, Part VI, line 48.

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

2017

Open to Public Inspection

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

Employer identification number
90-0656139

Part I

			YES	NO
1	Does the organization have a racially nondiscriminatory policy toward students by statement in its charter, bylaws, other governing instrument, or in a resolution of its governing body?	1	Yes	
2	Does the organization include a statement of its racially nondiscriminatory policy toward students in all its brochures, catalogues, and other written communications with the public dealing with student admissions, programs, and scholarships?	2	Yes	
3	Has the organization publicized its racially nondiscriminatory policy through newspaper or broadcast media during the period of solicitation for students, or during the registration period if it has no solicitation program, in a way that makes the policy known to all parts of the general community it serves? If "Yes," please describe If "No," please explain If you need more space use Part II	3	Yes	
4	Does the organization maintain the following?			
a	Records indicating the racial composition of the student body, faculty, and administrative staff?	4a	Yes	
b	Records documenting that scholarships and other financial assistance are awarded on a racially nondiscriminatory basis?	4b	Yes	
c	Copies of all catalogues, brochures, announcements, and other written communications to the public dealing with student admissions, programs, and scholarships?	4c	Yes	
d	Copies of all material used by the organization or on its behalf to solicit contributions? If you answered "No" to any of the above, please explain If you need more space, use Part II	4d	Yes	
5	Does the organization discriminate by race in any way with respect to			
a	Students' rights or privileges?	5a		No
b	Admissions policies?	5b		No
c	Employment of faculty or administrative staff?	5c		No
d	Scholarships or other financial assistance?	5d		No
e	Educational policies?	5e		No
f	Use of facilities?	5f		No
g	Athletic programs?	5g		No
h	Other extracurricular activities? If you answered "Yes" to any of the above, please explain If you need more space, use Part II	5h		No
6a	Does the organization receive any financial aid or assistance from a governmental agency?	6a	Yes	
b	Has the organization's right to such aid ever been revoked or suspended? If you answered "Yes" to either line 6a or line 6b, explain on Part II	6b		No
7	Does the organization certify that it has complied with the applicable requirements of sections 4 01 through 4 05 of Rev Proc 75-50, 1975-2 C B 587, covering racial nondiscrimination? If "No," explain on Part II	7	Yes	

Part II **Supplemental Information.** Provide the explanations required by Part I, lines 3, 4d, 5h, 6b, and 7, as applicable Also provide any other additional information (see instructions)

Return Reference	Explanation
SCHEDULE E QUESTION 3	THE INSTITUTE PUBLISHES ITS NON-DISCRIMINATORY POLICY IN ITS ONLINE COURSE CATALOG ON ITS WEBSITE, WWW MGHIHP EDU, THIS CATALOG IS ALSO AVAILABLE AS A PRINTED DOCUMENT UPON REQUEST AS PART OF ITS ORIENTATION, THE INSTITUTE NOTIFIES NEWLY MATRICULATED STUDENTS REGARDING THE WEB ADDRESS OF THE ONLINE CATALOG CONTINUING STUDENTS ALSO RECEIVE AN ANNUAL NOTICE REGARDING THE WEB ADDRESS INDIVIDUALS INQUIRING ABOUT THE INSTITUTE'S PROGRAMS RECEIVE PROGRAM INFORMATION THAT STATES THE INSTITUTE'S NON-DISCRIMINATORY POLICY THE INSTITUTE'S APPLICATION FOR ADMISSION ALSO INCLUDES A STATEMENT ON THIS POLICY
SCHEDULE E LINE 6A	THE INSTITUE EXTENDS FINANCIAL ASSISTANCE TO STUDENTS IN THE FORM OF GRANTS, LOANS, GRADUATE ASSISTANTSHIPS AND SCHOLARSHIPS IN ACCORDANCE WITH INSTITUTIONAL AND FEDERAL POLICY THE SELECTION FROM THE QUALIFIED STUDENT POPULATION FOR GRANT AND SCHOLARSHIP AID IS BASED ON MERIT AND/OR NEED, AS SPECIFIED BY THE CRITERIA OF EACH GRANT AND SCHOLARSHIP STUDENTS INDEPENDENTLY APPLY FOR GRADUATE ASSISTANTSHIPS AND ARE INFORMED OF SUCH OPPORTUNITIES AS THEY ARISE LOAN QUALIFICATIONS ARE DETERMINED IN ACCORDANCE WITH FEDERAL POLICY FINANCIAL AID AWARDS ARE MADE ON A NON-DISCRIMINATORY BASIS

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

OMB No 1545-0047

2017

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	3			130,378,881
b Total from continuation sheets to Part I					39,018,140
c **Totals** (add lines 3a and 3b)	0	4			169,397,021

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, do not file with Form 990)*

☐ Yes ☑ No

3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)*

☑ Yes ☐ No

4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*

☑ Yes ☐ No

5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*

☑ Yes ☐ No

6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, do not file with Form 990)*

☑ Yes ☐ No

Part V Supplemental Information

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

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	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	172,995
CENTRAL AMERICA & THE CARRIBEAN	0	0	PROGRAM SERVICES	JOINTLY OWNED FOR INS	111,593,983

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	348,017
EAST ASIA AND THE PACIFIC	0	1	PROGRAM SERVICES	PAT CARE, RES & EDUC	2,235,919

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	2,927,823
EUROPE	0	2	PROGRAM SERVICES	PAT CARE, RES & EDUC	8,229,735

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
EUROPE	0	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	4,437,598
MIDDLE EAST AND NORTH AFRICA	0	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	432,811

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	385,170
NORTH AMERICA	0	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	10,043,967

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	900,398
RUSSIA AND NEWLY INDEPENDENT STATES	0	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	80,330

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
RUSSIA AND NEWLY INDEPENDENT STATES	0	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	2,000
SOUTH AMERICA	0	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	320,357

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	4,420,549
SOUTH ASIA	0	0	PROGRAM SERVICES	PAT CARE, RES & EDUC	1,182,343

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	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	3,201,361
SUB-SAHARAN AFRICA	0	1	PROGRAM SERVICES	PAT CARE, RES & EDUC	1,304,259

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
SUB-SAHARAN AFRICA	0	0	PROGRAM SERVICES	INTERNATIONAL GRANTS	17,177,406

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)
		CENTRAL AMERICA AND THE CARIBBEAN	RESEARCH	348,017	WIRE TRANSFER			
		EAST ASIA AND THE PACIFIC	RESEARCH	2,889,489	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)
		EUROPE	RESEARCH	4,357,824	WIRE TRANSFER			
		MIDDLE EAST AND NORTH AFRICA	RESEARCH	385,170	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)
		NORTH AMERICA	RESEARCH	887,498	WIRE TRANSFER			
		SOUTH AMERICA	RESEARCH	4,416,549	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 ASIA	RESEARCH	3,201,361	WIRE TRANSFER			
		SUB-SAHARAN AFRICA	RESEARCH	17,155,384	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,	7	38,333	WIRE TRANSFER			
MEDICAL RESEARCH	EUROPE (INCLUDING ICELAND & GREENLAND) - ALBANIA, ANDORRA, AUSTRIA, BELGIU	13	79,774	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	4	12,900	WIRE TRANSFER			
MEDICAL RESEARCH	RUSSIA AND NEIGHBORING STATES - ARMENIA, AZERBIJAN, BELARUS,	1	2,000	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,	1	4,000	WIRE TRANSFER			
MEDICAL RESEARCH	SUB-SAHARAN AFRICA	4	22,022	WIRE TRANSFER			

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

2017

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	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 THE MOXIE AGENCY 535 ALBANY ST 5 FL BOSTON, MA 02118	FUNDRAISING STRATEGY		No	4,166,919	9,000	4,157,919
2 CCS CONSULTING SERVICES 155 FEDERAL ST SUITE 306 BOSTON, MA 02110	FUNDRAISING STRATEGY		No	943,075	177,875	765,200
3 BENTZ WHALEY FLESSNER 7251 OHMS LN MINNEAPOLIS, MN 02114	FUNDRAISING STRATEGY		No	0	45,233	-45,233
4 MARTS & LUNDY 1200 WALL ST W LYNDHURST, NJ 07071	FUNDRAISING STRATEGY		No	0	259,169	-259,169
5 THE MENTIBUS GROUP LLC 925 NORTH GAYOSO ST NEW ORLEANS, LA 70119	FUNDRAISING STRATEGY		No	0	19,240	-19,240
6 PLENTY CONSULTING 613 FRANKLIN ST SUITE A MICHIGAN CITY, IN 46360	FUNDRAISING STRATEGY		No	0	11,734	-11,734
7 RASKY 70 FRANKLIN ST 3 FL BOSTON, MA 02110	FUNDRAISING STRATEGY		No	0	5,250	-5,250
8 PGCALC 129 MOUNT AUBURN ST CAMBRIDGE, MA 02138	FUNDRAISING STRATEGY		No	0	79,200	-79,200
9						
10						
Total ▶				5,109,994	606,701	4,503,293

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.

		(a) Event #1 2018 POPS (event type)	(b) Event #2 2018 ASPIRE GALA (event type)	(c) Other events 259 (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts	3,419,443	2,511,525	24,756,173	30,687,141
	2 Less Contributions	3,027,677	2,303,225	23,106,597	28,437,499
	3 Gross income (line 1 minus line 2)	391,766	208,300	1,649,576	2,249,642
Direct Expenses	4 Cash prizes				
	5 Noncash prizes			1,322	1,322
	6 Rent/facility costs	25,000	30,593	122,815	178,408
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	1,383,630	688,242	3,609,676	5,681,548
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				5,861,278
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				-3,611,636

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

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	1 Gross revenue			166,982	166,982
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses			666	666
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☑ No	
	7 Direct expense summary Add lines 2 through 5 in column (d) ▶				666
	8 Net gaming income summary Subtract line 7 from line 1, column (d) ▶				166,316

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

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 provide any additional information (see instructions).

Return Reference	Explanation

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

2017

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 ☐ 100% ☑ 150% ☐ 200% ☐ Other ______ %	**3a**	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care ☐ 200% ☐ 250% ☑ 300% ☐ 350% ☐ 400% ☐ Other ______ %	**3b**	Yes	
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)			119,321,526	35,753,662	83,567,864	0 640 %
b Medicaid (from Worksheet 3, column a)			1,214,303,945	782,258,169	432,045,776	3 330 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			1,333,625,471	818,011,831	515,613,640	3 970 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			25,371,569	6,675,262	18,696,307	0 140 %
f Health professions education (from Worksheet 5)			224,253,118	65,536,774	158,716,344	1 220 %
g Subsidized health services (from Worksheet 6)			21,600,000		21,600,000	0 170 %
h Research (from Worksheet 7)			1,680,697,311	1,454,280,837	226,416,474	1 740 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			17,497,004		17,497,004	0 130 %
j **Total.** Other Benefits			1,969,419,002	1,526,492,873	442,926,129	3 400 %
k **Total.** Add lines 7d and 7j			3,303,044,473	2,344,504,704	958,539,769	7 370 %

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	69,480,545		
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	2,168,932,871
6	Enter Medicare allowable costs of care relating to payments on line 5	6	2,816,437,466
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-647,504,595

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

			Yes	No
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? **14** 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

		Line	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	
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)

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

			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 nonpayment?	**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

			Yes	No
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)

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

			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	
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)

Name of hospital facility or letter of facility reporting group THE BRIGHAM AND WOMEN'S HOSPITAL INC

			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 nonpayment?	**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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group THE BRIGHAM AND WOMEN'S HOSPITAL INC

		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 17			
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 17			
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)

Name of hospital facility or letter of facility reporting group NORTH SHORE MEDICAL CENTER INC

			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 nonpayment?	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group NORTH SHORE MEDICAL CENTER INC

		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 17			
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	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		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 17			
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)

Name of hospital facility or letter of facility reporting group NEWTON-WELLESLEY HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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

Name of hospital facility or letter of facility reporting group NEWTON-WELLESLEY HOSPITAL

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group NEWTON-WELLESLEY HOSPITAL

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

		Line	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	
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)

Name of hospital facility or letter of facility reporting group BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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

Name of hospital facility or letter of facility reporting group BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group BRIGHAM AND WOMEN'S FAULKNER HOSPITAL

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☑ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**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 17			
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)

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

			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

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

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	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

		Yes	No
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 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	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		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	
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)

Name of hospital facility or letter of facility reporting group: THE SPAULDING REHABILITATION HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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 nonpayment?	**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

		Yes	No
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)

Name of hospital facility or letter of facility reporting group THE SPAULDING REHABILITATION HOSPITAL

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

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	
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)

Name of hospital facility or letter of facility reporting group REHABILITATION HOSPITAL OF THE CAPE

			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

Name of hospital facility or letter of facility reporting group REHABILITATION HOSPITAL OF THE CAPE

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group REHABILITATION HOSPITAL OF THE CAPE

		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 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	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		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 17			
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)

Name of hospital facility or letter of facility reporting group SPAULDING HOSPITAL - CAMBRIDGE INC

			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 nonpayment?	**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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group SPAULDING HOSPITAL - CAMBRIDGE INC

		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 17			
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 17			
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)

Name of hospital facility or letter of facility reporting group NANTUCKET COTTAGE HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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 nonpayment?	**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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group NANTUCKET COTTAGE HOSPITAL

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

Name of hospital facility or letter of facility reporting group: MARTHA'S VINEYARD HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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 nonpayment?	**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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group MARTHA'S VINEYARD HOSPITAL

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

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 17			
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 17			
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)

Name of hospital facility or letter of facility reporting group NORTH SHORE MEDICAL CENTER INC

			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

Name of hospital facility or letter of facility reporting group NORTH SHORE MEDICAL CENTER INC

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group NORTH SHORE MEDICAL CENTER INC

		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

		Line	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	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	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)

Name of hospital facility or letter of facility reporting group COOLEY DICKINSON HOSPITAL INC

			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 nonpayment?	**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

			Yes	No
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 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 WENTWORTH-DOUGLASS HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 14

			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	Yes	
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)

Name of hospital facility or letter of facility reporting group: WENTWORTH-DOUGLASS HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	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 250 000000000000 % and FPG family income limit for eligibility for discounted care of 250 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

Name of hospital facility or letter of facility reporting group WENTWORTH-DOUGLASS HOSPITAL

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	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

			Yes	No
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)

Name of hospital facility or letter of facility reporting group WENTWORTH-DOUGLASS HOSPITAL

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

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? **93**

	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 IDEASEVERYTHING FROM RECYCLING BLUE WRAP, THE MATERIALS THAT WRAP SURGICAL INSTRUMENTS FOR OPERATING ROOMS, TO REPLACING BOTTLED WATER WITH FILTERED TAP WATER ON PATIENT FLOORSAND 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 $165,861 AND $139,554 IN 2018 AND 2017, RESPECTIVELY THE ESTIMATED COST OF PROVIDING THESE SERVICES WAS APPROXIMATELY $60,660 AND $49,501 FOR 2018 AND 2017, 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

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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 APERIOD 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'18 COMMUNITY BENEFIT REPORTS THAT WERE FILED WITH THE MASSACHUSETTS ATTORNEY GENERAL FOUND AT HTTPS //MASSAGO ONBASEONLINE COM/MASSAGO/1801CBS/ANNUALREPORT ASPXWENTWORTH-DOUGLASS FILES IT COMMUNITY BENEFIT REPORT WITH THE NH DEPARTMENT OF JUSTICE FOUND AT HTTPS //WWW DOJ NH GOV/CHARITABLE-TRUSTS/COMMUNITY-BENEFITS-2018 HTM

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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 TOPROVIDE 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 INSTATES OTHER THAN MASSACHUSETTS), AND PROVIDING INFORMATION REGARDING ALL ACCEPTABLE METHODS OFPAYMENT OF THE HOSPITAL BILL THE HOSPITAL WILL ENCOURAGE PATIENTS WHO ARE POTENTIALLY ELIGIBLE FORCOVERAGE FROM STATE PROGRAMS OR OTHER GOVERNMENT PROGRAMS TO APPLY FOR COVERAGE AND SHALL ASSISTTHE PATIENT IN APPLYING FOR BENEFITS PATIENTS MAY ALSO APPLY FOR AND BE APPROVED FOR COVERAGE BYTHE 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 ANDDESCRIBE WHERE TO GO TO FOR ASSISTANCE IN THE FOLLOWING LOCATIONS 1 INPATIENT, CLINIC, EMERGENCY DEPARTMENT, AND COMMUNITY HEALTH CENTER ADMISSION AND/ORREGISTRATION 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 LANGUAGEOF 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 PARTNERSHEALTHCARE 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-POCKETLIABILITY COMPLETE COPIES OF THIS POLICY AND THE PHS FINANCIAL ASSISTANCE POLICY AND PHSUNINSURED PATIENT DISCOUNT POLICY WILL ALSO BE MADE AVAILABLE TO PATIENTS AS REQUIRED BOTH POLICIESWILL ALSO BE POSTED ON THE INTERNET AT WWW PARTNERS ORG/PATIENTBILLING WITH LINKS TO THE HOMEPAGES OFALL HOSPITAL ENTITIES IN READILY IDENTIFIABLE LOCATIONS WENTWORTH-DOUGLASS WDH AND WDPC TAKE AN ACTIVE ROLE IN ASSISTING PATIENTS WHO MAY BE INTERESTED AND QUALIFY FOR FINANCIAL ASSISTANCE, WHETHER IT IS STATE, FEDERAL OR OUR OWN CHARITY CARE BENEFITS OUR FAMILY RESOURCE/COMMUNITY BENEFITS DEPARTMENT HAS SEVERAL PROCESSES IN PLACE TO ENSURE PATIENTS ARE AWARE OF THE FINANCIAL ASSISTANCE AVAILABLE TO THEM PATIENTS CAN LEARN MORE ABOUT THESE PROGRAMS BY VISITING OUR WEBSITE, READING OUR FOUNDATION NEWSLETTER, OR CONTACTING OUR FINANCIAL ASSISTANCE OFFICE FROM THE TIME OF REGISTRATION THROUGH OUR BILLING PROCESS, PATIENTS HAVE AVAILABLE THE OPPORTUNITY TO OBTAIN AN APPLICATION FOR FINANCIAL ASSISTANCE AS WELL AS OUR FINANCIAL ASSISTANCE POLICY ALL SELF-PAY PATIENTS AT THE TIME OF REGISTRATION ARE PROVIDED WITH OUR CHARITY CARE COVER LETTER AND APPLICATION, WITH INFORMATION ABOUT THE CHARITY CARE PROGRAM AND DETAILS ON HOW TO CONTACT OUR FINANCIAL ASSISTANCE REPRESENTATIVE(S) OUR REPRESENTATIVES ALSO SEE MANY PATIENTS WHILE THEY ARE HERE FOR SERVICES SOCIAL WORK SERVICES AND COMMUNITY BENEFITS TEAM UP TO ASSIST AND MAKE SURE OUR PATIENTS ARE RECEIVING THE OPPORTUNITIES TO GET ANY AND ALL ASSISTANCE AVAILABLE TO THEM WE SEND FIVE BILLING STATEMENTS TO OUR PATIENTS WITH THE FINANCIAL ASSISTANCE GUIDELINES AND CONTACT INFORMATION IF PATIENTS FEEL THEY MAY MEET THESE GUIDELINES AND NEED ASSISTANCE WITH THEIR BILL(S)
PART VI, LINE 4	PARTNERS 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 THROUGH INITIATIVES THAT INCLUDE ACCESS TO HEALTH CARE, PREVENTION, AND WORKFORCE DEVELOPMENT, PARTNERS AND ITS HOSPITALS ARE MAKING A DIFFERENCE IN THE COMMUNITIES IN WHICH WE LIVE AND WORK PARTNERS HAS A DEEP COMMITMENT TO COMMUNITY HEALTH CENTERS SINCE ITS FOUNDING IN 1994, PARTNERS AND ITS HOSPITALS HAVE PROVIDED MORE THAN $83M TO ENSURE THAT HEALTH CENTERS HAVE THE SPACE AND TECHNOLOGY THEY NEED TO PROVIDE PATIENTS WITH EXCELLENT CARE HTTPS //MASSAGO ONBASEONLINE COM/MASSAGO/1801CBS/DISPLAYREPORT ASPX?SID=02B56074F26C3DD3109B538C0F4F5C51&OBJID=0B30C19D43CFD489FB7398F844FD830D

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 AND WENTWORTH-DOUGLASS 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 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 AND THE NEW HAMPSHIRE DEPARTMENT OF JUSTICE IN THE CASE OF WENTWORTH-DOUGLASS HOSPITAL COORDINATING ACTIVITIES ON A SYSTEM-WIDE BASIS IS MATT FISHMAN, VICE PRESIDENT FOR COMMUNITY HEALTH FOR PARTNERS HEALTHCARE

Additional Data

Software ID:
Software Version:
EIN: 90-0656139
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? **14** 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			

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? 14 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? **14** 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			
14	WENTWORTH-DOUGLASS HOSPITAL 789 CENTRAL AVENUE DOVER, NH 03820 WWW WDHOSPITAL COM 02-0260334	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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
THE GENERAL HOSPITAL CORPORATION	PART V, SECTION B, LINE 5 BEGINNING FEBRUARY 2016, MGH CCHI WORKED WITH ITS MULTISECTOR 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
NORTH SHORE MEDICAL CENTER, INC	PART V, SECTION B, LINE 5 THE CHNA ENGAGED THE DIVERSE PERSPECTIVES OF RESIDENTS ACROSS THE NSMC SERVICE AREA AND WAS GUIDED BY A SOCIAL DETERMINANTS OF HEALTH FRAMEWORK, RECOGNIZING THAT MULTIPLE FACTORS AFFECT COMMUNITY HEALTH AND WELL-BEING QUANTITATIVE DATA THAT PROVIDE INSIGHT INTO THE SOCIAL, ECONOMIC, AND HEALTH-RELATED OUTCOMES OF THE NSMC SERVICE AREA WERE DRAWN FROM NATIONAL AND STATE SOURCES (E G , U S CENSUS, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, ETC) QUANTITATIVE DATA WAS SUPPLEMENTED BY A COMMUNITY FORUM IN LYNN INVOLVING SIX SMALL GROUP DISCUSSIONS WITH A TOTAL OF 40 PARTICIPANTS, FIVE FOCUS GROUPS WITH 55 PARTICIPANTS TOTAL, AND 20 KEY INFORMANT INTERVIEWS CONDUCTED FROM JANUARY TO MAY 2018 TO UNDERSTAND PARTICIPANTS' PERCEPTIONS OF THEIR COMMUNITIES, HEALTH NEEDS AND ASSETS, AND SUGGESTIONS FOR FUTURE PROGRAMMING AND SERVICES TO ADDRESS THESE 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
NEWTON-WELLESLEY HOSPITAL	PART V, SECTION B, LINE 5 THE CHNA USED A PARTICIPATORY, COLLABORATIVE APPROACH AND EXAMINED HEALTH IN ITS BROADEST CONTEXT AS PART OF THIS ASSESSMENT, NWH SOUGHT INPUT FROM ITS COMMUNITY BENEFITS COMMITTEE TO INFORM THE METHODOLOGY, INCLUDING RECOMMENDATION OF SECONDARY DATA SOURCES, AND IDENTIFICATION OF KEY INFORMANTS AND FOCUS GROUP SEGMENTS THE ASSESSMENT PROCESS INCLUDED SYNTHESIZING EXISTING DATA ON SOCIAL, ECONOMIC, AND HEALTH INDICATORS FROM VARIOUS SOURCES, AS WELL AS, CONDUCTING EIGHT INTERVIEWS AND SIX FOCUS GROUPS TO EXPLORE PERCEPTIONS OF THE COMMUNITY, HEALTH AND SOCIAL CHALLENGES FOR COMMUNITY MEMBERS, AND RECOMMENDATIONS FOR HOW TO ADDRESS THESE CONCERNS IN TOTAL, OVER 50 INDIVIDUALS WERE ENGAGED IN THE 2018 ASSESSMENT PROCESS

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 / REGIONALMOUNT 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 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=47540385STATECOMMONWEALTH 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 PDF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH OPIOID-RELATED OVERDOSE DATAHTTP //WWW MASS GOV/EOHHS/GOV/DEPARTMENTS/DPH/STOP-ADDICTION/CURRENT-STATISTICS HTMLTASK 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 DOCXMASSACHUSETTS 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 PDF 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 PDFBEHAVIORAL 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 PDFMCLEAN 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 ADDR ESSING NANTUCKET'S HUMAN SERVICES NEEDS THE SECOND FOCUS GROUP WAS CONDUCTED DURING A SPE CIAL MEETING OF NANTUCKET COTTAGE HOSPITAL'S PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) T HE PFAC, A STANDING COMMITTEE OF NCH, SEEKS THE COMMUNITY'S FEEDBACK AND INVOLVEMENT TO IM PROVE CARE AT NCH, AND HELPS THE HOSPITAL FULFILL ITS MISSION TO MEET THE NEEDS OF AN INCR EASINGLY DIVERSE AND EXPANDING NANTUCKET COMMUNITY A SEMI STRUCTURED GUIDE WAS USED DURIN G 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 2015 NANTUCKET QUALITY OF LIFE SURVEY WAS DISTRIBUTED THROUGHOUT ALL PATIENT WAITING AREAS WITH IN 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 PERIOD WA S ANNOUNCED IN THE ISLAND NEWSPAPER, THE INQUIRER AND MIRROR, AND POSTED ON A LOCAL MEDIA WEBSITE, THE NANTUCKET CHRONICLE AN ELECTRONIC VERSION OF THE SURVEY WAS POSTED ON THE NC H WEB SITE DURING MAY AND JUNE, AS WELL AS THE TOWN OF NANTUCKET'S WEB SITE, AND THE TOWN OF NANTUCKET BOARD OF HEALTH'S WEB SITE THE ELECTRONIC VERSION WAS ALSO SENT TO ISLAND RE SIDENTS VIA E-NEWSLETTERS FROM NCH AND THE TOWN OF NANTUCKET PHYSICAL COPIES OF THE SURVE Y WERE DISTRIBUTED AT SEVERAL OTHER LOCATIONS AROUND THE ISLAND, INCLUDING THE SALTMARSH S ENIOR CENTER, THE NANTUCKET CO

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
NANTUCKET COTTAGE HOSPITAL	MMUNITY SCHOOL, AND ST MARY'S CHURCH, AND COLLECTED BY NCH STAFF FOLLOWING THE CLOSE OF T HE 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
NORTH SHORE MEDICAL CENTER, INC	PART V, SECTION B, LINE 5 THE CHNA ENGAGED THE DIVERSE PERSPECTIVES OF RESIDENTS ACROSS THE NSMC SERVICE AREA AND WAS GUIDED BY A SOCIAL DETERMINANTS OF HEALTH FRAMEWORK, RECOGNIZING THAT MULTIPLE FACTORS AFFECT COMMUNITY HEALTH AND WELL-BEING QUANTITATIVE DATA THAT PROVIDE INSIGHT INTO THE SOCIAL, ECONOMIC, AND HEALTH-RELATED OUTCOMES OF THE NSMC SERVICE AREA WERE DRAWN FROM NATIONAL AND STATE SOURCES (E G , U S CENSUS, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, ETC) QUANTITATIVE DATA WAS SUPPLEMENTED BY A COMMUNITY FORUM IN LYNN INVOLVING SIX SMALL GROUP DISCUSSIONS WITH A TOTAL OF 40 PARTICIPANTS, FIVE FOCUS GROUPS WITH 55 PARTICIPANTS TOTAL, AND 20 KEY INFORMANT INTERVIEWS CONDUCTED FROM JANUARY TO MAY 2018 TO UNDERSTAND PARTICIPANTS' PERCEPTIONS OF THEIR COMMUNITIES, HEALTH NEEDS AND ASSETS, AND SUGGESTIONS FOR FUTURE PROGRAMMING AND SERVICES TO ADDRESS THESE ISSUES

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 TH AT INCLUDED REPRESENTATIVES FROM EACH HOSPITAL/INSURER COALITION MEMBER AS WELL AS PUBLIC HEALTH AND COMMUNITY STAKEHOLDERS FROM EACH HOSPITAL SERVICE AREA STAKEHOLDERS ON THE STE ERING COMMITTEE INCLUDED LOCAL AND REGIONAL PUBLIC HEALTH AND HEALTH DEPARTMENT REPRESENTA TIVES, REPRESENTATIVES FROM LOCAL AND REGIONAL ORGANIZATIONS SERVING OR REPRESENTING MEDIC ALLY UNDERSERVED, LOW-INCOME OR MINORITY POPULATIONS, AND INDIVIDUALS FROM ORGANIZATIONS T HAT REPRESENTED THE BROAD INTERESTS OF THE COMMUNITY WHEN IDENTIFYING COMMUNITY AND PUBLI C HEALTH REPRESENTATIVES TO PARTICIPATE, A STAKEHOLDER ANALYSIS WAS CONDUCTED BY THE COALI TION AND CONSULTANTS TO ENSURE GEOGRAPHIC, SECTOR (E G SCHOOLS, COMMUNITY SERVICE ORGANIZ ATIONS, HEALTHCARE PROVIDERS, PUBLIC HEALTH, AND HOUSING) AND RACIAL/ETHNIC DIVERSITY OF C OMMUNITY REPRESENTATIVES BY INCLUDING THESE STAKEHOLDERS ON THE STEERING COMMITTEE, THE C OMMUNITY AND PUBLIC HEALTH REPRESENTATIVES HAD INPUT ON THE CHNA PROCESS USED TO IDENTIFY AND PRIORITIZE COMMUNITY HEALTH NEEDS, CHNA FINDINGS, AND DISSEMINATION OF INFORMATION AS SESSMENT METHODS AND FINDINGS WERE MODIFIED BASED ON STEERING COMMITTEE FEEDBACK THE STEE RING 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 PRIORITY H EALTH NEEDS AND ENGAGE THE COMMUNITY KEY INFORMANT INTERVIEWS WERE CONDUCTED WITH HEALTH CARE PROVIDERS, HEALTH CARE ADMINISTRATORS, LOCAL AND REGIONAL PUBLIC HEALTH OFFICIALS, AN D LOCAL ORGANIZATIONAL LEADERS THAT REPRESENT THE BROAD INTERESTS OF THE COMMUNITY OR THAT SERVE MEDICALLY UNDERSERVED, LOW-INCOME OR COMMUNITIES OF COLOR POPULATIONS IN THE SERVIC E AREA INTERVIEWS WITH THE LOCAL AND REGIONAL PUBLIC HEALTH OFFICIALS WERE USED TO IDENTI FY CURRENT AND EMERGING HIGH PRIORITY HEALTH AREAS AND HEALTHCARE AND COMMUNITY FACTORS TH AT CONTRIBUTE TO HEALTH NEEDS FOCUS GROUP PARTICIPANTS INCLUDED INDIVIDUALS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY, INCLUDING COMMUNITY ORGANIZATIONAL REPRESENTATIVES, VULNERABLE POPULATION COMMUNITY MEMBERS (E G LOW-INCOME, PEOPLE OF COLOR), AND OTHER COMM UNITY STAKEHOLDERS TOPICS INCLUDED HEALTH NEEDS FOR TRANSGENDER AND LESBIAN POPULATIONS, VETERANS AND MILITARY FAMILIES, MATERNAL AND INFANT/CHILD HEALTH, AND FOR INDIVIDUALS WIT H MENTAL HEALTH AND SUBSTANCE USE CONDITIONS KEY INFORMANT INTERVIEWS AND FOCUS GROUPS WE RE CONDUCTED FROM FEBRUARY 2016 APRIL 2016 A PRELIMINARY CHNA FINDINGS REVIEW MEETING WAS HELD WITH HOSPITAL AND COMMUNITY REPRESENTATIVES TO VET FINDINGS AND OBTAIN INPUT ON WHET HER FINDINGS RESONATED WITH TH

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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

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

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Form and Line Reference	Explanation
WENTWORTH-DOUGLASS HOSPITAL	PART V, SECTION B, LINE 5 WENTWORTH-DOUGLASS HOSPITAL HELD TWENTY-ONE (21) FOCUS GROUPS AND INTERVIEWS TO ENGAGE CONSUMERS, PROVIDERS AND KEY LEADERS IN THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PARTICIPANTS WERE IDENTIFIED AND RECRUITED BY THE HOSPITAL, INCLUDING MEMBERS OF THE PUBLIC, COMMUNITY ORGANIZATIONS, LOCAL GOVERNMENT OFFICIALS, AND HEALTH, EDUCATION AND SOCIAL SERVICE PROVIDERS PARTICIPANTS WERE FROM GEOGRAPHIC AREAS THAT REPRESENT OUR COMMUNITY OR WHO REPRESENT VARIOUS STAKEHOLDER GROUPS SUCH AS PUBLIC HEALTH REPRESENTATIVES, FIRST RESPONDERS, THE LOCAL HOUSING AUTHORITY, SCHOOL NURSES, AND OTHERS GROUPS ALSO INCLUDED PHYSICIANS, NURSES, SOCIAL WORKERS, AND PROGRAM DIRECTORS A SUMMARY OF THE THEMESFROM THE STAKEHOLDER INTERVIEWS, AS WELL AS DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS AND THEIR RATINGS ARE INCLUDED IN THE 2016 CHNA 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
WENTWORTH-DOUGLASS HOSPITAL	PART V, SECTION B, LINE 6A THE HOSPITAL'S MOST RECENT CHNA WAS CONDUCTED WITH WENTWORTH-DOUGLASS PHYSICIAN CORP (WDPC), A RELATED 501(C) (3) ENTITY

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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/WP-CONTENT/UPLOADS/2019/07/NCH-CHNA-FY18 PDFMARTHA'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/WENTWORTH-DOUGLASS HOSPITALHTTPS //WWW WDHOSPITAL ORG/FILES/3314/7976/1169/WENTWORTH_DOUGLASS_HOSPITAL_CHNA_FINAL PDFHTTPS //WWW WDHOSPITAL ORG/FILES/9214/7976/1451/WENTWORTH-DOUGLASS_-_IMPLEMENTATION_STRATEGY_-_FINAL PDF

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 STRESSMANAGEMENT SKILL BUILDING TO STUDENTS--SUPPORT COALITI ON YOUTH GROUP TO CREATE STRESS MANAGEMENT OPPORTUNITIES WITH THEIR PEERS STRATEGY 6 IMPL EMENT SOCIAL MARKETING CAMPAIGN TO INCREASE PERCEPTION OF HARM OF ADOLESCENT MARIJUANA USE --DEVELOP AND IMPLEMENT ORIGINAL MEDIA CAMPAIGN ABOUT LOCAL YOUTH SUBSTANCE USE ISSUES, IN CLUDING LOCAL YRBS DATA, EDUCATION ON RECREATIONAL MARIJUANA, INCREASING AWARENESS OF MARI JUANA USE AND ITS EFFECTS ON THE DEVELOPING TEEN BRAIN--CREATE AND MAINTAIN SOCIAL MEDIA A CCOUNTS TO PROMOTE YOUTH CAMPAIGN AND OTHER YOUTH RELATED COMMUNITY & COALITION ACTIVITIES (INSTAGRAM, FACEBOOK, TWITTER)STRATEGY 7 COLLABORATE WITH SCHOOLS AND ORGANIZATIONS TO I NCORPORATE A CURRICULUM THAT ADDRESSES SUBSTANCE USE AND MENTAL WELL BEING--INVESTIGATE CU RRENT HEALTH PREVENTION CURRICULA IN SCHOOLS & COMMUNITY, COMMUNICATE RESULTS TO ALL STAKE HOLDERS--IDENTIFY OPPORTUNITIE

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	S TO STRENGTHEN/INCREASE IMPLEMENTATION OF EVIDENCE BASED PREVENTION CURRICULA AND HEALTH EDUCATION IN SCHOOLS, AFTER SCHOOL PROGRAMS, AND COMMUNITY ORGANIZATIONS THE BRIGHAM AND W OMEN'S HOSPITAL, INC OBJECTIVE PROVIDE AN INTEGRATED AND EFFECTIVE RESPONSE TO THOSE EXPER IENCING INTERPERSONAL VIOLENCE AND BUILD SYSTEM CAPACITY TO PROVIDE TRAUMA INFORMED CARE 1 1 1 INTERPERSONAL VIOLENCE--PROVIDE ADVOCACY, SAFETY PLANNING AND SUPPORTIVE COUNSELING F OR PATIENTS WHO EXPERIENCE INTERPERSONAL VIOLENCE (DOMESTIC VIOLENCE AND COMMUNITY VIOLENC E)--OFFER FREE AND CONFIDENTIAL ADVOCACY SERVICES TO THE WIDER COMMUNITY THROUGH A DOMESTI C VIOLENCE ADVOCATE BASED AT A COMMUNITY SITE --PROVIDE DIRECT INTERVENTION TO PATIENTS WH O ARE IMPACTED BY SEXUAL VIOLENCE AND HUMAN TRAFFICKING --COLLABORATE WITH KEY COMMUNITY P ARTNERS TO OFFER SUPPORTIVE VIOLENCE PREVENTION EDUCATION TO YOUNG PEOPLE IN HIGH RISK ENV IRONMENTS --COORDINATE AND COLLABORATE WITH THE CITY OF BOSTON AND LOCAL HOSPITALS ON ISSU ES OF INTERPERSONAL VIOLENCE PREVENTION AND INTERVENTION--DEVELOP AND IMPLEMENT STRATEGIES TO FURTHER INTEGRATE THE BWH RESPONSE WITH THE CITY OF BOSTON STREET-WORKER PROGRAM --DEV ELOP 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 COL LABORATION WITH THE PARTNERS TIC NETWORK, PROVIDE LEARNING OPPORTUNITIES FOR BWHC STAFF TO 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 PRIOR ITY 2 ACCESS TO HEALTHCARE STRENGTHEN ACCESS FOR COMMUNITY MEMBERS TO ENABLE IMPROVED HEAL TH OUTCOMES OBJECTIVE ADDRESS THE BARRIERS THAT HINDER ACCESS TO CARE FOR LOW INCOME PATIE NTS AND COMMUNITY MEMBERS NORTH SHORE MEDICAL CENTER, INC BOTH NSMC FACILITIESTHE KEY HE ALTH ISSUES WERE PRIORITIZED AS FOLLOWS 1 BEHAVIORAL HEALTH 2 HEALTH CARE ACCESS 3 HEA LTH CARE ENVIRONMENT AND TRUST, INCLUDING CULTURALLY SENSITIVE APPROACHES TO CARE WITHIN B EHAVIORAL HEALTH, KEY AREAS OF NEED IDENTIFIED THROUGH THE CHNA INCLUDED MENTAL HEALTH ISS UES (INCLUDING DEPRESSION, TRAUMA, AND STRESS), SUBSTANCE USE DISORDERS (INCLUDING USE OF OPIOIDS, ALCOHOL, MARIJUANA, AND VAPING), CO-OCCURRING DISORDERS, GAPS IN TREATMENT, AND S TIGMA WITHIN HEALTH CARE ACCESS, KEY AREAS OF NEED IDENTIFIED THROUGH THE CHNA INCLUDED I SSUES RELATED TO ACCESSIBILITY (TRANSPORTATION, ACCESS TO AFTER-HOURS CARE, ACCESS TO SPEC IALTY CARE), ISSUES RELATED TO HEALTH INSURANCE AND COST, AND THE NEED FOR EXPANDED CARE C OORDINATION AND NAVIGATION SERVICES WITHIN HEALTH CARE ENVIRONMENT AND TRUST, KEY AREAS O F NEED IDENTIFIED THROUGH THE CHNA INCLUDED ISSUES RELATED TO PROVIDING CULTURALLY-SENSITI VE APPROACHES TO CARE (INCLUDING TRAINING AND RETAINING A DIVERSE HEALTHCARE WORKFORCE) AN D PROVIDING SERVICES IN MULTIPLE LANGUAGES ADDITIONALLY, THE CAHAC RECOMMENDED MAINTAININ G A CROSS-CUTTING FOCUS ON VUL

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	NERABLE POPULATIONS (SUCH AS IMMIGRANTS, SENIORS, YOUTH, AND THE HOMELESS POPULATION) AND INCORPORATING HEALTH EDUCATION STRATEGIES WHEN ADDRESSING PRIORITIZED NEEDS,NEWTON-WELLESL EY HOSPITALWALTHAM, IN GENERAL OBJECTIVE WALTHAM IS A UNIQUE COMMUNITY IN THE NWH SERVICE AREA WHILE THE OTHER CITIES AND TOWNS IN THE SERVICE AREA TEND TO HAVE SIMILAR DEMOGRAPH IC PROFILES, WALTHAM LOOKS SOMEWHAT DIFFERENT WALTHAM HAS A MORE AFFORDABLE COST OF LIVIN G AND HAS MORE RACIAL AND ETHNIC DIVERSITY HOWEVER, WALTHAM RESIDENTS HAVE LOWER MEDIAN H OUSEHOLD INCOMES AND EDUCATIONAL ATTAINMENT WALTHAM ALSO EXPERIENCES DISPROPORTIONATELY W ORSE HEALTH OUTCOMES COMPARED TO THE OTHER CITIES AND TOWNS IN THE AREA BEING IDENTIFIED AS THE COMMUNITY IN NEED OF THE GREATEST NUMBER OF RESOURCES, NWH WILL SEEK TO ENGAGE WITH THE CITY OF WALTHAM THROUGH A VARIETY OF HIGH-IMPACT INITIATIVES THAT WILL ADDRESS THE AF OREMENTIONED NEEDS STRATEGIES --CREATE THE WALTHAM WELLNESS COLLABORATIVE IN PARTNERSHIP WITH HEALTHY WALTHAM --PROVIDE SCREENING MAMMOGRAMS FOR WOMEN AT THE HOME SUITES INN --PR OVIDE SCHOOL PHYSICALS FOR UNDERPRIVILEGED YOUTH --CONDUCT MENTAL WELLNESS SEMINARS FOR PA RENTS AT THE HOME SUITES INN --CONDUCT HEALTHCARE RELATED SEMINARS FOR THE HOMELESS --PROV IDE TAXI VOUCHERS TO HOMELESS SHELTERS SUBSTANCE ABUSE OBJECTIVE SUBSTANCE ABUSE WAS RAIS ED CONSISTENTLY DURING THE CHNA PROCESS DRUG USE CUTS ACROSS ALL SOCIOECONOMIC AND GEOGRA PHIC BOUNDARIES STRATEGIES --NWH WILL PROVIDE NASAL NALOXONE KITS (NARCAN) FOR USE BY FI RST 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 KITS --SPONSOR HIGH SCHOOL-BASED ON-SITE EVENT AS A MEANS FOR AN ALTERNATIVE SOCIAL OUTLET --SPONSOR ON -LINE ALCOHOL EDUCATION PROGRAM FOR 9TH GRADE STUDENTS AND PARENTS

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	BRIGHAM AND WOMEN'S FAULKNER HOSPITAL OBJECTIVE BY SEPTEMBER 2019, INCREASE AWARENESS OF CHRONIC DISEASE MANAGEMENT AND PREVENTION THROUGH EDUCATION AND SCREENINGS STROKE--EDUCATE THE COMMUNITY ON STROKE SIGNS AND SYMPTOMS AND THE IMPORTANCE OF GETTING TO THE HOSPITAL --PROVIDE A STROKE SUPPORT GROUP FOR STROKE SURVIVORS AND OR THEIR CAREGIVERS --MAINTAIN A N ACTIVE HOSPITAL BASED STROKE COMMITTEE TO ENSURE THE HIGHEST LEVEL OF CARE FOR STROKE PA TIENTS CARDIOVASCULAR DISEASE --EDUCATE THE COMMUNITY ABOUT HEART DISEASE AND DIABETES -- PROVIDE SCREENING PROGRAMS TO HELP RESIDENTS IDENTIFY AND OR MONITOR RISK FACTORS SUCH AS CHOLESTEROL LEVELS, GLUCOSE AND BLOOD PRESSURE --PARTICIPATE IN AWARENESS AND EDUCATION CA MPAIGNS --MAINTAIN A COLLABORATIVE CORE MEASURE IMPROVEMENT TEAM FOR THE PREVENTION OF CHF READMISSION DIABETES--DEVELOP AND IMPLEMENT A DIABETES EDUCATION PROGRAM BASED ON THE AA DE7 SELF-CARE BEHAVIORS --HEALTHY EATING MAKING HEALTHY FOOD CHOICES, UNDERSTANDING PORTI ON SIZES, LEARNING THE BEST TIMES TO EAT, LEARNING THE EFFECT FOOD HAS ON BLOOD GLUCOSE, R EADING LABELS, PLANNING AND PREPARING FOODS, UNDERSTANDING AND COPING WITH BARRIERS AND TR IGGERS, ETC --BEING ACTIVE REGULAR ACTIVITY FOR OVERALL FITNESS, WEIGHT MANAGEMENT, BLOO D GLUCOSE CONTROL, IMPROVE BMI, ENHANCE WEIGHT LOSS, CONTROL LIPIDS, BLOOD PRESSURE AND RE DUCE STRESS --MONITORING DAILY SELF-MONITORING OF BLOOD GLUCOSE TO HELP ASSESS HOW FOOD, PHYSICAL ACTIVITY AND MEDICATION AFFECT LEVELS MCLEAN HOSPITAL CORPORATION MCLEAN'S IMPL EMENTATION STRATEGY THAT ADDRESSES PRIORITIZED NEEDS IDENTIFIED IN THE 2016 COMMUNITY HEAL TH NEEDS ASSESSMENT WAS APPROVED BY THE MCLEAN HOSPITAL BOARD OF TRUSTEES ON SEPTEMBER 15, 2016 THE IMPLEMENTATION STRATEGY, APPROVED BY THE MCLEAN HOSPITAL BOARD OF TRUSTEES ON J ANUARY 19, 2017, FOCUSES ON PEOPLE AND FAMILIES AFFECTED BY PSYCHIATRIC ILLNESS AND SUBSTA NCE USE DISORDERS WITHIN CHNA 17 SERVICE AREAS AND MIDDLEBOROUGH FOR THE PERIOD 2017-2019 , MCLEAN'S IMPLEMENTATION STRATEGY INCLUDES EXPANDING PSYCHIATRIC SERVICES TO MEET COMMUN ITY NEEDS IMPROVING COMMUNITY MENTAL HEALTH THROUGH INNOVATIVE PROGRAMS CARING FOR UNINSUR ED AND UNDERINSURED STRENGTHENING MENTAL HEALTH THROUGH EDUCATION FOR PROFESSIONALS, CONSU MERS AND THEIR FAMILIES, AND THE PUBLIC PROVIDING COMMUNITY SUPPORT AND CONTRIBUTIONS SPAU LDING REHABILITATION HOSPITAL CORPORATION SPAULDING BOSTON'S COMMUNITY BENEFIT PROGRAM ADD RESSES FACTORS THAT IMPACT ACCESS TO CARE, AND THE HEALTH AND QUALITY OF LIFE OF OUR PATIE NTS, THEIR FAMILIES, AND THE COMMUNITIES IN WHICH THEY LIVE EVERY THREE YEARS, THROUGH CO MMUNITY HEALTH NEEDS ASSESSMENT, COLLABORATIVE PLANNING WITH COMMUNITY PARTNERS AND HOSPIT AL LEADERSHIP, AND WITH PARTICULAR ATTENTION TO THE SOCIAL DETERMINANTS OF HEALTH AND OPPO RTUNITIES FOR DISEASE PREVENTION AND WELLNESS PROMOTION, SPAULDING BOSTON DEVELOPS A COMPR EHENSIVE COMMUNITY BENEFIT PLAN BECAUSE BOSTON SPAULDING CARES FOR PATIENTS ACROSS MASSAC HUSETTS, SOME OF ITS COMMUNITY

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	BENEFIT PROGRAMS HAVE A STATEWIDE REACH GIVEN THAT OVER HALF OF SPAULDING BOSTON'S PATIE NTS RESIDE IN THIRTEEN METRO BOSTON COMMUNITIES, SEVERAL OF THE HOSPITAL'S COMMUNITY BENEF IT PROGRAMS TARGET THE METRO BOSTON AREA FINALLY, AS THE HOME OF THE SPAULDING BOSTON HOS PITAL CAMPUS, WE ARE COMMITTED TO CONTRIBUTING TO THE HEALTH AND WELL-BEING OF THE CHARLES TOWN COMMUNITY AND ITS RESIDENTS THEREFORE, SEVERAL OF SPAULDING BOSTON'S COMMUNITY BENEF IT PROGRAMS TARGET BOSTON'S CHARLESTOWN NEIGHBORHOOD REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION PRIORITY 1 ACCESS TO SPECIALTY REHABILITATION CARE GOAL 1 IDENTI FY AND REDUCE BARRIERS TO CARE STRATEGY 1 ADDRESS FINANCIAL BARRIERS TO ACCESSING CARE AC TIONS --CONTINUE TO ASSIST PATIENTS WITH APPLYING FOR STATE-FUNDED INSURANCE PROGRAMS (I E MASSHEALTH, COMMONHEALTH, CONNECTOR CARE, ETC) --CONTINUE TO ASSIST PATIENTS WITH APPL YING FOR FINANCIAL ASSISTANCE THROUGH THE PARTNERS FINANCIAL ASSISTANCE POLICY STRATEGY 2 ADDRESS TRANSPORTATION BARRIERS TO ACCESSING CARE ACTIONS --EXPLORE OPTIONS TO REMOVE T RANSPORTATION AS A BARRIER TO ACCESSING CARE IN BARNSTABLE COUNTY OPTIONS TO EXPLORE INCL UDE ---COLLABORATION WITH CCRTA/OTHER PROVIDERS --WHERE VIABLE OPTIONS ARE IDENTIFIED, SC C WILL PARTNER WITH APPROPRIATE ENTITIES TO BRING SUCH ITEMS TO FRUITION --EXPLORE THE FE ASIBILITY OF ADOPTING MODELS OF CARE THAT ENABLE DELIVERING TARGETED SERVICES OFF-SITE FOR POPULATIONS AT RISK SPAULDING HOSPITAL CAMBRIDGE PRIORITY 2 DISABILITY/ELDER SUPPORT GO AL 1 PROVIDE AND PROMOTE ACTIVITIES THAT PROMOTE SOCIAL INTERACTION AND FITNESS STRATEGY 1 CONNECT ELDER AND DISABLED PATIENTS/RESIDENTS TO COMMUNITY EVENTS ACTIONS --PROMOTE D ISABILITY REFRAMED FILM SERIES HOSTED AT SHC TO THE BROADER COMMUNITY --MAXIMIZE MARKETIN G IN LINE WITH DISABILITY AWARENESS MONTH (OCTOBER) --CONTINUE TO OFFER GROUP MUSIC THERA PY TO PATIENTS WITH NEUROLOGICAL INJURIES AND DISEASES FREE OF CHARGE FOR SHC'S INPATIENT RESIDENTS --CONTINUE TO INCLUDE RESIDENTS OF YOUVILLE HOUSE AS A PART OF MUSIC ON SUNDAY' S PROGRAM HOSTED AT SHC STRATEGY 2 OFFER PROGRAMS FOR DISABLED RESIDENTS TO ENGAGE IN FI TNESS ACTIVITIES ACTIONS --CONTINUE EXPD ROWING PROGRAM TO PROVIDE PARALYZED PERSONS WITH AN OPPORTUNITY TO IMPROVE THEIR CARDIOVASCULAR HEALTH AND MUSCULAR STRENGTH --CONTINUE T O OFFER ADAPTIVE SPORTS RECREATIONAL PROGRAM TO FOSTER FITNESS, WELL-BEING, SOCIAL INTERAC TION AND ENGAGEMENT WITH THE COMMUNITY --EXPAND COMMUNICATION EFFORTS TO PROMOTE ADAPTIVE SPORTS PROGRAMS --EXPLORE OPPORTUNITIES TO CONNECT ADAPTIVE SPORTS PROGRAM TO OTHER ACTI VE DISABLED GROUPS (E G ADAPTIVE CLIMBING GROUP AT BROOKLYN BOULDERS) --CONTINUE HOSTING THE ANNUAL YOUTH WITH DISABILITIES SOCCER CLINIC IN PARTNERSHIP WITH THE NEW ENGLAND REVOL UTION NANTUCKET COTTAGE HOSPITAL ALCOHOL AND SUBSTANCE USE DISORDERS TO ADDRESS THE ALCOH OL AND SUBSTANCE USE DISORDERS ISSUE IN THE NANTUCKET COMMUNITY, IDENTIFY GAPS IN SERVICES FOR THOSE IN NEED, AND SUPPOR

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	T THE EFFORTS OF THE NANTUCKET BEHAVIORAL HEALTH TASK FORCE AND OTHER COMMUNITY EFFORTS IN THESE AREAS ACCESS TO HOUSING PLAY A PROACTIVE ROLE IN HELPING TO ADDRESS THE ISLAND'S A FFORDABLE HOUSING CRISIS, AND USE NCH'S POSITION AS ONE OF THE LARGEST PRIVATE EMPLOYERS O N THE ISLAND TO ADVOCATE FOR AND IMPLEMENT SOLUTIONS MENTAL HEALTH DISORDERS CONTINUE TO SERVE AS THE ACUTE SAFETY NET FOR ISLAND PATIENTS REQUIRING PSYCHIATRIC EVALUATION, STABIL IZATION, OBSERVATION, AND/OR TRANSFER OFF ISLAND IDENTIFY GAPS IN SERVICES AND SUPPORT TH E WORK OF THE BEHAVIORAL HEALTH TASK FORCE TO FILL THEM AND COLLABORATE WITH OTHER COMMUNI TY AGENCIES AND INITIATIVES CANCER TO PROVIDE CANCER SCREENINGS AND EDUCATION TO THE NANT UCKET COMMUNITY, WHILE SUSTAINING THE GROWTH IN NCH'S CANCER CARE PROGRAM TO PROVIDE MORE ON ISLAND SERVICES TO CANCER PATIENTS

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 HIG HEST RATES FOUND IN AMHERST AND NORTHAMPTON TWENTY-SIX PERCENT OF CHILDREN LIVING IN THE CDHC SERVICE AREA QUALIFY FOR FREE OR REDUCED LUNCH ALTHOUGH THE MEDIAN FAMILY INCOME IN HAMPSHIRE COUNTY IS COMPARABLE TO THE STATE, A NUMBER OF COMMUNITIES FALL BELOW THIS AMOUN T 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 WA GE --HOUSING NEEDS A LACK OF AFFORDABLE HOUSING IS A NEED THAT IMPACTS CDHC SERVICE AREA R ESIDENTS OVER A THIRD OF THE POPULATION IN CDH'S SERVICE AREA IS HOUSING COST BURDENED H OMELESSNESS ALSO IMPACTS THE HEALTH OF RESIDENTS IN WESTERN MASSACHUSETTS, AND SOME INDIVI DUALS IN THE CDHC SERVICE AREA

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA	INCREASED SERVICES FOR HOMELESS INDIVIDUALS WERE IDENTIFIED AS A NEED POOR HOUSING COND ITIONS ALSO IMPACT THE HEALTH OF RESIDENTS OLDER HOUSING COMBINED WITH LIMITED RESOURCES TO MAINTAIN THE HOUSING LEADS TO CONDITIONS THAT CAN AFFECT ASTHMA, OTHER RESPIRATORY COND ITIONS AND SAFETY WENTWORTH-DOUGLASS HOSPITAL THE IMPLEMENTATION STRATEGY DESCRIBES HOW W ENTWORTH-DOUGLASS HOSPITAL PLANS TO ADDRESS THE SIGNIFICANT COMMUNITY HEALTH NEEDS IDENTIF IED IN THE 2016 CHNA THE HOSPITAL REVIEWED THE CHNA FINDINGS AND APPLIED THE FOLLOWING CR ITERIA TO DETERMINE THE MOST APPROPRIATE NEEDS FOR WENTWORTH-DOUGLASS HOSPITAL TO ADDRESS THE EXTENT TO WHICH THE HOSPITAL HAS RESOURCES AND COMPETENCIES TO ADDRESS THE NEED, THE IMPACT THAT THE HOSPITAL COULD HAVE ON THE NEED (I E , THE NUMBER OF LIVES THE HOSPITAL CA N IMPACT), THE FREQUENCY WITH WHICH STAKEHOLDERS IDENTIFIED THE NEED AS A SIGNIFICANT PRIO RITY, AND THE EXTENT OF COMMUNITY SUPPORT FOR THE HOSPITAL TO ADDRESS THE ISSUE AND POTENT IAL FOR PARTNERSHIPS TO ADDRESS THE ISSUE

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PART V, LINE 16A-C URLS FOR FINANCIAL ASSISTANCE POLICIES	HTTPS //WWW PARTNERS ORG/ASSETS/DOCUMENTS/FOR-PATIENTS/FINANCIAL-ASSISTANCE-BILLING/FINANCIAL-ASSISTANCE-POLICY PDFHTTPS //WWW PARTNERS ORG/ASSETS/DOCUMENTS/FOR-PATIENTS/FINANCIAL-ASSISTANCE-BILLING/PARTNERS-FINANCIAL-ASSISTANCE-APPLICATION PDFHTTPS //WWW PARTNERS ORG/ASSETS/DOCUMENTS/FOR-PATIENTS/FINANCIAL-ASSISTANCE-BILLING/GENERAL-INFORMATION-FINANCIAL-ASSISTANCE PDFFOR WENTWORTH-DOUGLASS HTTPS //WWW WDHOSPITAL ORG/FILES/5415/5387/0582/LD-71_-_FINANCIAL_AID_PROGRAM_2019 PDFHTTPS //WWW WDHOSPITAL ORG/FILES/2015/5423/2913/8241-41A PDFHTTPS //WWW WDHOSPITAL ORG/FILES/1915/5387/0504/FINANCIAL_ASSISTANCE_POLICY_PLAIN_LANGUAGE__1-1-19 PDF

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	1 - MGH SPORTS MEDICINE CENTER 175 CAMBRIDGE STREET 4TH FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
1	2 - MGH SLEEP DISORDERS TESTING UNIT 5 BLOSSOM STREET 2ND FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
2	3 - MGH OUTPATIENT CARE 275 CAMBRIDGE STREET 3RD FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
3	4 - MGH CHARLESTOWN MONUMENT STREET COUNSEL 76 MONUMENT STREET 1ST FLOOR CHARLESTOWN, MA 02129	OUTPATIENT CLINIC
4	5 - MASS GENERALNORTH SHORE CENTER FOR OUT 102 ENDICOTT STREET 1ST AND 2ND FLOORS DANVERS, MA 02129	OUTPATIENT CLINIC & HEALTHCARE CENTER
5	6 - MGH BROADWAY PRIMARY CARE - REVERE 385 BROADWAY REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
6	7 - MGH RADIATION ONCOLOGY AT NWH 2014 WASHINGTON STREET SOUTH WING NEWTON, MA 02462	OUTPATIENT CLINIC
7	8 - MGH HEALTH CENTER CHELSEA 100 EVERETT AVENUE 1ST FLOOR 16C CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
8	9 - MGH CHARLESTOWN HEALTHCARE CENTER 73 HIGH STREET CHARLESTOWN, MA 02129	OUTPATIENT CLINIC & HEALTHCARE CENTER
9	10 - MGH CHELSEA HEALTHCARE CENTER 151 EVERETT AVENUE FLOORS 1-4 CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
10	11 - MGH EVERETT FAMILY CARE 19-23 NORWOOD STREET EVERETT, MA 02149	OUTPATIENT CLINIC & HEALTHCARE CENTER
11	12 - STUDENT HEALTH CENTER AT CHELSEA HIGH S 299 EVERETT AVENUE CHELSEA, MA 02150	OUTPATIENT CLINIC & HEALTHCARE CENTER
12	13 - EMERSON HOSPITAL MGH-RADIATION ONCOLOGY ROUTE 2 JOHN CUMMINGS BUILDING CONCORD, MA 01742	OUTPATIENT CLINIC & HEALTHCARE CENTER
13	14 - MGH REVERE HEALTHCARE CENTER 300 OCEAN AVENUE 3RD FLOOR REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
14	15 - MGH BACK BAY HEALTHCARE CENTER 388 COMMONWEALTH AVENUE BOSTON, MA 02115	OUTPATIENT CLINIC & HEALTHCARE CENTER

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	16 - MGH WEST 40 SECOND AVENUE 200 360 420 1110 21 WALTHAM, MA 02154	OUTPATIENT CLINIC & HEALTHCARE CENTER
1	17 - MGH REVERE SCHOOL BASED HEALTH CENTER 101 SCHOOL STREET REVERE, MA 02151	OUTPATIENT CLINIC & HEALTHCARE CENTER
2	18 - LABORATORY FOR MOLECULAR MEDICINE 65 LANSDOWNE STREET 3RD FLOOR CAMBRIDGE, MA 02139	OUTPATIENT DIAGNOSTIC LABORATORY
3	19 - MGH VOICE DISORDER PROGRAM ONE BOWDOIN SQUARE 7TH 11TH FLOOR BOSTON, MA 02114	OUTPATIENT CLINIC
4	20 - MGH CARDIOVASCULAR DISEASE PREVENTION CE 25 NEW CHARDON STREET SUITE 301 BOSTON, MA 02114	OUTPATIENT CLINIC & HEALTHCARE CENTER
5	21 - YAWKEY CENTER FOR OUTPATIENT CARE 32 FRUIT STREET BOSTON, MA 02114	OUTPATIENT CLINIC
6	22 - MGH CHARLES RIVER PLAZA 165 CAMBRIDGE STREET 3RD 5TH 7TH-9TH FL BOSTON, MA 02114	OUTPATIENT CLINIC
7	23 - BROOKSIDE COMMUNITY HEALTH CENTER 3297 WASHINGTON STREET BOSTON, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
8	24 - SOUTHERN JAMAICA PLAIN HEALTH CENTER 640 CENTRE STREET JAMAICA PLAIN, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
9	25 - BRIGHAM AND WOMEN'S HEALTH CARE CTR 850 BOYLSTON STREET CHESTNUT HILL, MA 02467	OUTPATIENT CLINIC & HEALTHCARE CENTER
10	26 - BWH ADVANCED MRI CENTER 221 LONGWOOD AVENUE GROUND LEVEL BOSTON, MA 02115	OUTPATIENT CLINIC
11	27 - BRIGHAM DERMATOLOGY ASSOCIATES 221 LONGWOOD AVENUE 1ST FLOOR BOSTON, MA 02115	OUTPATIENT CLINIC
12	28 - BWH ENDOCRINOLOGY AND METABOLIC SERVICES 221 LONGWOOD AVENUE 2ND FLOOR BOSTON, MA 02115	OUTPATIENT CLINIC
13	29 - BWH BEHAVIORAL AND COGNITIVE NEUROLOGY 221 LONGWOOD AVENUE RFB MEZZANINE BOSTON, MA 02115	OUTPATIENT CLINIC
14	30 - BWH OUTPATIENT PSYCHIATRY 221 LONGWOOD AVENUE 4TH FLOOR 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	31 - BWH IMMUNOLOGY LAB 221 LONGWOOD AVENUE BL-059 BOSTON, MA 02115	CLINICAL LABORATORY
1	32 - BWH NEWBORN MEDICINE 221 LONGWOOD AVENUE BLI L 1 3 BOSTON, MA 02115	OUTPATIENT CLINIC
2	33 - BRIGHAM AND WOMEN'S HOSPITAL CARE CENTER 1153 CENTRE STREET 1ST FLOOR BOSTON, MA 02130	OUTPATIENT CLINIC & HEALTHCARE CENTER
3	34 - BRIGHAM AND WOMEN'S HOSPITAL MOHS AND D 1153 CENTRE STREET SUITE 4349 BOSTON, MA 02130	OUTPATIENT CLINIC
4	35 - BRIGHAM AND WOMEN'S MRI - WEST BRIDGEWATER 711 WEST CENTER STREET WEST BRIDGEWATER, MA 02379	OUTPATIENT CLINIC
5	36 - BRIGHAM AND WOMEN'S HOSPITAL ADVANCED P 301 SOUTH HUNTINGTON AVENUE JAMAICA PLAIN, MA 02115	OUTPATIENT CLINIC
6	37 - KRAFT FAMILY BLOOD DONOR CTR AT DFCI 35 BINNEY STREET 1ST FLOOR BOSTON, MA 02115	BLOOD DONOR CENTER
7	38 - NSMC OUTPATIENT SERVICES 1 HUTCHINSON DRIVE 1ST FLOOR DANVERS, MA 01923	OUTPATIENT CLINIC
8	39 - NSMC PROFESSIONAL SERVICES HIGHLAND HALL 55 HIGHLAND AVENUE SALEM, MA 01970	OUTPATIENT CLINIC
9	40 - NORTH SHORE MEDICAL CENTER OUTP HARTMAN HALL 490 LYNNFIELD STREET LYNN, MA 01904	OUTPATIENT CLINIC
10	41 - RADIOLOGY SERVICES AT LYNN COMMUNITY H 269 UNION STREET LYNN, MA 01901	OUTPATIENT CLINIC
11	42 - NSMC MAGNETIC IMAGING 4 CENTENNIAL DRIVE SUITE 104 PEABODY, MA 01960	OUTPATIENT CLINIC
12	43 - NORTH SHORE MEDICAL CENTER ULTRASOUND AT 383 PARADISE ROAD SWAMPSCOTT, MA 01907	OUTPATIENT CLINIC
13	44 - NEWTON-WELLESLEY FAMILY MEDICINE 111 NORFOLK AVENUE 1ST FLOOR WALPOLE, MA 02081	OUTPATIENT CLINIC
14	45 - NEWTON-WELLESLEY URGENT CARE - WALTHAM DEVINCENT BUILDING 9 HOPE AVENUE WALTHAM, MA 02453	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	46 - NEWTON-WELLESLY HOSPITAL HAND THERAPY 830 BOYLSTON STREET SUITE 212 CHESTNUT HILL, MA 02467	OUTPATIENT CLINIC
1	47 - NEWTON-WELLESLEY AMBULATORY CARE CENTER 307 WEST CENTRAL STREET 1ST FLOOR NATICK, MA 01760	OUTPATIENT CLINIC
2	48 - NEWTON-WELLESLEY SLEEP CENTER AT NEWTON 2345 COMMONWEALTH AVENUE BUILDING C NEWTON, MA 02446	OUTPATIENT CLINIC
3	49 - NEWTON-WELLESLEY HOSPITAL REMOTE RADIOL 2000 WASHINGTON STREET NEWTON, MA 02462	OUTPATIENT CLINIC
4	50 - NEWTON-WELLESLEY OUTPATIENT SURGERY CTR 25 WASHINGTON STREET WELLESLEY, MA 02481	OUTPATIENT CLINIC
5	51 - NEWTON-WELLESLEY AMBULATORY CARE CENTER 159 WELLS AVENUE NEWTON, MA 02459	OUTPATIENT CLINIC
6	52 - MCLEAN SOUTHEAST 23 ISAAC STREET MIDDLEBOROUGH, MA 02346	OUTPATIENT CLINIC
7	53 - SPAULDING OUTPATIENT CENTER - BRIGHTON 20 GUEST STREET SUITE 150 BOSTON, MA 02135	OUTPATIENT CLINIC
8	54 - SPAULDING OUTPATIENT CENTER - FRAMINGHAM 570 WORCESTER ROAD FRAMINGHAM, MA 01702	OUTPATIENT CLINIC
9	55 - SPAULDING OUTPATIENT CENTER - MEDFORD 101 MAIN STREET SUITE 101 AND 118-119 MEDFORD, MA 02155	OUTPATIENT CLINIC
10	56 - SPAULDING OUTPATIENT CENTER - WELLESLEY 65 WALNUT STREET WELLESLEY, MA 02181	OUTPATIENT CLINIC
11	57 - SPAULDING OUTPATIENT CENTER - BRAINTREE 300 GRANITE STREET 1ST FLOOR BRAINTREE, MA 02184	OUTPATIENT CLINIC
12	58 - SPAULDING OUTPATIENT CENTER - DOWNTOWN 294 WASHINGTON STREET SUITE 215 BOSTON, MA 02114	OUTPATIENT CLINIC
13	59 - SPAULDING OUTPATIENT CENTER - CAMBRIDGE 1575 CAMBRIDGE STREET 1ST FLOOR CAMBRIDGE, MA 02138	OUTPATIENT CLINIC
14	60 - SPAULDING OUTPATIENT CENTER FOR CHILDREN 1 MAGUIRE ROAD 1ST FLOOR LEXINGTON, MA 02421	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	61 - SPAULDING OUTPATIENT CENTER - WESTBOROUGH 112 TURNPIKE ROAD SUITE 301 WESTBOROUGH, MA 01581	OUTPATIENT CLINIC
1	62 - SPAULDING OUTPATIENT CENTER - PEABODY 4 CENTENNIAL DRIVE PEABODY, MA 01960	OUTPATIENT CLINIC
2	63 - SPAULDING OUTPATIENT CENTER - MARBLEHEAD 40 LEGGIS HILL ROAD MARBLEHEAD, MA 01945	OUTPATIENT CLINIC
3	64 - SPAULDING OUTPATIENT CENTER - MIDDLETON 147 SOUTH MAIN STREET MIDDLETON, MA 01949	OUTPATIENT CLINIC
4	65 - SPAULDING OUTPATIENT CENTER - CAPE ANN 1 BLACKBURN DRIVE GLOUCESTER, MA 01930	OUTPATIENT CLINIC
5	66 - SPAULDING OUTPATIENT CENTER - MARBLEHEAD 4 COMMUNITY ROAD MARBLEHEAD, MA 01945	OUTPATIENT CLINIC
6	67 - SPAULDING OUTPATIENT CENTER - LYNN 583 CHESTNUT STREET 3RD FLOOR LYNN, MA 01904	OUTPATIENT CLINIC
7	68 - SPAULDING OUTPATIENT CENTER - SALEM 35 CONGRESS STREET 2ND FLOOR SALEM, MA 01970	OUTPATIENT CLINIC
8	69 - SPAULDING OUTPATIENT CENTER - QUINCY 79 CODDINGTON STREET 2ND FLOOR QUINCY, MA 02169	OUTPATIENT CLINIC
9	70 - SPAULDING OUTPATIENT CENTER - EMILSON 75 MILL STREET HANOVER, MA 02339	OUTPATIENT CLINIC
10	71 - SPAULDING MALDEN 350 MAIN STREET 1ST FLOOR MALDEN, MA 02148	OUTPATIENT CLINIC
11	72 - SPAULDING OUTPATIENT CENTER - ORLEANS 65 OLD COLONY WAY SUITE 2 ORLEANS, MA 02653	OUTPATIENT CLINIC
12	73 - SPAULDING OUTPATIENT CENTER - YARMOUTH 130 ANSEL HALLET ROAD WEST YARMOUTH, MA 02675	OUTPATIENT CLINIC
13	74 - SPAULDING EILEEN M WARD OUTPATIENT CTR 280-D ROUTE 130 SUITE 7 FORESTDALE, MA 02644	OUTPATIENT CLINIC
14	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	76 - SPAULDING OUTPATIENT CENTER - PLYMOUTH 1 SCOBEE CIRCLE PLYMOUTH, MA 02360	OUTPATIENT CLINIC
1	77 - SPORTS MEDICINE AND PT ASSOCIATES OF NCH 6 BAYBERRY COURT GROUND LEVEL NANTUCKET, MA 02554	OUTPATIENT CLINIC
2	78 - COOLEY DICKINSON SOUTH DEERFIELD CENTER 21 B ELM STREET 1ST FLOOR SOUTH DEERFIELD, MA 01373	OUTPATIENT CLINIC
3	79 - COOLEY DICKINSON HOSPITAL 170 UNIVERSITY DRIVE AMHERST, MA 01002	OUTPATIENT CLINIC
4	80 - THE COOLEY DICKINSON HOSPITAL OUTPATIENT 10 COLLEGE HIGHWAY SOUTHAMPTON, MA 01073	OUTPATIENT CLINIC
5	81 - COOLEY DICKINSON HOSPITAL REHAB SERV 58 OLD NORTH ROAD SUITE 1 WORTHINGTON, MA 01098	OUTPATIENT REHAB CLINIC
6	82 - COOLEY DICKINSON HOSPITAL REHAB SERV 380 RUSSELL STREET 1ST FLOOR HADLEY, MA 01035	OUTPATIENT REHAB CLINIC
7	83 - COOLEY DICKINSON HOSPITAL P& OCC T 4 WEST STREET 2ND FLOOR WEST HATFIELD, MA 01088	OUTPATIENT CLINIC
8	84 - COOLEY DICKINSON HOSPITAL P S & OCC T 8 ATWOOD DRIVE NORTHAMPTON, MA 01060	OUTPATIENT CLINIC
9	85 - COOLEY DICKINSON HOSPITAL OUTPATIENT DIAG 22 ATWOOD DRIVE NORTHAMPTON, MA 01060	DIAGNOSTIC SERVICES
10	86 - SEACOAST CANCER CENTER 10 MEMBERS WAY SUITE 200 DOVER, NH 03820	SPECIALTY CARE PRACTICE
11	87 - LEE OTPTIMAGING 65 CALEF HIGHWAY LEE, NH 03861	OCCUPATIONAL/PHYSICAL THERAPY/IMAGING
12	88 - EXPRESS CARE DOVER 781 CENTRAL AVENUE DOVER, NH 03820	EXPRESS CARE
13	89 - WDH PROFESSIONAL CENTER 10 MEMBERS WAY DOVER, NH 03820	DIAGNOSTIC SERVICES
14	90 - EXPRESS CARE LEE 65 CALEF HIGHWAY LEE, NH 03861	EXPRESS CARE

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)
91	91 - DIAGNOSTIC CARDIOLOGY 19 OLD ROLLINSFORD ROAD DOVER, NH 03820	CARDIOLOGY SERVICES
1	92 - DURHAM REHAB & SPORTS THERAPY CENTER 16 JENKINS COURT DURHAM, NH 03824	SPECIALTY CARE PRACTICE
2	93 - WDH EARLY LEARNING CENTER 789 CENTRAL AVENUE DOVER, NH 03820	CHILDCARE SERVICES

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

2017

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 noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(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 . . . . ▶

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) SCHOLARSHIPS	377	5,682,161	0		
(2) TUITION REDUCTION - VARIOUS RECIPIENTS	0	975,337	0		
(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
GRANTS AND OTHER ASSISTANCE DETAIL	FINANCIAL AID OF $6,657,498 CONSISTS OF SCHOLARSHIPS PROVIDED BY THE INSTITUTE OF $5,682,161 FOR 377 STUDENTS AND $975,337 FOR TUITION REDUCTIONS RELATED TO VOUCHERS TO CLINICAL SITES AND REDEEMED BY STUDENTS TO OFFSET TUITION CHARGES TOTAL FINANCIAL AID OF $6,657,498 OFFSETS TUITION AND FEES ONLY

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)	301,134,066				TO SUPPORT TAX EXEMPT AFFILIATE
THE GENERAL HOSPITAL CORPORATION 55 FRUIT STREET BOSTON, MA 02114	04-2697983	501(C)(3)	27,354,950				TO SUPPORT TAX EXEMPT AFFILIATE

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 SPAULDING REHABILITATION HOSPITAL CORP 300 FIRST AVENUE CHARLESTOWN, MA 02129	04-2551124	501(C)(3)	14,000,000				TO SUPPORT TAX EXEMPT AFFILIATE
FRC INC 101 MERRIMAC STREET BOSTON, MA 02114	22-2632121	501(C)(3)	12,194,650				TO SUPPORT TAX EXEMPT AFFILIATE

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
SPAULDING HOSPITAL - CAMBRIDGE INC 1575 CAMBRIDGE STREET CAMBRIDGE, MA 02138	27-0273715	501(C)(3)	5,399,380				TO SUPPORT TAX EXEMPT AFFILIATE
PARTNERS CONTINUING CARE INC 800 BOYLSTON STREET BOSTON, MA 02199	26-0003495	501(C)(3)	4,330,927				TO SUPPORT TAX EXEMPT AFFILIATE

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 311 SERVICE ROAD EAST SANDWICH, MA 02537	04-3071419	501(C)(3)	1,518,118				TO SUPPORT TAX EXEMPT AFFILIATE
MCLEAN HEALTHCARE INC 115 MILL STREET BELMONT, MA 02478	20-4572876	501(C)(3)	16,970,297				TO SUPPORT TAX EXEMPT AFFILIATE

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 HEALTH INC 75 FRANCIS STREET BOSTON, MA 02115	04-2921338	501(C)(3)	245,235,089				TO SUPPORT TAX EXEMPT AFFILIATE
THE BRIGHAM AND WOMEN'S HOSPITAL INC 75 FRANCIS STREET BOSTON, MA 02115	04-2312909	501(C)(3)	32,357,382				TO SUPPORT TAX EXEMPT AFFILIATE

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)	38,686,014				TO SUPPORT TAX EXEMPT AFFILIATE
BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC 1153 CENTRE STREET BOSTON, MA 02130	04-2768256	501(C)(3)	133,766				TO SUPPORT TAX EXEMPT AFFILIATE

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
NSMC HEALTHCARE INC 81 HIGHLAND AVENUE SALEM, MA 01970	04-3294420	501(C)(3)	4,106,846				TO SUPPORT TAX EXEMPT AFFILIATE
NORTH SHORE MEDICAL CENTER INC 81 HIGHLAND AVENUE SALEM, MA 01970	04-3399616	501(C)(3)	19,304,402				TO SUPPORT TAX EXEMPT AFFILIATE

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 PHYSICIANS GROUP INC 81 HIGHLAND AVENUE SALEM, MA 01970	04-3080484	501(C)(3)	7,627,325				TO SUPPORT TAX EXEMPT AFFILIATE
NEWTON-WELLESLEY HOSPITAL 2014 WASHINGTON STREET NEWTON, MA 02462	04-2103611	501(C)(3)	6,112,425				TO SUPPORT TAX EXEMPT AFFILIATE

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)	6,833,629				TO SUPPORT TAX EXEMPT AFFILIATE
NEWTON-WELLESLEY CHILDREN'S CORNER INC 2014 WASHINGTON STREET NEWTON, MA 02462	04-2650246	501(C)(3)	19,244				TO SUPPORT TAX EXEMPT AFFILIATE

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 HEALTHCARE SYSTEM INC 2014 WASHINGTON STREET NEWTON, MA 02462	20-4295282	501(C)(3)	37,953,873				TO SUPPORT TAX EXEMPT AFFILIATE
NANTUCKET COTTAGE HOSPITAL 57 PROSPECT STREET NANTUCKET, MA 02554	04-2103823	501(C)(3)	19,988,000				TO SUPPORT TAX EXEMPT AFFILIATE

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
WNR INC 1 LINTON LANE OAK BLUFFS, MA 02557	04-3419920	501(C)(3)	900,000				TO SUPPORT TAX EXEMPT AFFILIATE
COOLEY DICKINSON HOSPITAL INC 30 LOCUST STREET NORTHAMPTON, MA 01060	22-2617175	501(C)(3)	27,909,835				TO SUPPORT TAX EXEMPT AFFILIATE

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 POBOX 911 NORTHAMPTON, MA 01060	04-3194547	501(C)(3)	14,400,000				TO SUPPORT TAX EXEMPT AFFILIATE
THE MGH INSTITUTE OF HEALTH PROFESSIONS INC 36 FIRST AVE CHARLESTOWN, MA 02129	04-2868893	501(C)(3)	129,900				TO SUPPORT TAX EXEMPT AFFILIATE

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
WENTWORTH-DOUGLASS PHYSICIAN CORPORATION 789 CENTRAL AVENUE DOVER, NH 03820	02-0497927	501(C)(3)	47,553,000				TO SUPPORT TAX EXEMPT AFFILIATE
WENTWORTH-DOUGLASS HOSPITAL & HEALTH FOUNDATION 789 CENTRAL AVENUE DOVER, NH 03820	51-0491062	501(C)(3)	1,508,000				TO SUPPORT TAX EXEMPT AFFILIATE

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)	188,331,282				TO SUPPORT TAX EXEMPT AFFILIATE
HARVARD MEDICAL SCHOOL 25 SHATTUCK STREET BOSTON, MA 02115	04-2103580	501(C)(3)	4,291,769				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 END WATERFRONT 332 HANOVER STREET BOSTON, MA 02113		501(C)(3)	3,570,816				COMMUNITY BENEFIT PROGRAM
HARVARD MEDICAL SCHOOL 25 SHATTUCK STREET BOSTON, MA 02115	04-2103580	501(C)(3)	3,117,546				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)	2,085,752				COMMUNITY BENEFIT PROGRAM
EAST BOSTON NHC 10 GOVE STREET EAST 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
BRIDGEWELL 10 DEARBORN ROAD PEABODY, MA 01960	04-2477820	501(C)(3)	1,309,079				COMMUNITY BENEFIT PROGRAM
HEALTH RESOURCES IN ACTION (HRIA) 2 BOYLSTON STREET 4TH FLOOR BOSTON, MA 02116	04-2229839	501(C)(3)	904,056				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)	588,852				COMMUNITY BENEFIT PROGRAM
NORTH SHORE COMMUNITY HEALTH 27 CONGRESS STREET SALEM, MA 01970	04-2610447	501(C)(3)	473,779				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
NEW HAMPSHIRE HEALTH PROTECTION PROGRAM 125 AIRPORT ROAD CONCORD, NH 03301	02-0275078	501(C)(3)	446,432				COMMUNITY BENEFIT PROGRAM
HARVARD MEDICAL SCHOOL 25 SHATTUCK STREET BOSTON, MA 02115	04-2103580	501(C)(3)	292,050				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
BOYS & GIRLS CLUB OF BOSTON 50 CONGRESS STREET SUITE 730 BOSTON, MA 02109	04-2103922	501(C)(3)	251,267				COMMUNITY BENEFIT PROGRAM
HEALTH IMPERATIVES 942 WEST CHESTNUT STREET BROCKTON, MA 02301	04-2609177	501(C)(3)	226,271				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
MISSION HILL NEIGHBORHOOD HOUSING SERVICES 1620 TREMONT STREET BOSTON, MA 02120	23-7428011	501(C)(3)	201,000				COMMUNITY BENEFIT PROGRAM
CAMP HARBOR VIEW FOUNDATION C/O THE CONNORS FAMILY OFFICE 200 CLARENDON STREET 60TH FLOOR BOSTON, MA 02116	75-3235491	501(C)(3)	200,000				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 RESOURCES IN ACTION (HRIA) ATTN FINANCE DEPT 95 BERKELEY STREET BOSTON, MA 02116	04-2229839	501(C)(3)	200,000				COMMUNITY BENEFIT PROGRAM
GREATER LYNN SENIOR SERVICES INC 8 SILSBEE STREET LYNN, MA 01901	04-2581129	501(C)(3)	181,932				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 729 MASSACHUSETTS AVENUE BOSTON, MA 02118	04-3160480	501(C)(3)	181,204				COMMUNITY BENEFIT PROGRAM
HABITAT FOR HUMANITY PO BOX 1022 / 35 OLD SOUTH ROAD NANTUCKET, MA 02554	04-3553383	501(C)(3)	175,000				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 RESOURCES IN ACTION (HRIA) 2 BOYLSTON STREET 4TH FLOOR BOSTON, MA 02116	04-2229839	501(C)(3)	129,840				COMMUNITY BENEFIT PROGRAM
CITY OF DOVER POLICE 262 SIXTH STREET DOVER, NH 03820		501(C)(1)	125,000				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
WHITTIER STREET HEALTH CENTER 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	501(C)(3)	116,353				COMMUNITY BENEFIT PROGRAM
EDWARD M KENNEDY ACADEMY 360 HUNTINGTON AVENUE - 102CA BOSTON, MA 02115	04-3286409	501(C)(3)	115,000				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
GOODWIN COMMUNITY HEALTH 311 ROUTE 108 SOMERSWORTH, NH 03878	02-0304203	501(C)(3)	110,000				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
GOSNOLD ON NANTUCKET 200 TER HEUN DRIVE FALMOUTH, MA 02540	04-2502970	501(C)(3)	100,000				COMMUNITY BENEFIT PROGRAM
TRIANGLE CLUB 120 BROADWAY DOVER, NH 03820	22-2533853	501(C)(3)	92,640				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
STRAFFORD HEALTH ALLIANCE 200 ROUTE 108 SUITE 3 SOMERSWORTH, NH 03878	02-0389434	501(C)(3)	83,666				COMMUNITY BENEFIT PROGRAM
COLLEGE BOUND DORCHESTER 18 SAMOSET STREET DORCHESTER, MA 02124	04-2383512	501(C)(3)	80,000				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
MAURICE J TOBIN K-8 SCHOOL 40 SMITH STREET ROXBURY, MA 02120		501(C)(3)	75,000				COMMUNITY BENEFIT PROGRAM
NANTUCKET AFFORDABLE HOUSING TRUST FUND 2 FAIRGROUNDS ROAD NANTUCKET, MA 02554		501(C)(3)	75,000				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
NAMI 5 MARKS LANE HYANNIS, MA 02601	04-2785229	501(C)(3)	70,000				COMMUNITY BENEFIT PROGRAM
SOCIEDAD LATINA 1530 TREMONT STREET ROXBURY, MA 02120	04-2678255	501(C)(3)	70,000				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 AVENUE 222 YMC BOSTON, MA 02115	04-3286409	501(C)(3)	69,918				COMMUNITY BENEFIT PROGRAM
DIMOCK COMMUNITY HEALTH CENTER INC 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	68,333				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
CITY OF REVERE 281 BROADWAY REVERE, MA 02151		501(C)(1)	66,300				COMMUNITY BENEFIT PROGRAM
MISSIONSAFE 18 JOHN ELIOT SQUARE ROXBURY, MA 02119	04-3457195	501(C)(3)	65,000				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 STREET LYNN, MA 01902	04-6001397	501(C)(1)	62,500				COMMUNITY BENEFIT PROGRAM
COMMUNITY SERVICE CARE INC PO BOX 300040 JAMAICA PLAIN, MA 02130	04-2754281	501(C)(3)	61,362				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 STREET BOSTON, MA 02115	04-2103580	501(C)(3)	60,985				COMMUNITY BENEFIT PROGRAM
MOTHERS FOR JUSTICE AND EQUALITY 184 DUDLEY STREET SUITE 109 LL ROXBURY, MA 02119	45-3741482	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
URBAN LEAGUE OF EASTERN MA 88 WARREN STREET ROXBURY, MA 02119	23-7349132	501(C)(3)	60,000				COMMUNITY BENEFIT PROGRAM
HEALTH RESOURCES IN ACTION (HRIA) 2 BOYLSTON STREET 4TH FLOOR BOSTON, MA 02116	04-2229839	501(C)(3)	58,980				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
BPHC 1010 MASSACHUSETTS AVENUE BOSTON, MA 02118	04-3316655	501(C)(3)	56,344				COMMUNITY BENEFIT PROGRAM
MATTAPAN COMMUNITY HEALTH CENTER 1575 BLUE HILL AVENUE BOSTON, MA 02126	04-2544151	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
ALL DORCHESTER SPORTS LEAGUE 1565 DORCHESTER AVENUE DORCHESTER, MA 02122	22-2827346	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
BEYOND CONFLICT (BOSTON EQUITY INITIATIVE) 30 WINTER STREET BOSTON, MA 02138	27-2008529	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 STREET SUITE 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 8 EAST 37TH STREET NEW YORK, NY 10016	45-5047215	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
CAMP HARBOR VIEW FOUNDATION C/O THE CONNORS FAMILY OFFICE 200 CLARENDON STREET 60TH FLOOR BOSTON, MA 02116	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
CCHERS (FOR HEART CONSORTIUM) 716 COLUMBUS AVENUE BOSTON, MA 02120	04-3112225	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
HOPE ON HAVEN HILL 326 ROCHESTER HILL RD ROCHESTER, NH 03867	47-4623824	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
NEIGHBORHOOD DEVELOPERS 4 GERRISH AVENUE CHELSEA, MA 02150	04-2660283	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
ROCA INC 101 PARK STREET CHELSEA, MA 02150	22-3223641	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
YOUTH AND FAMILY ENRICHMENT SERVICES INC 1234 HYDE PARK AVENUE SUITE 104 HYDE PARK, MA 02136	05-0588064	501(C)(3)	50,000				COMMUNITY BENEFIT PROGRAM
HAWC 27 CONGRESS STREET SALEM, MA 01970	04-2655367	501(C)(3)	49,095				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
DIMOCK COMMUNITY HEALTH CENTER INC 55 DIMOCK STREET ROXBURY, MA 02119	04-3487835	501(C)(3)	48,333				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
WALTHAM PARTNERSHIP FOR YOUTH 510 MOODY STREET WALTHAM, MA 02453	04-3399437	501(C)(3)	39,362				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
UU URBAN MINISTRIES 10 PUTMAN STREET ROXBURY, MA 02119	04-2105897	501(C)(3)	35,000				COMMUNITY BENEFIT PROGRAM
UMASS DONAHUE INSTITUTE 100 VENTURE WAY SUITE 9 HADLEY, MA 01035	04-3167352	501(C)(3)	32,768				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
GIRLS INCORPORATED OF LYNN 50 HIGH STREET LYNN, MA 01902	04-2104250	501(C)(3)	31,608				COMMUNITY BENEFIT PROGRAM
ALTERNATIVE FOR COMMUNITY AND ENVIRONMENT 2201 WASHINGTON ST SUITE 302 ROXBURY, MA 02119	04-3228509	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
ARTHRITIS FOUNDATION 1355 PEACHTREE STREET SUITE 600 ATLANTA, GA 30309	58-1341679	501(C)(3)	30,000				COMMUNITY BENEFIT PROGRAM
BARAKA COMMUNITY WELLNESS 122 ELM HILL AVENUE UNIT 200 BOSTON, MA 02121	46-2584139	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
CITY OF DOVER FIRE & RESCUE 46 CHESTNUT STREET DOVER, NH 03820		501(C)(1)	30,000				COMMUNITY BENEFIT PROGRAM
ST STEPHEN'S YOUTH PROGRAM 31 LENOX STREET BOSTON, MA 02118	26-1749602	501(C)(3)	30,000				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)	28,167				COMMUNITY BENEFIT PROGRAM
ARTISTS ASSOICATION OF NANTUCKET PO BOX 1104 NANTUCKET, MA 02554	04-2458501	501(C)(3)	27,600				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 BOSTON, MA 02109	04-2676661	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
CITIZENS UNITED FOR RESEARCH IN EPILEPSY 430 WEST ERIE STREET SUITE 210 CHICAGO, IL 60654	36-4253176	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
DIRECT RELIEF 6100 WALLACE BECKNELL ROAD SANTA BARBARA, CA 93117	95-1831116	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
PROJECT PLACE 1145 WASHINGTON STREET 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
RED SOX FOUNDATION INC 4 YAWKEY WAY BOSTON, MA 02215	33-1007984	501(C)(3)	25,000				COMMUNITY BENEFIT PROGRAM
ST MARY - ST CATHERINE OF SIENA PARISH FOR HARVEST ON THE VINE 46 WINTHROP ST CHARLESTOWN, MA 02129	33-1136053	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
NANTUCKET CIVIC LEAGUE PO BOX 3126 NANTUCKET, MA 02554	04-6006527	501(C)(3)	23,332				COMMUNITY BENEFIT PROGRAM
HEALTH CAREERS CONNECTION 300 FRANK OGAWA PLAZA STE 243 OAKLAND, CA 94612	25-1904312	501(C)(3)	20,700				COMMUNITY BENEFIT PROGRAM

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

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BOSTON PUBLIC HOUSING CORPORATION 76 MONUMENT STREET 2ND FLOOR CHARLESTOWN, MA 02129	04-3576423	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM
INTERNATIONAL OCD FOUNDATION CONFERENCE PO BOX 961029 BOSTON, MA 02196	22-2894564	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM

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

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JF KENNEDY FAMILY SERVICES CENTER INC 23A MOULTON STREET CHARLESTOWN, MA 02129	04-2373976	501(C)(3)	20,000				COMMUNITY BENEFIT PROGRAM
DARTMOUTH HITCHCOCK MEMORIAL HOSPITAL 1 MEDICAL CENTER DRIVE LEBANON, NH 03756	02-0222140	501(C)(3)	19,848				COMMUNITY BENEFIT PROGRAM

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

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MARIA MITCHELL ASSOCIATION 4 VESTAL STREET NANTUCKET, MA 02554	04-2129139	501(C)(3)	19,590				COMMUNITY BENEFIT PROGRAM
HOMESTART INC 105 CHAUNCY STREET SUITE 502 BOSTON, MA 02111	04-3311270	501(C)(3)	17,649				COMMUNITY BENEFIT PROGRAM

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

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WARREN PRESCOTT FOUNDATION INC 50 SCHOOL STREET CHARLESTOWN, MA 02129	20-1745447	501(C)(3)	16,500				COMMUNITY BENEFIT PROGRAM
WALTHAM PARTNERSHIP FOR YOUTH INC 510 MOODY STREET WALTHAM, MA 02453	04-3399437	501(C)(3)	15,055				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 HEART ASSOCIATION 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVENUE 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
BOYS & GIRLS CLUB OF BOSTON CHARLESTOWN CLUB 15 GREEN STREET CHARLESTOWN, MA 02129	04-2103922	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
DECORDOVA SCULPTURE PARK AND MUSEUM 51 SANDY POND ROAD LINCOLN, MA 01773	04-2067315	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
HEALTH AND EDUCATION SERVICES (HES) ZERO CENTENNIAL DRIVE PEABODY, MA 01960	04-2777145	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
MA COALITION FOR HOMELESS 15 BUBIER STREET LYNN, MA 01901	22-2599662	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
MISSION HILL MAIN STREETS 812 HUNTINGTON AVENUE BOSTON, MA 02115	04-3400164	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
SCHWARTZ CENTER FOR COMPASSIONATE CARE PO BOX 417597 BOSTON, MA 02241	04-1564655	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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URBAN IMPROV 8 ST JOHN STREET JAMAICA PLAIN, MA 02130	04-2789576	501(C)(3)	15,000				COMMUNITY BENEFIT PROGRAM
FAIRWINDS 20 VESPER LANE L1 NANTUCKET, MA 02554	04-2308993	501(C)(3)	14,400				COMMUNITY BENEFIT PROGRAM

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

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SMALL FRIENDS PO BOX 2826 NANTUCKET, MA 02554	04-3001787	501(C)(3)	14,285				COMMUNITY BENEFIT PROGRAM
SPECIAL TOWNIES 336 MAIN STREET CHARLESTOWN, MA 02129	04-2696004	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
WALTHAM CHAMBER OF COMMERCE 84 SOUTH STREET WALTHAM, MA 02453	04-1944360	501(C)(6)	12,750				COMMUNITY BENEFIT PROGRAM
TOWN OF MIDDLEBORO FAMILY RESOURCE CENTER AND COUNCIL ON AGING 41 MAYFLOWER AVENUE MIDDLEBORO, MA 02346	04-6001221	501(C)(1)	12,500				COMMUNITY BENEFIT PROGRAM

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

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AMERICAN CONGRESS OF REHABILITATION MEDICINE 11654 PLAZA AMERICA DRIVE SUITE 535 535 RESTON, VA 20190	36-2170784	501(C)(3)	12,031				COMMUNITY BENEFIT PROGRAM
NORTH SHORE CARDIOVASCULAR ASSOCIATES 80 HIGHLAND AVENUE SALEM, MA 01970	04-2499010	501(C)(3)	11,400				COMMUNITY BENEFIT PROGRAM

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NEWTON-NEEDHAM CHAMBER COMMERCE 281 NEEDHAM STREET NEWTON, MA 02464	04-1670500	501(C)(6)	11,300				COMMUNITY BENEFIT PROGRAM
AMERICAN CANCER SOCIETY 30 SPEEN STREET FRAMINGHAM, MA 01701	13-1788491	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
CASA LATINA 140 PINE STREET ROOM 6 FLORENCE, MA 01062	22-2477843	501(C)(3)	10,600				COMMUNITY BENEFIT PROGRAM
SERVICENET 131 KING STREET NORTHAMPTON, MA 01060	04-2526194	501(C)(3)	10,500				COMMUNITY BENEFIT PROGRAM

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

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NANTUCKET COMMUNITY SCHOOL 10 SURFSIDE ROAD NANTUCKET, MA 02554		501(C)(3)	10,300				COMMUNITY BENEFIT PROGRAM
ARTHRITIS FOUNDATION 1355 PEACHTREE STREET SUITE 600 ATLANTA, GA 30309	58-1341679	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
CHARLESTOWN COMMUNITY CENTERS 255 MEDFORD STREET BOSTON, MA 02129	04-2602576	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN LACROSSE & LEARNING CENTER 14 GREEN STREET CHARLESTOWN, MA 02129	04-3484770	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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CITY OF NORTHAMPTON 210 MAIN STREET ROOM 18 NORTHAMPTON, MA 01060		501(C)(1)	10,000				COMMUNITY BENEFIT PROGRAM
EASTHAMPTON PUBLIC SCHOOLS 50 PAYSON AVENUE EASTHAMPTON, MA 01027		501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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

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FRESH TRUCK INC 69 SHIRLEY STREET BOSTON, MA 02119	46-2848535	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
IMPOSSIBLE DREAM 50 W 47TH STREET SUITE 2113 NEW YORK, NY 10036	80-0969365	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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JOHN F KENNEDY FAMILY SERVICE CENTER 23A MOULTON STREET CHARLESTOWN, MA 02129	04-2373978	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
MATTAPAN COMMUNITY HEALTH CENTER INC 1575 BLUE HILL AVENUE BOSTON, MA 02126	04-2544151	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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MULTISERVICE EATING DISORDER ASSOCIATION 92 PEARL STREET NEWTON, MA 02458	04-3224394	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
OUR LADY OF PERPETUAL HELP MISSION GRAMMAR SCHOOL 94 ST ALPHONSUS STREET BOSTON, MA 02120	04-2106198	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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

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SPECIAL TOWNIES 336 MAIN STREET CHARLESTOWN, MA 02129	04-2696004	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
UNITED WAY OF HAMPSHIRE COUNTY 71 KING STREET NORTHAMPTON, MA 01060	04-2104792	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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

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WELLESLEY SENIOR CENTER 500 WASHINGTON STREET WELLESLEY, MA 02482	04-6001343	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
Y W C A OF BOSTON INC 316 HUNTINGTON AVENUE BOSTON, MA 02115	04-2103551	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM

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

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YW BOSTON 140 CLARENDON STREET BOSTON, MA 02116	04-2103548	501(C)(3)	10,000				COMMUNITY BENEFIT PROGRAM
AMERICAN CANCER SOCIETY 30 SPEEN STREET FRAMINGHAM, MA 01701	13-1788491	501(C)(3)	9,500				COMMUNITY BENEFIT PROGRAM

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

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FOUNDATION FOR BCYF CAMP JOY THE 1483 TREMONT STREET BOSTON, MA 02120	04-2602576	501(C)(3)	9,500				COMMUNITY BENEFIT PROGRAM
CHARLESTOWN BOYS AND GIRLS CLUB 15 GREEN STREET CHARLESTOWN, MA 02129	04-2103922	501(C)(3)	9,196				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 PO BOX 290799 BOSTON, MA 02129	04-3457195	501(C)(3)	8,500				COMMUNITY BENEFIT PROGRAM
CANCER CONNECTION 41 LOCUST STREET NORTHAMPTON, MA 01060	04-3493483	501(C)(3)	8,300				COMMUNITY BENEFIT PROGRAM

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HEALTHY WALTHAM 510 MOODY STREET WALTHAM, MA 02453	46-1174988	501(C)(3)	7,950				COMMUNITY BENEFIT PROGRAM
GREATER NORTHAMPTON CHAMBER OF COMMERCE 99 PLEASANT STREET NORTHAMPTON, MA 01060	04-1679420	501(C)(6)	7,500				COMMUNITY BENEFIT PROGRAM

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N E H I INC 1 BROADWAY 15TH FLOOR CAMBRIDGE, MA 02142	01-0624865	501(C)(3)	7,500				COMMUNITY BENEFIT PROGRAM
RESEARCH AMERICA 241 18TH STREET SOUTH SUITE 501 ARLINGTON, VA 22202	52-1609875	501(C)(3)	7,500				COMMUNITY BENEFIT PROGRAM

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PHYSICIAN HEALTH SERVICES 860 WINTER STREET WALTHAM, MA 02451	22-3234975	501(C)(3)	7,100				COMMUNITY BENEFIT PROGRAM
SUSTAINABLE NANTUCKET PO BOX 1244 NANTUCKET, MA 02554	04-3427501	501(C)(3)	6,800				COMMUNITY BENEFIT PROGRAM

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CHARLESTOWN LITTLE LEAGUE 126 ELM STREET CHARLESTOWN, MA 02129	37-1513586	501(C)(3)	6,500				COMMUNITY BENEFIT PROGRAM
CITY OF NEWTON 1000 COMMONWEALTH AVENUE NEWTON, MA 02459	46-0014040	501(C)(1)	6,250				COMMUNITY BENEFIT PROGRAM

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CAMP HARBOR VIEW FOUNDATION C/O THE CONNORS FAMILY OFFICE 200 CLARENDON STREET 60TH FLOOR BOSTON, MA 02116	75-3235491	501(C)(3)	6,000				COMMUNITY BENEFIT PROGRAM
EPILEPSY FOUNDATION 335 MAIN STREET WILMINGTON, MA 01887	22-2505819	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
FRIENDS OF THE CHARLESTOWN LIBRARY LTD 179 MAIN STREET CHARLESTOWN, MA 02129	04-3330182	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
NEWTON COMMUNITY PRIDE 492 WALTHAM STREET NEWTON, MA 02465	22-2793743	501(C)(3)	6,000				COMMUNITY BENEFIT PROGRAM
CODMAN SQUARE HEALTH CENTER 637 WASHINGTON STREET DORCHESTER, MA 02124	04-2678774	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
SOUTH BOSTON COMMUNITY HEALTH CENTER 409 W BROADWAY SOUTH BOSTON, MA 02127	04-2682152	501(C)(3)	5,500				COMMUNITY BENEFIT PROGRAM
WHITTIER STREET HEALTH CENTER 1290 TREMONT STREET ROXBURY, MA 02120	04-2619517	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
SAFE PASSAGE 43 CENTER STREET NORTHAMPTON, MA 01060	04-2690131	501(C)(3)	5,250				COMMUNITY BENEFIT PROGRAM
LYNN COMMUNITY HEALTH CENTER PO BOX 526 LYNN, MA 01901	04-2525066	501(C)(3)	5,051				COMMUNITY BENEFIT PROGRAM

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

2017

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 appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☑ First-class or charter travel ☑ Travel for companions ☐ Tax idemnification and gross-up payments ☐ Discretionary spending account ☐ Housing allowance or residence for personal use ☐ Payments for business use of personal residence ☑ Health or social club dues or initiation fees ☐ 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 ☑ Independent compensation consultant ☑ Form 990 of other organizations ☑ Written employment contract ☑ Compensation survey or study ☑ 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? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III	**4c**		No
	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? If "Yes," on line 5a or 5b, describe in Part III	**5b**		No
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? If "Yes," on line 6a or 6b, describe in Part III	**6b**		No
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed 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
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 APPROVED BY THE PARTNERS HEALTHCARE COMPENSATION COMMITTEE AND WAS TREATED AS NON-TAXABLE BUSINESS EXPENSE 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 I, LINE 3	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 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 LYNN MALLOY STOFER ELIZABETH NABEL, M D SCOTT RAUCH, M D DAVID J ROBERTS, M D PETER SLAVIN, M D , M B A DAVID STORTO
PART I, LINES 4A-B	RECEIPT OF SEVERANCE PAYMENTS KENNETH CHISHOLM - $178,620 JEFFREY P DION - $25,343 PAULA M HEREAU - $37,397 CHRISTINE REILLY - $20,691 LESLIE G SELBOVITZ, M D - $370,643 KERRY R WATSON - $593,725 JOSEPH L WOODIN - $125,536 NONQUALIFIED RETIREMENT PLAN PARTICIPATION IN A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN THESE AMOUNTS ARE ALREADY INCLUDED IN THE COMPENSATION DISCLOSED ON SCHEDULE J, PART II LAURIE LAMOUREUX - $25,628 PETER K MARKELL - $411,586 JOANNE MARQUSEE - $23,997 ELIZABETH G NABEL, M D - $360,043 ANTHONY J SCIBELLI, MS, MBA - $13,575 PETER L SLAVIN, M D , M B A - $59,413 DAVID E STORTO - $231,297 DAVID F TORCHIANA, M D - $2,193,186 RON M WALLS, M D - $781,629
PART I, LINE 7	CERTAIN EMPLOYEES RECEIVED INCENTIVE COMPENSATION BASED ON ACHIEVEMENT OF ORGANIZATIONAL AND INDIVIDUAL GOALS THE COMPENSATION COMMITTEE OF PARTNERS HEALTHCARE OR THE COMPENSATION COMMITTEES OF PARTNERS SUBORDINATE ENTITIES HAVE THE FINAL AUTHORITY FOR SUCH PAYMENTS
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

Additional Data

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

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			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 DALE ADLER MD SEE SCHEDULE O - O & T TITLES	(i)	495,634	35,914	11,428	36,842	19,964	599,782	0
	(ii)	0	0	0	0	0	0	0
1 KATRINA ARMSTRONG MD SEE SCHEDULE O - O & T TITLES	(i)	692,750	109,350	100,303	36,841	21,197	960,441	0
	(ii)	0	0	0	0	0	0	0
2 STANLEY W ASHLEY MD SEE SCHEDULE O - O & T TITLES	(i)	498,545	103,820	68,022	29,700	20,976	721,063	0
	(ii)	0	0	0	0	0	0	0
3 MAUREEN BANKS SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	438,585	48,383	95,987	29,700	10,004	622,659	0
4 ROBERT L BARBIERI MD SEE SCHEDULE O - O & T TITLES	(i)	466,534	109,506	20,452	36,843	28,127	661,462	0
	(ii)	0	0	0	0	0	0	0
5 GREGORY A BIRD SEE SCHEDULE O - O & T TITLES	(i)	234,250	0	74,120	41,886	8,227	358,483	0
	(ii)	0	0	0	0	0	0	0
6 CHRISTINE A BLASKI MD SEE SCHEDULE O - O & T TITLES	(i)	215,972	163	12,437	3,395	21,878	253,845	0
	(ii)	0	0	0	0	0	0	0
7 SALLY MASON BOEMER SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	741,084	217,600	69,172	29,700	23,054	1,080,610	0
8 GILES W BOLAND MD SEE SCHEDULE O - O & T TITLES	(i)	640,090	101,250	55,895	36,841	30,383	864,459	0
	(ii)	0	0	0	0	0	0	0
9 CHRISTOPHER M BONO MD SEE SCHEDULE O - O & T TITLES	(i)	343,478	34,263	29,730	24,300	22,430	454,201	0
	(ii)	0	0	0	0	0	0	0
10 JAMES A BRINK MD SEE SCHEDULE O - O & T TITLES	(i)	700,590	110,700	104,955	36,840	22,449	975,534	0
	(ii)	0	0	0	0	0	0	0
11 O'NEIL BRITTON MD SEE SCHEDULE O - O & T TITLES	(i)	625,679	97,209	70,825	29,700	28,272	851,685	0
	(ii)	0	0	0	0	0	0	0
12 CALVIN A BROWN III MD SEE SCHEDULE O - O & T TITLES	(i)	263,854	29,025	38,102	27,000	20,012	377,993	0
	(ii)	0	0	0	0	0	0	0
13 DAVID F BROWN MD SEE SCHEDULE O - O & T TITLES	(i)	544,500	173,700	71,974	36,840	23,134	850,148	0
	(ii)	0	0	0	0	0	0	0
14 DEBRA A BURKE MSN SEE SCHEDULE O - O & T TITLES	(i)	216,899	12,485	21,537	39,216	20,277	310,414	0
	(ii)	0	0	0	0	0	0	0
15 ELLEN L CAILLE SEE SCHEDULE O - O & T TITLES	(i)	299,859	107,414	20,124	62,318	29,820	519,535	0
	(ii)	0	0	0	0	0	0	0
16 PAUL R CASS DO SEE SCHEDULE O - O & T TITLES	(i)	413,785	422,941	1,524	76,164	22,110	936,524	0
	(ii)	0	0	0	0	0	0	0
17 BRUCE A CHABNER SEE SCHEDULE O - O & T TITLES	(i)	214,698	1,000	30,455	19,021	25,510	290,684	0
	(ii)	0	0	0	0	0	0	0
18 ENNIO A CHIOCCA MD SEE SCHEDULE O - O & T TITLES	(i)	1,487,990	352,000	141,018	36,840	28,441	2,046,289	0
	(ii)	0	0	0	0	0	0	0
19 CHRISTOPHER MARK COBURN SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	605,417	337,286	74,068	27,000	20,459	1,064,230	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 CHRISTOPHER M COLEY MD SEE SCHEDULE O - O & T TITLES	(i)	335,995	2,000	31,060	36,845	20,177	426,077	0
	(ii)	0	0	0	0	0	0	0
1 YOLONDA L COLSON MD SEE SCHEDULE O - O & T TITLES	(i)	426,840	21,241	26,844	36,840	25,041	536,806	0
	(ii)	0	0	0	0	0	0	0
2 WILLIAM S DANFORD SEE SCHEDULE O - O & T TITLES	(i)	381,300	44,391	1,524	10,800	15,027	453,042	0
	(ii)	0	0	0	0	0	0	0
3 ERNESTO DASILVA MD SEE SCHEDULE O - O & T TITLES	(i)	315,799	7,097	14,001	9,941	25,012	371,850	0
	(ii)	0	0	0	0	0	0	0
4 MARCELA DEL CARMEN MD SEE SCHEDULE O - O & T TITLES	(i)	539,259	86,907	81,390	36,842	9,605	754,003	0
	(ii)	0	0	0	0	0	0	0
5 JEFFREY P DION SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	256,768	0	67,024	30,399	27,280	381,471	0
6 GERARD M DOHERTY MD SEE SCHEDULE O - O & T TITLES	(i)	1,164,840	180,650	81,677	36,840	30,291	1,494,298	0
	(ii)	0	0	0	0	0	0	0
7 TERENCE P DOORLY MD SEE SCHEDULE O - O & T TITLES	(i)	398,629	280,094	25,286	14,850	20,540	739,399	0
	(ii)	0	0	0	0	0	0	0
8 PETER M DOUBILET MD SEE SCHEDULE O - O & T TITLES	(i)	405,809	116,747	28,446	36,843	25,041	612,886	0
	(ii)	0	0	0	0	0	0	0
9 SUNIL EAPPEN MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	522,201	81,499	19,259	36,840	21,335	681,134	0
10 JEFFREY L ECKER MD SEE SCHEDULE O - O & T TITLES	(i)	598,750	91,800	68,857	36,840	21,429	817,676	0
	(ii)	0	0	0	0	0	0	0
11 JONATHAN M FALLON MD SEE SCHEDULE O - O & T TITLES	(i)	606,854	22,822	9,914	6,674	18,602	664,866	0
	(ii)	0	0	0	0	0	0	0
12 THOMAS L FAZIO MD SEE SCHEDULE O - O & T TITLES	(i)	532,530	142,780	23,649	0	20,488	719,447	0
	(ii)	0	0	0	0	0	0	0
13 CARLOS FERNANDEZ-DEL CASTILLO MD SEE SCHEDULE O - O & T TITLES	(i)	629,246	7,800	236,004	36,843	25,987	935,880	0
	(ii)	0	0	0	0	0	0	0
14 TIMOTHY G FERRIS MD SEE SCHEDULE O - O & T TITLES	(i)	687,209	114,148	80,614	36,843	22,484	941,298	0
	(ii)	0	0	0	0	0	0	0
15 CRISTINA R FERRONE MD SEE SCHEDULE O - O & T TITLES	(i)	420,798	9,500	57,509	36,844	31,992	556,643	0
	(ii)	0	0	0	0	0	0	0
16 MARY ANN GAGNON SEE SCHEDULE O - O & T TITLES	(i)	121,354	20,417	357	4,915	21,113	168,156	0
	(ii)	0	0	0	0	0	0	0
17 JOSEPH MICHAEL GARASIC MD SEE SCHEDULE O - O & T TITLES	(i)	361,945	2,000	30,856	36,845	1,149	432,795	0
	(ii)	0	0	0	0	0	0	0
18 TERRY J GARFINKLE MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	393,668	32,513	81,524	27,000	21,275	555,980	0
19 ROYA GHAZINOURI PT SEE SCHEDULE O - O & T TITLES	(i)	126,513	5,360	-6,148	11,160	21,996	158,881	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)(i) Base Compensation	(B)(ii) Bonus & incentive compensation	(B)(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
41STEVEN A GILGEN SEE SCHEDULE O - O & T TITLES	(i)	226,028	0	49,670	1,082	2,318	279,098	0
	(ii)	0	0	0	0	0	0	0
1RICHARD S GITOMER MD SEE SCHEDULE O - O & T TITLES	(i)	428,250	42,432	22,175	12,624	34,097	539,578	0
	(ii)	0	0	0	0	0	0	0
2MATTHEW J GOLDBERG SEE SCHEDULE O - O & T TITLES	(i)	266,277	17,667	1,524	13,409	11,228	310,105	0
	(ii)	0	0	0	0	0	0	0
3JEFFREY A GOLDEN MD SEE SCHEDULE O - O & T TITLES	(i)	736,164	115,905	58,245	36,843	28,335	975,492	0
	(ii)	0	0	0	0	0	0	0
4TERRI E GORMAN MD SEE SCHEDULE O - O & T TITLES	(i)	256,705	25,500	111,797	24,300	21,404	439,706	0
	(ii)	0	0	0	0	0	0	0
5PETER A GRAPE MD SEE SCHEDULE O - O & T TITLES	(i)	481,451	104,830	61,845	36,843	21,449	706,418	0
	(ii)	0	0	0	0	0	0	0
6 MICHAEL L GUSTAFSON MD SEE SCHEDULE O - O & T TITLES	(i)	428,631	70,230	76,387	29,700	8,418	613,366	0
	(ii)	0	0	0	0	0	0	0
7 DAPHNE ADELE HAAS-KOGANMD SEE SCHEDULE O - O & T TITLES	(i)	699,018	114,059	125,727	24,300	21,404	984,508	0
	(ii)	0	0	0	0	0	0	0
8ROBERT HANDIN MD SEE SCHEDULE O - O & T TITLES	(i)	263,467	11,578	2,710	36,849	20,579	335,183	0
	(ii)	0	0	0	0	0	0	0
9MARGOT K HARTMANN MD SEE SCHEDULE O - O & T TITLES	(i)	326,270	240	21,754	6,924	11,149	366,337	0
	(ii)	0	0	0	0	0	0	0
10 ANNEMARIE HEATH CNM DNP SEE SCHEDULE O - O & T TITLES	(i)	131,104	5,092	2,982	3,959	17,563	160,700	0
	(ii)	0	0	0	0	0	0	0
11JAMES L HEFFERNAN SEE SCHEDULE O - O & T TITLES	(i)	499,750	96,350	94,838	41,886	20,495	753,319	0
	(ii)	0	0	0	0	0	0	0
12THEODORE S HONG MD SEE SCHEDULE O - O & T TITLES	(i)	699,650	10,000	104,031	36,842	20,334	870,857	0
	(ii)	0	0	0	0	0	0	0
13TERRIE E INDER MBCHB SEE SCHEDULE O - O & T TITLES	(i)	527,166	82,500	52,016	24,300	30,692	716,674	0
	(ii)	0	0	0	0	0	0	0
14MICHAEL R JAFF DO SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	679,600	107,700	132,564	29,700	22,839	972,403	0
15ALAN ANTHONY JAMES SEE SCHEDULE O - O & T TITLES	(i)	378,500	57,900	66,662	33,786	9,167	546,015	0
	(ii)	0	0	0	0	0	0	0
16WILLIAM C JOHNSTON SEE SCHEDULE O - O & T TITLES	(i)	472,664	230,138	37,861	32,400	25,994	799,057	0
	(ii)	0	0	0	0	0	0	0
17ANNE KALTER SEE SCHEDULE O - O & T TITLES	(i)	142,187	45,281	18,553	4,928	25,697	236,646	0
	(ii)	0	0	0	0	0	0	0
18JAMES D KANG MD SEE SCHEDULE O - O & T TITLES	(i)	1,213,590	201,034	57,560	36,842	31,041	1,540,067	0
	(ii)	0	0	0	0	0	0	0
19STEVEN E KAPFHAMMER SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	258,453	14,649	64,519	21,600	17,196	376,417	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			(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				
61BARRETT KITCH MD SEE SCHEDULE O - O & T TITLES	(i)	311,872	16,000	27,042	12,150	6,730	373,794	0
	(ii)	0	0	0	0	0	0	0
1RONALD E KLEINMAN MD SEE SCHEDULE O - O & T TITLES	(i)	492,590	79,650	81,554	36,841	22,433	713,068	0
	(ii)	0	0	0	0	0	0	0
2ANNE KLIBANSKI MD SEE SCHEDULE O - O & T TITLES	(i)	736,162	119,525	119,678	36,843	20,558	1,032,766	0
	(ii)	0	0	0	0	0	0	0
3THOMAS S KUPPER MD SEE SCHEDULE O - O & T TITLES	(i)	486,580	108,750	27,498	36,841	23,252	682,921	0
	(ii)	0	0	0	0	0	0	0
4JOSEPH LOSCALZO MD SEE SCHEDULE O - O & T TITLES	(i)	631,759	124,135	25,566	36,844	23,913	842,217	0
	(ii)	0	0	0	0	0	0	0
5DAVID N LOUIS MD SEE SCHEDULE O - O & T TITLES	(i)	550,186	95,590	90,904	36,841	20,652	794,173	0
	(ii)	0	0	0	0	0	0	0
6HUGH MACDONALD SEE SCHEDULE O - O & T TITLES	(i)	216,249	82,068	1,460	10,455	29,783	340,015	0
	(ii)	0	0	0	0	0	0	0
7HEATHER COLMORE MACK SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	202,338	9,975	29,899	13,680	15,786	271,678	0
8PETER K MARKELL SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	1,448,400	692,198	3,153,371	29,700	22,022	5,345,691	2,500,000
9JOANNE MARQUSEE SEE SCHEDULE O - O & T TITLES	(i)	437,776	70,930	69,601	5,348	13,152	596,807	0
	(ii)	0	0	0	0	0	0	0
10NAVNEET MARWAHA MD SEE SCHEDULE O - O & T TITLES	(i)	281,931	1,950	7,834	13,089	21,203	326,007	0
	(ii)	0	0	0	0	0	0	0
11 DAVID MCCREADY MBA MHA SEE SCHEDULE O - O & T TITLES	(i)	399,975	86,400	54,947	24,300	25,758	591,380	0
	(ii)	0	0	0	0	0	0	0
12MAURY E MCGOUGH MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	517,603	42,530	95,440	29,700	21,214	706,487	0
13 PAULA MILONE-NUZZO PHD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	166,271	75,000	29,927	0	27,281	298,479	0
14ELIZABETH A MORT MD SEE SCHEDULE O - O & T TITLES	(i)	479,949	77,700	78,113	36,843	20,799	693,404	0
	(ii)	0	0	0	0	0	0	0
15ELIZABETH G NABEL MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	1,357,200	448,644	733,116	29,700	11,252	2,579,912	265,000
16ALBERT NAMIAS MD SEE SCHEDULE O - O & T TITLES	(i)	454,524	0	23,845	14,850	21,704	514,923	0
	(ii)	0	0	0	0	0	0	0
17ANDREA NG MD SEE SCHEDULE O - O & T TITLES	(i)	389,903	67,925	885	32,400	22,088	513,201	0
	(ii)	0	0	0	0	0	0	0
18NAWAL M NOUR MD MPH SEE SCHEDULE O - O & T TITLES	(i)	324,353	190,851	49,587	32,400	5,365	602,556	0
	(ii)	0	0	0	0	0	0	0
19JOHN NOVELLO SEE SCHEDULE O - O & T TITLES	(i)	309,779	20,000	1,002	14,354	18,859	363,994	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)(i) Base Compensation	(B)(ii) Bonus & incentive compensation	(B)(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 JOHANNA M O'CONNOR MD SEE SCHEDULE O - O & T TITLES	(i)	466,648	9,500	51,044	36,846	23,769	587,807	0
	(ii)	0	0	0	0	0	0	0
1 GREGORY J PAULY SEE SCHEDULE O - O & T TITLES	(i)	557,500	226,050	90,363	36,486	21,185	931,584	0
	(ii)	0	0	0	0	0	0	0
2 STEVEN B PESTKA MD SEE SCHEDULE O - O & T TITLES	(i)	367,363	35,800	7,037	10,800	19,843	440,843	0
	(ii)	0	0	0	0	0	0	0
3 PIETER PIL MD SEE SCHEDULE O - O & T TITLES	(i)	517,908	53,700	58,584	13,603	27,447	671,242	0
	(ii)	0	0	0	0	0	0	0
4 NANCY S PITTMAN SEE SCHEDULE O - O & T TITLES	(i)	135,192	0	13,714	3,794	1,188	153,888	0
	(ii)	0	0	0	0	0	0	0
5 DAVID S PLADZIEWICZ MD SEE SCHEDULE O - O & T TITLES	(i)	540,074	19,897	21,017	0	21,369	602,357	0
	(ii)	0	0	0	0	0	0	0
6 ALLYSON L PRESTON MD SEE SCHEDULE O - O & T TITLES	(i)	359,410	9,879	25,362	14,850	26,206	435,707	0
	(ii)	0	0	0	0	0	0	0
7 JAMES P RATHMELL MD SEE SCHEDULE O - O & T TITLES	(i)	620,500	97,600	93,486	29,700	25,513	866,799	0
	(ii)	0	0	0	0	0	0	0
8 DAVID W RATTNER MD SEE SCHEDULE O - O & T TITLES	(i)	737,825	102,000	113,183	36,842	26,070	1,015,920	0
	(ii)	0	0	0	0	0	0	0
9 SCOTT L RAUCH MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	585,325	93,630	75,725	29,700	26,330	810,710	0
10 MITCHELL S REIN MD SEE SCHEDULE O - O & T TITLES	(i)	527,694	24,261	84,164	36,842	22,197	695,158	0
	(ii)	0	0	0	0	0	0	0
11 PHILLIP L RICE JR MD SEE SCHEDULE O - O & T TITLES	(i)	443,978	0	37,081	14,850	23,452	519,361	0
	(ii)	0	0	0	0	0	0	0
12 DAVID J ROBERTS MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	464,899	48,000	43,630	0	10,007	566,536	0
13 MARC S RUBIN MD SEE SCHEDULE O - O & T TITLES	(i)	771,973	26,000	113,682	36,841	27,067	975,563	0
	(ii)	0	0	0	0	0	0	0
14 ROXANNE C RUPPEL SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	268,328	14,245	29,193	27,000	21,570	360,336	0
15 ALI SALIM MD SEE SCHEDULE O - O & T TITLES	(i)	469,345	25,146	80,656	24,300	24,329	623,776	0
	(ii)	0	0	0	0	0	0	0
16 MARTIN A SAMUELS MD SEE SCHEDULE O - O & T TITLES	(i)	502,740	81,680	56,824	36,840	23,081	701,165	0
	(ii)	0	0	0	0	0	0	0
17 JOAN A SAPIR SEE SCHEDULE O - O & T TITLES	(i)	416,000	67,095	82,918	41,886	21,005	628,904	0
	(ii)	0	0	0	0	0	0	0
18 MARK A SCHECHTER MD SEE SCHEDULE O - O & T TITLES	(i)	317,152	15,400	25,980	12,501	22,222	393,255	0
	(ii)	0	0	0	0	0	0	0
19 FREDERICK J SCHOEN MD SEE SCHEDULE O - O & T TITLES	(i)	323,830	21,790	22,569	36,847	24,945	429,981	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			(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				
101 DAVID SILBERSWEIG MD SEE SCHEDULE O - O & T TITLES	(i)	570,784	89,170	30,968	36,844	24,079	751,845	0
	(ii)	0	0	0	0	0	0	0
1 ANEESH B SINGHAL MD SEE SCHEDULE O - O & T TITLES	(i)	367,903	29,665	37,099	36,844	19,203	490,714	0
	(ii)	0	0	0	0	0	0	0
2 PETER L SLAVIN MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	1,532,500	545,668	460,246	29,700	27,535	2,595,649	298,200
3 ALLEN L SMITH MD MS SEE SCHEDULE O - O & T TITLES	(i)	721,340	112,500	53,784	241,262	24,707	1,153,593	0
	(ii)	0	0	0	0	0	0	0
4 LYNN MALLOY STOFER SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	607,275	94,001	82,661	24,300	26,382	834,619	0
5 DAVID E STORTO SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	567,950	84,966	307,257	29,700	21,489	1,011,362	0
6 THORALF M SUNDT MD SEE SCHEDULE O - O & T TITLES	(i)	677,456	127,000	119,319	36,844	25,984	986,603	0
	(ii)	0	0	0	0	0	0	0
7 KHALID SYED MD SEE SCHEDULE O - O & T TITLES	(i)	333,503	585	34,841	15,614	24,103	408,646	0
	(ii)	0	0	0	0	0	0	0
8 DAVID F TORCHIANA MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	2,280,893	1,500,000	2,294,942	29,700	22,551	6,128,086	0
9 GARY USHER SEE SCHEDULE O - O & T TITLES	(i)	249,991	77,545	1,518	7,698	10,479	347,231	0
	(ii)	0	0	0	0	0	0	0
10 MICHAEL J VANROOYEN MD SEE SCHEDULE O - O & T TITLES	(i)	570,745	92,572	45,288	36,841	23,340	768,786	0
	(ii)	0	0	0	0	0	0	0
11 PETER E WALCEK SEE SCHEDULE O - O & T TITLES	(i)	339,404	75,216	63,563	71,202	22,163	571,548	0
	(ii)	0	0	0	0	0	0	0
12 GREGORY J WALKER SEE SCHEDULE O - O & T TITLES	(i)	492,652	170,737	193,829	128,889	21,871	1,007,978	0
	(ii)	0	0	0	0	0	0	0
13 TIMOTHY J WALSH SEE SCHEDULE O - O & T TITLES	(i)	268,361	100	33,480	12,565	2,519	317,025	0
	(ii)	0	0	0	0	0	0	0
14 ANDREW L WARSHAW MD SEE SCHEDULE O - O & T TITLES	(i)	471,885	25,450	550,889	36,842	25,640	1,110,706	0
	(ii)	0	0	0	0	0	0	0
15 DEBRA F WEINSTEIN MD SEE SCHEDULE O - O & T TITLES	(i)	424,173	8,705	69,398	36,845	20,358	559,479	0
	(ii)	0	0	0	0	0	0	0
16 ROSS D ZAFONTE DO SEE SCHEDULE O - O & T TITLES	(i)	508,291	54,420	81,518	36,842	20,928	701,999	0
	(ii)	0	0	0	0	0	0	0
17 JEANETTE IVES-ERICKSON DNP SEE SCHEDULE O - O & T TITLES	(i)	496,750	80,400	100,648	41,886	9,092	728,776	0
	(ii)	0	0	0	0	0	0	0
18 LOUIS JENIS MD SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	553,616	18,375	86,284	14,850	9,900	683,025	0
19 CHARLES E ADAMS SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	191,243	10,284	25,944	24,169	23,498	275,138	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			(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				
121CINDY L AIENA SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	199,223	12,250	15,429	18,823	24,603	270,328	0
1SARAH ARNHOLZ ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	230,641	11,655	8,003	25,766	24,648	300,713	0
2MELISSA P BRENNAN ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	163,871	7,300	-3,563	12,254	34,452	214,314	0
3MICHAEL R CARTER SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	217,118	43,800	16,045	0	5,534	282,497	0
4EFFIE J CHAN ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	170,025	300	15,468	15,462	29,926	231,181	0
5 JULIE C CHATTOPADHYAY ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	173,021	4,800	12,161	12,040	27,717	229,739	0
6DAVID P CONNOLLY SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	303,600	32,000	30,359	27,000	25,740	418,699	0
7PAUL G CUSHING ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	229,492	13,265	45,968	29,700	23,595	342,020	0
8CHRISTOPHER DUNLEAVY SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	728,831	113,220	138,058	14,850	1,717	996,676	0
9ATLAS D EVANS SEE SCHEDULE O - O & T TITLES	(i)	246,510	10,000	19,506	36,844	22,260	335,120	0
	(ii)	0	0	0	0	0	0	0
10KEVIN T GIORDANO SEE SCHEDULE O - O & T TITLES	(i)	230,220	24,334	5,947	15,148	32,015	307,664	0
	(ii)	0	0	0	0	0	0	0
11 MICHELE L GOUGEON MSC SEE SCHEDULE O - O & T TITLES	(i)	361,441	45,900	21,175	41,886	22,738	493,140	0
	(ii)	0	0	0	0	0	0	0
12JUDI S GREENBERG ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	180,702	300	17,465	22,303	27,721	248,491	0
13GERARD F HADLEY SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	210,547	20,196	17,739	25,289	15,634	289,405	0
14JOHN R HIGHAM ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	292,328	49,155	13,047	24,900	20,870	400,300	0
15STEPHEN R JENNEY SEE SCHEDULE O - O & T TITLES	(i)	268,648	98,573	46,702	36,845	23,618	474,386	0
	(ii)	0	0	0	0	0	0	0
16 LAURA STEPHENS KHOSHBIN ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	189,788	3,800	5,541	21,384	7,207	227,720	0
17 KATHERINE M KNEELAND ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	229,935	13,500	51,772	29,700	8,503	333,410	0
18DAVID A LAGASSE SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	263,188	36,792	79,323	29,700	30,514	439,517	0
19LAURIE R LAMOUREUX SEE SCHEDULE O - O & T TITLES	(i)	216,064	47,875	64,048	15,371	7,764	351,122	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			(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				
141EDWARD J OLIVIER SEE SCHEDULE O - O & T TITLES	(i)	200,723	34,486	58,295	10,492	17,004	321,000	0
	(ii)	0	0	0	0	0	0	0
1ANDREA G RE ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	136,551	300	14,651	13,258	8,134	172,894	0
2MARY E SHAUGHNESSY SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	310,640	35,090	68,784	29,700	19,044	463,258	0
3TRACY A SYKES ESQ SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	199,008	300	22,485	22,210	24,245	268,248	0
4PAUL ANDERSON MD PHD SEE SCHEDULE O - O & T TITLES	(i)	515,379	82,500	53,626	36,843	25,512	713,860	0
	(ii)	0	0	0	0	0	0	0
5SHELLY ANDERSON MPM SEE SCHEDULE O - O & T TITLES	(i)	402,327	83,379	98,154	18,900	21,416	624,176	0
	(ii)	0	0	0	0	0	0	0
6SUSAN DEMPSEY SEE SCHEDULE O - O & T TITLES	(i)	269,228	26,127	29,153	29,700	20,749	374,957	0
	(ii)	0	0	0	0	0	0	0
7KEREN DIAMOND SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	211,301	35,491	41,438	26,181	15,935	330,346	0
8 MARGARET M DUGGAN MD SEE SCHEDULE O - O & T TITLES	(i)	220,051	193,590	80,702	27,000	27,477	548,820	0
	(ii)	0	0	0	0	0	0	0
9LINDA FLAHERTY RN SEE SCHEDULE O - O & T TITLES	(i)	191,812	25,644	20,998	33,433	19,009	290,896	0
	(ii)	0	0	0	0	0	0	0
10TIMOTHY E FOSTER MD SEE SCHEDULE O - O & T TITLES	(i)	861,375	51,850	15,100	13,500	22,741	964,566	0
	(ii)	0	0	0	0	0	0	0
11 LAWRENCE S FRIEDMAN MD SEE SCHEDULE O - O & T TITLES	(i)	438,879	30,627	39,509	14,850	19,801	543,666	0
	(ii)	0	0	0	0	0	0	0
12JOANNE M FUCILE SEE SCHEDULE O - O & T TITLES	(i)	211,579	22,596	22,779	32,333	9,331	298,618	0
	(ii)	0	0	0	0	0	0	0
13MARY JO GAGNON SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	219,784	12,861	51,502	29,271	11,636	325,054	0
14JOSEPH GOLD MD SEE SCHEDULE O - O & T TITLES	(i)	403,430	48,168	-1,575	41,886	22,993	514,902	0
	(ii)	0	0	0	0	0	0	0
15GEORGE GOUGIAN SEE SCHEDULE O - O & T TITLES	(i)	126,074	15,183	17,551	8,292	20,123	187,223	0
	(ii)	0	0	0	0	0	0	0
16ROSEMARY HENCHEY SEE SCHEDULE O - O & T TITLES	(i)	161,251	5,250	24,419	10,336	8,749	210,005	0
	(ii)	0	0	0	0	0	0	0
17MICHAEL J HESSION MD SEE SCHEDULE O - O & T TITLES	(i)	269,476	39,569	38,577	36,845	22,762	407,229	0
	(ii)	0	0	0	0	0	0	0
18ALEX F JOHNSON SEE SCHEDULE O - O & T TITLES	(i)	276,588	25,000	12,890	36,845	19,341	370,664	0
	(ii)	0	0	0	0	0	0	0
19PARDON R KENNEY MD SEE SCHEDULE O - O & T TITLES	(i)	416,675	32,660	45,799	36,840	25,048	557,022	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			(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				
161 CHRISTOPHER J KWOLEK MD SEE SCHEDULE O - O & T TITLES	(i)	817,600	40,750	106,196	36,842	33,693	1,035,081	0
	(ii)	0	0	0	0	0	0	0
1JANET LARSON MD SEE SCHEDULE O - O & T TITLES	(i)	389,359	30,700	30,038	12,150	20,801	483,048	0
	(ii)	0	0	0	0	0	0	0
2PAMELA K LEVANGIE SEE SCHEDULE O - O & T TITLES	(i)	176,630	0	20,604	18,436	3,173	218,843	0
	(ii)	0	0	0	0	0	0	0
3KEITH D LILLEMOE MD SEE SCHEDULE O - O & T TITLES	(i)	762,928	137,500	116,263	36,841	26,100	1,079,632	0
	(ii)	0	0	0	0	0	0	0
4 EDWARD LISTON-KRAFT PHD SEE SCHEDULE O - O & T TITLES	(i)	214,100	19,048	29,488	26,662	961	290,259	0
	(ii)	0	0	0	0	0	0	0
5 CORI LOESCHER MM BSN RN SEE SCHEDULE O - O & T TITLES	(i)	214,574	5,000	14,754	18,018	4,372	256,718	0
	(ii)	0	0	0	0	0	0	0
6ROBERT T MCCALL SEE SCHEDULE O - O & T TITLES	(i)	190,265	21,420	16,979	20,028	21,476	270,168	0
	(ii)	0	0	0	0	0	0	0
7CHERYL MERRILL RN SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	261,000	14,250	38,067	27,000	6,694	347,011	0
8ELLEN A MOLONEY SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	486,457	157,828	59,803	29,700	12,378	746,166	0
9STEPHANIE N NADOLNY SEE SCHEDULE O - O & T TITLES	(i)	156,610	17,230	16,145	10,014	15,109	215,108	0
	(ii)	0	0	0	0	0	0	0
10 BRITAIN W NICHOLSON MD SEE SCHEDULE O - O & T TITLES	(i)	576,564	97,504	89,660	36,843	20,603	821,174	0
	(ii)	0	0	0	0	0	0	0
11DOST ONGUR MD PHD SEE SCHEDULE O - O & T TITLES	(i)	258,768	10,500	-9,664	18,689	25,877	304,170	0
	(ii)	0	0	0	0	0	0	0
12JEFFREY C POLLOCK SEE SCHEDULE O - O & T TITLES	(i)	222,930	57,316	1,462	18,000	34,383	334,091	0
	(ii)	0	0	0	0	0	0	0
13LESLIE PORTNEY SEE SCHEDULE O - O & T TITLES	(i)	154,128	0	36,363	25,028	19,551	235,070	0
	(ii)	0	0	0	0	0	0	0
14ANN L PRESTIPINO SEE SCHEDULE O - O & T TITLES	(i)	492,800	78,045	95,977	41,886	9,020	717,728	0
	(ii)	0	0	0	0	0	0	0
15CHRISTINE REILLY SEE SCHEDULE O - O & T TITLES	(i)	112,313	0	61,082	7,396	704	181,495	0
	(ii)	0	0	0	0	0	0	0
16KERRY J RESSLER MD SEE SCHEDULE O - O & T TITLES	(i)	287,998	29,325	2,707	18,900	21,286	360,216	0
	(ii)	0	0	0	0	0	0	0
17JOHN SARRO SEE SCHEDULE O - O & T TITLES	(i)	317,250	0	18,139	14,850	20,781	371,020	0
	(ii)	0	0	0	0	0	0	0
18SCOTT L SCHISSEL MD SEE SCHEDULE O - O & T TITLES	(i)	273,352	15,398	35,673	29,700	19,997	374,120	0
	(ii)	0	0	0	0	0	0	0
19NANCY D SCHMIDT SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	254,075	29,460	92,266	29,700	21,260	426,761	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			(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				
181 ANTHONY J SCIBELLI MS SEE SCHEDULE O - O & T TITLES	(i)	254,309	39,560	24,251	11,051	13,094	342,265	0
	(ii)	0	0	0	0	0	0	0
1ARTHUR ST GERMAIN SEE SCHEDULE O - O & T TITLES	(i)	0	0	0	0	0	0	0
	(ii)	119,098	10,545	37,944	17,186	21,825	206,598	0
2DENIS G STRATFORD SEE SCHEDULE O - O & T TITLES	(i)	195,737	0	-4,469	24,965	20,427	236,660	0
	(ii)	0	0	0	0	0	0	0
3INEZ TUCK SEE SCHEDULE O - O & T TITLES	(i)	208,088	0	31,995	28,475	9,291	277,849	0
	(ii)	0	0	0	0	0	0	0
4ALAMJIT S VIRK MD SEE SCHEDULE O - O & T TITLES	(i)	408,554	12,100	1,163	10,800	20,973	453,590	0
	(ii)	0	0	0	0	0	0	0
5RON M WALLS MD SEE SCHEDULE O - O & T TITLES	(i)	1,212,750	187,275	845,884	29,700	26,885	2,302,494	0
	(ii)	0	0	0	0	0	0	0
6ROBERT D WELCH SEE SCHEDULE O - O & T TITLES	(i)	175,897	19,890	25,041	26,166	20,920	267,914	0
	(ii)	0	0	0	0	0	0	0
7SHEILA M WOOLLEY SEE SCHEDULE O - O & T TITLES	(i)	242,621	43,235	41,003	36,470	21,613	384,942	0
	(ii)	0	0	0	0	0	0	0
8DAVID C BROOKS MD SEE SCHEDULE O - O & T TITLES	(i)	190,234	11,888	1,364,337	25,722	23,630	1,615,811	0
	(ii)	0	0	0	0	0	0	0
9BOB S CARTER MD SEE SCHEDULE O - O & T TITLES	(i)	1,039,289	652,587	77,329	32,400	40,259	1,841,864	0
	(ii)	0	0	0	0	0	0	0
10 THOMAS F HOLOVACS MD SEE SCHEDULE O - O & T TITLES	(i)	1,150,905	324,283	109,402	36,842	22,304	1,643,736	0
	(ii)	0	0	0	0	0	0	0
11AMAN B PATEL MD SEE SCHEDULE O - O & T TITLES	(i)	1,349,386	2,000	307,098	36,841	26,099	1,721,424	0
	(ii)	0	0	0	0	0	0	0
12JON P WARNER MD SEE SCHEDULE O - O & T TITLES	(i)	1,618,938	18,350	108,701	36,841	22,304	1,805,134	0
	(ii)	0	0	0	0	0	0	0
13JANIS P BELLACK PHD FORMER O - IHP	(i)	0	0	0	0	0	0	0
	(ii)	375,951	12,901	50,851	28,342	8,171	476,216	0
14DANIEL J GROSS FORMER O - NWCF, NWH, NWHC, NWMG	(i)	0	0	0	0	0	0	0
	(ii)	393,138	43,297	72,665	29,700	22,813	561,613	0
15THOMAS LYNCH JR MD FORMER O - MGPO	(i)	237,537	0	9,595	18,422	9,983	275,537	0
	(ii)	0	0	0	0	0	0	0
16REYNOLD G SPADONI FORMER O - PHC	(i)	0	0	0	0	0	0	0
	(ii)	229,116	0	30,131	21,380	14,561	295,188	0
17KERRY R WATSON FORMER O - NWH, NWHC	(i)	0	0	0	0	0	0	0
	(ii)	0	0	596,520	0	552	597,072	0
18JOSEPH L WOODIN FORMER O - MVH, WNR	(i)	158,205	60,000	146,292	8,100	19,545	392,142	0
	(ii)	0	0	0	0	0	0	0
19DENNIS AUSIELLO MD FORMER K - GHC	(i)	344,701	500	115,084	36,845	21,836	518,966	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)(i) Base Compensation	(B)(ii) Bonus & incentive compensation	(B)(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
201BARBARA E BIERER MD FORMER K - BWH	(i)	317,555	0	34,108	36,842	26,470	414,975	0
	(ii)	0	0	0	0	0	0	0
1STEVEN D BROWELL MD FORMER K - NSPG	(i)	514,259	3,140	17,620	10,800	23,645	569,464	0
	(ii)	0	0	0	0	0	0	0
2MAUREEN N CHESLEY FORMER K - PHC	(i)	0	0	0	0	0	0	0
	(ii)	156,349	18,000	23,382	17,542	22,943	238,216	0
3KENNETH CHISHOLM FORMER K - MVH	(i)	34,838	0	186,254	10,208	2,239	233,539	0
	(ii)	0	0	0	0	0	0	0
4MARY BETH DIFILIPPO FORMER K - SKRH	(i)	184,359	250	11,315	22,330	19,841	238,095	0
	(ii)	0	0	0	0	0	0	0
5GARY W GARBERG FORMER K - PHC	(i)	0	0	0	0	0	0	0
	(ii)	145,769	2,500	23,740	15,329	24,681	212,019	0
6JUDY HAYES FORMER K - BWFH	(i)	114,493	0	14,859	13,991	9,577	152,920	0
	(ii)	0	0	0	0	0	0	0
7PAULA M HEREAU FORMER K - SRH	(i)	115,387	0	67,904	22,000	10,012	215,303	0
	(ii)	0	0	0	0	0	0	0
8HARRY W ORF PHD FORMER K - GHC	(i)	489,590	79,200	83,773	36,840	19,513	708,916	0
	(ii)	0	0	0	0	0	0	0
9SHEILA K PARTRIDGE MD FORMER K - NWH	(i)	760,056	125,419	32,311	10,800	19,171	947,757	0
	(ii)	0	0	0	0	0	0	0
10LESLIE G SELBOVITZ MD FORMER K - NWH	(i)	0	0	0	0	0	0	0
	(ii)	0	0	380,068	0	0	380,068	0
11JULIA SINCLAIR MBA FORMER K - BWH	(i)	392,000	86,400	56,337	29,700	25,658	590,095	0
	(ii)	0	0	0	0	0	0	0
12JEFFREY R ZACK MD FORMER K - MVH	(i)	306,482	100	22,490	12,150	24,418	365,640	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

2017

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 Yes	A No	B Yes	B No	C Yes	C No	D Yes	D 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 Yes	A No	B Yes	B No	C Yes	C No	D Yes	D 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

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

2017

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
(1) D A HAAS-KOGAN MD	DIRECTOR	PHYSICIAN RECRUITMENT		X	250,000	83,334		No	Yes		Yes	
(2) E OLIVIER	OFFICER	RECRUITMENT		X	100,000	60,000		No	Yes		Yes	
(3) M BELSKY MD	DIRECTOR	PHYSICIAN RECRUITMENT		X	271,922	166,239		No	Yes		Yes	
(4) S GILGEN	OFFICER	EMPLOYMENT/HOUSING PURCHASE		X	125,000	99,703		No	Yes		Yes	
Total				▶ $		409,276						

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
See Additional Data Table					

Part V Supplemental Information

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

Return Reference	Explanation

Additional Data

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

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
(1) B MILLER	SPIESS, TRU (FAM)	98,913	SALARY		No
(1) B RATTNER	RATTNER, TRU (FAM)	202,025	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
(3) B TILS	MARQUSEE, TRU, OFF (FAM)	11,900	SALARY		No
(1) BAUPOST GROUP LLC	MOONEY, OFF	2,967,817	INVESTMENT MGMT		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
(5) C BENSON	DOUBILET, TRU	575,996	SALARY		No
(1) C OLIVIER	OLIVIER, OFF (FAM)	95,522	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
(7) J RAY	RAY, TRU (FAM)	51,993	SALARY		No
(1) K CASPER	PIL, TRU (FAM)	293,001	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**
(9) NPP DEVELOPMENT	KRAFT, TRU (FAM)	4,449,630	LEASE		No
(1) NS CARDIO ASSOC	ROBERTS, TRU	641,280	SERVICES		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
(11) P HEARON	HIGHAM, OFF (FAM)	64,573	SALARY		No
(1) R VANDERHOOP	SWEET, TRU,OFF (FAM)	162,600	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
(13) SUFFOLK CONSTRUCTION	FISH, TRU	13,389,724	CONSTRUCTION SERVICES		No
(1) TEN MAIN ST RE LLC	ZUCKER, TRU	178,276	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
(15) VIDOC	WEITZMAN, TRU (FAM)	227,105	LEASE		No

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

2017

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	6	12,423	FMV
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications	X		2,792	FMV
5 Clothing and household goods	X		12,866	FMV
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded	X	910	66,662,432	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	20	3,452	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** — 2

			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 nonstandard 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 ▶ (MEDICAL EQUIPMENT)	X	6	805,431	FMV
Other ▶ (GIFT CERTIFICATES)	X	303	259,735	FMV
Other ▶ (MISCELLANEOUS)	X	207	161,908	FMV
Other ▶ (JEWLERY)	X	12	54,508	FMV
Other ▶ (PORTRAITS)	X	29	50,404	FMV
Other ▶ (FOOD)	X	109	40,119	FMV
Other ▶ (ROUNDS OF GOLF)	X	19	36,290	FMV
Other ▶ (SPORTING EVENT/THEATER/MUSEUM TICKETS)	X	50	29,161	FMV
Other ▶ (HOTEL PACKAGES)	X	49	26,759	FMV
Other ▶ (ADVERTISING)	X	12	15,755	FMV
Other ▶ (TRAVEL/AIRFARE/TRANSPORTATION)	X	8	2,300	FMV
Other ▶ (STUDIO PARTY/PARTY)	X	2	1,150	FMV

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

2017

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 type of entity
DUE FROM AFFILIATES	01-31-2018	500	FMV	04-2650246	NEWTON-WELLESLEY HOSPITAL 399 REVOLUTION DRIVE SUITE 645 SOMERVILLE, MA 021451446	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?	2a		No
b	Become an employee of, or independent contractor for, a successor or transferee organization?	2b		No
c	Become a direct or indirect owner of a successor or transferee organization?	2c		No
d	Receive, or become entitled to, compensation or other similar payments as a result of the organization's liquidation, termination, or dissolution?	2d		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-

		Line	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

		Line	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
PART I, LINE 6C	MERGERTHE FOLLOWING ORGANIZATION MERGED INTO ITS 501(C)(3) TAX EXEMPT PARENT ORGANIZATION NEWTON-WELLESLEY HOSPITAL CHARITABLE FOUNDATION, INC (04-3455952) MERGED INTONEWTON-WELLESLEY HOSPITAL (04-2103611) EFFECTIVE JANUARY 31, 2018

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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

2017

Open to Public Inspection

Name of the organization	Employer identification number
PARTNERS HEALTHCARE SYSTEM INC & AFFILIATES GROUP RETURN	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 2018, E NDING SEPTEMBER 30, 2018 PARTNERS HEALTHCARE RECORDED 162,190 ADMISSIONS AND 1,012,974 PAT IENT DAYS AMBULATORY CARE EACH OF PARTNERS HEALTHCARE'S NINE ACUTE CARE HOSPITALS PROVID ES EMERGENCY, AMBULATORY AND OUTPATIENT CARE ACROSS MAJOR SPECIALTIES COMBINED, THEY COMP RISE THE LARGEST OUTPATIENT NETWORK IN EASTERN MASSACHUSETTS IN 2018, PARTNERS HEALTHCARE ACUTE CARE HOSPITAL BASED AND NON-HOSPITAL BASED AMBULATORY CARE PROGRAMS RESULTED IN APP ROXIMATELY 1,882,000 ROUTINE VISITS, APPROXIMATELY 426,000 EMERGENCY SERVICES VISITS AND A PPROXIMATELY 607,000 HOME HEALTH VISITS BWH IS THE RESULT OF A 1975 MERGER OF THE PETER B ENT BRIGHAM HOSPITAL, THE ROBERT BRECK BRIGHAM HOSPITAL AND THE BOSTON HOSPITAL FOR WOMEN, WHOSE INPATIENT FACILITIES WERE PHYSICALLY CONSOLIDATED IN 1980 IN THE 2018-19 U S NEWS AND WORLD REPORT, BWH RANKED #13 IN THE NATION, #2 IN MASSACHUSETTS AND #2 IN BOSTON METR O AREA AND WAS NATIONALLY RECOGNIZED IN ELEVEN ADULT SPECIALTIES AND NINE PROCEDURES AND C ONDITIONS, INCLUDING CANCER, CARDIOLOGY AND HEART SURGERY, DIABETES AND ENDOCRINOLOGY, GA STROENTEROLOGY & GI SURGERY, GERIATRICS, GYNECOLOGY, NEPHROLOGY, NEUROLOGY & NEUROSURGERY, ORTHOPEDICS, PULMONOLOGY, AND RHEUMATOLOGY BWH PROVIDES OUTPATIENT SERVICES, INCLUDING P RIMARY CARE, SPECIALTY CARE, DIAGNOSTICS, IMAGING AND AMBULATORY PROCEDURES AT NUMEROUS AM BULATORY PRACTICES IN VARIOUS LOCATIONS FOUR PRACTICE SITES ON THE BWH DISTRIBUTED MAIN C AMPUS AND THE BRIGHAM AND WOMEN'S AMBULATORY CARE CENTER IN CHESTNUT HILL HOUSE THE MAJORI TY 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 PATRI OT PLACE IN FOXBOROUGH, MASSACHUSETTS IN ADDITION, BWH OPERATES NEIGHBORHOOD HEALTH CENTE RS IN THE JAMAICA PLAIN SECTION OF BOSTON NEAR ITS HOSPITAL FACILITIES AND SERVES AS A REF ERRAL FACILITY FOR BOTH HEALTH CENTERS THESE COMMUNITY HEALTH CENTERS PROVIDE COMPREHENSI VE SERVICES SIMILAR TO THOSE OFFERED BY SATELLITE PRACTICES AND INCLUDE PRIMARY CARE, DENT ISTRY, PEDIATRICS, PODIATRY, OBSTETRICS, GYNECOLOGY, MENTAL HEALTH, NUTRITION, OUTPATIENT SUBSTANCE ABUSE COUNSELING AND SOCIAL SERVICES BWH IS LICENSED BY THE MASSACHUSETTS DEPAR TMENT OF PUBLIC HEALTH (DPH) T

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	O OPERATE 804 BEDS, 799 OF WHICH WERE STAFFED AS OF SEPTEMBER 30, 2018 PURSUANT TO A JOIN T VENTURE IN ADULT ONCOLOGY BETWEEN BWH AND DANA FARBER CANCER INSTITUTE, INC (DFCI), THI RTY BEDS THAT ARE ON DFCI'S LICENSE ARE LOCATED ON BWH'S MAIN CAMPUS AND ARE SUPPORTED BY BWH PURSUANT TO SERVICE CONTRACTS WITH DFCI ORIGINALLY A DIVISION OF MGH, WHICH WAS FOUND ED BY SPECIAL ACT OF THE MASSACHUSETTS LEGISLATURE IN 1811, THE GENERAL WAS SEPARATELY INC ORPORATED AS A SUBSIDIARY OF MGH IN 1980 THE GENERAL HOSPITAL ADMITTED ITS FIRST PATIENT IN 1821 IT IS THE THIRD OLDEST GENERAL, NON-MILITARY HOSPITAL IN THE UNITED STATES AND TH E OLDEST IN NEW ENGLAND IN THE 2018-19 U S NEWS AND WORLD REPORT, THE GENERAL RANKED #2 IN THE NATION, #1 IN MASSACHUSETTS AND #1 IN BOSTON BASED ON QUALITY OF CARE, PATIENT SAFE TY AND REPUTATION IN SIXTEEN CLINICAL SPECIALTIES, INCLUDING CANCER, CARDIOLOGY & HEART SU RGERY, DIABETES & ENDOCRINOLOGY, EAR, NOSE & THROAT, GASTROENTEROLOGY & GI SURGERY, GERIAT RICS, GYNECOLOGY, NEPHROLOGY, NEUROLOGY & NEUROSURGERY, OPHTHALMOLOGY, ORTHOPEDICS, PSYCHI ATRY, PULMONOLOGY, REHABILITATION, RHEUMATOLOGY, AND UROLOGY ADDITIONALLY, THE GENERAL RA NKED #1 FOR PSYCHIATRY, #2 FOR DIABETES & ENDOCRINOLOGY, EAR, NOSE & THROAT THE GENERAL H OSPITAL IS RECOGNIZED AS A "MAGNET" HOSPITAL BY THE AMERICAN NURSES CREDENTIALING CENTER MAGNET DESIGNATION REPRESENTS THE HIGHEST HONOR AVAILABLE FOR NURSING EXCELLENCE AND IS AC HIEVED BY FEWER THAN 7% OF HOSPITALS IN THE UNITED STATES THE GENERAL HOSPITAL IS LICENSE D BY THE DPH TO OPERATE 1,035 BEDS, 1,011 OF WHICH WERE STAFFED AS OF SEPTEMBER 30, 2018 COMMUNITY HOSPITALS PARTNERS HEALTHCARE CURRENTLY OPERATES EIGHT ACUTE CARE COMMUNITY HOSP ITALS AS SHOWN IN THE TABLE 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, W HICH IS CURRENTLY UNDERGOING RENOVATIONS TO ACCOMMODATE THIS CONSOLIDATION AND PLANNED PRO GRAMMATIC CHANGES GENERALLY, EACH OF THE MAINLAND COMMUNITY HOSPITALS OFFER A BROAD RANGE OF INPATIENT AND OUTPATIENT SERVICES INCLUDING BUT NOT LIMITED TO SOME OR ALL OF THE FOLL OWING, DEPENDING ON THE PARTICULAR HOSPITAL MEDICAL/SURGICAL, ORTHOPEDIC, PEDIATRIC, GERI ATRIC, GYNECOLOGICAL, OBSTETRICS, EMERGENCY, INTENSIVE CARE, PSYCHIATRIC AND REHABILITATIV E PROGRAMS THE ISLAND HOSPITALS, MVH AND NCH, HAVE A SOMEWHAT MORE LIMITED RANGE OF INPAT IENT AND OUTPATIENT SERVICES, BUT EACH OF THEM HAS LONG-STANDING COLLABORATIONS WITH THE G ENERAL IN A VARIETY OF SPECIALTIES AND USES TELEMEDICINE LINKS TO THE GENERAL MOST OF THE COMMUNITY HOSPITALS OFFER RESIDENCY PROGRAMS IN SELECTED MEDICAL SERVICES AND SPECIALTIES AND SERVE AS TRAINING SITES FOR STUDENTS IN MEDICINE, NURSING AND OTHER FIELDS THROUGH AF FILIATIONS WITH HARVARD UNIVERSITY'S MEDICAL AND DENTAL SCHOOLS AND THE TUFTS UNIVERSITY S CHOOL OF MEDICINE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	NAME LOCATION LICENSED BEDS AS OF 9/30/18 BWFH JAMAICA PLAIN (BOSTON), MA 162 CDH NORTHAMP TON, MA 140 MVH MARTHA'S VINEYARD ISLAND, MA 25 NCH NANTUCKET ISLAND, MA 19 NSMC SALEM, MA /LYNN, MA 372 NWH NEWTON, MA 265 WDH DOVER, NH 178 PARTNERS HEALTHCARE COMMUNITY HOSPITALS ALSO OFFER EXTENSIVE AMBULATORY CARE SERVICES FOR EXAMPLE, BWFH OFFERS AN OUTPATIENT CEN TER IN BREAST HEALTH CARE, AND OUTPATIENT SERVICES AT NWH INCLUDE A CANCER CENTER, SPINE C ENTER, WOMEN'S IMAGING CENTER, CARDIOVASCULAR HEALTH CENTER, JOINT RECONSTRUCTION CENTER, DIABETES CENTER AND AN AMBULATORY SURGERY CENTER NSMC OFFERS IMAGING SERVICES, CARDIOLOGY TESTING AND SURGICAL SUITES DESIGNED EXCLUSIVELY FOR OUTPATIENT SURGERY AND DIAGNOSTIC EN DOSCOPIC PROCEDURES PHYSICIAN SECTOR PARTNERS HEALTHCARE HAS AN EXTENSIVE NETWORK OF APPR OXIMATELY 6,800 EMPLOYED AND AFFILIATED PHYSICIANS THAT CONSISTS OF APPROXIMATELY 1,100 CO MMUNITY AND ACADEMIC PCPS, APPROXIMATELY 1,650 COMMUNITY SPECIALISTS AND APPROXIMATELY 4,0 50 ACADEMIC SPECIALISTS INCLUDED WITHIN THESE PHYSICIAN TOTALS ARE APPROXIMATELY 1,550 PH YSICIANS WHO ARE NOT EMPLOYED BY PARTNERS HEALTHCARE AND THEREFORE THE FINANCIAL RESULTS O F THEIR PRACTICES ARE NOT INCLUDED IN THE FINANCIAL RESULTS OF THE PARTNERS HEALTHCARE PHY SICIAN SECTOR THE TWO ACADEMIC PHYSICIAN ORGANIZATIONS, BWPO AND MGPO, EMPLOY SUBSTANTIAL LY ALL OF THE STAFF PHYSICIANS WHO PROVIDE HEALTHCARE SERVICES TO PATIENTS 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, RESPE CTIVELY REHABILITATION CARE SECTOR PARTNERS CONTINUING CARE OVERSEES THE MANAGEMENT, DELI VERY AND INTEGRATION OF NON-ACUTE SERVICES IN THE PARTNERS HEALTHCARE SYSTEM SPAULDING RE HABILITATION NETWORK THE SPAULDING REHABILITATION NETWORK INCLUDES SPAULDING REHABILITATI ON HOSPITAL IN CHARLESTOWN, AS WELL AS SPAULDING REHABILITATION HOSPITAL CAPE COD, SPAULDI NG HOSPITAL CAMBRIDGE AND SPAULDING NURSING AND THERAPY CENTER BRIGHTON, AS WELL AS TWENTY -FIVE OUTPATIENT SITES THROUGHOUT EASTERN MASSACHUSETTS THE NETWORK INVOLVES THREE HOSPIT AL FACILITIES AS SHOWN IN THE TABLE BELOW, TWO OF WHICH ARE INPATIENT REHABILITATION FACIL ITIES (IRFS) AND ONE OF WHICH IS LICENSED AS A LONG-TERM ACUTE CARE (LTAC) FACILITY SPAUL DING BOSTON IS ONE OF THE LARGEST SPECIALTY IRFS IN THE UNITED STATES AND SERVES AS A REFE RRAL HOSPITAL FOR ACUTE CARE HOSPITALS IN THE REGION IN THE 2018-19 U S NEWS AND WORLD R EPORT SPAULDING REHABILITATION HOSPITAL RANKED #3 FOR REHABILITATION EACH OF THE SPAULDIN G IRFS OPERATES A NUMBER OF OUTPATIENT FACILITIES OFFERING A VARIETY OF THERAPY SERVICES SPAULDING REHABILITATION NETWORK NAME AND LOCATION FACILITY TYPE LICENSED BEDS SPAULDING B OSTON IRF 132 SPAULDING CAMBRIDGE LTAC 180 SPAULDING CAPE COD IRF 60 (EAST SANDWICH) SKILL ED NURSING PARTNERS HEALTHCARE OWNS FREE-STANDING SKILLED NURSING FACILITIES (SNFS) TO AC COMMODATE BOTH SHORT TERM AND

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	LONGER-TERM PATIENT NEEDS FREE-STANDING SNFS INCLUDE SPAULDING BRIGHTON AND THE CLARK HOU SE THE FORMER SPAULDING NORTH END (140-BED SNF) AND WEST ROXBURY (81-BED SNF) SITES WERE CONSOLIDATED INTO SPAULDING BRIGHTON, A 123-BED SNF THAT OPENED IN OCTOBER 2017 THE MGH H EALTH SERVICES CORPORATION IS A GENERAL PARTNER IN FOX HILL VILLAGE PARTNERSHIP WHICH OPER ATES 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 INTO THE COMMUNITY, PROMOTES THEIR INDEPENDENCE, REDUCES THE NEED FOR HOSPITALIZATION AND INSTITUTIONALIZATIO N AND IS A COST-EFFECTIVE ALTERNATIVE TO INPATIENT CARE PHH SERVES A GEOGRAPHIC AREA FROM NEWBURYPORT TO THE NORTH OF BOSTON, TO FRAMINGHAM IN THE WEST, AND PLYMOUTH IN THE SOUTH WITH REGIONAL BRANCH OFFICES IN BEVERLY, WALTHAM AND BRAINTREE, PHH EMPLOYS APPROXIMATELY 860 STAFF MEMBERS AND IS ONE OF THE LARGEST HOME HEALTH CARE PROVIDERS IN EASTERN MASSACH USETTS PHH'S MEDICARE-CERTIFIED DIVISION IS ACCREDITED BY THE JOINT COMMISSION PSYCHIATR IC CARE SECTOR MCLEAN IS A TERTIARY PSYCHIATRIC REFERRAL AND RESEARCH HOSPITAL LICENSED FO R 324 BEDS LOCATED IN BELMONT, MASSACHUSETTS MCLEAN PROVIDES A CONTINUUM OF INPATIENT, AC UTE AND LONG-TERM RESIDENTIAL, PARTIAL HOSPITALIZATION AND TREATMENT-SPECIFIC OUTPATIENT S ERVICES TO CHILDREN, ADOLESCENTS, ADULTS AND GERIATRIC PATIENTS IT ALSO HAS TWO SPECIALIZ ED SCHOOLS FOR CHILDREN AND ADOLESCENTS THAT OFFER A RANGE OF THERAPEUTIC SERVICES IT IS THE LARGEST PSYCHIATRIC TEACHING AFFILIATE OF HARVARD MEDICAL SCHOOL IN THE 2018-19 U S NEWS AND WORLD REPORT, MCLEAN HOSPITAL RANKED #2 IN THE NATION FOR PSYCHIATRY MCLEAN BENE FITS FROM A WIDE ARRAY OF CLINICAL AND HOSPITAL REFERRAL SOURCES AND ATTRACTS PATIENTS REQ UIRING COMPLEX TREATMENT BOTH FROM THE GREATER EASTERN MASSACHUSETTS REGION AND, TO A DEGR EE, NATIONALLY AND INTERNATIONALLY FOR EACH OF THE LAST 20 YEARS, MCLEAN HAS RECEIVED MOR E NIH RESEARCH FUNDING THAN ANY PRIVATE PSYCHIATRIC HOSPITAL IN THE COUNTRY MCLEAN'S RESE ARCH FOCUS IS ON BASIC BENCHTOP, PRECLINICAL, TRANSLATIONAL AND CLINICAL NEUROSCIENCE ALL OF MCLEAN'S ACTIVE STAFF OF 136 PHYSICIANS AND PSYCHOLOGISTS HOLD HARVARD MEDICAL SCHOOL APPOINTMENTS MCLEAN, IN CONJUNCTION WITH THE GENERAL, OPERATES TRAINING PROGRAMS FOR RESI DENTS AND OTHERS IN ALL FIELDS OF PSYCHIATRY AND FOR STUDENTS AND FELLOWS IN PSYCHOLOGY, S UBSTANCE ABUSE TREATMENT AND NEUROLOGY MCLEAN OFFERS A NUMBER OF CLINICAL PROGRAMS, BOTH ON AND OFF CAMPUS THESE INCLUDE, BUT ARE NOT LIMITED TO, SATELLITE PROGRAMS AT NINE SITES IN THE GREATER EASTERN MASSACHUSETTS REGION AND ONE IN MAINE THAT OFFER ONE OR MORE OF IN PATIENT, RESIDENTIAL, PARTIAL HOSPITAL, SUBSTANCE ABUSE TREATMENT AND INTENSIVE EVALUATION AND DIAGNOSTIC SERVICES FOR PATIENTS OF ALL AGES PHYSICIAN SECTOR PARTNERS HEALTHCARE PR OVIDES EMERGENCY AND OTHER CAR

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Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 1)	E TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY THE COST OF PROVIDING THAT CARE IS REFLE CTED IN THE STATEMENTS OF OPERATIONS SERVICES PROVIDED TO CHARITY CARE PATIENTS, FOR WHIC H ACUTE CARE HOSPITALS RECEIVE REIMBURSEMENT THROUGH THE STATEWIDE HEALTH SAFETY NET TRUST FUND (HSN), AND TO PATIENTS COVERED UNDER THE MEDICARE AND MEDICAID PROGRAMS GENERATE COS TS FOR WHICH PARTNERS HEALTHCARE IS NOT FULLY REIMBURSED SEE "PATIENT CARE REVENUE TRENDS AND METHODOLOGIES" ABOVE FOR A MORE DETAILED DESCRIPTION OF EACH OF THESE PROGRAMS FOR C HARITY CARE, MEDICAID AND MEDICARE, THE TOTAL ESTIMATED COST OF SERVICES PROVIDED BY PARTN ERS HEALTHCARE EXCEEDED THE NET REIMBURSEMENT RECEIVED UNDER THESE PROGRAMS BY $1,430 MILL ION IN 2018 THE ESTIMATED COST OF SERVICES PROVIDED IS EITHER OBTAINED DIRECTLY FROM A CO STING SYSTEM OR IS BASED ON AN ENTITY SPECIFIC RATIO OF COST TO GROSS CHARGES IN THE LATT ER CASE, COST IS DERIVED BY APPLYING THIS RATIO TO GROSS CHARGES ASSOCIATED WITH PROVIDING CARE TO CHARITY CARE, MEDICAID AND MEDICARE PATIENTS

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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 AT PARTNERS HEALTHCARE, W E KNOW THE IMPORTANCE OF RESEARCH AND INNOVATION CANNOT BE OVERSTATED THE FOUNDING HOSPIT ALS OF PARTNERS HAVE A LONG TRADITION OF MEDICAL BREAKTHROUGHS, FROM THE FIRST USE OF ETHE R FOR SURGERY AT MASSACHUSETTS GENERAL HOSPITAL TO THE FIRST SUCCESSFUL ORGAN TRANSPLANT A T BRIGHAM AND WOMEN'S HOSPITAL VIRTUALLY EVERY TREATMENT, TEST, DRUG, OR MEDICAL DEVICE I N USE TODAY IS THE RESULT OF SUCCESSFUL RESEARCH FROM THE PAST THE PARTNERS RESEARCH ENTE RPRISE COVERS THE SPECTRUM FROM BASIC SCIENCE TO TRANSLATIONAL AND CLINICAL INVESTIGATION THIS RESEARCH IS PRIMARILY FUNDED BY THE NATIONAL INSTITUTES OF HEALTH (NIH), BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL CONTINUE TO TOP THE LIST OF INDEPENDE NT HOSPITALS RECIPIENTS OF NIH FUNDING IN THE COUNTRY MCLEAN HOSPITAL RANKS AS A TOP RECI PIENT AMONG PRIVATE PSYCHIATRIC HOSPITALS SCIENTISTS FROM A SPECTRUM OF DISCIPLINES ALSO COLLABORATE WITH DISEASE FOUNDATIONS AND INDUSTRY TO ADVANCE OUR KNOWLEDGE AND HELP TRANSL ATE OUR DISCOVERIES INTO PATIENT CARE AS SOON AS POSSIBLE PARTNERS HEALTHCARE SUPPORTS VA RIOUS RESEARCH PROGRAMS TO FACILITATE THE TRANSLATION OF MEDICAL ADVANCES TO ITS PATIENTS PARTNERS PERSONALIZED MEDICINE (PPM) WAS ESTABLISHED IN 2001 TO REALIZE THE PROMISE OF GE NETICS AND GENOMICS IN RESEARCH AND IN MEDICAL PRACTICE ONE OF THE GOALS OF PPM IS TO HEL P 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 APPROPRI ATE DRUGS) FOR INDIVIDUAL PATIENTS SERVED BY THE PARTNERS HEALTHCARE INSTITUTIONS UNDER T HE OVERSIGHT OF PPM, PARTNERS HEALTHCARE ESTABLISHED THE PARTNERS BIOBANK - A REPOSITORY O F 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 DIFFERENT DISEASES, OVERALL THE BIO BANK HAS SUPPORTED OVER $160 MILLION IN FUNDED RESEARCH STUDIES AS AN EXAMPLE, THE BIOBAN K ENABLED PARTNERS HEALTHCARE TO BE AWARDED TWO GRANTS TOTALING $12 MILLION AS PART OF THE NIH ELECTRONIC MEDICAL RECORD

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FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 2)	S AND GENOMICS NETWORK (EMERGE) THE PRIMARY GOAL OF THE EMERGE NETWORK IS TO DEVELOP, DIS SEMINATE, AND APPLY APPROACHES TO RESEARCH THAT COMBINE DNA BIOREPOSITORIES WITH THE ELECT RONIC MEDICAL RECORD SYSTEM FOR LARGE-SCALE, HIGH-THROUGHPUT GENETIC RESEARCH PARTNERS HE ALTHCARE IS ABLE TO LEVERAGE ITS INVESTMENT IN ECARE AND THE 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 INVOLVED IN FORMULATING THE PRECISIO N MEDICINE INITIATIVE - A NATIONAL RESEARCH EFFORT ESTABLISHED IN 2015 TO REVOLUTIONIZE HE ALTH CARE AND THE TREATMENT OF DISEASE THE INITIATIVE AIMS TO GIVE MEDICAL PROFESSIONALS THE RESOURCES THEY NEED TO TARGET SPECIFIC TREATMENTS FOR ILLNESSES AND FURTHER DEVELOP SC IENTIFIC AND MEDICAL RESEARCH, TAKING INTO ACCOUNT INDIVIDUAL DIFFERENCES IN PEOPLE'S GENE S, ENVIRONMENTS AND LIFESTYLES PARTNERS HEALTHCARE ALONG WITH BOSTON MEDICAL CENTER HAVE FORMED THE NEW ENGLAND PRECISION MEDICINE CONSORTIUM, A REGIONAL RECRUITMENT SITE FOR THE ALL OF US (AOU) BIOMEDICAL RESEARCH PROGRAM THAT IS THE CORNERSTONE OF THE LARGER PRECISIO N 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 BIOBANK WITH ADVANCES IN BIG DATA ANALYTICS AND MACHINE LEARNING, HEALTH CARE DATA HAS BECOME THE CORNERSTONE OF MANY NEW D ISCOVERIES IN THE DIAGNOSIS AND TREATMENT OF DISEASE PARTNERS HEALTHCARE HAS A ROBUST PAT IENT DATA ASSET, CREATING TOOLS THAT ALLOW THE COMPLIANT USE OF AND ACCESS TO THIS DATA UN DER THE PURVIEW OF THE PARTNERS RESEARCH INFORMATION SCIENCE AND COMPUTING (RISC) DEPARTME NT LEVERAGING DATA SCIENTISTS, MACHINE LEARNING/ARTIFICIAL INTELLIGENCE, AND CLINICAL EXP ERTISE, RISC DEVELOPS NEW CLINICAL APPLICATIONS FOR CLINICAL CARE AND WITH THE POTENTIAL F OR COMMERCIALIZATION THE PARTNERS BIG DATA COMMONS IS THE FOUNDATION, LAUNCHED IN 2013 TO INTEGRATE DISPARATE ISLANDS OF PATIENT DATA ONTO A COMMON PLATFORM, 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 OUTCOMES AND TREATMENT RESPONSES IN ADDITION, GENERAL ELECTRIC AND PARTNERS HEALTHCARE ESTABLISHED A TEN-YEAR COLLABORATION F OCUSED ON HEALTHCARE AI IN APRIL 2017 LEVERAGING CO-INVESTMENT BY BWH AND THE GENERAL TO LAUNCH THE CENTER FOR CLINICAL DATA SCIENCE, GE AND PARTNERS HEALTHCARE WILL COLLABORATE T O DEVELOP A LEARNING PLATFORM AND CLINICAL APPLICATIONS TO ADVANCE THE USE OF ARTIFICIAL I NTELLIGENCE ACROSS A BROAD RANGE OF DIAGNOSTIC AND TREATMENT PARADIGMS THE IMPLEMENTATION OF ECARE IS ACCELERATING THE TRANSLATION OF NEW DISCOVERIES AND INVENTIONS TO PATIENT CAR E THIS INCLUDES ENABLING TARGETED RESEARCH OPPORTUNITIES TO BE INTEGRATED AT THE POINT-OF -CARE USING TOOLS BUILT BY PARTNERS, INTEGRATING INNOVATIVE HEALTHCARE APPS WITH THE CLINI CAL WORKFLOW TO GUIDE CLINICAL

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Return Reference	Explanation
FORM 990, PART III - PROGRAM SERVICE (ATTACHEMENT 2)	DECISION MAKING, AND ALLOWING PATIENTS TO DIRECTLY ENGAGE WITH RESEARCHERS THE PARTNERS RESEARCH PATIENT PORTAL IS A COMPREHENSIVE, LEADING-EDGE PATIENT RESEARCH ENGAGEMENT SOLUT ION THAT CONNECTS PATIENTS WITH RESEARCH STUDIES, PROVIDING OPPORTUNITIES FOR PATIENTS AND RESEARCHERS TO ENGAGE AT DIFFERENT LEVELS OF PARTICIPATION, AND FACILITATES RESEARCH-BASE D 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 ONE OF THREE NIH CENTERS FOR A CCELERATED INNOVATION WITH MATCHING INSTITUTIONAL, COMMERCIAL AND OTHER FEDERAL FUNDS TO E STABLISH THE BOSTON BIOMEDICAL INNOVATION CENTER (B-BIC) B-BIC WAS DESIGNED TO PARTNER WI TH INDUSTRY TO ACCELERATE THE DEVELOPMENT OF DIAGNOSTIC PRODUCTS IN THE AREAS OF CARDIAC, PULMONARY, SLEEP AND HEMATOLOGIC DISEASES PARTNERS HEALTHCARE CONTINUES TO COLLABORATE WI TH HARVARD UNIVERSITY, WHICH ESTABLISHED THE HARVARD CATALYST, AN NIH FUNDED ENTERPRISE DE DICATED TO IMPROVING HUMAN HEALTH THAT INCLUDES OTHER HARVARD MEDICAL SCHOOL AFFILIATED ED UCATIONAL 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 GRANT 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, THE MGH INSTITUTE OF HEALTH PROFESSIONS PROVIDES EDUCATIONAL TRAINING TO 1,593 STUDENTS IN THE FIELDS OF NURSING, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, PHYSICIAN ASSISTANTS STUDIES AND COMMUNICATION SCIENCES & DISORDERS IHP AWARDED 571 DEGRESS AND ALSO CONDUCTS HEALTHRELATED RESEARCH SUPPORTED BY RESEARCH PROFESSORSHIPS 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	ANTHONY A KLEIN & KEVIN T BOTTOMLEY - BUSINESS RELATIONSHIP JAMES BRANNEN & MICHAEL BOLDOC, ESQ - BUSINESS RELATIONSHIP JEFFREY N SHRIBMAN & ANTHONY A KLEIN - BUSINESS RELATIONSHIP JOHN M DEUTCH & ARTHUR L GOLDSTEIN - BUSINESS RELATIONSHIP JOHN M DEUTCH & RONALD L SKATES - BUSINESS RELATIONSHIP PAMELA D A REEVE & DAVID ABELMAN - BUSINESS RELATIONSHIP PAULA NESS SPEERS & MARY E SHAUGHNESSY - BUSINESS RELATIONSHIP PETER K MARKELL & WILLIAM MAURICE COWAN - BUSINESS RELATIONSHIP RICHARD E HOLBROOK & J BRIAN MCCARTHY & TERENCE A MCGINNIS & CHARLES FRANK DESMOND & JEFFREY N SHRIBMAN - BUSINESS RELATIONSHIP RICHARD E HOLBROOK & TERENCE A MCGINNIS & RICHARD C BANE & J BRIAN MCCARTHY - BUSINESS RELATIONSHIP ROGER HAMEL & DAVID VERNO - BUSINESS RELATIONSHIP SCOTT M SPERLING & MARC N CASPER - 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 26, 2019 MEETING THE PROCESS FOR PREPARING AND REVIEWING FORM 990 WAS DISCUSSED AT THE MAY 2, 2019 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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Return Reference	Explanation
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 O & T TITLES	CHARLES E ADAMS O - NSMC, NSHC, NSPG DALE ADLER, M D T - BWPO CINDY L AIENA O - IHP PAUL ANDERSON, M D , PH D K - BWFH SHELLY ANDERSON, MPM K - BWFH KATRINA ARMSTRONG, M D , M S C E T - GHC, MGH SARAH ARNHOLZ, ESQ O - MGPO STANLEY W ASHLEY, M D T - BWPO (OFF 07/16/18), MED (OFF 06/04/18), IHP MAUREEN BANKS O - FRC, RHCI, SHC, SKRH, T - HSC RO BERT L BARBIERI, M D T - BWPO GREGORY A BIRD T - NPO (ON 08/17/18) CHRISTINE A BLASK I, M D T - NSMC, NSHC, NSPG SALLY MASON BOEMER T - NCH GILES W BOLAND, M D T - BWPO CHRISTOPHER M BONO, M D T - BWPO (OFF 06/01/18) MELISSA P BRENNAN, ESQ O - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH JAMES A BRINK, M D T - CDH (ON 01/01/18), CDHC (ON 01/01/18) , VHCD (ON 01/01/18) O'NEIL BRITTON, M D T - MVH, WNR DAVID C BROOKS, M D HIGHEST COM PENSATED EMPLOYEE CALVIN A BROWN III, M D T - BWPO DAVID F BROWN, M D T - CDH, CDHC, VHCD DEBRA A BURKE, DNP, MBA, RN T - MVH, WNR ELLEN CAILLE T - WDPC BOB S CARTER, M D HIGHEST COMPENSATED EMPLOYEE MICHAEL CARTER O - PHSSP PAUL CASS T - WDPC BRUCE A CHA BNER, M D T - NCH EFFIE J CHAN, ESQ O - BWPO, HMA, SSEC JULIE C CHATTOPADHYAY, ESQ O - NWH, NWHC, NWMG ENNIO A CHIOCCA, M D , PH D T - BWPO CHRISTOPHER MARK COBURN O & T - PMI CHRISTOPHER M COLEY, M D T - MGPO YOLONDA LORIG COLSON, M D , PH D T - BWPO (ON 11/29/17) DAVID P CONNOLLY O - PCPO RAYMOND F CONWAY, M D T - CDH (OFF 09/24/18), CDHC (OFF 09/24/18), VHCD (OFF 09/24/18) PAUL G CUSHING, ESQ O - NSMC, NSHC, NSPG WILLI AM DANFORD T - WDHF ERNESTO DASILVA, M D T - NSPG MARCELA G DEL CARMEN, M D T - WDH SUSAN DEMPSEY K - BWFH KEREN DIAMOND K - PHC JEFFREY P DION O & T - NWMG (O - OFF 10/2 3/17), O - NWCF (OFF 10/23/17), NWH (OFF 10/23/17), NWHC (OFF 10/23/17) GERARD M DOHERTY, M D T - BH, BWFH, BWH, BWPO TERENCE P DOORLY, M D T - NSPG PETER M DOUBILET, M D , PH D T - BWPO (ON 11/29/17) MARGARET M DUGGAN, M D K - BWFH CHRISTOPHER DUNLEAVY O - BCP, BH, BRF, BWH, BWHR SUNIL EAPPEN, M D T - BWPO (ON 07/16/18) JEFFREY L ECKER, M D T - CDH, CDHC, CDPA (OFF 09/30/18), VHCD KHAMA D ENNIS, M D , M P H T - CDH, CDHC, VH CD ATLAS D EVANS O - IHP JONATHAN M FALLON, M D T - CDPA THOMAS L FAZIO, M D T - P CPO CARLOS FERNANDEZ-DEL CASTILLO, M D T - MGPO (OFF 06/15/18) TIMOTHY G FERRIS, M D O & T - MGPO, T - GHC, MGH, PCPO, WDH (OFF 01/19/18) CRISTINA R FERRONE, M D T - MGPO (ON 06/15/18) AARON S FISHMAN O & T - NPO (O - ON 09/17/18, T - ON 08/17/18) LINDA FLAHER TY, R N K - MCL TIMOTHY E FOSTER, M D K - NWH LAWRENCE S FRIEDMAN, M D K - NWH JOA NNE M FUCILE K - SHC MARY ANN GAGNON T - WDPC MARY JO GAGNON K - NSMC JOSEPH M GARASI C, M D T - NCH (ON 08/17/18) TERRY J GARFINKLE, M D , M B A T - PCPO ROYA GHAZINOURI, PT, DPT, MS T - IHP (ON 06/15/18) STEVEN A GILGEN O & T - NPO (O - OFF 09/17/18, T - O FF 08/17/18), O - NCH, NCHF KEVIN T GIORDANO O - MED RICHARD S GITOMER, M D , M B A T - BWPO JOSEPH GOLD, M D K -

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FORM 990, PART VII O & T TITLES	MCL MATTHEW GOLDBERG T - WDH JEFFREY A GOLDEN, M D T - BH, BWFH, BWH, BWPO TERRI E G ORMAN, M D T - BWPO MICHELE L GOUGEON M SC O - MCL, MHC GEORGE GOUGIAN K - FRC PETER A GRAPE, M D O & T - HMA, SSEC, T - BWPO JUDI S GREENBERG, ESQ O - IHP ROSEMARY B GUILTINAN, ESQ O - PMI MICHAEL L GUSTAFSON, M D , M B A O & T - BWFH (O & T - OFF 07/ 18/18), T - SSEC (OFF 07/18/18) DAPHNE ADELE HAAS-KOGAN, M D T - BWPO GERARD F HADLEY O - BWFH ROBERT HANDIN, M D T - MED MARGOT HARTMANN, M D , PH D O - NCH, O & T - NPO A NNEMARIE HEATH, CNM T - CDPA JAMES L HEFFERNAN O - MGPO, T - WDH (ON 01/19/18) ROSEMARY HENCHEY K - NSMC MICHAEL J HESSION, M D K - HMA JOHN R HIGHAM, ESQ O - GHC, MGH TH OMAS F HOLOVACS, M D HIGHEST COMPENSATED EMPLOYEE THEODORE S HONG, M D T - MGPO TERR IE E INDER, M B CH B T - BWPO JEANETTE IVES ERICKSON, DNP, RN, FAAN K - GHC, T - IHP M ICHAEL R JAFF, D O T & O - NWCF (T & O - OFF 01/31/18), NWH, NWHC, NWMG, T - MVH, PCPO, WNR ALAN ANTHONY JAMES T - CDH, CDHC, VHCD, MVH, WDH, WNR LOUIS G JENIS, M D K - NWH, T - NWMG (ON 07/01/18) STEPHEN R JENNEY O - BWPO ALEX F JOHNSON K - IHP WILLIAM C JO HNSTON O - BWPO, HMA, O & T - SSEC ANNE KALTER, M D T - WDH JAMES D KANG, M D T - BW PO STEVEN E KAPFHAMMER O & T - NSPG PARDON R KENNEY, M D K - BWFH LAURA STEPHENS KHOS HBIN, ESQ O - PHSSP BARRETT KITCH, M D T - NSPG RONALD E KLEINMAN, M D T - MGPO ANN E KLIBANSKI, M D T - PMI KATHERINE M KNEELAND, ESQ O - HSC (OFF 06/15/18) THOMAS S K UPPER, M D T - BWPO CHRISTOPHER J KWOLEK, M D K - NWH DAVID A LAGASSE O - MCL & MHC LAURIE LAMOUREUX O - CDH, CDPA JANET LARSON, M D K - NWH PATRICK T LEE, M D T - NSP G (ON 01/16/18) PAMELA K LEVANGIE K - IHP KEITH D LILLEMOE, M D K - GHC EDWARD LISTON -KRAFT, PH D K - BWFH CORI LOESCHER, MM, BSN, RN, NEA-BC K - BWFH JOSEPH LOSCALZO, M D , PH D O & T - MED, T - BCP, BH, BWFH, BWH, BWPO DAVID N LOUIS, M D T - MGPO HUGH MAC DONALD T - WDPC (OFF 06/01/18) HEATHER COLMORE MACK O & T - NWCF (O & T - OFF 01/31/18) PETER K MARKELL O & T - BCP, BRF, BWHR, HSC, PHSSP, PMI, O - BH, BWFH, BWH, GHC, MGH, NW H (ON 12/13/17, OFF 01/10/18), T - MCL, MHC JOANNE MARQUSEE O & T - CDH, CDHC, CDPA, VHCD NAVNEET MARWAHA, M D T - CDPA ROBERT T MCCALL K - PCC DAVID O MCCREADY, MBA, MHA O & T - BWFH (O & T - ON 07/18/18) MAURY E MCGOUGH, M D T - NSMC, NSHC, NSPG CHERYL MERRI LL, R N , M S N , N E A -B C K - NSMC PAULA MILONE-NUZZO, PHD, RN, FAAN, FHHC O & T - I HP ELLEN A MOLONEY K - NWH ELIZABETH A MORT CALCAGNI, M D , M P H T - CDH, CDHC, VHCD ELIZABETH G NABEL, M D O & T - BH, BRF, BWH, BWHR, T - BWPO, PMI STEPHANIE N NADOLNY K - RHCI ALBERT NAMIAS, M D T - NSPG ANDREA NG, M D T - BWPO BRITAIN W NICHOLSON, M D K - GHC NAWAL M NOUR, M D , M P H T - BH, BWFH, BWH JOHN NOVELLO, M D T - WDH JOH ANNA M O'CONNOR, M D T - NSMC (ON 10/24/17), NSHC (ON 10/24/17) EDWARD OLIVIER O - MVH , WNR DOST ONGUR, M D , PH D

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FORM 990, PART VII O & T TITLES	K - MCL TIMOTHY PARSONS, M D T - CDH, CDHC, CDPC, VHCD AMAN B PATEL, M D HIGHEST COM PENSATED EMPLOYEE GREGORY J PAULY T - NCH STEVEN B PESTKA, M D T - NWH, NWHC PIETER P IL, M D T - MVH, WNR NANCY S PITTMAN O & T - NPO DAVID S PLADZIEWICZ, M D T - PCPO JEFFREY C POLLOCK K - WDH LESLIE PORTNEY K - IHP ANN L PRESTIPINO K - GHC ALLYSON 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 O & T - MCL, MHC ANDREA GEIGER RE, ESQ O - PCPO CHRISTINE REI LLY K - FRC MITCHELL S REIN, M D T - NSPG, PCPO (OFF 11/07/17) KERRY J , RESSLER, M D , PH D K - MCL PHILLIP L RICE JR , M D T - NSPG (ON 01/16/18) DAVID J ROBERTS, M D O & T - NSMC, NSHC ALLAN H ROPPER, M D T - BWPO (ON 06/26/18) MARC S RUBIN, M D T - NSMC, NSHC ROXANNE C RUPPEL T - NSPG ALI SALIM, M D T - BH, BWFH, BWH MARTIN A SAMUE LS, M D T - BWPO (OFF 06/26/18) JOAN A SAPIR T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH J OHN SARRO K - PCPO MARK A SCHECHTER, M D T - NSPG (OFF 11/13/17) SCOTT L SCHISSEL, M D , PH D K - BWFH NANCY D SCHMIDT K - PCC FREDERICK J SCHOEN, M D , PH D T - BWPO (ON 11/29/17) ANTHONY J SCIBELLI, MS, MBA K - CDH MARY E SHAUGHNESSY O - FRC, HSC, PCC, PHC, RHCI, SHC, SKRH, SRH DAVID SILBERSWEIG, M D T - BWPO, FRC (ON 11/08/17), PCC, PHC (ON 11/08/17), RHCI (ON 11/08/17), SHC (ON 11/08/17), SKRH (ON 11/08/17), SRH (ON 11/08/17) ANEESH BHIM SINGHAL, M D T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH PETER L SLAVIN, M D , M B A O & T - GHC, MGH, T - MGPO, PMI ALLEN L SMITH, M D , M S O & T - BCP, BWPO, T - HMA, PCPO ARTHUR ST GERMAIN K - PHC LYNN MALLOY STOFER O & T - PCPO DAVID E STORTO O & T - PHC (O - ON 03/07/18), SRH, O - PCC, T - FRC, HSC, RHCI, SHC, SKRH DENIS G STRAT FORD K - IHP THORALF M SUNDT, M D T - MGPO KHALID SYED, M D T - NSPG TRACY A SYKES, ESQ O - BCP, BRF, BWHR DAVID F TORCHIANA, M D T - PMI INEZ TUCK K - IHP GARY USHER T - WDPC MICHAEL J VANROOYEN, M D T - BWPO ALAMJIT S VIRK, M D K - MVH PETER WALCEK T - WDHF, WDPC GREGORY WALKER, FACHE O & T - WDHF, WDPC, O - WDH RON M WALLS, M D K - BWH TIMOTHY J WALSH O & T - MVH (O & T - OFF 01/16/18), WNR (O & T - OFF 01/16/18) JON P WARNER, M D HIGHEST COMPENSATED EMPLOYEE ANDREW L WARSHAW, M D T - WDH DEBRA F W EINSTEIN, M D T - IHP ROBERT D WELCH K - PCC SHEILA M WOOLLEY K - WDH ROSS D ZAFONT E, D O T - PCC, RHCI, SHC, SKRH, SRH

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FORM 990, PART VII O & T TITLES	DAVID ABELMAN O - PCPO CAROL BAILEY T - WDH, WDHF (ON 08/01/18), WDPC RICHARD C BANE T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) WILLIAM S BARKER T - NWCF (OFF 01/31/18) DAV ID S BARLOW T - MCL (OFF 03/15/18), MHC (OFF 03/15/18) JOAN M BARRETT T - NWCF (OFF 01 /31/18) FRASER BENNETT BEEDE T - CDH (ON 09/24/18), CDHC (ON 09/24/18), VHCD (ON 09/24/18) JUDITH G BELASH O & T - NCH SANFORD ADAMS BELDEN O & T - CDPA, T - CDH (OFF 09/24/18) , CDHC (OFF 09/24/18), VHCD (OFF 09/24/18) MARK R BELSKY, M D T - NWH (OFF 01/31/18, ON 02/14/18), NWHC (OFF 01/31/18, ON 02/14/18), NWCF (OFF 01/31/18) SIBEL BESSIM, M D T - NWCF (OFF 01/31/18) JEANNE E BLAKE T - MCL, MHC EDWARD B BLOOM T - NWH, NWHC MICHAEL B OLDOC, ESQ O & T - WDH, WDPC KENNETH R BORDEWIECK T - CDH, CDHC, CDPA, VHCD JEANINE M BORTHWICK T - NCH KEVIN T BOTTOMLEY T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) JAMES BRANNEN O & T - WDH (O ON 08/06/18), WDPC (O & T ON 08/06/18) DEBRA K BREDE T - NWH, N WHC MARY R BROWN O & T - MVH (O & T OFF 12/15/17), WNR (O & T OFF 12/15/17) JOHN J BURK E T - NCH WILLIAM R CAMP, JR O & T - NCH JAMES A CANFIELD T - IHP JOHN C CANNISTRAR O T - NWCF (OFF 01/31/18) RICHARD CARD T - WDHF MICHAEL CARELLA T - WDHF (ON 07/01/18) MARC N CASPER T - BH, BWH, BWFH WILLIAM REED CHISHOLM II T - NCH EUGENE H CLAPP T - F RC, PCC, PHC, RHCI, SHC, SKRH, SRH PHILLIP L CLAY, PH D T - FRC, PCC, PHC, RHCI, SHC, S KRH, SRH JAMES P COHEN, M D T - PCPO EARL M COLLIER, JR T - NWH (OFF 06/13/18), NWCF (OFF 01/31/18), NWHC (OFF 06/13/18), NWMG (OFF 06/28/18) RICHARD CONLEY O & T - WDHF (O ON 09/01/18) GARGI B COOPER, FNP T - NSMC (ON 11/28/17), NSHC (ON 11/28/17) DHARMA E CO RTS, PH D T - NSMC, NSHC WILLIAM MAURICE COWAN T - GHC, MGH SUSAN C CRAMPTON O & T - MVH, WNR MONICA S CURHAN T - CDH, CDHC, VHCD KAREN D CURRAN, MBA, CHFC, CFP O & T - CD H (O ON 09/24/18), CDHC (O ON 09/24/18), VHCD (O ON 09/24/18) RICHARD L CURTIS, M D O - NWCF (OFF 01/31/18), PCPO ROBERT A DANZIGER T - NWCF (OFF 01/31/18) BRUCE DANZIGER T - NWCF (OFF 01/31/18) PETER A D'ARRIGO, JR T - IHP JAMES L DEMETROULAKOS, M D T - NSM C, NSHC LINDA DERENZO, ESQ T - NWH, NWHC, NWMG (ON 07/01/18) CHARLES FRANK DESMOND T - NSMC, NSHC JOHN M DEUTCH T - MGPO JOANNE "HONEY" DIBONA T - NWCF (OFF 01/31/18) PETER D IRKSMEIER, M D T - WDH JAMES MANNING DONNELLY T - CDH (OFF 09/24/18), CDHC (OFF 09/24/1 8), VHCD (OFF 09/24/18) JOHN P DRISLANE T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) DEB ORAH DUNSIRE, M D T - MGPO (OFF 08/01/18) JACKIE EASTWOOD O & T - WDHF (O - OFF 09/01/1 8) WILLIAM R ELFERS T - NWCF (OFF 01/31/18), NWH, NWHC, NWMG DEBORAH C ENOS T - BH, BW FH, BWH ARTHUR J EPSTEIN T - NSMC, NSHC JOHN FANIKOS T - PHSSP JULIETTE E FAY T - MVH (ON 03/02/18), WNR (ON 03/02/18) LAURIE FENLASON T - CDH, CDHC, VHCD JOANNE J FINCK T - CDH, CDHC, VHCD ANNE M FINUCANE T - BH, BWFH, BWH JOHN F FISH T - BH, BRF (ON 07/18/ 18), BWFH, BWH, BWHR (ON 07/18

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FORM 990, PART VII O & T TITLES	/18) JUDITH A FONG, BA, RN T - IHP (OFF 06/15/18), PCC (ON 09/25/18) CHRISTOPHER R FORT IER T - PHSSP NANCY S FOSTER T - NWCF (OFF 01/31/18) BRUCE FREEDMAN T - NWCF (OFF 01/3 1/18), NWH, NWHC NEIL GARVEY T - WDH WILLIAM GEARY, BS T - IHP (OFF 06/15/18) LAUREN A GEDDES WIRTH, M D T - PCPO CHARLES K GIFFORD, SR T - NCH THOMAS P GLYNN, PH D T - MCL, MHC ARTHUR L GOLDSTEIN T - MGPO BENJAMIN A GOMEZ T - NWH, NWHC LISA B GRAIN, D D S T - MVH (ON 04/20/18), WNR (ON 04/20/18) THOMAS H GRAPE T - NWH (OFF 07/01/18), NWH C (OFF 07/01/18), NWMG (OFF 07/01/18) ERWIN L GREENBERG T - NCH (OFF 08/17/18) SALLY GRI GGS O & T - CDH (O - ON 09/24/18), CDHC (O - ON 09/24/18), VHCD (O - ON 09/24/18) KAREN R HALE T - BH (ON 05/09/18), BWFH (ON 05/09/18), BWH (ON 05/09/18) ROGER HAMEL T - WDH, WDHF (OFF 08/06/18) ALEXANDER A HANNENBERG, M D T - NWH, NWHC NANCY HAWTHORNE T - NSMC (ON 09/25/18), NSHC (ON 09/25/18) BRENDA E HAYNES, M D T - NWCF (OFF 01/31/18) JENNIFE R HELZBERG T - NWCF (OFF 01/31/18) BRENT L HENRY, ESQ T - MVH (ON 04/20/18), WNR (ON 0 4/20/18) KEVIN F HICKEY T - NCH, O & T - NCHF RICHARD E HOLBROOK T - NSMC, NSHC ALBERT A HOLMAN III O & T - BH, BWFH, BWH H ROBERT HORVITZ, PH D T - GHC, MGH ROBERT S HUC KMAN T - BWPO (ON 09/26/18) ANN INGRAM T - NWCF (OFF 01/31/18) RICHARD IORIO T - BWPO (ON 09/26/18) DAVID W IVES T - NSMC, NSHC RONALD J JACKSON T - MCL, MVH ANNE JAMIESON T - WDH MELISSA WEINER JANFAZA T - BH, BWFH, BWH ROBERT E JOHNSON, PH D T - IHP (ON 06 /15/18) DANIEL G JONES T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH ELIZABETH JOYCE, B S T - IHP CHAD KAGELEIRY T - WDHF (ON 06/01/18) KAREN T KAPLAN T- BH, BWFH, BWH JAMES L KA PLAN, PH D T - NWCF (OFF 01/31/18), NWH, NWHC, NWMG STEPHEN R KARP T - NCH STEVEN M K AYE T - BH, BWFH, BWH RICHARD M KELLEHER T - MCL, MHC PAUL G KELLIHER T - CDH (ON 09/ 24/18), CDHC (ON 09/24/18), VHCD (ON 09/24/18) CHRISTOPHER J KELLY T - NWCF (OFF 01/31/1 8), NWH, NWHC GERARD J KENEALLY T - NCH (ON 08/17/18) JAMES KIRCHHOFFER, M D T - CDH, CDHC, VHCD ANTHONY A KLEIN T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) JOHN H KNOWLES, JR , MBA, MPH T - IHP WENDELL J KNOX T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH ADAM M K OPPEL T - NWH, NWHC JOSHUA M KRAFT T - BH, BWFH, BWH JONATHAN A KRAFT T - GHC, MGH VI NAY KUMAR, M D T - PCPO (ON 11/01/17) ELIZA B LAKE T - CDH, CDHC, VHCD KEVIN LISTER LA KE O & T - CDH (O & T - OFF 09/24/18), CDHC (O & T - OFF 09/24/18), VHCD (O & T - OFF 09/ 24/18) RENE M LANDERS T - GHC, MGH THOMAS LAVASSEUR T - WDHF PAMELA L LAWRENCE T - NS PG (ON 01/16/18) JEFFREY M LEIDEN, M D , PH D T - BH, BWFH, BWH TIMOTHY J LEPORE, M D , F A C S T - NCH DONNA LEVIN T - PCPO (ON 09/11/18) BEN S LEVITAN T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH JAY LEVY T - WDHF DAVID H LONG T - GHC, MGH IAN K LORING T - NC H (ON 08/17/18) STACEY LUCCHINO T - MCL, MCH JULIE A MARRIOTT T - NWCF (OFF 01/31/18), NWH, NWHC CARL J MARTIGNETTI

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FORM 990, PART VII O & T TITLES	T - GHC, MGH J BRIAN MCCARTHY T - NSMC, NSHC VINCENT T MCDERMOTT O - NWH (ON 01/10/18), NWHC (ON 01/10/18), O & T - NWMG (O & T - ON 02/14/18) TERENCE A MCGINNIS O & T - NSP G, T - NSMC, NSHC, PCPO JEROME T MCMANUS T - NSMC (ON 11/28/17), NCMCHC (ON 11/28/17) JO SEPH C MCNAY T - BWPO (OFF 05/22/18) CAROLINE "ANN" MERRIFIELD T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH EDWARD F MILLER T - MVH, WNR BARRY MILLS T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH CATHY E MINEHAN T - GHC, MGH, MGPO JAMES F MOONEY III T - GHC (ON 03/02/18), MGH (ON 02/27/18) CHARLES A MORRIS, M D T - MED (ON 06/04/18) LAURA BARKER MORSE T - MGPO MICHAEL J MUEHE T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH PHILIP A NARDONE, JR T - NCH (OFF 08/17/18) EMILY A NEILL T - NWCF (OFF 01/31/18) MARC A NIVET, ED D , M B A T - IHP NITIN NOHRIA T - GHC, MGH JOHN N NUNNELLY T - CDH (OFF 09/24/18), CDHC (OFF 09/2 4/18), CDPA, VHCD (OFF 09/24/18) MARK NUNNELLY T - BH, BWFH, BWH GINA L O'BRIEN, M D T - VHCD (ON 01/18/18, OFF 04/01/18) MICHAEL F O'CONNELL, ESQ T - BWPO JAY O'NEILL T - WDHF (OFF 04/01/18) ROBERT L PAGLIA T - NWCF (OFF 01/31/18) MARIE-LOUISE PALANDJIAN T - NWCF (OFF 01/31/18) WILLIAM M PARIZEAU T - NWCF (OFF 01/31/18) DIANE B PATRICK, ESQ T - GHC, MGH RICHARD A PENN T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH ADELENE Q PERKINS T - GHC, MGH DONALD M PERRIN T - NWCF (OFF 01/31/18) H BRADLEE PERRY T - NWCF (OFF 01/ 31/18) SUSAN P PETERS T - GHC (OFF 12/21/17), MGH (OFF 12/21/17) ANGELLEEN PETERS-LEWIS, PH D , R N T - IHP PATRICIA P PETRAGLIA T - BWPO ROBERT W PIERCE, JR T - MCL, MHC JENNIFER L PORTER T - MCL, MHC MARY G PUMA T - NSMC, NSHC DAVID L RABIN, M D T - NS PG (ON 01/16/18) PHILLIP T RAGON T - GHC, MGH LARRY RAICHE T - WDHF BABU RAMDEV T - WD HF (OFF 09/01/18) EARLE A RAY O & T - MVH (O - OFF 05/25/18), WNR (O - OFF 05/25/18) PAM ELA D A REEVE T - MGPO, PCPO NANCY R REEVES T - CDH, CDHC, VHCD LAURA REYNOLDS T - N CH (OFF 08/17/18) AUGUSTE E RIMPEL, JR , PH D T - MCL (OFF 01/31/18), MHC (OFF 02/15/18) THEODORE RISTAINO T - WDH (OFF 08/06/18) JOS DE JSUS RIVERA, JD T - IHP CARMICHAEL S ROBERTS T - MGPO MICHAEL A F ROBERTS T - NCH INGO ROEMER T - WDH WILLIAM J ROMAN T - MVH, WNR JOSEPH F RYAN, ESQ T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH MELANIE R SABELHA US T - NCH JOHN SALMON O & T - WDH (O - OFF 08/06/18), T - WDHF, WDPC ELISABETH SCHADAE PERCELAY T - NCH JOHN H SCHAEFER T - MVH, WNR DENISE M SCHEPICI O & T - MVH (O & T - ON 01/16/18), WNR (O & T - ON 01/16/18) JEROME SCHLACHTER T - WDPC (ON 07/01/18) ERIC D SCHLAGER T - BH, BWFH, BWH

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Return Reference	Explanation
FORM 990, PART VII O & T TITLES	SCOTT A SCHOEN T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH SCOTT SCHUSTER T - BH, BWFH, BWH, BWPO MARK SCHWARTZ T - GHC, MGH S CHRISTOPHER SCOTT O & T - MVH (O - ON 05/25/18, T - ON 03/02/18), WNR (O - ON 05/25/18, T - ON 03/02/18) JEFFREY N SHRIBMAN T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) RICKEL SHUSTER T - NWCF (OFF 01/31/18) RICHARD N SILVERMAN T - NWCF (01/13/18) SHIRLEY SINGLETON T - NSMC, NSHC RONALD L SKATES T - MGPO BARRY R SLOANE T - GHC, MGH LAUREN A SMITH, M D , M P H T - NWH, NWHC JONATHAN SNIDER, M D T - NWCF (01/13/18) W LLOYD SNYDER, III T - MCL, MHC ALISON SOLLEE T - WDHF JOSIAH A SPAULDING, JR T - FRC (OFF 06/30/18), PCC (OFF 06/30/18), PHC (OFF 06/30/18), RHCI (OFF 06/30/18), SHC (OFF 06/30/18), SKRH (OFF 06/30/18), SRH (OFF 06/30/18) PAULA NESS SPEERS T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH DENISE SPENCE, M D T - CDPA (OFF 07/11/18) SCOTT M SPERLING T - BH (OFF 01/17/18), BRF (OFF 01/17/18), BWFH (OFF 01/17/18), BWH (OFF 01/17/18), BWHR (OFF 01/17/18) GARY A SPIESS, ESQ T - NSMC (OFF 08/01/18), NSHC (OFF 08/01/18) CHARLES PHILIP STAELIN O & T - CDH (O - OFF 09/24/18), CDHC (O - OFF 09/24/18), CDPA, VHCD (O - OFF 09/24/18), T - CDPA (ON 09/24/18) KATHLEEN M STANSKY T - NWCF (OFF 01/31/18) ANNE E STEER T - NWCF (OFF 01/31/18) DAVID PIERPONT STEVENS T - CDH, CDHC, VHCD JAMES STEVENS T - WDHF (OFF 09/01/18) ELLEN S STORY T - CDH, CDHC, VHCD STEPHEN G SULLIVAN T - NWCF (OFF 01/31/18), NWH, NWHC TIMOTHY D SWEET T - NVH, WNR JAMES D TAICLET T - BH, BWFH, BWH WALTER TELLER, ESQ T - MVH (OFF 06/15/18), WNR (OFF 06/15/18) GEORGE E THIBAULT, M D T - IHP (OFF 06/15/18) JEFFREY S THOMAS T - NWCF (OFF 01/31/18) ALEXANDER L THORNDIKE T - BH, BWFH, BWH THOMAS TORR O & T - WDHF HEATHER UNRUH T - IHP (ON 06/15/18) CAROL A VALLONE T - MCL, MHC DAVID VERNO T - WDHF JOAN M VITELLO-CICCIU, RN, PH D T - NWH, NWHC JOSEF H VON RICKENBACH T - MCL (ON 07/19/18), MHC (ON 06/15/18) CATHERINE S WARD T - NCH PETER WEITZMAN, M D T - CDPA BENAREE P WILEY T - FRC, PCC, PHC, RHCI, SHC, SKRH, SRH MICHELLE A WILLIAMS T - MCL (ON 05/24/18), MHC (ON 04/20/18) ELIZABETH WINSHIP T - NCH AMY M WINSLOW T - BWPO (ON 06/18/18) CHARLES F WU T - NWH, NWHC GWILL YORK T - BH, BWFH, BWH, FRC, PCC, PHC, RHCI, SHC, SKRH, SRH GEOFFREY M ZUCKER, M D T - CDH (ON 09/24/18), CDHC (ON 09/24/18), CDPA (OFF 09/27/18), VHCD (ON 09/24/18)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	EQUITY INVESTMENT ACTIVITY (UNREALIZED G/L ON INVESTMENTS) 139,030,881 CHANGE IN FUNDED STATUS OF DEFINED BENEFIT PLAN 390,965,477 NET ASSET ADDITIONS FROM ADDED GROUP SUBORDINATES 432,558,573

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 COMMUNITY PRACTICES, INC (BCP) - EIN 22-2588069 BRIGH AM HEALTH, INC (BH) - EIN 04-2921338 F/K/A BRIGHAM AND WOMEN'S HEALTH, INC BRIGHAM AND W OMEN'S PHYSICIANS ORGANIZATION, INC (BWPO) - EIN 04-3466314 BRIGHAM MEDICAL RESEARCH & ED UCATIONAL FOUNDATION, INC (MED) - EIN 04-3539249 BWH RESEARCH, INC (BWHR) - EIN 04-30114 45 CD PRACTICE ASSOCIATES, INC (CDPA) - EIN 04-3194547 COOLEY DICKINSON HEALTH CARE CORPO RATION (CDHC) - EIN 04-2103561 COOLEY DICKINSON HOSPITAL, INC (CDH) - EIN 22-2617175 FRC, INC (FRC), ALSO REFERRED TO AS SPAULDING NURSING AND THERAPY CENTER - WEST ROXBURY & SPA ULDING NURSING AND THERAPY CENTER - NORTH END - EIN 22-2632121 HARBOR MEDICAL ASSOCIATES, INC (HMA) - EIN 04-2702579 MARTHA'S VINEYARD HOSPITAL, INC (MVH) - EIN 04-2104691 MASSAC HUSETTS GENERAL PHYSICIANS ORGANIZATION, INC (MGPO) - EIN 04-2807148 MCLEAN HEALTHCARE, I NC (MHC) - EIN 20-4572876 NANTUCKET COTTAGE HOSPITAL FOUNDATION, INC (NCHF) - EIN 04-382 9745 NANTUCKET COTTAGE HOSPITAL (NCH) - EIN 04-2103823 NANTUCKET PHYSICIAN ORGANIZATION, I NC (NPO) - EIN 26-4349357 NEWTON-WELLESLEY MEDICAL GROUP, INC (NWMG) - EIN 22-2560501 NE WTON-WELLESLEY HEALTH CARE SYSTEM, INC (NWHC)- EIN 20-4295282 NEWTON-WELLESLEY HOSPITAL (NWH) - EIN 04-2103611 NEWTON-WELLESLEY HOSPITAL CHARITABLE FOUNDATION, INC (NWCF) - EIN 0 4-3455952 NORTH SHORE MEDICAL CENTER, INC (NSMC) - EIN 04-3399616 NORTH SHORE PHYSICIANS GROUP, INC (NSPG) - EIN 04-3080484 NSMC HEALTHCARE, INC (NSHC) - EIN 04-3294420 PARTNERS COMMUNITY PHYSICIANS ORGANIZATION, INC (PCPO) - EIN 04-3236175 PARTNERS CONTINUING CARE, INC (PCC) - EIN 26-0003495 PARTNERS HEALTHCARE SP, INC (PHSSP) - EIN 82-1707493 PARTNER S MEDICAL INTERNATIONAL, INC (PMI) - EIN 04-3197711 PARTNERS HOME CARE, INC (PHC), ALSO REFERRED TO AS PARTNERS HEALTHCARE AT HOME - HOME CARE - EIN 04-2918280 REHABILITATION HOS PITAL OF THE CAPE AND ISLANDS CORPORATION (RHCI), ALSO REFERRED TO AS SPAULDING REHABILITA TION HOSPITAL - CAPE COD - EIN 04-3071419 SHAUGHNESSY-KAPLAN REHABILITATION HOSPITAL, INC (SKRH), ALSO REFERRED TO AS SPAULDING HOSPITAL FOR CONTINUING MEDICAL CARE - NORTH SHORE - EIN 04-3067082 SOUTH SHORE ENDOSCOPY CENTER, INC (SSEC) - EIN 04-3306443 SPAULDING HOSP ITAL - CAMBRIDGE, INC (SHC), ALSO REFERRED TO AS SPAULDING HOSPITAL FOR CONTINUING MEDICA L 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 MASSACH USETTS GENERAL HOSPITAL (MGH) - EIN 04-1564655 THE MCLEAN HOSPITAL CORPORATION (MCL)- EIN 04-2697981 THE MGH HEALTH SERVICES CORPORATION (HSC) - EIN 22-2717383 THE MGH INSTITUTE OF HEALTH PROFESSIONS, INC (IHP

990 Schedule O, Supplemental Information

Return Reference	Explanation
ENTITIES INCLUDED IN THE GROUP RETURN	) - EIN 04-2868893 THE SPAULDING REHABILITATION HOSPITAL CORPORATION (SRH), ALSO REFERRED TO AS SPAULDING REHABILITATION HOSPITAL - BOSTON - EIN 04-2551124 VNA & HOSPICE OF COOLEY DICKINSON, INC (VHCD) - EIN 04-2104788 WENTWORTH-DOUGLASS HOSPITAL (WDH) - EIN 02-0260334 WENTWORTH-DOUGLASS HOSPITAL & HEALTH FOUNDATION (WDHF) - EIN 51-0491062 WENTWORTH-DOUGLAS S PHYSICIAN CORPORATION (WDPC) - EIN 02-0497927 WNR, INC (WNR) - EIN 04-3419920

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

2017

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.

See Additional Data Table

(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

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	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?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHS BAY COLONY FUND 245 PARK AVENUE NEW YORK, NY 10167 13-3887448	INVESTMENTS	DE	PPIA	EXCLUDED	35,660	219,459		No			No	93 870 %
(2) PARTNERS HEALTHCARE SYSTEM POOLED INVEST 101 MERRIMAC STREET BOSTON, MA 02114 04-3268842	INVESTMENTS	MA	PHS	EXCLUDED	20,975,117	25,386,929		No		Yes		100 000 %
(3) RADIATION THERAPY OF SOUTHEASTERN MA LLC 375 LONGWOOD AVENUE BOSTON, MA 02115 01-0873580	RADIATION THERAPY SERVICES	MA	BH	EXCLUDED	196,004	1,472,809		No		Yes		51 000 %
(4) PARTNERS INNOVATION FUND LLC 101 HUNTINGTON AVENUE BOSTON, MA 02199 26-2899986	INVESTMENTS	MA	PHS	EXCLUDED		32,163,181		No		Yes		100 000 %
(5) PARTNERS HEALTHCARE ACCOUNTABLE CARE ORGANIZATION LLC 399 REVOLUTION DRIVE SOMERVILLE, MA 02145 81-2762122	ACCOUNTABLE CARE ORGANIZATION	MA	PHS	EXCLUDED	1,554,572	13,441,441		No		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	No
(1)NEWTON-WELLESLEY PHYSICIAN HOSPITAL ORG 2014 WASHINGTON STREET NEWTON, MA 02462 04-3209749	HEALTHCARE	MA	NWHC	C	4,469,909	6,310,300	100 000 %		No
(2)ALLWAYS HEALTH PARTNERS INSURANCE COMPANY 399 REVOLUTION DRIVE SOMERVILLE, MA 02145 83-0970929	INSURANCE COMPANY	MA	PHS	C	17,223	4,017,223	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
PARTNERS HEALTHCARE INTERNATIONAL LLC 800 BOYLSTON STREET BOSTON, MA 02199 20-5281203	GLOBAL HEALTH CARE	MA	7,132,362	15,047,000	PHS
PARTNERS HARVARD MEDICAL INTERNATIONAL GULF FZ LLC	GLOBAL HEALTH CARE	MA	0	0	PHS
MERRIMACK VALLEY ENDOSCOPY LLC ONE PARKWAY HAVERHILL, MA 01830 04-3578297	MEDICAL SERVICES	MA	238,158	55,295	PCPO
PARTNERS INNOVATION II LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4444790	INVESTMENTS	MA	0	9,394,125	PHS
PARTNERS INNOVATION MANAGEMENT COMPANY LLC 800 BOYLSTON STREET BOSTON, MA 02199 81-4431654	INVESTMENTS	MA	0	0	PHS
MASSACHUSETTS EYE & EAR ASSOCIATES LLC 243 CHARLES STREET BOSTON, MA 02114 47-4262843	BILLING SERVICES	MA	680,934	0	MEEA
WDPC ORTHOPEDICS LLC 789 CENTRAL AVENUE DOVER, NH 03820 82-4754998	BILLING SERVICES	NH	0	0	WDH
PORTLAND INVESTMENTS-PIA LLC 101 MERRIMAC STREET BOSTON, MA 02114	INVESTMENTS	ME	0	0	PIA
PORTLAND INVESTMENTS-EP LLC 101 MERRIMAC STREET BOSTON, MA 02114	INVESTMENTS	ME	0	0	PIA
MASS GENERAL INTERNATIONAL LLC 55 FRUIT STREET BOSTON, MA 02114 83-1131673	GLOBAL HEALTH CARE	MA	0	0	MGPO
CODAMETRIX LLC 55 FRUIT STREET BOSTON, MA 02114 82-3924135	MEDICAL CODING SOFTWARE	MA	0	0	MGPO
COCHECO DEVELOPMENT LLC 95 MARKET STREET MANCHESTER, NH 03101	ACQUISITION ENTITY	NH	0	264,022	WDH
BRIGHAM HEALTH INTERNATIONAL 75 FRANCIS STREET BOSTON, MA 02115 83-1118331	GLOBAL HEALTH CARE	MA	0	0	BH
SPAULDING INTERNATIONAL LLC 300 FIRST AVENUE CHARLESTOWN, MA 02129 83-1146009	GLOBAL HEALTH CARE	MA	0	0	SRH
PARTNERS HEALTHCARE INSURANCE HOLDING COMPANY LLC 399 REVOLUTION DRIVE SOMERVILLE, MA 02145 83-1039882	HOLDING COMPANY	MA	0	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
55 FRUIT STREET BOSTON, MA 02114 04-1564655	HEALTHCARE	MA	501(C)(3)	7	PHS	Yes	
55 FRUIT STREET BOSTON, MA 02114 04-2697983	HOSPITAL	MA	501(C)(3)	3	MGH	Yes	
55 FRUIT STREET BOSTON, MA 02114 04-2807148	HEALTHCARE	MA	501(C)(3)	10	MGH	Yes	
55 FRUIT STREET BOSTON, MA 02114 22-2717383	HEALTHCARE	MA	501(C)(3)	12A	MGH	Yes	
36 FIRST AVENUE CHARLESTOWN, MA 02129 04-2868893	MED EDUCATION	MA	501(C)(3)	2	MGH	Yes	
115 MILL STREET BELMONT, MA 02478 20-4572876	ADMIN SUPPORT	MA	501(C)(3)	12A	MGH	Yes	
115 MILL STREET BELMONT, MA 02478 04-2697981	HOSPITAL	MA	501(C)(3)	3	MHC	Yes	
LINTON LANE PO BOX 1477 OAK BLUFFS, MA 02557 04-2104691	HEALTHCARE	MA	501(C)(3)	3	MGH	Yes	
1 LINTON LANE OAK BLUFFS, MA 02557 04-3419920	NURSING SVCS	MA	501(C)(3)	10	MVH	Yes	
57 PROSPECT STREET NANTUCKET, MA 02554 04-2103823	HOSPITAL	MA	501(C)(3)	3	MGH	Yes	
57 PROSPECT STREET NANTUCKET, MA 02554 04-3829745	ADMIN SUPPORT	MA	501(C)(3)	12A	NCH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 04-2921338	ADMIN SUPPORT	MA	501(C)(3)	7	PHS	Yes	
75 FRANCIS STREET BOSTON, MA 02115 04-2312909	HOSPITAL	MA	501(C)(3)	3	BH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 22-2483849	PROMOTE RES	MA	501(C)(3)	12A	BH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 04-3011445	MED RESEARCH	MA	501(C)(3)	12A	BH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 22-2588069	HEALTHCARE	MA	501(C)(3)	10	BH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 04-3466314	HEALTHCARE	MA	501(C)(3)	10	BH	Yes	
75 FRANCIS STREET BOSTON, MA 02115 04-3539249	MED RES & EDU	MA	501(C)(3)	12A	BWPO	Yes	
1153 CENTRE STREET BOSTON, MA 02130 04-2768256	HOSPITAL	MA	501(C)(3)	3	BH	Yes	
PRUDENTIAL TOWER 800 BOYLSTON STREE BOSTON, MA 02199 26-0003495	ADMIN SUPPORT	MA	501(C)(3)	12A	PHS	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
300 FIRST AVENUE CHARLESTOWN, MA 02129 04-2551124	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
311 SERVICE ROAD EAST SANDWICH, MA 02537 04-3071419	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
DOVE AVENUE SALEM, MA 01970 04-3067082	HEALTHCARE	MA	501(C)(3)	3	PCC	Yes	
281 WINTER STREET WALTHAM, MA 02451 04-2918280	HOME HEALTH	MA	501(C)(3)	10	PCC	Yes	
101 MERRIMAC STREET BOSTON, MA 02114 22-2632121	HEALTHCARE	MA	501(C)(3)	3	PCC	Yes	
81 HIGHLAND AVENUE SALEM, MA 01970 04-3294420	ADMIN SUPPORT	MA	501(C)(3)	12A	PHS	Yes	
81 HIGHLAND AVENUE SALEM, MA 01970 04-3399616	HOSPITAL	MA	501(C)(3)	3	NSHC	Yes	
81 HIGHLAND AVENUE SALEM, MA 01970 04-3080484	HEALTHCARE	MA	501(C)(3)	12A	NSHC	Yes	
2014 WASHINGTON STREET NEWTON, MA 02462 20-4295282	ADMIN SUPPORT	MA	501(C)(3)	12A	PHS	Yes	
2014 WASHINGTON STREET NEWTON, MA 02462 04-2103611	HOSPITAL	MA	501(C)(3)	3	NWHC	Yes	
2014 WASHINGTON STREET NEWTON, MA 02462 22-2560501	HEALTHCARE	MA	501(C)(3)	12A	NWHC	Yes	
2014 WASHINGTON STREET NEWTON, MA 02462 04-3455952	FUNDRAISING	MA	501(C)(3)	7	NWHC	Yes	
100 CAMBRIDGE STREET BOSTON, MA 02114 04-3197711	MED TRAINING	MA	501(C)(3)	12A	PHS	Yes	
1575 CAMBRIDGE STREET CAMBRIDGE, MA 02138 27-0273715	HOSPITAL	MA	501(C)(3)	3	PCC	Yes	
57 PROSPECT STREET NANTUCKET, MA 02554 26-4349357	HEALTHCARE	MA	501(C)(3)	10	MGH	Yes	
253 SUMMER STREET BOSTON, MA 02210 04-2932021	INSURANCE	MA	501(C)(4)	NONE	PHS	Yes	
253 SUMMER STREET BOSTON, MA 02210 04-3454185	INSURANCE	MA	501(C)(3)	12A	NHP	Yes	
30 LOCUST STREET NORTHAMPTON, MA 01060 22-2617175	HOSPITAL	MA	501(C)(3)	3	CDHCC	Yes	
168 INDUSTRIAL DRIVE NORTHAMPTON, MA 01060 04-2104788	HOME HEALTH	MA	501(C)(3)	10	CDHCC	Yes	
30 LOCUST STREET NORTHAMPTON, MA 01060 04-2103561	ADMIN SUPPORT	MA	501(C)(3)	12B	MGH	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
POBOX 911 NORTHAMPTON, MA 01060 04-3194547	HEALTHCARE	MA	501(C)(3)	10	CDHCC	Yes	
789 CENTRAL AVE DOVER, NH 03820 02-0260334	HOSPITAL	NH	501(C)(3)	3	MGH	Yes	
789 CENTRAL AVE DOVER, NH 03820 02-0497927	HEALTHCARE	NH	501(C)(3)	3	WDH	Yes	
789 CENTRAL AVE DOVER, NH 03820 51-0491062	SUPPORT	NH	501(C)(3)	12B	WDH	Yes	
243 CHARLES STREET BOSTON, MA 02114 04-2785453	SUPPORT	MA	501(C)(3)	7	MEEI	Yes	
243 CHARLES STREET BOSTON, MA 02114 04-2103591	HOSPITAL	MA	501(C)(3)	3	MEEI	Yes	
243 CHARLES STREET BOSTON, MA 02114 22-2658209	HEALTHCARE	MA	501(C)(3)	10	MEEI	Yes	
800 BOYLSTON STREET BOSTON, MA 02199 82-1715859	SUPPORT ORGANIZATION - HOLDS INTERESTS IN PPIA	MA	501(C)(3)	12A	PHS	Yes	
800 BOYLSTON STREET BOSTON, MA 02199 82-1707493	SPECIALTY PHARMACY	MA	501(C)(3)	12A	PHS	Yes	
920 WINTER STREET WALTHAM, MA 02451 47-1683619	URGENT CARE CENTERS	MA	501(C)(3)	10	PHS	Yes	
541 MAIN STREET SUITE 400 SO WEYMOUTH, MA 02190 04-2702579	PROVIDES PHYSICIAN SERVICES TO PATIENTS	MA	501(C)(3)	10	BH	Yes	
541 MAIN STREET SUITE 400 SO WEYMOUTH, MA 02190 04-3306443	PROVIDES PHYSICIAN SERVICES TO PATIENTS	MA	501(C)(3)	10	BH	Yes	
800 BOYLSTON STREET BOSTON, MA 02199 04-3236175	ORGANIZE AND OPERATE PHYSICIAN NETWORK	MA	501(C)(3)	10	PHS	Yes	
14 DAVID MUGAR WAY BOSTON, MA 02114 04-3272965	SUPPORT ORGANIZATION	MA	501(C)(3)	12A	MEEI	Yes	
243 CHARLES STREET BOSTON, MA 02114 04-2801797	TITLE HOLDING COMPANY	MA	501(C)(25)	NONE	MEEI	Yes	
20 STANIFORD STREET BOSTON, MA 02114 04-2129889	RESEARCH	MA	501(C)(3)	7	MEEI	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
BRIGHAM AND WOMEN'S FAULKNER HOSPITAL INC	C	25,707,889	FMV
THE BRIGHAM AND WOMEN'S HOSPITAL INC	C	219,527,200	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	4,422,416	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	5,890,487	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	1,903,348	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	254,713	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	1,093,298	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	1,517,960	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	2,682,141	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	12,444,233	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	1,381,144	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	3,845,112	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	486,603	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	548,831	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	606,181	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	706,462	FMV
BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION INC	C	445,447	FMV
HARBOR MEDICAL ASSOCIATES INC	C	457,139	FMV
THE MCLEAN HOSPITAL CORPORATION	C	16,970,297	FMV
NANTUCKET COTTAGE HOSPITAL	A	110,455	FMV
MARTHA'S VINEYARD HOSPITAL INC	A	109	FMV
REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORP	A	12,492	FMV
THE MGH INSTITUTE OF HEALTH PROFESSIONS INC	B	100,000	FMV
NANTUCKET COTTAGE HOSPITAL	B	19,968,000	FMV
THE GENERAL HOSPITAL CORPORATION	C	297,912,415	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
MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION INC	C	3,221,651	FMV
THE GENERAL HOSPITAL CORPORATION	L	440,464	FMV
MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION INC	L	100,091	FMV
NORTH SHORE MEDICAL CENTER INC	C	4,106,846	FMV
NEWTON-WELLESLEY HOSPITAL	C	33,282,831	FMV
NEWTON-WELLESLEY HOSPITAL CHARITABLE FOUNDATION INC	C	4,671,042	FMV
THE SPAULDING REHABILITATION HOSPITAL CORPORATION	B	13,994,488	FMV
FRC INC	B	4,976,433	FMV
REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORP	B	1,500,000	FMV
PARTNERS HOME CARE INC	C	3,115,476	FMV
THE SPAULDING REHABILITATION HOSPITAL CORPORATION	L	6,107,150	FMV
PARTNERS HOME CARE INC	L	6,815,380	FMV
FRC INC	L	2,078,856	FMV
SPAULDING HOSPITAL - CAMBRIDGE INC	L	3,513,740	FMV
REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORP	L	2,060,819	FMV
WNR INC	B	900,000	FMV
COOLEY DICKINSON HOSPITAL	B	24,912,292	FMV
WENTWORTH-DOUGLASS PHYSICIAN CORPORATION	B	47,553,000	FMV
WENTWORTH-DOUGLASS HOSPITAL & HEALTH FOUNDATION	B	1,508,000	FMV