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Return of Organization Exempt From Income Tax

OMB No 1545-0047

Department of the Treasury Internal Revenue Service

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.

, Open to Public Inspection

ĀF	or th	ne 2013 calendar year, or tax year beginning	, 2013,	and ending	3	, 20
_		C Name of organization			D Employer ident	ification number
В	heck if a	CAPITAL HEALTH SYSTEM, INC			22-35486	595
	Addre	ess Doing Business As				
-	7	Number and street (or P O box if mail is not delivered to street address)	1	Room/suite	E Telephone num	ber
-	+	750 BRUNSWICK AVENUE			(609) 278-	-5415
-	7	City or town, state or province, country, and ZIP or foreign postal code			(003/ 2/0	
X	⊣				G Gross receipts	\$ 563,709,226.
1	Appli	E Name and address of procedulation AT MACHAZEUE DU	D 1	TACHE	H(a) Is this a group i	
L	pend	750 BRUNSWICK AVENUE TRENTON, NJ 08638	.D., E	ACHE	subordinates?	
	Taylor		4777-1741	507	H(b) Are all subordinat	es included? Yes No
÷		rempt status X 501(c)(3) 501(c)() ◀ (insert no) 49- inter ► WWW.CAPITALHEALTH.ORG	47(a)(1) o	527	 1	
3				11.74	H(c) Group exemptio	
_				L Year or	formation 1997 M Sta	ate of legal domicile NJ
	art'İ,	· · · · · · · · · · · · · · · · · · ·		CD 117 CD DT	011 TO CONDITION	1D MO
	1	Briefly describe the organization's mission or most significant activities.				5D TO
Governance		PROVIDING COMPREHENSIVE, QUALITY HEALTHCARE			H IMPROVE AND	
na:		SUSTAIN THE HEALTH STATUS OF THE COMMUNITIES				
Ş.	2	Check this box ▶ ☐ if the organization discontinued its operations or	•		and the second s	1
ŏ	3	Number of voting members of the governing body (Part VI, line 1a) \dots				
చ గ్ర	4	Number of independent voting members of the governing body (Part VI, III				
ž.	5	Total number of individuals employed in calendar year 2013 (Part V, line 2	^(a)		5	
Activities	6	Total number of volunteers (estimate if necessary)				304.
∢	7a	Total unrelated business revenue from Part VIII, column (C), line 12				a 0
	b	Net unrelated business taxable income from Form 990-T, line 34				b 0
					Prior Year	Current Year
ø	8	Contributions and grants (Part VIII, line 1h)			7,894,663	
Revenue	9	Program service revenue (Part VIII, line 2g)		[516,041,705	
ě	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)			10,350,624	. 10,493,187.
<u>u_</u>	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e).			4,523,278	4,029,049.
_	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), li	ne 12) . .		538,810,270	. 562,500,629.
	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)				0
	14	Benefits paid to or for members (Part IX, column (A), line 4)				0 0
ø	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines			292,333,398	. 292,736,719.
nse	16a	Professional fundraising fees (Part IX, column (A), line 11e)				0 0
Expenses	ь	Total fundraising expenses (Part IX, column (D), line 25) ▶				
ú	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)			304,593,779	. 305,027,141.
	18	Total expenses Add lines 13-17 (must equal Part IX, column (A), line.25)		11	596,927,177	. 597,763,860.
	19	Revenue less expenses Subtract line 18 from line 12.			-58,116,907	35,263,231.
or			3 201	र शि	Beginning of Current Yea	
ets		Total assets (Part X, line 16)	ψ 2 01.	7S-C		. 1,081,018,223.
ASS		Total habilities (Port V. Inc. 26)			884,201,694	
Net /	22	Net assets or fund balances Subtract line 21 from line 20.	IN, L) 1 · · · i h	240,930,610	
	rt II	Signature Block			210,000,020	
			na schedul	es and stateme	ents, and to the best of m	v knowledge and belief, it is
tru	e, corre	nallies of perjury. I difitale that I have examined this return, including accompanyir ect, and complete Not Aration of preparer (other than officer) is based on all informati	on of whic	h preparer has	any knowledge	
), \ \VX\			02/18	12015
Sig	ın	Signature of officer			Date	10010
He		Shane Fleming CFO,				
		Type or print name and title				
		Print/Type preparer's name Preparer's signature Preparer's signature		Date 1		PTIN
Par	d	4 - 11/0/14			2615 Check if self-employed	
	- parer	SCOTT MARIANI	 	1414	3cir-ciripidyed	P00642486
	Only		}	1 1	Firm's EIN ▶ 22	
		Firm's address >465 SOUTH ST STE 200 MORRISTOWN, NJ 07960-6497	+		Phone no 97	3-898-9494
_		RS discuss this return with the preparer shown above? (see instructions) .	<u>,\</u>	· · · · · · ·	<u></u>	X Yes No
For	Pape	rwork Reduction Act Notice, see the separate instructions.				Form 990 (2013)
						G. 18-34 V

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_	m 990 (2013) Page 2
P	art III Statement of Program Service Accomplishments
_	Check if Schedule O contains a response or note to any line in this Part III
1	ATTACHMENT 1
2	Did the organization undertake any significant program services during the year which were not listed on the
	prior Form 990 or 990-EZ?
_	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?
4	If "Yes," describe these changes on Schedule O. 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 \$
	EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY GENERAL MEDICAL/SURGICAL SERVICES TO ALL INDIVIDUALS IN A
	NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX,
	NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. PLEASE REFER TO
	SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.
	COMBOND C TON THE CAGAMENTION & COMMONTH BENEFIT OFFICERE.
4b	(Code) (Expenses \$63,112,618 including grants of \$0 (Revenue \$45,754,807_)
	EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY MATERNAL/CHILD
	HEALTH SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION
	OR ABILITY TO PAY. PLEASE REFER TO SCHEDULE O FOR THE
	ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.
	OKOMILATION O COMMONITI BENEFIT OTTIBULAT.
40	(Code) (Expenses \$
	EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY EMERGENCY
	SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER
	REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION
	OR ABILITY TO PAY. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.
	ORGANIZATION S COMMONITI BENEFIT STATEMENT.
40	Other program services (Describe in Schedule O)
	(Expenses \$ 170, 289, 156. including grants of \$ 0) (Revenue \$ 260, 822, 945)
46	• Total program service expenses ► 537, 985, 435.

Pari	V Checklist of Required Schedules			. age c
			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes,"			l
_	complete Schedule A	1	х	
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2	Х	
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]	Х
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h)	<u> </u>		
	election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	x	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues,			
	assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C,			
	Part III	5		Х
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		Х
7	Did the organization receive or hold a conservation easement, including easements to preserve open space,	Ť		
	the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>	7		Х
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes,"			
•	complete Schedule D, Part III	8		Х
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		i	
	debt negotiation services? If "Yes," complete Schedule D, Part IV	9		х
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted	-		<u> </u>
	endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	10		х
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D. Parts VI.	10		
	VII, VIII, IX, or X as applicable.			
2	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes,"			
a		11a	х	
h	complete Schedule D, Part VI	1 la		
D	of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	446		v
•	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more	11b		X_
·	of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	x	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets	116		
u	reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d		Х
_	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X		X	
	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses	11e		
1		445		Х
12.	the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f		
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes,"	40-		v
	complete Schedule D, Parts XI and XII	12a		X
D	Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if	405	х	
42	the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b		
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	х	<u> </u>
	Did the organization maintain an office, employees, or agents outside of the United States?	14a		
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	446	х	
4-	foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	^	
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or			v
4.0	for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15		_ <u>X</u> _
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other		l	37
4-	assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16		_ <u>X</u>
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on			.,
46	Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17		X
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on	_		
	Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18		<u> </u>
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		_X_
	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a	X	
<u>b</u>	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	
JSA		Form	990 (2013)

Part	V Checklist of Required Schedules (continued)			- age 1
			Yes	No
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or			
	government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21	'	Х
22	Did the organization report more than \$5,000 of grants or other assistance to individuals in the United States			
	on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22		Х
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	X	
24 a	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		Х
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
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		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25 a	Section 501(c)(3) and 501(c)(4) 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		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior			
	year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ?			
	If "Yes," complete Schedule L, Part L	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payable to any			
	current or former officers, directors, trustees, key employees, highest compensated employees, or			
	disqualified persons? If so, complete Schedule L, Part II	26	X	
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		X
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)			
		28a		X
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete			
	Schedule L, Part IV	28b	X	
С	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	X	
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	29		_X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified			
	conservation contributions? If "Yes," complete Schedule M	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N,			.,
	Part I	31		<u> </u>
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		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations			v
	sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	33		<u>X</u>
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III,		Х	
	or IV, and Part V, line 1	34	_^ X	
	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		
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	256	х	
26	• • • • • • • • • • • • • • • • • • • •	35b		
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		х
27	Did the organization conduct more than 5% of its activities through an entity that is not a related organization	30		
37	and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R,			
		37		Х
20	Part VI	31		
38	19? Note. All Form 990 filers are required to complete Schedule O	38	х	
	13. Note: An I om I add mera are required to complete deficulte O			(2013)

	Statements Regarding Other IRS Filings and Tax Compliance			
	Check if Schedule O contains a response or note to any line in this Part V		<u></u>	
			Yes	No
	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	-		
	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	4 . /		
С	Did the organization comply with backup withholding rules for reportable payments to vendors and	1		
_	reportable gaming (gambling) winnings to prize winners?	1c	X	
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 4,506	1	١	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		,,	1
	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	X	
	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	_^	-
ra	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	4.	X	
h	account)?	4a		 - -
			/^	_
	See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts	. .		v
	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	-	- ^
	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c		
	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the	6-	İ	X
	organization solicit any contributions that were not tax deductible as charitable contributions?	6a		
	·	6.		
	gifts were not tax deductible?	6b		
	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	x	~~
	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	X	 -
	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was	10		-
•	required to file Form 8282?	7c		x
Н	If "Yes," indicate the number of Forms 8282 filed during the year	· ·	· · · · ·	
	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		x
	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	-	X
	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
_	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting	- ,	, ` <i>,</i>	
	organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring		-	
	organization, have excess business holdings at any time during the year?	8	1	
	Sponsoring organizations maintaining donor advised funds.			
	Did the organization make any taxable distributions under section 4966?	9a	_ ^	
	Did the organization make a distribution to a donor, donor advisor, or related person?	9b		
	Section 501(c)(7) organizations. Enter			
3	Initiation fees and capital contributions included on Part VIII, line 12			-
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities [10b]	, ,	,	-
	Section 501(c)(12) organizations. Enter	_	-	
a	Gross income from members or shareholders			
0	Gross income from other sources (Do not net amounts due or paid to other sources		-	- ^
	against amounts due or received from them)	, , , , , , , , , , , , , , , , , , ,	, ~	
3	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			
	Section 501(c)(29) qualified nonprofit health insurance issuers.]
	Is the organization licensed to issue qualified health plans in more than one state?	13a		
	Note. See the instructions for additional information the organization must report on Schedule O	- ,'	. 3	1.5
b	Enter the amount of reserves the organization is required to maintain by the states in which		1	
	the organization is licensed to issue qualified health plans	-		-
	Enter the amount of reserves on hand	<u> </u>		_ ,
	Did the organization receive any payments for indoor tanning services during the tax year?	14a		Х
а	• • • • • • • • • • • • • • • • • • •	444		
	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 line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O See instructions

Sect	ion 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 21							
	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 14							
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_		X				
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_		X				
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		Х				
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		Χ				
6	Did the organization have members or stockholders?	6		Х				
7a	a 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		Х				
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		Х				
8	Did the organization contemporaneously document the meetings held or written actions undertaken during							
	the year by the following							
а	The governing body?	8a	X					
b	Each committee with authority to act on behalf of the governing body?	8ь	Х					
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		Х				
Secti	on 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		X				
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters,							
	affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		ļ 				
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	11a	X					
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	X					
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give		١					
	rise to conflicts?	12b	X					
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	X					
13	Did the organization have a written whistleblower policy?	13	X					
14	Did the organization have a written document retention and destruction policy?	14	X					
15	Did the process for determining compensation of the following persons include a review and approval by			ļ				
	independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		.,,					
а	The organization's CEO, Executive Director, or top management official	15a						
b	Other officers or key employees of the organization	15b	X					
	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			x				
	with a taxable entity during the year?	16a		_				
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	466						
<u>C4</u>	organization's exempt status with respect to such arrangements?	16b	<u>. </u>	l				
	ion C. Disclosure							
17	List the states with which a copy of this Form 990 is required to be filed ► NJ.							
18	Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section available for public inspection. Indicate how you made these available Check all that apply	501(c)(3)s	only)				
	Own website Another's website X 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 int	erest	policy	, and				
	financial statements available to the public during the tax year							
20	State the name, physical address, and telephone number of the person who possesses the books and records of the	ne						
ISA	organization ► SHANE F FLEMING, CPA 750 BRUNSWICK AVENUE TRENTON, NJ 08638 (609)278-5415			/2012)				

Form 990 (2013	<u> </u>									Page
Part VII	Compensation of	Officers,	Directors,	Trustees,	Key	Employees,	Highest	Compensated	Employees,	and
	1									

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, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's former directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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 (C) Position (A) (B) (D) (F) (do not check more than one Name and Title Average Reportable Reportable Estimated box, unless person is both an hours per compensation compensation from amount of officer and a director/trustee) week (list an from related other compensation hours for the organizations Officer Individual Highest employee nstitutional from the organization (W-2/1099-MISC) related director employee organization organizations (W-2/1099-MISC) and related below dotted compensated trustee organizations line) trustee (1)SAMUEL J PLUMERI JR 5.00 CHAIRMAN - TRUSTEE Х Χ (2)NANCY H BECKER 5.00 VICE CHAIR - TRUSTEE Х Χ 0 (3)GILBERT W LUGOSSY 3.00 SECRETARY - TRUSTEE X Х 0 (4)JOHN F-RICCI-3.00 TREASURER - TRUSTEE Χ C 0 (5)CARMEN M GARCIA ESQ 3.00 ASSISTANT SECRETARY - TRUSTEE Χ C 0 0 (6)RANDI A AXELROD MD 1.00 TRUSTEE C0 ____(7)GIOVANNI CAFORIO MD 1.00 TRUSTEE Χ Ω 0 (8)LOUIS F DAMELIO MD 55.00 TRUSTEE Χ 844,836 0 24,697. (9)KATHLEEN GEKOWSKI MD FACP 1.00 TRUSTEE Х 10,031 O (10)MARTIN P JOHNSON 1.00 TRUSTEE Χ 0 C (11)RAMAN KAPUR 1.00 TRUSTEE Х 0 (12)JULIE A KARNS 1.00 TRUSTEE Х 0 0 (13)DANIEL J LEE MD 25.00 TRUSTEE 70,100. 0 0 (14)DONALD J LOFF 1.00 TRUSTEE Χ 0 0

	(A) Name and title	(B) Average hours per week (list any hours for	(C) Position (do not check more than or box, unless person is both officer and a director/truster		ne an ee)	(D) Reportable compensation from the	(E) Reportable compensation from related organizations	E:	(F) stimated nount of other	of			
		related organizations below dotted line)	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	organization (W-2/1099-MISC)	(W-2/1099-MISC)	org an	om the anizatio d relate anizatio	on ed
(15) AL MAGHAZEHE PHD FACHE TRUSTEE - PRESIDENT/CEO	55.00	х		х				1,476,147.	(80,8	 893
(16) JOSHUA MARKOWITZ ESQ TRUSTEE	1.00	Х						0	(1	00,0	0
(17) SEAN S MURRAY	1.00											
	TRUSTEE		X						0	(0
(18) CLINTON H OGOLO MD TRUSTEE	1.00	Х						0	(0
(19) MICHAEL L SOMERSTEIN MD TRUSTEE	1.00	Х						0				0
(20) TELECHERY A SUDHAKAR MD	1.00		\vdash		-					1		
`	TRUSTEE - VP, MEDICAL STAFF		х						0	(0
(21) JOHN P THURBER	1.00											
	TRUSTEE		Х						0	(0
(22) SHANE F FLEMING CPA	55.00			.,				226 606			20 /	- 7.0
(CHIEF FINANCIAL OFFICER 23) EUGENE W GROCHALA	55.00		$\left \cdot \cdot \right $	X		_		336,686.			38,5	579.
1	CHIEF INFORMATION OFFICER				х				429,685.	(71.1	235.
(24) STEPHEN A MILLER JD	55.00					-	-			1		
	CHIEF COMPLIANCE OFFICER				Х				218,355.			28,7	703.
(25) LARRY DISANTO EXECUTIVE VICE PRESIDENT/COO	55.00			Х				804,151.		3	37,3	337.
	1b Sub-total ▶ 924,967. 0									 	24,697.		
	c Total from continuation sheets to Part VII, Se							▶	12,181,909.	(1,4	70,4	30.
	d Total (add lines 1b and 1c)							>	13,106,876.		1,4	95,1	.27.
-	2 Total number of individuals (including but not l reportable compensation from the organization		hose l 505		d at	OOVE	e) who	re	ceived more than	\$100,000 of	-		
		<u> </u>	500									Yes	No
	3 Did the organization list any former office	er, directo	r, or	tru	ste	e, I	кеу є	emp	loyee, or highes	t compensated	_		
	employee on line 1a? If "Yes," complete Schedu	lle J for suc	ch ınd	ividu	ıal .						3	Х	
	4 For any individual listed on line 1a, is the s										·-		
	organization and related organizations gre							-	•		1-	X	
	5 Did any person listed on line 1a receive or										4		-
	5 Did any person listed on line 1a receive or for services rendered to the organization? If "Ye										5	- 1	X
	Section B. Independent Contractors												L
	 Complete this table for your five highest component of compensation from the organization. Report of year. 												
	(A) Name and business add	ress				-			(B) Description of se	ruces	(C) Compens	sation	
	ATTACHMENT 2								233.101.01.01				
								\bot					
								+					
							.	+-					
	2 Total number of independent contractors (in	icludina hi	ıt not	lım	uter	d to	thos	ie li	isted above) who	received	-		
	more than \$100,000 in compensation from the					15					•	, * _v	
	ISA				_	_							

Part VII Section A. Officers, Directors, Tru (A)	(B)	<u> </u>			C)		<u> </u>		1			
Name and title	Average hours per week (list any hours for	box,	unle er an	Pos heck ss pe	morerson	e than our than or/trust	an lee)	(D) Reportable compensation from the	(E) Reportable compensation from related organizations	com	(F) stimated mount of other opensal	of Ion
	related organizations below dotted line)	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	organization (W-2/1099-MISC)	(W-2/1099-MISC)	org an	rom the gantzatio id relate anizatio	on d
26) ALEXANDER D GLADNEY ESQ	55.00			-								
GENERAL COUNSEL				Х				323,980.	0		7,8	863
27) JOSHUA A EISENBERG MD CHIEF MEDICAL OFFICER	55.00	-		Х				593,528.	0		26,2	242
28) MARGARET SULLIVAN VP, QUALITY RESOURCE MGMT.	55.00			х				545,596.	0		17,3	321
29) ROBERT REMSTEIN DO VP, ACCOUNTABLE CARE	55.00			Х				418,553.	0		27,	734
30) GREGORY N DADAMO VP, SUPPORT & PROFESSIONAL SVCS	55.00			Х				348,625.	0		58,8	319
31) J SCOTT CLEMMENSEN VP, HUMAN RESOURCES	55.00			Х				347,765.	0		75,3	346
32) EILEEN M HORTON VP, PATIENT SERVICES/CNO	55.00			Х	ļ <u>.</u>	į	<u></u>	343,841.	0		32,8	374
33) NATHAN BOSK FACHE VP, AMBULATORY SERVICES	55.00			Х				340,079.	0		34,4	146
34) DENNIS DOOLEY VP, PLANNING/VP, COMM & GOV'T	55.00			Х				306,651.	0		70,9	908
35) ARLENE WALSH VP, TRANSFORMATION	55.00			Х				234,214.	0		29,2	297
36) SUZANNE B BORGOS VP, PLANNING (EFF 7/1/13)	55.00			Х				115,486.	0			916
1b Sub-total	ection A .		 	 	 	<u></u>	> >				·	
Total number of individuals (including but not reportable compensation from the organization)		hose 505		d al	bove	e) who	o re	ceived more than	\$100,000 of		 -	_
3 Did the organization list any former offic employee on line 1a? If "Yes," complete Schedi										3	Yes	No
4 For any individual listed on line 1a, is the organization and related organizations groups												
5 Did any person listed on line 1a receive or									on or individual	4	X	· X

Section B. Independent Contractors

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

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

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

(A) Name and title		~~~~		,	, ,	anu	119	hest Compensat	od Linpioy coo (c	onunuea)		
	(B) Average hours per week (list any hours for	box,	not ch unles	s pe	ition more rson irect	Reportable Reports nore than one compensation compensation son is both an rector/trustee) the organiza		(E) Reportable compensation from related organizations	(F) Estimated amount of other compensation			
	related organizations below dotted Ime)	Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	organization (W-2/1099-MISC)	(W-2/1099-MISC)	from the organization and related organizations		
37) ARLAN H MINTZ MD PHYSICIAN	55.00							1 060 770				
38) LEE M BUONO MD	55.00					Х		1,062,772.	0	17,349		
PHYSICIAN 39) STEVEN A JOHNSON MD	55.00					Х		897,498.	0	17,649		
PHYSICIAN	33.00					Х		714,281.	0	25,422		
10) GARY A TUMA MD PHYSICIAN	55.00					х		610,562.		21,393		
11) JOSEPH E SHERRILL II MD	55.00				_			010,302.		21,393		
PHYSICIAN 12) RONALD J GUY	0					Х		546,353.	0	11,662		
FORMER CFO							Х	626,036.	0	7,594		
13) JAN GABIN ESQ FORMER GENERAL COUNSEL	0						х	307,461.	0	16,996		
14) LINDA DITE	0											
FORMER VP, CLINICAL SERVICES							X	233,604.	0	13,852		
	}											
1b Sub-total Continuation sheets to Part VII, Section A Control (add lines 1b and 1c) Control (a												
	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 ► 505											
2 Total number of individuals (including but not		hose I	ıste				ге	ceived more than s	\$100,000 ⁻ of			
Total number of individuals (including but not reportable compensation from the organization)	n ▶ cer, directo	hose I 505 or, or	tru	d ab	ove 	e) who	mp	loyee, or highest	compensated	Yes No		
 Total number of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched 	eer, directoule J for suc sum of repeater than	505 or, or och ind oortab \$15	tru vidu le c 0,00	stee	e, l	cey e	mp	loyee, or highest	compensated			
 Total number of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than	or, or or or table \$15	tru vidu le c 0,00	stee	e, l	e) who	emp	loyee, or highest	compensated ation from the J for such	3 X 4 X		
 2 Total number of individuals (including but not reportable compensation from the organization) 3 Did the organization list any former office employee on line 1a? If "Yes," complete Sched 4 For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue cores," completing pensated in	or, or ch ind sortab	tru vidu le c 0,00 satio	stee	pen If rom for	e) who	emp n ar ;" (uni pers	loyee, or highest	compensated ation from the e J for such on or individual	3 X 4 X 5 X		
 Total number-of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue confes," completion pensated in compensated in compensa	or, or ch ind sortab	tru vidu le c 0,00 satio	stee	pen If rom for	e) who	emp n ar ;" (uni pers	loyee, or highest	ation from the e J for such on or individual than \$100,000 coin the organizatio	3 X 4 X 5 X		
 Total number of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue confes," completion pensated in compensated in compensa	or, or ch ind sortab	tru vidu le c 0,00 satio	stee	pen If for cont	e) who	emp n ar ;" (uni pers	loyee, or highest	ation from the e J for such on or individual than \$100,000 coin the organizatio	3 X 4 X 5 X		
 Total number-of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue confes," completion pensated in compensated in compensa	or, or ch ind sortab	tru vidu le c 0,00 satio	stee	pen If for cont	e) who	emp n ar ;" (uni pers	loyee, or highest	ation from the e J for such on or individual than \$100,000 coin the organizatio	3 X 4 X 5 X		
2 Total number of individuals (including but not reportable compensation from the organization) 3 Did the organization list any former office employee on line 1a? If "Yes," complete Sched 4 For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue contes," completion pensated in compensation dress	hose I 505 or, or ch ind portab \$15 mpenate Sch	truuvidu le c 0,000 satio	stee	pen If If If If If If If If If If If If If	e) who	emp	loyee, or highest	ation from the e J for such on or individual than \$100,000 coin the organizatio	3 X 4 X 5 X		
 Total number of individuals (including but not reportable compensation from the organization) Did the organization list any former office employee on line 1a? If "Yes," complete Sched For any individual listed on line 1a, is the organization and related organizations grandividual	cer, directorule J for such sum of repeater than accrue contes," completion compensated in compe	hose I 505 or, or ch ind portab \$15 mpenate Sch ndepean for	truuvidulle c 0,000	stee	pen If If If If If If If If If If If If If	e) who	emp	loyee, or highest	ation from the e J for such on or individual than \$100,000 coin the organizatio	3 X 4 X 5 X		

Part VIII Statement of Revenue Check if Schedule O contains a response or note to any line in this Part VIII (C) Unrelated (A) (B) Related or (D) Revenue Total revenue exempt business excluded from tax function revenue under sections revenue 512-514 Federated campaigns . . . 1b Membership dues b Gifts, a 1 c Fundraising events . . . C 1 d 9,002,463 Related organizations Contributions, G and Other Simil 1e 2,774,113 Government grants (contributions) . . All other contributions, gifts, grants, and similar amounts not included above Noncash contributions included in lines 1a-1f \$. Total, Add lines 1a-1f 11,776,576 Program Service Revenue **Business Code** 541900 2a NET PATIENT SERVICE REVENUE 520,772,042 520,772,042 911 COUNTY SUPPORT & FIRE DISPATCH 541900 112,800 112,800 OTHER HEALTHCARE RELATED REVENUE 541900 15,059,352 15,059,352 257,623 AUXILIARY REVENUE 541900 257,623 All other program service revenue . . . Total. Add lines 2a-2f 536,201,817 3 Investment income (including dividends, interest, and other similar amounts). ATTACHMENT 3 2,714,422 Income from investment of tax-exempt bond proceeds Royalties · · · · · · · (ı) Real (ii) Personal Gross rents 1,710,824 Less rental expenses . . . Rental income or (loss) . . d Net rental income or (loss) (i) Securities (II) Other 7a Gross amount from sales of 8,987,362 assets other than inventory Less cost or other basis 208,597 and sales expenses . . . 8,987,362 -1,208,597 Gain or (loss) d Net gain or (loss) Other Revenue Gross income from fundraising events (not including \$ _ of contributions reported on line 1c) See Part IV, line 18 Less direct expenses c Net income or (loss) from fundraising events . 9a Gross income from gaming activities See Part IV, line 19 c Net income or (loss) from gaming activities . 10a Gross sales of inventory, less returns and allowances Less cost of goods sold Net income or (loss) from sales of inventory. Miscellaneous Revenue **Business Code** CAFE/DIETARY 900099 2,318,225 2,318,225 11a All other revenue . . . 2,318,225 Total, Add lines 11a-11d . . Total revenue See instructions 562,500,629 536,201,817 14,522,236

3E1051 1 000

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 resp	onse or note to any lin	e in this Part IX	 	<u> </u>
	not include amounts reported on lines 6b, 7b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and				
	organizations in the United States See Part IV, line 21 .	o			
2	Grants and other assistance to individuals in				
	the United States See Part IV, line 22	o			
3	Grants and other assistance to governments,				·
	organizations, and individuals outside the			İ	
	United States See Part IV, lines 15 and 16	o			
4	Benefits paid to or for members	0			
	Compensation of current officers, directors,				
	trustees, and key employees	9,471,522.	8,524,369.	947,153.	
6	Compensation not included above, to disqualified			, , , , , , , , , , , , , , , , , , , ,	
	persons (as defined under section 4958(f)(1)) and				
	persons described in section 4958(c)(3)(B)	d			
7	Other salaries and wages	245,520,494.	220,968,445.	24,552,049.	
	Pension plan accruals and contributions (include section				
U	401(k) and 403(b) employer contributions)	432,719.	389,447.	43,272.	
۵	· · · · · · · · · · · · · · · · · · ·	19,061,951.	17,155,756.	1,906,195.	
	Other employee benefits	18,250,033.	16,425,030.	1,825,003.	
10	Payroll taxes		10,120,000.	2,023,003.	
	Fees for services (non-employees) Management	o			
	1	365,912.	329,321.	36,591.	
	Legal	285,923.	257,331.	28,592.	
	Accounting	284,249.	255,824.	28,425.	
	Lobbying	0	233,024.	20,423.	· · · · · · · · · · · · · · · · · · ·
	Professional fundraising services. See Part IV, line 17.	748,001.	673,201.	74,800.	
	Investment management fees	740,001.	0/3,201.	74,000.	
9	Other (If line 11g amount exceeds 10% of line 25, column	64,660,399.	58,194,359.	6,466,040.	
4.0	(A) amount, list line 11g expenses on Schedule O)	3,303,026.	2,972,723.	330,303.	
	Advertising and promotion	14,414,597.	12,973,137.		
13	Office expenses	2,830,457.	2,547,411.	1,441,460. 283,046.	
14	Information technology	2,030,437.	2,547,411.	203,046.	
15	Royalties	14,269,156.	12,842,240.	1 426 016	
16	Occupancy	14,209,130.	12,042,240.	1,426,916.	
	Travel			-	
18	Payments of travel or entertainment expenses				
40	for any federal, state, or local public officials	728,523.	655,671.	72,852.	
	Conferences, conventions, and meetings	48,136,797.	43,323,117.		
	Interest	10,130,131.	40,020,111.	4,813,680.	
	Payments to affiliates	63,534,770.	57,181,293.	6,353,477.	
	Depreciation, depletion, and amortization	1,942,189.	1,747,970.	194,219.	
	Insurance	1,942,109.	1, 141, 510.	194,219.	
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)				
	MEDICAL SUPPLIES	74,943,805.	67,449,425.	7,494,380.	
-		7,841,252.	7,057,127.	784,125.	
_	REPAIRS AND MAINTENANCE DUES AND SUBSCRIPTIONS	1,423,325.	1,280,993.	142,332.	······································
					
	OTHER EXPENSES	5,314,760.	4,781,245.	533,515.	
	All other expenses	597,763,860.	537,985,435.	59,778,425.	
	Total functional expenses Add lines 1 through 24e Joint costs. Complete this line only if the	391,103,000.	337, 363, 435.	33,110,425.	
_ 0	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)				
164	1010 ming 001 00-2 (rtd0 800-720)	<u> </u>			

JSA 3E1052 1 000

Pa	rt X	Balance Sheet		rage (1
		Check if Schedule O contains a response or note to any line in this P	art X <u>.</u>	X
			(A) Beginning of year	(B) End of year
	1	Cash - non-interest-bearing	0 1	0
	2	Savings and temporary cash investments	9,115,996. 2	7,072,198.
	3	Pledges and grants receivable, net	0 3	
	4	Accounts receivable, net	74,582,682. 4	81,682,299.
	5	Loans and other receivables from current and former officers, directors,		
		trustees, key employees, and highest compensated employees		
	_	Complete Part II of Schedule L Loans and other receivables from other disqualified persons (as defined under section	142,500. 5	445,000.
	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	0 6	0
ets	7	Notes and loans receivable, net	0 7	0
Assets	8	Inventories for sale or use	3,077,734. 8	10,695,567.
_	9	Inventories for sale or use Prepaid expenses and deferred charges ATCH 4	18,232,763. 9	
	10 a	Land, buildings, and equipment cost or		
		other basis Complete Part VI of Schedule D 1268630571.		
	b	Less accumulated depreciation	800,684,426. 10	c 745,783,134.
	11	Investments - publicly traded securities	0 1	1 0
	12	Investments - other securities See Part IV, line 11	0 1:	
	13	Investments - program-related. See Part IV, line 11	181,843,460. 1:	186,728,785.
	14	Intangible assets	13,433,796. 14	12,599,362.
	15	Other assets. See Part IV, line 11	24,018,947. 1	5 20,425,703.
	16	Total assets. Add lines 1 through 15 (must equal line 34)	1,125,132,304.	i 1,081,018,223.
	17	Accounts payable and accrued expenses	65, 355, 358. 1 7	68,550,768.
	18	Grants payable	0 18	
	19	Deferred revenue	0 19	9 0
	20	Tax-exempt bond liabilities	0 20	
es	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0 2	1 0
Liabilities	22	Loans and other payables to current and former officers, directors,	1	
de		trustees, key employees, highest compensated employees, and		
		disqualified persons. Complete Part II of Schedule L	0 2:	
	23	Secured mortgages and notes payable to unrelated third parties ATCH. 5.		
	24	Unsecured notes and loans payable to unrelated third parties	0 24	1 0
	25	Other liabilities (including federal income tax, payables to related third		
		parties, and other liabilities not included on lines 17-24) Complete Part X	60 076 001	- 45 000 040
		of Schedule D	62,876,991. 2	
	26	Total liabilities. Add lines 17 through 25	884,201,694. 20	868,329,110.
ç	ļ	Organizations that follow SFAS 117 (ASC 958), check here ► X and complete lines 27 through 29, and lines 33 and 34.		
JC LC	27	•	240,930,610.	7 212,689,113.
a	28	Unrestricted net assets Temporarily restricted net assets		
8	29	Permanently restricted net assets	0 2	
Net Assets or Fund Balances		Organizations that do not follow SFAS 117 (ASC 958), check here and complete lines 30 through 34.		<u> </u>
Š	30	Capital stock or trust principal, or current funds	30	n
set	31	Paid-in or capital surplus, or land, building, or equipment fund	3.	
As	32	Retained earnings, endowment, accumulated income, or other funds	3	
et	33	Total net assets or fund balances	240,930,610. 3:	
~	34	Total liabilities and net assets/fund balances		
_	<u> </u>	Total maximos and not additional additions.	1 - , 120 , 102 , 504 . 30	- 1-,001,010,223.

	00 (2013)			Pa	age 12	
Part	XI Reconciliation of Net Assets					
	Check if Schedule O contains a response or note to any line in this Part XI		<u></u>		X	
1	Total revenue (must equal Part VIII, column (A), line 12)	1	562,	500,	629.	
2	Total expenses (must equal Part IX, column (A), line 25)	2	597,	763,	860.	
3	Revenue less expenses. Subtract line 2 from line 1	3	-35,2	35,263,231.		
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	240,9	610.		
5	Net unrealized gains (losses) on investments	5	1,	508,	734.	
6	Donated services and use of facilities	6			0	
7	Investment expenses	7			0	
8	Prior period adjustments	8			0	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	5,	513,	000.	
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line	1				
	33, column (B))	10	212,	589,	113.	
P <u>art</u>						
	Check if Schedule O contains a response or note to any line in this Part XII	<u> </u>	· · · · · ·	· · ·	X	
				Yes	No	
1	Accounting method used to prepare the Form 990 CashX Accrual Other		i			
	If the organization changed its method of accounting from a prior year or checked "Other," e	xplaın	ın			
	Schedule O.			İ		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		2a	<u>L</u> .	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were com-	ipiled (or			
	reviewed on a separate basis, consolidated basis, or both		į			
	Separate basis Consolidated basis Both consolidated and separate basis			1	l	
b	Were the organization's financial statements audited by an independent accountant?		2b	X		
	If "Yes," check a box below to indicate whether the financial statements for the year were audi	ted on	а		1	
	separate basis, consolidated basis, or both					
	Separate basis X Consolidated basis Both consolidated and separate basis				}	
С	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for overs	sight				
	of the audit, review, or compilation of its financial statements and selection of an independent account	ntant?	2c	X	<u> </u>	
	If the organization changed either its oversight process or selection process during the tax year, e	xplain	ın			
	Schedule O.					
3a	As a result of a federal award, was the organization required to undergo an audit or audits as se	t forth	ın			
	the Single Audit Act and OMB Circular A-133?		3a	X	<u> </u>	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not und		ne	1		
	required audit or audits, explain why in Schedule O and describe any steps taken to undergo such au	dits	3b	X		
			Form	990	(2013)	
	· · · · · · · · · · · · · · · · · · ·					

SCHEDULE A (Form 990 or 990-EZ)

Public Charity Status and Public Support

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

2013

OMB No 1545-0047

Department of the Treasury Internal Revenue Service

10

► 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.

Open to Public Inspection

Name of the organization Employer identification number CAPITAL HEALTH SYSTEM, INC 22-3548695 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 11, check only one box.) A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i). 1 A school described in section 170(b)(1)(A)(ii). (Attach Schedule E.) 2 Х 3 A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii). 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. 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). 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) R A community trust described in section 170(b)(1)(A)(vi). (Complete Part II.) An organization that normally receives (1) more than 331/3 % 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 331/3% 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)

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

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

	a Type I		c Type III-Functio				· —	Type II		9		oara	tod
еГ			e organization is not con										
_			other than one or more										
	or section 509(a)(2				,							,,,,,	~/(· /
f	If the organization	received a writte	en determination from th	e IRS	that it	ıs a T	vpe I. T	vpe II.	or Typ	e III s	troggu	ına	
												5	
g	Since August 17, 2	006, has the orga	nization accepted any gift	t or co	 ntributi	on from	anv of	the		• • • •		• •	
3	following persons?	_					, 0.						
	J .		tly controls, either alone	or toge	ether v	with nei	sons de	escribe	d in (ii)	and		Yes	No
			f the supported organizati								11g(ı)		
											11g(II)		<u> </u>
			son described in (i) or (ii) a	hove?							11g(uı)	ļ	
h		•	out the supported organization			• • • •					7.9()	L	L
(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	col (I) your go	Is the zation in listed in overning ment?	the orga	ou notify enization of your	organi; col (i) o	s the zation in rganized US?	(viı) A	mount o		etary
				Yes	No	Yes	No	Yes	No	1			
A)													
В)													
C)		<u>.</u>											
D)													
E)													

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

Schedule A (Form 990 or 990-EZ) 2013

Schedule A (Form 990 or 990-EZ) 2013 Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi) (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.) Section A. Public Support Calendar year (or fiscal year beginning in) (a) 2009 (b) 2010 (c) 2011 (d) 2012 (e) 2013 (f) Total Gifts grants. contributions. membership fees received (Do not include any "unusual grants") revenues levied for organization's benefit and either paid to or expended on its behalf The value of services or facilities furnished by a governmental unit to the organization without charge Total Add lines 1 through 3..... The portion of total contributions by each person (other than governmental unit ог publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)..... Public support. Subtract line 5 from line 4 Section B. Total Support Calendar year (or fiscal year beginning in) (a) 2009 (b) 2010 (c) 2011 (d) 2012 (e) 2013 (f) Total Amounts from line 4 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources.......... Net income from unrelated business activities, whether or not the business is regularly carried on Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV) Total support. Add lines 7 through 10 . . ! 12 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) Section C. Computation of Public Support Percentage Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f) 14 % % 16a 331/3% support test - 2013. If the organization did not check the box on line 13, and line 14 is 331/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ b 331/3 % support test - 2012. If the organization did not check a box on line 13 or 16a, and line 15 is 331/3 % or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ 17a 10%-facts-and-circumstances test - 2013. 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported b 10%-facts-and-circumstances test - 2012. 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see

Schedule A (Form 990 or 990-EZ) 2013

Schedule	A (Form	1990 or 9	90-F71	2013

Part III	Suppo	rt Schedule t	for O	rganizations	Described in	Section	509(2)(2)

(Complete only if you checked the box on line 9 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)

Sec	tion A. Public Support						
Cale	ndar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 201	3 (f) Total
1	Gifts, grants, contributions, and membership fees						
	received (Do not include any "unusual grants ")						
2	Gross receipts from admissions, merchandise			<u> </u>			
	sold or services performed, or facilities				j		
	furnished in any activity that is related to the		[İ	
	organization's tax-exempt purpose						
3	Gross receipts from activities that are not an			ļ			
	unrelated trade or business under section 513				ļ		
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						
	Amounts included on lines 1, 2, and 3						
	received from disqualified persons			Ì			
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					<u> </u>	-
8	Add lines 7a and 7b Public support (Subtract line 7c from						
Ū	line 6)						
Sec	tion B. Total Support			<u> </u>	L	1	<u> </u>
	ndar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 201	3 (f) Total
9	Amounts from line 6,						
	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				ľ		
-	acquired after June 30, 1975			1			
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 IV)		<u></u>				
13	Total support. (Add lines 9, 10c, 11,						
	and 12)		L		<u> </u>		
14	First five years. If the Form 990 is for	•	·		•		```
	organization, check this box and stop here				• • • • • • • •	· · · · · ·	
	tion C. Computation of Public Sup						
15	Public support percentage for 2013 (line 8					_15	%
16	Public support percentage from 2012 Sche			<u> </u>	· · · · · · · · · · ·	16	<u>%</u>
	tion D. Computation of Investmen			10 1 10		T T	
17	Investment income percentage for 2013 (li					17	<u>%</u>
18	Investment income percentage from 2012					18	<u>%</u>
19 a	33 1/3% support tests - 2013. If the or						
	17 is not more than 331/3%, check th						
b	331/3% support tests - 2012. If the orga				*		· . —
	line 18 is not more than 331/3%, check		-	-		• •	-
20 JSA	Private foundation If the organization	aid HOL Check	a DOX DIT TIME	14, 198, OF 190			Form 990 or 990-FZ) 2013

SCHEDULE C (Form 990 or 990-EZ)

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 ► See separate instructions

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

OMB No 1545-0047 Open to Public

Department of the Treasury Internal Revenue Service

If the organization answered "Yes," to 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," to 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

f the	e organization answered "Yes,"	to Form 990, Part IV, line 5 (Proxy Ta	ax) or Form 990-EZ, Pa	rt V, line 35c (Proxy Tax), th	те п					
	Section 501(c)(4), (5), or (6) orga	anizations Complete Part III								
Name	e of organization			Employer identi	fication number					
CAP	PITAL HEALTH SYSTEM,	INC		22-35	48695					
Par	rt I-A Complete if the c	organization is exempt under	section 501(c) or	is a section 527 orgai	nization.					
1	Provide a description of the	organization's direct and indirect p	olitical campaign ac	ctivities in Part IV						
2	Political expenditures			▶\$						
3										
Par	t I-B Complete if the c	organization is exempt under s	section 501(c)(3).							
1	Enter the amount of any exc	ise tax incurred by the organizatio	n under section 495	5, , , , , , ▶ \$						
2	Enter the amount of any exc	cise tax incurred by organization m	anagers under secti	on 4955 ▶ \$						
3	If the organization incurred a	a section 4955 tax, did it file Form	4720 for this year?		. Yes No					
4a										
	If "Yes." describe in Part IV.									
Par	t I-C Complete if the c	organization is exempt under	section 501(c), ex	cept section 501(c)(3).					
1	Enter the amount directly e	xpended by the filing organization	n for section 527 ex	xempt function						
	activities			▶\$						
2	Enter the amount of the filir	ng organization's funds contributed	I to other organizati	ons 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									
		s For each organization listed, en								
-		ributions received that were prom nd or a political action committee (I								
			I .							
	(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's	(e) Amount of political contributions received and					
				funds if none, enter -0-	promptly and directly					
				, i	delivered to a separate					
					political organization If					
					none, enter -0-					
(1)										
										
(2)										
(3)										
(4)										
(5)										
(6)										
					l					

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

Schedule C (Form 990 or 990-EZ) 2013

_	nedule C (Form 990 or 990-EZ) 2013 art II-A Complete if the organiza	tion is exer	npt under section	n 501(c)(3) and f	iled Form 5768 (ele	Page :
	section 501(h)).		•	(-,(-,	(
Ā	Check ▶ if the filing organization name, address, ElN, ex	n belongs t penses, and	o an affiliated grou d share of excess I	p (and list in Par obbying expendit	t IV each affiliated g tures).	roup member's
В	Check ► if the filing organization	n checked	box A and "limited	control" provisio	ns apply.	
	Limits on Lob	bying Expen	ditures		(a) Filing	(b) Affiliated
_	(The term "expenditures" r	neans amou	nts paid or incurred.)	organization's totals	group totals
1:	Total lobbying expenditures to influer	nce public op	inion (grass roots lo	bbying)		
I	 Total lobbying expenditures to influe 	yıng)				
(Total lobbying expenditures (add line 		_			
•	d Other exempt purpose expenditures					
•	 Total exempt purpose expenditures (
1		table in both				
	columns.					<u> </u>
	If the amount on line 1e, column (a) or (b) I	s: The lobbyi	ng nontaxable amount	s·		
	Not over \$500,000	20% of the	amount on line 1e			
	Over \$500,000 but not over \$1,000,000	\$100,000 p	lus 15% of the excess	over \$500,000		
	Over \$1,000,000 but not over \$1,500,000	\$175,000 p	lus 10% of the excess	over \$1,000,000		
	Over \$1,500,000 but not over \$17,000,000	\$225,000 p	lus 5% of the excess of	ver \$1,500,000		
	Over \$17,000,000	\$1,000,000				
9	g Grassroots nontaxable amount (ente					
ı	Subtract line 1g from line 1a If zero	or less, enter	-0			
i	Subtract line 1f from line 1c if zero c					
j	If there is an amount other than ze			_		
	reporting section 4911 tax for this ye	ar?		<i></i>		Yes No
		4-Year Ave	raging Period Under	Section 501(h)		
	(Some organizations th			٠,	complete all of the fiv	ve ·
			instructions for lin		•	
	Lot	bying Expe	nditures During 4-Ye	ear Averaging Peri	od	
	Calendar year (or fiscal year					

	Lobbying Expenditures During 4-Year Averaging Period									
	Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total				
2a	Lobbying nontaxable amount									
b	Lobbying ceiling amount (150% of line 2a, column (e))									
С	Total lobbying expenditures			-						
d	Grassroots nontaxable amount									
е	Grassroots ceiling amount (150% of line 2d, column (e))									
f	Grassroots lobbying expenditures									

Schedule C (Form 990 or 990-EZ) 2013

Pa	t II-B Complete if the organization is exempt under section 501(c)(3) and has NOT (election under section 501(h)).	filed	For	m 576	68		
For	each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed	(a)		(b))	
	i an an an an an an an an an an an an an	Yes	No		Amo	ount	
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	ĺ					
	referendum, through the use of		I				
a b	Volunteers? Paid staff or management (include compensation in expenses reported on lines 1c through 1)?		X				
C		_	X				
d	Media advertisements? Mailings to members, legislators, or the public?		X X				
e	Mailings to members, legislators, or the public? Publications, or published or broadcast statements?		$\frac{\wedge}{X}$				
f	Publications, or published or broadcast statements? Grants to other organizations for lobbying purposes?		X				
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		X				
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		Х				
i	Other activities?	Х				284	,249
j	Total Add lines 1c through 1i					284	,249
2 a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		Х	-			
b	If "Yes," enter the amount of any tax incurred under section 4912	ı	ļ				
С	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?						
Pa	t III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5)	c)(5),	or s	ectio	n		
	501(c)(6).					Т	T
1	Were substantially all (90% or more) dues received nondeductible by members?					Yes	No
2	Did the organization make only in house labburg expenditures of \$2,000 or less?				1 -	 	-
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?				3	-	
Pai	t III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)						
	501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," (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 amour political expenses for which the section 527(f) tax was paid).						
а	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						
	excess does the organization agree to carryover to the reasonable estimate of nondeductible lol and political expenditure next year?	obyin	9				
5	Taxable amount of lobbying and political expenditures (see instructions)		• • -	5			
Pai		• • •	<u> </u>	3]			
Prov	ide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, Part II-A (affiliated gi II-B, line 1. Also, complete this part for any additional information	roup I	st), P	art II-A	, line ?	2, and	j
SEE	PAGE 4						
			-				

Part IV Supplemental Information (continued)

SCHEDULE C, PART II-B; LINE 1I

DURING 2013, THE ORGANIZATION PAID TWO OUTSIDE LOBBYING FIRMS A TOTAL OF \$240,044 FOR LOBBYING ON A FEDERAL AND STATE LEVEL RELATED TO MEDICARE, MEDICAID AND OTHER HEALTHCARE LEGISLATIVE MATTERS.

IN ADDITION, THE ORGANIZATION IS A MEMBER OF THE NEW JERSEY HOSPITAL ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION AND NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION WHICH ENGAGE IN LOBBYING EFFORTS ON BEHALF OF THEIR MEMBER HOSPITALS. A PORTION OF THE DUES PAID TO THESE ORGANIZATIONS HAS BEEN ALLOCATED TO LOBBYING ACTIVITES PERFORMED ON BEHALF OF THE ORGANIZATION. THIS ALLOCATION AMOUNTED TO \$44,205 IN 2013.

SCHEDULE D (Form 990)

Department of the Treasury

Supplemental Financial Statements
► Complete If the organization answered "Yes," to Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

Internal Revenue Service Name of the organization

► Attach to Form 990. ▶ Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990 OMB No 1545-0047 2013

Open to Public Inspection Employer identification number

CAI	ITAL HEALTH SYSTEM, INC		22-3548695
Pai	Organizations Maintaining Donor Advi- Complete if the organization answered		ccounts.
		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate 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
3	funds are the organization's property, subject to the	-	
6	Did the organization inform all grantees, donors, a		
Ü	only for charitable purposes and not for the benef	5	
	conferring impermissible private benefit?	•	
Par			
1	Purpose(s) of conservation easements held by th		11 330, 1 art IV, line 1
•	Preservation of land for public use (e.g., rec	· · · · · · · · · · · · · · · · · ·	f an historically important land area
	Protection of natural habitat		f a certified historic structure
	Preservation of open space	Freservation of	a certified historic structure
2			the form of a source store
2	Complete lines 2a through 2d if the organization heasement on the last day of the tax year.	neid a qualified conservation contribution in	the form of a conservation
	easement on the last day of the tax year.	Γ	Held at the End of the Tax Year
_	Total number of concentation accompany	<u> </u>	
a	Total number of conservation easements		2a
b	Total acreage restricted by conservation easemen		2b
C	Number of conservation easements on a certified	` '	20
d	Number of conservation easements included in (c		24
_	historic structure listed in the National Register Number of conservation easements modified, tra		
3		nsierred, released, extinguished, or termina	nted by the organization during the
	tax year ►	and the second s	
4	Number of states where property subject to cons		
5	Does the organization have a written policy regard	- -	
_	violations, and enforcement of the conservation e		
6	Staff and volunteer hours devoted to monitoring,	inspecting, and enforcing conservation ease	ements during the year
_	Amount of expenses incurred in monitoring, inspe	and anfarance conservation accommon	to during the year
7		ecting, and enforcing conservation easemen	is during the year
	►\$ Does each conservation easement reported on lin	no 2(d) above catisfy the requirements of car	ction 170/b)/4)/B)
8	•	• • •	
9	(i) and section 170(h)(4)(B)(ii)?		
9	balance sheet, and include, if applicable, the text		
	organization's accounting for conservation easem		
Pai		s of Art, Historical Treasures, or Other	Similar Assets.
	Complete if the organization answered	d "Yes" to Form 990, Part IV, line 8.	
1a	If the organization elected as permitted under S	SEAS 116 (ASC 958), not to report in its re	evenue statement and balance sheet
ıa	If the organization elected, as permitted under Sworks of art, historical treasures, or other similarity	ilar assets held for public exhibition, educ	cation, or research in furtherance of
	public service, provide, in Part XIII, the text of the	footnote to its financial statements that desc	cribes these items
b	If the organization elected, as permitted under	SFAS 116 (ASC 958), to report in its re	evenue statement and balance sheet
	works of art, historical treasures, or other similable service, provide the following amounts rela-		cation, or research in turtherance of
	(i) Revenues included in Form 990, Part VIII, line		▶ \$
	(ii) Assets included in Form 990, Part X		
2	If the organization received or held works of		
2	following amounts required to be reported under		
_	Revenues included in Form 990, Part VIII, line 1.	of the trie (the south relating to these items	•
a b	Assets included in Form 990, Part X		
	aperwork Reduction Act Notice, see the Instructions for		Schedule D (Form 990) 2013

_	tule D (Form 990) 2013									Page 2
Par	t Organizations Maintain	ing Colle	ctions of	Art, His	storical	Treasure	s, or Ot	her Simil	ar Asse	ts (continued)
3	Using the organization's acquisition collection items (check all that approximately seems)	on, acces ply)	sion, and c	ther rec	ords, chec	k any of	the follow	ving that a	ire a sigr	nificant use of its
а	Public exhibition			d [Loan	or exchar	nge progra	ms		
b	Scholarly research			e	Other		-3- F3			
С	Preservation for future gene	erations		_						
4	Provide a description of the orga	ınızatıon's	collections	and exp	lain how	they furth	ner the or	ganızatıon'	s exemp	t purpose in Part
	XIII									
5	During the year, did the organization									
	assets to be sold to raise funds rat	her than t	o be mainta	ined as p	art of the	organızat	ion's colle	ction?	<u> [</u>	Yes No
Par	t IV Escrow and Custodial A					nization a	inswered	"Yes" to F	Form 99	0, Part IV, line 9,
	or reported an amount o	n Form 9	90, Part X	<u>, line 21</u>						····
	1. 11									
٦а	Is the organization an agent, trust									~
L.	included on Form 990, Part X?								L	Yes No
D	If "Yes," explain the arrangement i	n Part XIII	and comple	ete the fo	liowing ta	oie L				
_	Beginning balance					-		A	mount	
	Additions during the year									
e	Distributions during the year									
f	Ending balance)				
2a	Did the organization include an ar									Yes No
b	If "Yes," explain the arrangement	n Part XIII.	. Check her	e if the e	xplanation	has beer	n provided	in Part XIII		
	t V Endowment Funds. Con									
			rrent year		ıor year		years back	(d) Three y		(e) Four years back
1a	Beginning of year balance									
b	Contributions									
С	Net investment earnings, gains,									
	and losses									
	Grants or scholarships							ļ <u>-</u>		
е	Other expenditures for facilities									
	and programs									
	Administrative expenses							ļ		
g 2	End of year balance Provide the estimated percentage		ront voor o	nd balane	o /line 1e	aalumn /	-\\ hald as			
	Board designated or quasi-endow		rent year er	%	e (me rg	, coluititi (a)) neiu as	•		
	Permanent endowment >			- ^-						
	Temporarily restricted endowmen		%							
	The percentages in lines 2a, 2b, a	nd 2c sho	uld equal 10	00%.						
3a	Are there endowment funds not in				ation that	are held	and admi	nistered for	the	
	organization by									Yes No
	(i) unrelated organizations									3a(i)
	(ii) related organizations									3a(ii)
b	If "Yes" to 3a(II), are the related or	_		•				. .		3b
4	Describe in Part XIII the intended		e organization	on's endo	wment fu	nds				
Par	t VI Land, Buildings, and Equ Complete if the organize	uipment.	wered "Ye	s" to For	m 990 P	art IV lin	e 11a S	ee Form 9	190 Par	t X line 10
	Description of property	ation and	(a) Cost or	other basis		or other basi	s (c) Ac	cumulated		1) Book value
4.5	Tool Tool		(investi	ment)		other)		reciation		40 300 005
	Land					382,285 509,081		30,320.		49,382,285.
	Leasehold improvements	1	ļ		520,	JU9, U61	12/1/	50,520.		392,778,761.
	Equipment		<u> </u>		658	383 N10	38/ 9	75,344.		274,007,675.
	Other					355,013 356,186		241,773.		29,614,413.
	I Add lines 1a through 1e (Colum		egual Form	990 Par				.41,775. ▶		745, 783, 134

Schedule D (Form 990) 2013

_	•
Page	

Part VII Investments - Other Securities.	- d 11\/11 t- F 000	Deat IV I I - 14th Con France 000	Dart V. Iva - 40
Complete if the organization answer	ed Yes to 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 valuati Cost or end-of-year mark	
(1) Financial derivatives			
(2) Closely-held equity interests			
(3) Other			
(A)			
(B)			
(C)			
(D)			
(E)			
(F)			
(G)			
(H)			
Total. (Column (b) must equal Form 990, Part X, col (B) line 12)			
Part VIII Investments - Program Related.			
Complete if the organization answer	ed "Yes" to Form 990,	Part IV, line 11c. See Form 990,	Part X, line 13.
(a) Description of investment	(b) Book value	(c) Method of valuati	
ATTACHMENT 1	<u> </u>	Cost or end-of-year mark	et value
(1) MUTUAL FUNDS - FIXED INCOME			· · · · · · · · · · · · · · · · · · ·
(2) SECURITIES	67,357,923.	FMV	·····
(3) MUTUAL FUNDS - EQUITY	50.000.106		
(4) SECURITIES	58,928,496.	FMV	
(5) INVESTMENT IN SUBSIDIARIES	18,845,649.	FMV	
(6) ACCRUED INTEREST	79,227.	FMV	
(7) CASH AND CASH EQUIVALENTS;	20 010 405	TIME 7	
(8) LIMITED USE	32,819,485.	FMV	
(9) LIMITED USE ASSETS HELD UNDER Total (Column (b) must equal Form 990, Part X, col (B) line 13) ▶	186,728,785.		
Part IX Other Assets. Complete if the organization answer	ed "Yes" to Form 990,	Part IV, line 11d. See Form 990,	Part X, line 15.
(1)	(-/	, , ,	(-,
(2)			
(3)			
(4)			
(5)	······································		
(6)			
(7)			
(8)			
(9)			
Total. (Column (b) must equal Form 990, Part X, col (E	3) line 15)		
Part X Other Liabilities. Complete if the organization answer	red "Yes" to Form 990,	, Part IV, line 11e or 11f. See Forr	n 990, Part X,
line 25.			
1. (a) Description of liability	(b) Book valu	e 1:1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
(1) Federal income taxes			
(2) ACCRUED PENSION EXPENSE;			•
(3) NON-CURRENT	45 160	- · · · · · · · · · · · · · · · · · · ·	* -*
(4) OTHER LIABILITIES	45,168,	 1	
(5) CONSTRUCTION AND RETAINAGE PAYABL	E 61,	459.	,
(6)			
(7)			
(8)		 	
(9)	5) 45 220 0	2/0	
Total. (Column (b) must equal Form 990, Part X, col (B) line 2			
2 Liability for uncertain tax positions. In Part XIII, provide the organization's liability for uncertain tax positions under FIN	48 (ASC 740) Check here	e organization's financial statements that re e if the text of the footnote has been pro	vided in Part XIII

	le D (Form 840) 2012	Page 4
Part	Reconciliation of Revenue per Audited Financial Statements With Revenue per Retur Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.	n.
1	Total revenue, gains, and other support per audited financial statements	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12	1
- а	Net unrealized gains on investments	
b	Donated services and use of facilities 2b	
C	Recoveries of prior year grants 2c	
d	Other (Describe in Part XIII.)	
е	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	
а	Investment expenses not included on Form 990, Part VIII, line 7b	
b	Other (Describe in Part XIII.)	
С	Add lines 4a and 4b	4c
5	Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12)	
Part	Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.	ırn.
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	
а	Donated services and use of facilities 2a	
b	Prior year adjustments 2b	
С	Other losses 12c 1	
ď	Other (Describe in Part XIII.) Add lines 2a through 2d	
	Add lines 24 through 24	2e
3	Subtract line 2e from line 1	3
4	Amounts included on Form 990, Part IX, line 25, but not on line 1 Investment expenses not included on Form 990, Part VIII, line 7b 4a	
a b	Other (December of Boot VIII.)	
	Other (Describe in Part XIII.) Add lines 4a and 4b	4.0
5	Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18).	4c 5
	XIII Supplemental Information.	3
	e the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Pa	art V, line 4, Part X, line
2, Par	t XI, lines 2d and 4b, and Part XII, lines 2d and 4b. Also complete this part to provide any additional inform	nation
SEE	PAGE 5	
JSA		Schedule D (Form 990) 2013

Part XIII Supplemental Information (continued)

SCHEDULE D, PART X

THE ORGANIZATION IS THE PARENT ORGANIZATION OF THE CAPITAL HEALTH SYSTEM ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. THE SYSTEM ISSUES CONSOLIDATED AUDITED FINANCIAL STATEMENTS WHICH INCLUDE ALL RELATED ENTITIES; INCLUDING THIS ORGANIZATION. THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS ALSO CONTAIN CONSOLIDATING SCHEDULES ON AN ENTITY BY ENTITY BASIS. THE FIN 48 (ASC 740) FOOTNOTE BELOW IS FROM THE SYSTEM'S 2007 CONSOLIDATED AUDITED FINANCIAL STATEMENTS.

IN JULY 2006, FASB INTERPRETATION NO. 48 (FIN 48), ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES, AN INTERPRETATION OF FASB STATEMENT NO. 109, ACCOUNTING FOR INCOME TAXES, WAS ISSUED. FIN 48 CREATES A SINGLE MODEL TO ADDRESS UNCERTAINTY IN TAX POSITIONS AND CLARIFIES THE ACCOUNTING FOR INCOME TAXES BY PRESCRIBING THE MINIMUM RECOGNITION THRESHOLD A TAX POSITION IS REQUIRED TO MEET BEFORE BEING RECOGNIZED IN THE FINANCIAL STATEMENTS. UNDER THE REQUIREMENTS OF FIN 48, TAX-EXEMPT ORGANIZATIONS COULD BE REQUIRED TO RECORD AN OBLIGATION AS THE RESULT OF A TAX POSITION THEY HAVE HISTORICALLY TAKEN ON VARIOUS TAX EXPOSURE ITEMS. PRIOR TO FIN 48, THE DETERMINATION OF WHEN TO RECORD A LIABILITY FOR A TAX EXPOSURE WAS BASED ON WHETHER A LIABILITY WAS CONSIDERED PROBABLE AND REASONABLY ESTIMABLE IN ACCORDANCE WITH FASB STATEMENT NO. 5, ACCOUNTING FOR CONTINGENCIES. ON JANUARY 1, 2007, THE SYSTEM'S ADOPTED FIN 48. THE IMPACT OF THE ADOPTION OF FIN 48 ON THE SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS IS NOT SIGNIFICANT.

Conceder D (1 cm eve) zero		Page
Part XIII Supplemental Information (continued)		
	ATTACHMENT 1	
SCHEDULE D, PART VIII - INVESTMENTS - PROGRAM RELATED		
		COST
DESCRIPTION	BOOK VALUE	OR FMV
SUPPLEMENTAL RETIREMENT PLAN	7,716,777.	FMV
ALTERNATIVE INVESTMENTS	981,228.	FMV
TOTALS	186,728,785.	

SCHEDULE F (Form 990)

Statement of Activities Outside the United States

OMB No 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization

Part I

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16 ► Attach to Form 990. ► See separate instructions.

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

CAPITAL HEALTH SYSTEM, INC

Employer identification number 22-3548695

Form 990, Part IV, line 14b.	
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?	X Yes No

General Information on Activities Outside the United States. Complete if the organization answered "Yes" on

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

(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) CENTRAL AMERICA/CARIBBEAN	1.	1	INVESTMENTS		17,820,689
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(14)					
(15)					
(16)		,			
(17)					
3a Sub-total	1	1.			17,820,689
c Totals (add lines 3a and 3b)) 1	1			17,820,689

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

Schedule F (Form 990) 2013

Schedule F (Form 990) 2013

Part II Grants and Other Assistance to Organizations or Entities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part II can be duplicated if additional space is needed.

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) l	(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)
· ·									
3)		*							
· ·		n h							
	*	, , ,							
(9)		2014	-						
		* , *							
, , , , , , , , , , , , , , , , , , ,									
(10)			-						
(11)	, , ,								
(12)		197							
(13)	, .	256	-						
(14)		- 53							
(16)									

3 Enter total number of other organizations or entitles...

Schedule F (Form 990) 2013

Schedule F (Form 990) 2013

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

Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of Cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(9)							
(1)							
(8)							
(6)	-						
(10)	-						
(11)	-						
(12)							
(13)	-						
(14)							
(15)							
(16)							
(17)							
(18)							
						Sche	Schedule F (Form 990) 2013

Sched	ule F (Form 990) 2013				Page 4
Par	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	X	No
2	Did the organization have an interest in a foreign trust during the tax year? If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A)		Yes	X	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)	Х	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	x	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	X	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 file Form 5713, International Boycott Report (see Instructions

Schedule F (Form 990) 2013

X No

Yes

SCHEDULE H (Form 990)

Hospitals

OMB No 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20 ► Attach to Form 990. ► See separate instructions.

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

Employer identification number

CAP	TTAL HEALTH SISTE	SM, INC				22-3548695			
Par	H Financial Assis	tance and	Certain O	ther Community Bene	fits at Cost				
								Yes	No
1a	Did the organization has	ve a financia	al assistanc	ce policy during the tax ye	ear? If "No." skip to que	stion 6a	1a	Х	
							1b	Χ	
2		policy to its to all hospit	various hos al facilities						
3		pased on th	e financial	assistance eligibility crit	eria that applied to the	ne largest number of		-, v-	•
а	Did the organization u	se Federal	Poverty G	uidelines (FPG) as a fac owing was the FPG fam Other			3a		X
b		llowing was		in determining eligibility income limit for eligibility 350% 400%			3b		X
С	criteria for determinin	ig eligibility isset test o	y for free	PG in determining eligib or discounted care eshold, regardless of inc	Include in the desc	ription whether the			
4				olicy that applied to the the "medically indigent"?	_	s patients during the	4	X	
5a	Did the organization budge	et amounts fo	or free or dis	counted care provided unde	er its financial assistance p	olicy during the tax year?	5a	X	
b	b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?								
С	c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or								
	discounted care to a par	tient who w	as eligible f	for free or discounted car	e [?]		5c		X
6a	6a Did the organization prepare a community benefit report during the tax year?						6a		X
b	If "Yes," did the organiz	ation make	ıt avaılable	to the public?			6b		
				ksheets provided in the	Schedule H instruct	tions Do not submit	-		-
	these worksheets with t						ل	\Box	
7	Financial Assistance an	id Certain C	(b) Persons		(d) Direct offsetting	(e) Net community	(6)	Percei	
	inancial Assistance and eans-Tested Government Programs	activities or programs (optional)	served (optional)	(c) Total community benefit expense	revenue	benefit expense	` `	f total	
а	Financial Assistance at cost			60 100 646	00 170 150	20 252 126		_	
	(from Worksheet 1)			62,128,646.	29,170,450.	32,958,196.		5	<u>.51</u>
b	Medicaid (from Worksheet 3,			20 550 664	10 724 662	7 925 001		1	.31
	column a)			20,559,664.	12,734,663.	7,825,001.			. 31
đ	Total Financial Assistance and Means-Tested Government Programs			82,688,310.	41,905,113.	40,783,197.		6	.82
	Other Benefits								
е	Community health improvement services and community benefit operations (from Worksheet 4)	232	48272	139,593.	2,894.	136,699.		·····	.02
f	Health professions education			0.765.700	7 006 750	7 670 041			0.0
	(from Worksheet 5)			8,765,799.	7,086,758.	1,679,041.	ļ		.28
g	Subsidized health services (from								
	Worksheet 6)			60,371.		60,371.	<u> </u>		01
h	Research (from Worksheet 7)			00,3/1.	······································	00,3/1.	<u> </u>		.01
i	Cash and in-kind contributions for community benefit (from Worksheet 8)	120	40070	257,583.	7,000,050	257,583.			.04
j	Total Other Benefits	352	48272	9,223,346.	7,089,652.	2,133,694.			.35
L	Total Add lines 7d and 7t.	352	48272	91,911,656.	48,994,765.	42,916,891.	!	- 7	.17

Schedule H	(Form 990) 2013			
Part II	Community Building Activitie	es Complete this table if the	organization condi	ucted any co

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	communit	ies it serve	es.					
	(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		Percer al expe	
1 Physical improvements and housing								
2 Economic development				· · · · · · · · · · · · · · · · · · ·				
3 Community support						<u> </u>		
4 Environmental improvements								
5 Leadership development and								
training for community members						<u> </u>		
6 Coalition building								
7 Community health improvement								
advocacy						<u> </u>		
8 Workforce development					 , , ,			
9 Other					_ 	 		
10 Total	-l' 0	Callastia	- Desetions	<u> </u>		<u></u>		
Part III Bad Debt, Me		Collection	n Practices				T	
Section A. Bad Debt Expens				Jahanna Cinanasal Manas	^		Yes	No
1 Did the organization rep		•		-	· I			х
			debt symmes Evilen			1		
2 Enter the amount of the	_		nate this amount	1 1	43,103,479.		ŀ	
3 Enter the estimated am				· · · · · · · · · 	13/103/1/31			
		_	icial assistance policy. E					
the methodology used b	_			· 1				
if any, for including this p				, ,			-	
4 Provide in Part VI the t					describes had debt	İ		
			otnote is contained in the					
Section B. Medicare	inder dir win	1011 11113 100	Anoto lo contained in the	attached mandar state				
5 Enter total revenue rece	ived from M	Medicare (i	ncluding DSH and IME) .		110,315,567.			
6 Enter Medicare allowable	e costs of	care relatin	a to payments on line 5.	6	133,879,188.	}		
7 Subtract line 6 from line	5 This is t	he surplus	(or shortfall)	7	-23,563,621.			
8 Describe in Part VI the					ited as community			
			methodology or source					
on line 6. Check the box	that descri	bes the me	thod used.			1		-
Cost accounting sy	/stem	X Cost t	o charge ratio 🔲 O	ther		1		
Section C. Collection Practic			_					
9a Did the organization have	e a written	debt collec	ction policy during the tax	year ⁹		9a	Χ	
b If "Yes," did the organization's	collection pol	cy that apple	ed to the largest number of its	patients during the tax year	contain provisions on the	l		
collection practices to be follow	ed for patients	who are know	wn to qualify for financial assista	nce? Describe in Part VI		9b	Χ	L.,
Part IV Management	Companie	es and Jo	int Ventures (owned 10% or	more by officers, directors, trustees	, key employees, and physicians -	see inst	ruction	s)
(a) Name of entity	İ	(b)	Description of primary activity of entity	(c) Organization's profit % or stock	(d) Officers, directors, trustees, or key		Physic it % or	
			activity of citility	ownership %	employees' profit %		mersh	
					or stock ownership %	┼		
_1						 		
2						+-		
3						$+\!-\!\!-$		
4						┼		
5						-		
6						 		
7						+		
8						+		
9						+		
11					 	+		
12				-		+		
13						1		
ISA					Sahadula	H (5 a)	00	0) 2012

Schedule H (Form 990) 2013 Page **3**

Part V Facility Information	, <u> </u>				,	,		,		
Section A. Hospital Facilities		Ger	율	Tea	Cnt	Res	Ę.	ER-other		
	nsec	eral	dren	율	<u>\vec{g}</u>	earc	ER-24 hours	othei		
(list in order of size, from largest to smallest - see instructions)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ours	,		
How many hospital facilities did the organization operate	utal	<u>a</u>	pital) stal	30d	₹				
during the tax year? 2		surg			pital					Facility
Name, address, primary website address, and state license number		<u>g</u>							Other (describe)	reporting group
1 CAPITAL HEALTH MEDICAL CNTR-HOPEWELL										
ONE CAPITAL WAY]									
PENNINGTON NJ 08534										
WWW.CAPITALHEALTH.ORG										
11104	X	Х	<u> </u>	Х	ļ	ļ	Х			1
2 CAPITAL HEALTH REGIONAL MEDICAL CNTR. 750 BRUNSWICK AVENUE	-									
TRENTON NJ 08638										
WWW.CAPITALHEALTH.ORG	{									
11102	x	Х		х		ĺ	x			1
3	1	^		<u> </u>	_	-	1			
										}
	1									
4										
									}	
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7										
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	Information	
Part V		

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 facility reporting group $\underline{CAPITAL}$ HEALTH MEDICAL CENTER							
If reporting on Part V, Section B for a single hospital facility only: line number of							
1	1 2						

	orting of Fact 4, Section B for a single nospital facility only. The number of			
nospi	tal facility (from Schedule H, Part V, Section A)	-	Yes	No
Comn	nunity Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)	Γ	162	No
1	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 9	1	x	
	If "Yes," indicate what the CHNA report describes (check all that apply)	<u> </u>	-	
а	X A definition of the community served by the hospital facility		-	. "
b	X Demographics of the community	ĺ [′] -	-	1
С	X Existing health care facilities and resources within the community that are available to respond to the	,**	Í	-
	health needs of the community		-	
d	X How data was obtained	١.		-
е	X The health needs of the community	ľ		^
f	X Primary and chronic disease needs and other health issues of uninsured persons, low-income persons,			
	and minority groups	-		
g	X The process for identifying and prioritizing community health needs and services to meet the	,	١.	
	community health needs		1	
h	The process for consulting with persons representing the community's interests	-		
i	Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA 20 1 3		,	
3	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	3_	Х	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other			
	hospital facilities in Section C	4	Х	
5	Did the hospital facility make its CHNA report widely available to the public?	5	Х	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
а	X Hospital facility's website (list url) WWW.CAPITALHEALTH.ORG			*
b	X Other website (list url) WWW TRENTONHEALTHTEAM ORG			-
С	Available upon request from the hospital facility		`	
d	X Other (describe in Section C)	l ;	-	-
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check	_		
	all that apply as of the end of the tax year)	_	, ,	
а	Adoption of an implementation strategy that addresses each of the community health needs identified			-
	through the CHNA		` `:	· · ·
b	Execution of the implementation strategy			
C	X Participation in the development of a community-wide plan		`]
d	X Participation in the execution of a community-wide plan X Inclusion of a community benefit section in operational plans		_	
e	includion of a community sorient section in operational plans	1	-	, 2
f	X Adoption of a budget for provision of services that address the needs identified in the CHNA X Prioritization of health needs in its community	*		-
g				
h	— · · · · · · · · · · · · · · · · · · ·			l .
i	Other (describe in Section C)	İ		^
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs.	,		X
0 ~	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a	7		<u> </u>
8 a	· · · · · · · · · · · · · · · · · · ·	8a	1	Х
h	CHNA as required by section 501(r)(3)?	8b		
b	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form	100	 -	
С	4720 for all of its hospital facilities? \$			
	Schedul	a U (Ca		0) 004

Schedu	le H (Form 990) 2013			Page 5
Part	V Facility Information (continued)			
Finar	ncial Assistance Policy CAPITAL HEALTH MEDICAL CENTER		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that	T		
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted			
	care?	9	x	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	10		Х
	If "Yes," indicate the FPG family income limit for eligibility for free care %	-	T -	١,
	If "No," explain in Section C the criteria the hospital facility used.	- ,	-	
11	Used FPG to determine eligibility for providing discounted care?	11	i	X
	If "Yes," indicate the FPG family income limit for eligibility for discounted care%		-	
	If "No," explain in Section C the criteria the hospital facility used	-		
12	Explained the basis for calculating amounts charged to patients?	12	Х	1
	If "Yes," indicate the factors used in determining such amounts (check all that apply)			<u> </u>
а	Income level			*_
b	Asset level		_	.
С	Medical indigency			, î
d	Insurance status			
е	Uninsured discount			
f	X Medicaid/Medicare			`
g	X State regulation	,`		
h	Residency			-
i	Other (describe in Section C)	١,		
13	Explained the method for applying for financial assistance?	13	x	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	- 17		-
а	The policy was posted on the hospital facility's website			_
b	The policy was attached to billing invoices			
c	The policy was posted in the hospital facility's emergency rooms or waiting rooms] .	
d	The policy was posted in the hospital facility's admissions offices		- "	· *.
e	The policy was provided, in writing, to patients on admission to the hospital facility	 	-	,
f	X The policy was available on request	' '		,
g g	X Other (describe in Section C)	'	_	
	ng and Collections	┼──		<u> </u>
		┼		
15	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 actions the hospital facility may take upon non-payment?	15	Х	
4.0		13		<u> </u>
16	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	- 15		
	facility's FAP	, ; `	-	
а	Reporting to credit agency			
b	Lawsuits	- 4-		7
C	Liens on residences			. ,
d	Body attachments			
e	Other similar actions (describe in Section C)		, ,	'
17	Did the hospital facility or an authorized third 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?	17		x
	If "Yes," check all actions in which the hospital facility or a third party engaged.		 	-
а	Reporting to credit agency	-	- ,	
b	Lawsuits		l` _	*
C	Liens on residences	1	•	
d	Body attachments			
u c	Other similar actions (describe in Section C)	1		1

Schedu	ile H (Form 990) 2013		1	Page 6
Part				
18	Indicate which efforts the hospi	tal facility made before initiating any of the actions listed in line 17 (check all that apply)	
а	Notified individuals of the	e financial assistance policy on admission		
b	Notified individuals of the	e financial assistance policy prior to discharge		
c	X Notified individuals of the	e financial assistance policy in communications with the individuals regarding the indiv	/iduals	s' bills
d		ination of whether individuals were eligible for financial assistance under the hospi		
	financial assistance polic			-
е	Other (describe in Section			
Polic	cy Relating to Emergency Med	dical Care		
			Yes	s No
19		place during the tax year a written policy relating to emergency medical care		
		ty to provide, without discrimination, care for emergency medical conditions to		
		gibility under the hospital facility's financial assistance policy?	9 X	
	If "No," indicate why			
а	1 1	not provide care for any emergency medical conditions		
b	The hospital facility's po		_	
C		ed who was eligible to receive care for emergency medical conditions (describe		
	in Section C)	,	-	
d	Other (describe in Section			
		r Assistance under the FAP (FAP-Eligible Individuals)		
20		ty determined, during the tax year, the maximum amounts that can be charged		1
	to FAP-eligible individuals for en	nergency or other medically necessary care		
а		sed its lowest negotiated commercial insurance rate when calculating the	1.	.
	maximum amounts that	<u> </u>		
b		d the average of its three lowest negotiated commercial insurance rates when amounts that can be charged		
С	The hospital facility use	ed the Medicare rates when calculating the maximum amounts that can be	7.	
	charged	- '	-	1
d	X Other (describe in Sectio	in C)	1	
21	During the tax year, did the h	ospital 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 of	covering such care?	1	X
	If "Yes," explain in Section C.		. :	
22		ospital facility charge any FAP-eligible individual an amount equal to the gross		
		to that individual?	2	X
	If "Yes," explain in Section C.			

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 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.

SCHEDULE H, PART V, SECTION B, QS 1J,6I,9,12H,16E,17E,18E,19C,19D,21&22

NOT APPLICABLE.

SCHEDULE H, PART V, SECTION B, QUESTION 3

AS A COLLABORATIVE MEMBER OF THE TRENTON HEALTH TEAM, CAPITAL HEALTH

CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT AND TOOK INTO ACCOUNT INPUT

FROM REPRESENTATIVES OF THE COMMUNITY SERVED, INCLUDING THOSE WITH

SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH, THROUGH 300 INDIVIDUAL

INTERVIEWS AND 30 FORUMS HELD IN PLACES OF WORSHIP, COMMUNITY

ORGANIZATIONS, AND PUBLIC FACILITIES.

AS A FOUNDING MEMBER OF THE GREATER MERCER PUBLIC HEALTH PARTNERSHIP

(GMPHP), CAPITAL HEALTH ALONG WITH THE OTHER FOUNDING PARTNERS, ST.

LAWRENCE REHABILITATION CENTER, ROBERT WOOD JOHNSON AT HAMILTON MEDICAL

CENTER AND THE UNIVERSITY MEDICAL CENTER OF PRINCETON AT PLAINSBORO

DIRECTED A PROCESS INVOLVING OVER 400 COMMUNITY MEMBERS THROUGH 28 FOCUS

GROUPS, 15 INDIVIDUAL INTERVIEWS WITH COMMUNITY LEADERS, AND SIX

DISCUSSION GROUPS CONDUCTED TO TEST OUR PRELIMINARY FINDINGS.

SCHEDULE H, PART V, SECTION B, QUESTION 4

THE TRENTON HEALTH TEAM IS A COLLABORATIVE OF TRENTON'S TWO HOSPITALS, ST. FRANCIS MEDICAL CENTER AND CAPITAL HEALTH.

Part V Facility Information (continued)

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

GMPHP HAS SUBSEQUENTLY ENGAGED AS MEMBERS OF CAPITAL HEALTH'S POLICY
BOARD (GOVERNING BODY WHICH MEETS QUARTERLY) AND CAPITAL HEALTH'S
STEERING COMMITTEE (OPERATIONS FOCUSED GROUP WHICH MEETS AT LEAST ONCE A
MONTH) THE PUBLIC HEALTH OFFICERS OF FIVE MUNICIPALITIES AS WELL AS THE
COUNTY'S PUBLIC HEALTH DIRECTOR.

SCHEDULE H, PART V, SECTION B, QUESTION 5D

RESULTS OF THE COMMUNITY HEALTH NEEDS ASSESSMENT WERE PRESENTED IN A NUMBER OF PUBLIC FORUMS ARE PUBLISHED ON THE TRENTON HEALTH TEAM WEBSITE:

HTTP://WWW.TRENTONHEALTHTEAM.ORG/THT/TRENTONCOMMUNITYHEALTHNEEDSASSESSMENT
JULY2013.PDF

THE GMPHP CHNA IS AVAILABLE ON CAPITAL HEALTH'S WEBSITE, WITH A LINK ON THE HOMEPAGE.

SCHEDULE H, PART V, SECTION B, QUESTION 7

TRENTON'S HEALTH CHALLENGES WHICH FELL BEYOND THE SCOPE INCLUDE:

- HIV/AIDS AND HEPATITIS C
- TEEN PREGNANCY AND POOR BIRTH OUTCOMES
- SEXUALLY TRANSMITTED DISEASES
- LEAD POISONING

Part V Facility Information (continued)

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

- OTHER CHRONIC CONDITIONS, INCLUDING ASTHMA
- TRANSPORTATION

THE CHNA WAS A COMPREHENSIVE DOCUMENT THAT DETAILED NUMEROUS ISSUES.

WORKING WITH GMPHP PARTNERS, CAPITAL HEALTH PRIORITIZED ACTIONS INTO A

SERIES OF WELLNESS AND HEALTH SCREENING ACTIVITIES WHICH ADDRESSED THE

MOST CRITICAL AREAS OF CONCERN. MOST RECENTLY, CAPITAL HEALTH CREATED A

WEBSITE TO CENTRALIZE ALL INFORMATION REGARDING ALL HEALTH AND WELLNESS

ACTIVITIES OCCURRING IN MERCER COUNTY. THIS WAS IN DIRECT RESPONSE TO AN

IDENTIFIED PRIORITY NEED AS EXPRESSED THROUGH CAPITAL HEALTH OUTREACH

INTERVIEWS.

SCHEDULE H, PART V, SECTION B, QUESTIONS 10 AND 11

THE ORGANIZATION UTILIZES NEW JERSEY STATE CHARITY CARE GUIDELINES IN DETERMINING ELIGIBILITY FOR PROVIDING FREE OR DISCOUNTED CARE. CHARGES FOR SELF-PAY PATIENTS ARE REDUCED TO 115% OF THE MEDICARE RATE. PATIENTS WHOSE INCOME AND ASSETS CRITERIA ARE AT OR BELOW TWICE THE CURRENT THRESHOLD FOR ELIGIBILITY FOR NEW JERSEY CHARITY CARE WILL BE PROVIDED WITH A 100% DISCOUNT OFF OF THE ORGANIZATION'S USUAL AND CUSTOMARY CHARGES.

THE INCOME BASED CRITERIA USED TO DETERMINE ELIGIBILITY IS PER NEW JERSEY
ADMINISTRATIVE CODE 10:52 SUB CHAPTERS 11, 12 AND 13, AND BASED UPON THE
2011 POVERTY GUIDELINES (DEPARTMENT OF HEALTH AND SENIOR SERVICES). FPG
ARE INCLUDED IN THE CRITERIA FOR DETERMINING ELIGIBILITY FOR CHARITY AND

Part V Facility Information (continued)

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.

DISCOUNTED CARE.

SCHEDULE H, PART V, SECTION B, QUESTION 14G

BILLING STATEMENTS PROVIDED TO PATIENTS INDICATE THAT THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IS AVAILABLE UPON REQUEST.

SCHEDULE H, PART V, SECTION B, QUESTION 20D

THE FACILITY USES 115% OF THE MEDICARE RATE AS THE MAXIMUM AMOUNT THAT CAN BE CHARGED TO FAP-ELIGIBLE INDIVIDUALS FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE.

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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? ____33

Name and address	Type of Facility (describe)
1 CAPITAL HEALTH SYSTEM IN HAMILTON	OUTPATIENT FACILITY
1401-1445 WHITEHORSE-MERCERVILLE ROAD	
HAMILTON NJ 08619	
2 CAPITAL HEALTH - MEDICAL OFFICE BUILDING	GENERAL MEDICINE
2 CAPITAL WAY	
PENNINGTON NJ 08534	
3 CAPITAL HEALTH-MEDICAL ARTS OFFICE BLDG	GENERAL MEDICINE
40 FULD STREET	
TRENTON NJ 08638	
4 MICU	MICU
65 PROSPECT STREET	
TRENTON NJ 08618	
5 CHS REHABILITATION SERVICES	REHABILITATION SERVICES
832 BRUNSWICK AVENUE	
TRENTON NJ 08618	
6 CAPITAL HEALTH FAMILY HEALTH CENTER	FAMILY HEALTH AND ADULT DAY
433 BELLEVUE AVENUE	CARE CENTER
TRENTON NJ 08618	
7 CHS PARTIAL HOSPITALIZATION SERVICES	MENTAL HEALTH
832 BRUNSWICK AVENUE	
TRENTON NJ 08618	
8 CAPITAL HEALTH PRIMARY CARE - EWING	GENERAL MEDICINE
1230 PARKWAY AVENUE	
EWING NJ 08628	
9 CORPORATE HEALTH CENTER	HEALTH CENTER
832 BRUNSWICK AVENUE	
TRENTON NJ 08618	
10 CAPITAL HEALTH PRIMARY CARE BORDENTOWN	FAMILY MEDICNE
1 THIRD STREET	
BORDENTOWN NJ 08505	

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Part V	Facility	Information	(continued)
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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 CAPITAL HEALTH PRIMARY CARE - PENNINGTON	GENERAL MEDICINE
2480 PENNINGTON ROAD	
PENNINGTON NJ 08534	
2 CAPITAL SURGICAL ASSOCIATES	GENERAL MEDICINE
40 FULD STREET	
TRENTON NJ 08638	
3 CAPITAL ENDOCRINOLOGY	ENDOCRINOLOGY
1235 WHITEHORSE-MERCERVILLE ROAD	
HAMILTON NJ 08619	
4 CAPITAL HEALTH HEARTCARE SPECIALISTS	CARDIOLOGY
2 CAPITAL WAY	
PENNINGTON NJ 08534	
5 CAPITAL HEALTH PRIMARY CARE QUAKERBRIDGE	GENERAL MEDICINE
4056 QUAKERBRIDGE ROAD	
LAWRENCEVILLE NJ 08648	
6 CAPITAL HEALTH PRIMARY CARE PRINCETON	GENERAL MEDICINE
MONTGOMERY COMMONS BLDG 8 811 EXEC DR	
PRINCETON NJ 08540	
7 CAPITAL HEALTH PLASTIC SURGERY ASSOC NJ	PLASTIC SURGERY
850 BEAR TAVERN ROAD	
EWING NJ 08628	
8 CAPITAL HEALTH PRIM CARE LOWERMAKEFIELD	GENERAL MEDICINE
1050 STONY HILL ROAD	
YARDLEY PA 19067	
9 CAPITAL HEALTH CLINICAL CARDIOLOGY	CARDIOLOGY
2480 PENNINGTON ROAD	
PENNINGTON NJ 08534	
10 CAPITAL HEALTH PRIMARY CARE - HAMILTON	GENERAL MEDICINE
1445 WHITEHORSE AVENUE	
HAMILTON NJ 08619	

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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?

lame and address	Type of Facility (describe)
1 CAPITAL HEALTH CETNER FOR WOMENS HEALTH	WOMEN'S MEDICINE
1401 WHITEHORSE MERCERVILL ROAD	
HAMILTON NJ 08619	
2 CAPITAL HLTH CENTER FOR DIGESTIVE HEALTH	DIGESTIVE HEALTH
850 BEAR TAVERN ROAD	
EWING NJ 08628	
3 CAPITAL HEALTH SURGICAL GROUP	SURGICAL MEDICINE
40 FULD STREET	
TRENTON NJ 08638	
4 CAPITAL HEALTH INSTITUTE NEURO ONCOLOGY	NEURO ONCOLOGY MEDICINE
2 CAPITAL WAY	
PENNINGTON NJ 08534	
5 CAPITAL HEALTH INSTITUTE NEUROSCIENCE	NEURO MEDICINE
2 CAPITAL WAY	
PENNINGTON NJ 08534	
6 CAPITAL HEALTH COMPREHENSIVE SLEEP CTR	SLEEP STUDIES
1401 WHITEHORSE AVENUE	
HAMILTON NJ 08619	
7 CAPITAL HEALTH RADIATION ONCOLOGY	RADIATION ONCOLOGY MEDICINE
ONE CAPITAL WAY	
PENNINGTON NJ 08534	
8 CAPITAL HEALTH SPINE CENTER	SPINE HEALTH
1401 WHITEHORSE AVENUE	
HAMILTON NJ 08619	
9 CAPITAL HEALTH CENTER FOR LIVER DISEASE	LIVER HEALTH
ONE CAPITAL WAY	
PENNINGTON NJ 08534	
10 CAPITAL HEALTH PATHOLOGY	PATHOLOGY STUDIES
2 CAPITAL WAY	-
PENNINGTON NJ 08534	

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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 durit	ig the tax	x year?	
---	------------	---------	--

Name and address	Type of Facility (describe)
1 CAPITAL HEALTH MATERNAL FETAL	WOMEN'S MEDICINE
ONE CAPITAL WAY	
PENNINGTON NJ 08534	
2 CAPITAL HLTH METABOLIC & WEIGHT LOSS CTR	WEIGHT LOSS MEDICINE
2 CAPITAL WAY	
PENNINGTON NJ 08534	
3 CAPITAL HLTH PRIMARY CARE - MOUNTAINVIEW	GENERAL MEDICINE
850 BEAR TAVERN ROAD	
EWING NJ 08628	
4	
5	
6	
<u></u>	
8	
9	
10	
<u> </u>	-

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.

SCHEDULE H, PART I, LINE 3C

THE ORGANIZATION UTILIZES NEW JERSEY STATE CHARITY CARE GUIDELINES IN DETERMINING ELIGIBILITY FOR PROVIDING FREE OR DISCOUNTED CARE. CHARGES FOR SELF-PAY PATIENTS ARE REDUCED TO 115% OF THE MEDICARE RATE. PATIENTS WHOSE INCOME AND ASSETS CRITERIA ARE AT OR BELOW TWICE THE CURRENT THRESHOLD FOR ELIGIBILITY FOR NEW JERSEY CHARITY CARE WILL BE PROVIDED WITH A 100% DISCOUNT OFF OF THE ORGANIZATION'S USUAL AND CUSTOMARY CHARGES.

THE INCOME BASED CRITERIA USED TO DETERMINE ELIGIBILITY IS PER NEW JERSEY ADMINISTRATIVE CODE 10:52 SUB CHAPTERS 11, 12 AND 13, AND BASED UPON THE 2011 POVERTY GUIDELINES (DEPARTMENT OF HEALTH AND SENIOR SERVICES). FPG ARE INCLUDED IN THE CRITERIA FOR DETERMINING ELIGIBILITY FOR CHARITY AND DISCOUNTED CARE.

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

- 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

SCHEDULE H, PART I, LINE 6A

NOT APPLICABLE.

SCHEDULE H, PART I; QUESTION 7G

NO COSTS RELATING TO SUBSIDIZED HEALTHCARE SERVICES ARE ATTRIBUTABLE TO ANY PHYSICIAN CLINICS.

SCHEDULE H, PART I, QUESTION 7

WORKSHEET 2 WAS USED FOR THE COST TO CHARGE RATIO

SCHEDULE H, PART III, SECTION A; QUESTION 1

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION STATEMENT NO. 15 ("STATEMENT 15") PROVIDES GUIDELINES FOR DISTINGUISHING CHARITY CARE FROM BAD DEBT STATEMENT 15 REQUIRES THAT CHARITY CARE IS NOT RECOGNIZED AS

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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
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RECEIVABLE OR REVENUE IN THE FINANCIAL STATEMENTS. STATEMENT 15 FURTHER EXPLAINS THAT SELF-PAY PATIENTS THAT DO HAVE A REASONABLE LIKELIHOOD OF PAYMENT SHOULD BE REPORTED AS CHARITY CARE AND NOT BAD DEBT EXPENSE. THE HOSPITAL GENERALLY FOLLOWS THE GUIDELINES OUTLINED IN STATEMENT 15. IN ADDITION, THE HOSPITAL FOLLOWS THE STATE OF NEW JERSEY GUIDELINES IN DETERMINING CHARITY CARE ELIGIBILITY. IN CERTAIN INSTANCES, IT IS UNLIKELY THAT UNINSURED PATIENTS WILL PAY FOR THE SERVICES RENDERED, BUT THEY DO NOT QUALIFY FOR THE STATE'S CHARITY CARE PROGRAM BECAUSE OF LACK OF PATIENT COOPERATION OR OTHER REASONS. THE HOSPITAL PURSUES COLLECTION OF THESE AMOUNTS AND UNPAID BALANCES ARE REPORTED AS BAD DEBT EXPENSE. UNDER STATEMENT 15, THESE AMOUNTS WOULD BE RECORDED AS CHARITY CARE RATHER THAN BAD DEBT EXPENSE AND THIS IS THE RATIONALE FOR OUR RESPONSE: "NO".

SCHEDULE H, PART III, SECTION A; QUESTION 4

BAD DEBT EXPENSE WAS CALCULATED USING THE PROVIDERS' BAD DEBT EXPENSE FROM ITS AUDITED FINANCIAL STATEMENTS, MULTIPLIED BY ITS COST TO CHARGE

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RATIO.

CAPITAL HEALTH SYSTEM, INC. AND ITS AFFILIATES, INCLUDING ITS HOSPITALS AND SUBSIDIARIES, PREPARE AND ISSUE AUDITED CONSOLIDATED FINANCIAL STATEMENTS. THE SYSTEM'S ALLOWANCE FOR DOUBTFUL ACCOUNTS (BAD DEBT EXPENSE) METHODOLOGY AND CHARITY CARE POLICIES ARE CONSISTENTLY APPLIED ACROSS ALL HOSPITAL AFFILIATES. THE ATTACHED TEXT WAS OBTAINED FROM THE FOOTNOTES TO THE AUDITED FINANCIAL STATEMENTS OF CAPITAL HEALTH SYSTEM.

CHARITY CARE

CAPITAL HEALTH PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA

DEFINED BY THE NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

("DOHSS") WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES.

BECAUSE CAPITAL HEALTH DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED

TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. CAPITAL

HEALTH'S RECORDS IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT

Part VI Supplemental Information

Provide the following information.

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PROVIDES AND INCLUDE THE AMOUNT OF CHARGES FORGONE FOR SERVICES AND SUPPLIES FURNISHED. DOHSS ALLOWS RETROACTIVE APPLICATION FOR CHARITY CARE UP TO TWO YEARS FROM THE DATE OF SERVICE.

THE COST OF CHARITY CARE IS DERIVED FROM BOTH ESTIMATED AND ACTUAL DATA.

THE ESTIMATED COST OF CHARITY CARE INCLUDES THE DIRECT AND INDIRECT COST

OF PROVIDING SUCH SERVICES AND IS ESTIMATED UTILIZING CAPITAL HEALTH'S

RATIO OF COST TO GROSS CHARGES, WHICH IS THEN MULTIPLIED BY THE GROSS

UNCOMPENSATED CHARGES ASSOCIATED WITH PROVIDING CARE TO CHARITY PATIENTS.

CHARITY CARE PROVIDED, AT COST, DURING 2013 AND 2012 TOTALED

APPROXIMATELY \$62,129,000 AND \$57,617,000, RESPECTIVELY.

CAPITAL HEALTH RECEIVES PAYMENTS FROM THE NEW JERSEY HEALTH CARE SUBSIDY FUNDS FOR CHARITY CARE AND SUCH AMOUNTS TOTALED APPROXIMATELY \$29,170,000 AND \$28,864,000 FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012, RESPECTIVELY.

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SCHEDULE H, PART III, SECTION B; QUESTION 8

MEDICARE COSTS WERE DERIVED FROM THE 2012 MEDICARE COST REPORT.

MEDICARE UNDERPAYMENTS AND BAD DEBT ARE COMMUNITY BENEFIT AND ASSOCIATED COSTS ARE INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I.

THE ORGANIZATION BELIEVES THAT MEDICARE UNDERPAYMENTS (SHORTFALL) AND BAD DEBT ARE COMMUNITY BENEFIT AND ASSOCIATED COSTS ARE INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I. AS OUTLINED MORE FULLY BELOW THE ORGANIZATION BELIEVES THAT THESE SERVICES AND RELATED COSTS PROMOTE THE HEALTH OF THE COMMUNITY AS A WHOLE AND ARE RENDERED IN CONJUNCTION WITH THE ORGANIZATION'S CHARITABLE TAX-EXEMPT PURPOSES AND MISSION IN PROVIDING MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER WITHOUT REGARD TO RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY AND CONSISTENT WITH THE COMMUNITY BENEFIT STANDARD PROMULGATED BY THE IRS. THE COMMUNITY BENEFIT STANDARD IS THE CURRENT STANDARD FOR A HOSPITAL FOR RECOGNITION AS A

Provide the following information.

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TAX-EXEMPT AND CHARITABLE ORGANIZATION UNDER INTERNAL REVENUE CODE ("IRC") \$501(C)(3).

THE ORGANIZATION IS RECOGNIZED AS A TAX-EXEMPT ENTITY AND CHARITABLE

ORGANIZATION UNDER \$501(C)(3) OF THE IRC. ALTHOUGH THERE IS NO DEFINITION

IN THE TAX CODE FOR THE TERM "CHARITABLE" A REGULATION PROMULGATED BY THE

DEPARTMENT OF THE TREASURY PROVIDES SOME GUIDANCE AND STATES THAT "THE

TERM CHARITABLE IS USED IN SECTION 501(C)(3) IN ITS GENERALLY ACCEPTED

LEGAL SENSE," AND PROVIDES EXAMPLES OF CHARITABLE PURPOSES, INCLUDING THE

RELIEF OF THE POOR OR UNPRIVILEGED; THE PROMOTION OF SOCIAL WELFARE; AND

THE ADVANCEMENT OF EDUCATION, RELIGION, AND SCIENCE. NOTE IT DOES NOT

EXPLICITLY ADDRESS THE ACTIVITIES OF HOSPITALS. IN THE ABSENCE OF

EXPLICIT STATUTORY OR REGULATORY REQUIREMENTS APPLYING THE TERM

"CHARITABLE" TO HOSPITALS, IT HAS BEEN LEFT TO THE IRS TO DETERMINE THE

CRITERIA HOSPITALS MUST MEET TO QUALIFY AS IRC \$501(C)(3) CHARITABLE

ORGANIZATIONS. THE ORIGINAL STANDARD WAS KNOWN AS THE CHARITY CARE

STANDARD. THIS STANDARD WAS REPLACED BY THE IRS WITH THE COMMUNITY

BENEFIT STANDARD WHICH IS THE CURRENT STANDARD.

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
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CHARITY CARE STANDARD

IN 1956, THE IRS ISSUED REVENUE RULING 56-185, WHICH ADDRESSED THE REQUIREMENTS HOSPITALS NEEDED TO MEET IN ORDER TO QUALIFY FOR IRC \$501(C)(3) STATUS. ONE OF THESE REQUIREMENTS IS KNOWN AS THE "CHARITY CARE STANDARD." UNDER THE STANDARD, A HOSPITAL HAD TO PROVIDE, TO THE EXTENT OF ITS FINANCIAL ABILITY, FREE OR REDUCED-COST CARE TO PATIENTS UNABLE TO PAY FOR IT. A HOSPITAL THAT EXPECTED FULL PAYMENT DID NOT, ACCORDING TO THE RULING, PROVIDE CHARITY CARE BASED ON THE FACT THAT SOME PATIENTS ULTIMATELY FAILED TO PAY. THE RULING EMPHASIZED THAT A LOW LEVEL OF CHARITY CARE DID NOT NECESSARILY MEAN THAT A HOSPITAL HAD FAILED TO MEET THE REQUIREMENT SINCE THAT LEVEL COULD REFLECT ITS FINANCIAL ABILITY TO PROVIDE SUCH CARE. THE RULING ALSO NOTED THAT PUBLICLY SUPPORTED COMMUNITY HOSPITALS WOULD NORMALLY QUALIFY AS CHARITABLE ORGANIZATIONS BECAUSE THEY SERVE THE ENTIRE COMMUNITY, AND A LOW LEVEL OF CHARITY CARE WOULD NOT AFFECT A HOSPITAL'S EXEMPT STATUS IF IT WAS DUE TO THE SURROUNDING COMMUNITY'S LACK OF CHARITABLE DEMANDS.

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COMMUNITY BENEFIT STANDARD

IN 1969, THE IRS ISSUED REVENUE RULING 69-545, WHICH "REMOVED" FROM
REVENUE RULING 56-185 "THE REQUIREMENTS RELATING TO CARING FOR PATIENTS
WITHOUT CHARGE OR AT RATES BELOW COST." UNDER THE STANDARD DEVELOPED IN
REVENUE RULING 69-545, WHICH IS KNOWN AS THE "COMMUNITY BENEFIT
STANDARD," HOSPITALS ARE JUDGED ON WHETHER THEY PROMOTE THE HEALTH OF A
BROAD CLASS OF INDIVIDUALS IN THE COMMUNITY.

THE RULING INVOLVED A HOSPITAL THAT ONLY ADMITTED INDIVIDUALS WHO COULD PAY FOR THE SERVICES (BY THEMSELVES, PRIVATE INSURANCE, OR PUBLIC PROGRAMS SUCH AS MEDICARE), BUT OPERATED A FULL-TIME EMERGENCY ROOM THAT WAS OPEN TO EVERYONE. THE IRS RULED THAT THE HOSPITAL QUALIFIED AS A CHARITABLE ORGANIZATION BECAUSE IT PROMOTED THE HEALTH OF PEOPLE IN ITS COMMUNITY. THE IRS REASONED THAT BECAUSE THE PROMOTION OF HEALTH WAS A CHARITABLE PURPOSE ACCORDING TO THE GENERAL LAW OF CHARITY, IT FELL WITHIN THE "GENERALLY ACCEPTED LEGAL SENSE" OF THE TERM "CHARITABLE," AS

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REQUIRED BY TREAS. REG. § 1.501(C)(3)-1(D)(2). THE IRS RULING STATED THAT THE PROMOTION OF HEALTH, LIKE THE RELIEF OF POVERTY AND THE ADVANCEMENT OF EDUCATION AND RELIGION, IS ONE OF THE PURPOSES IN THE GENERAL LAW OF CHARITY THAT IS DEEMED BENEFICIAL TO THE COMMUNITY AS A WHOLE EVEN THOUGH THE CLASS OF BENEFICIARIES ELIGIBLE TO RECEIVE A DIRECT BENEFIT FROM ITS ACTIVITIES DOES NOT INCLUDE ALL MEMBERS OF THE COMMUNITY, SUCH AS INDIGENT MEMBERS OF THE COMMUNITY, PROVIDED THAT THE CLASS IS NOT SO SMALL THAT ITS RELIEF IS NOT OF BENEFIT TO THE COMMUNITY.

THE IRS CONCLUDED THAT THE HOSPITAL WAS "PROMOTING THE HEALTH OF A CLASS OF PERSONS THAT IS BROAD ENOUGH TO BENEFIT THE COMMUNITY" BECAUSE ITS EMERGENCY ROOM WAS OPEN TO ALL AND IT PROVIDED CARE TO EVERYONE WHO COULD PAY, WHETHER DIRECTLY OR THROUGH THIRD-PARTY REIMBURSEMENT. OTHER CHARACTERISTICS OF THE HOSPITAL THAT THE IRS HIGHLIGHTED INCLUDED THE FOLLOWING: ITS SURPLUS FUNDS WERE USED TO IMPROVE PATIENT CARE, EXPAND HOSPITAL FACILITIES, AND ADVANCE MEDICAL TRAINING, EDUCATION, AND RESEARCH; IT WAS CONTROLLED BY A BOARD OF TRUSTEES THAT CONSISTED OF INDEPENDENT CIVIC LEADERS; AND HOSPITAL MEDICAL STAFF PRIVILEGES WERE

Schedule H (Form 990) 2013_

Part VI Supplemental Information

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AVAILABLE TO ALL QUALIFIED PHYSICIANS.

THE AMERICAN HOSPITAL ASSOCIATION ("AHA") BELIEVES THAT MEDICARE

UNDERPAYMENTS (SHORTFALL) AND BAD DEBT ARE COMMUNITY BENEFIT AND THUS

INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I. THIS ORGANIZATION AGREES

WITH THE AHA POSITION. AS OUTLINED IN THE AHA LETTER TO THE IRS DATED

AUGUST 21, 2007 WITH RESPECT TO THE FIRST PUBLISHED DRAFT OF THE NEW FORM

990 AND SCHEDULE H, THE AHA FELT THAT THE IRS SHOULD INCORPORATE THE FULL

VALUE OF THE COMMUNITY BENEFIT THAT HOSPITALS PROVIDE BY COUNTING

MEDICARE UNDERPAYMENTS (SHORTFALL) AS QUANTIFIABLE COMMUNITY BENEFIT FOR

THE FOLLOWING REASONS:

- PROVIDING CARE FOR THE ELDERLY AND SERVING MEDICARE PATIENTS IS AN ESSENTIAL PART OF THE COMMUNITY BENEFIT STANDARD.
- MEDICARE, LIKE MEDICAID, DOES NOT PAY THE FULL COST OF CARE. RECENTLY,
 MEDICARE REIMBURSES HOSPITALS ONLY 92 CENTS FOR EVERY DOLLAR THEY SPEND
 TO TAKE CARE OF MEDICARE PATIENTS. THE MEDICARE PAYMENT ADVISORY

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Part VI Supplemental Information

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COMMISSION ("MEDPAC") IN ITS MARCH 2007 REPORT TO CONGRESS CAUTIONED THAT UNDERPAYMENT WILL GET EVEN WORSE, WITH MARGINS REACHING A 10-YEAR LOW AT NEGATIVE 5.4 PERCENT.

- MANY MEDICARE BENEFICIARIES, LIKE THEIR MEDICAID COUNTERPARTS, ARE
POOR. MORE THAN 46 PERCENT OF MEDICARE SPENDING IS FOR BENEFICIARIES
WHOSE INCOME IS BELOW 200 PERCENT OF THE FEDERAL POVERTY LEVEL. MANY OF
THOSE MEDICARE BENEFICIARIES ARE ALSO ELIGIBLE FOR MEDICAID -- SO CALLED
"DUAL ELIGIBLES."

THERE IS EVERY COMPELLING PUBLIC POLICY REASON TO TREAT MEDICARE AND MEDICAID UNDERPAYMENTS SIMILARLY FOR PURPOSES OF A HOSPITAL'S COMMUNITY BENEFIT AND INCLUDE THESE COSTS ON FORM 990, SCHEDULE H, PART I. MEDICARE UNDERPAYMENT MUST BE SHOULDERED BY THE HOSPITAL IN ORDER TO CONTINUE TREATING THE COMMUNITY'S ELDERLY AND POOR. THESE UNDERPAYMENTS REPRESENT A REAL COST OF SERVING THE COMMUNITY AND SHOULD COUNT AS A QUANTIFIABLE COMMUNITY BENEFIT.

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BOTH THE AHA AND THIS ORGANIZATION ALSO FEEL THAT PATIENT BAD DEBT IS A COMMUNITY BENEFIT AND THUS INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I. LIKE MEDICARE UNDERPAYMENT (SHORTFALLS), THERE ALSO ARE COMPELLING REASONS THAT PATIENT BAD DEBT SHOULD BE COUNTED AS QUANTIFIABLE COMMUNITY BENEFIT AS FOLLOWS:

- A SIGNIFICANT MAJORITY OF BAD DEBT IS ATTRIBUTABLE TO LOW-INCOME PATIENTS, WHO, FOR MANY REASONS, DECLINE TO COMPLETE THE FORMS REQUIRED TO ESTABLISH ELIGIBILITY FOR HOSPITALS' CHARITY CARE OR FINANCIAL ASSISTANCE PROGRAMS. A 2006 CONGRESSIONAL BUDGET OFFICE ("CBO") REPORT, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, CITED TWO STUDIES INDICATING THAT "THE GREAT MAJORITY OF BAD DEBT WAS ATTRIBUTABLE TO PATIENTS WITH INCOMES BELOW 200% OF THE FEDERAL POVERTY LINE."
- THE REPORT ALSO NOTED THAT A SUBSTANTIAL PORTION OF BAD DEBT IS

 PENDING CHARITY CARE. UNLIKE BAD DEBT IN OTHER INDUSTRIES, HOSPITAL BAD

 DEBT IS COMPLICATED BY THE FACT THAT HOSPITALS FOLLOW THEIR MISSION TO

 THE COMMUNITY AND TREAT EVERY PATIENT THAT COMES THROUGH THEIR EMERGENCY

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- 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

DEPARTMENT, REGARDLESS OF ABILITY TO PAY. PATIENTS WHO HAVE OUTSTANDING BILLS ARE NOT TURNED AWAY, UNLIKE OTHER INDUSTRIES. BAD DEBT IS FURTHER COMPLICATED BY THE AUDITING INDUSTRY'S STANDARDS ON REPORTING CHARITY CARE. MANY PATIENTS CANNOT OR DO NOT PROVIDE THE NECESSARY, EXTENSIVE DOCUMENTATION REQUIRED TO BE DEEMED CHARITY CARE BY AUDITORS. AS A RESULT, ROUGHLY 40% OF BAD DEBT IS PENDING CHARITY CARE.

THE CBO CONCLUDED THAT ITS FINDINGS "SUPPORT THE VALIDITY OF THE USE OF UNCOMPENSATED CARE [BAD DEBT AND CHARITY CARE] AS A MEASURE OF COMMUNITY BENEFITS" ASSUMING THE FINDINGS ARE GENERALIZABLE NATIONWIDE; THE EXPERIENCE OF HOSPITALS AROUND THE NATION REINFORCES THAT THEY ARE GENERALIZABLE.

AS OUTLINED BY THE AHA, DESPITE THE HOSPITALS' BEST EFFORTS AND DUE
DILIGENCE, PATIENT BAD DEBT IS A PART OF THE HOSPITAL'S MISSION AND
CHARITABLE PURPOSES. BAD DEBT REPRESENTS PART OF THE BURDEN HOSPITALS
SHOULDER IN SERVING ALL PATIENTS REGARDLESS OF RACE, COLOR, CREED, SEX,
NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. IN ADDITION, THE HOSPITAL

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.

INVESTS SIGNIFICANT RESOURCES IN SYSTEMS AND STAFF TRAINING TO ASSIST PATIENTS THAT ARE IN NEED OF FINANCIAL ASSISTANCE.

SCHEDULE H, PART III, SECTION B; QUESTION 9B

ACCOUNTS CONSIDERED TO BE CHARITY CARE ARE NOT INCLUDED IN THE BAD DEBT EXPENSE, BUT RATHER, ACCOUNTED FOR AS AN ALLOWANCE.

IT IS THE POLICY OF CAPITAL HEALTH SYSTEM, AND ALL ITS HOSPITAL

AFFILIATES, TO TREAT ALL PATIENTS EQUALLY REGARDLESS OF INSURANCE AND

THEIR ABILITY TO PAY. FOR ACCOUNTS DETERMINED TO BE "SELF-PAY" AND/OR

ACCOUNTS WITH BALANCE AFTER PRIMARY INSURANCE PAYMENTS, THE COLLECTION

POLICY REQUIRES: SENDING THREE STATEMENTS, A MINIMUM OF ONE

PRE-COLLECTION LETTER, TELEPHONE CONTACT FOR ANY ACCOUNT OVER \$5,000.00

OR AT THE DISCRETION OF THE ACCOUNT REPRESENTATIVE AND/OR SUPERVISOR.

THE FACILITY ALSO HAS A CHARITY CARE ACCESS POLICY TO ASSURE PATIENTS ARE PROVIDED WITH CHARITY CARE ASSISTANCE DETERMINED BY STATE AND FEDERAL

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.

REGULATIONS. IT IS THE POLICY TO INFORM ALL PATIENTS DEEMED SELF-PAY OF
THE APPROPRIATE ASSISTANCE PROGRAMS AVAILABLE. PATIENTS APPLYING FOR
CHARITY CARE ASSISTANCE WILL BE FINANCIALLY SCREENED BY A RESOURCE
ADVISOR TO DETERMINE ELIGIBILITY ACCORDING TO STATE AND FEDERAL
GUIDELINES AND WILL BE INFORMED OF DOCUMENTATION NEEDED TO COMPLETE A
CHARITY CARE APPLICATION. PATIENTS NOT ELIGIBLE FOR CHARITY CARE WILL BE
FINANCIALLY COUNSELED FOR ALL OTHER OPTIONS. QUALIFIED PATIENTS WILL BE
REFERRED TO ALL APPROPRIATE AGENCIES OR PROGRAMS TO MEET OTHER FINANCIAL
NEEDS.

AT THE TIME OF THE PATIENT VISIT AND PART OF THE REGISTRATION PROCESS AT THE FACILITY, THE FOLLOWING OPTIONS ARE MADE AVAILABLE TO PATIENTS:

- FINANCIAL COUNSELING FOR POSSIBLE ELIGIBILITY FOR MEDICAL ASSISTANCE INCLUDING MEDICALD AND SSI;
- FINANCIAL COUNSELING FOR POSSIBLE ELIGIBILITY FOR THE NEW JERSEY
 HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM; AND,
- FINANCIAL ARRANGEMENTS INCLUDING:

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
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- 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
- CASH/CREDIT CARD (AMERICAN EXPRESS, DISCOVER, VISA, MASTERCARD).

IN ADDITION TO THE ABOVE OPTIONS, THE FACILITY HAS ESTABLISHED A SELF-PAY ASSISTANCE PROGRAM FOR ITS UNINSURED PATIENTS THAT DO NOT QUALIFY FOR MEDICAID OR THE NEW JERSEY HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM. THE SELF-PAY ASSISTANCE PROGRAM RATES ARE REFLECTIVE OF MEDICARE REIMBURSEMENT, AS REFERRED BY THE STATE OF NEW JERSEY.

SCHEDULE H, PART VI; QUESTION 2

IN ADDITION TO THE INTERNAL REVENUE CODE \$501(R) COMMUNITY HEALTH NEEDS ASSESSMENT INFORMATION OUTLINED IN FORM 990, SCHEDULE H, PART V, SECTION B, CAPITAL HEALTH ROUTINELY MONITORS DEMAND FOR THE SERVICES IT PROVIDES WHILE SIMULTANEOUSLY UTILIZING A VARIETY OF INFORMATION SOURCES TO DETERMINE UNMET OR UNDERSERVED NEEDS OF THE COMMUNITIES IT SERVES.

CAPITAL HEALTH MEETS AT LEAST MONTHLY WITH THE OTHER HEALTHCARE PROVIDERS

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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
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- 6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN ITS SERVICE AREA AS WELL AS A COMMUNITY HEALTH DEPARTMENT DIRECTOR TO DISCUSS UNMET NEEDS AND COLLABORATIVELY STRATEGIZE THE PRIORITIZATION OF NEEDS AND DEVELOP PROGRAMS TO ADDRESS THEM IN A COORDINATED WAY. CAPITAL HEALTH ALSO ROUTINELY REVIEW AVAILABLE DATA REGARDING INCIDENTS OF HEALTH ISSUES AND PROPOSE PROGRAMS TO ADDRESS THESE ISSUES AND ULTIMATELY IMPLEMENT THOSE WHICH WILL HAVE THE GREATEST IMPACT.

ADDITIONALLY, WE REGULARLY INTERACT WITH COMMUNITY LEADERS AND RECEIVE
FEEDBACK ON THEIR SATISFACTION WITH OUR SERVICES. WE BELIEVE THIS
COMPREHENSIVE APPROACH OF MONITORING AND ANALYZING BOTH OBJECTIVE DATA
AND SUBJECTIVE FEEDBACK GIVES US A CURRENT UNDERSTANDING OF HOW WE ARE
ADDRESSING COMMUNITY NEEDS AND WHAT WE NEED TO DO TO OPTIMIZE OUR IMPACT
UPON THE HEALTHCARE STATUS OF OUR REGION.

SCHEDULE H, PART VI; QUESTION 3

CAPITAL HEALTH SYSTEM, INC. EDUCATES PATIENTS ABOUT ELIGIBILITY FOR ASSISTANCE WITH THEIR BILLS IN NUMEROUS WAYS.

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
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- 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.

INSURANCE INFORMATION IS OBTAINED AT ALL REGISTRATION POINTS AT EACH VISIT. IF A PATIENT IS FOUND NOT TO HAVE INSURANCE, OR IS UNDERINSURED THE FOLLOWING PROCEDURE IS FOLLOWED;

- 1. WHEN A PATIENT IS FOUND TO BE UNINSURED AND IN NEED OF FINANCIAL

 ASSISTANCE, A NEW JERSEY CARE PAYMENT FACT SHEET IS REVIEWED WITH THE

 PATIENT, AND A WRITTEN COPY IS PROVIDED TO THE PATIENT BY THE HEALTH

 ACCESS STAFF. THE FACT SHEET EXPLAINS WHO IS ELIGIBLE, HOW TO APPLY WITH

 THE PHONE NUMBER OF EACH CAMPUS CHARITY CARE OFFICE, AND WHAT DOCUMENTS

 ARE NEEDED TO DETERMINE ELIGIBILITY.
- 2. WHEN A PATIENT IS ADMITTED TO THE HOSPITAL, A CHARITY CARE WORKER WILL VISIT THE PATIENT'S BEDSIDE TO START THE CHARITY CARE PROCESS. IF A PATIENT IS FINANCIALLY SCREENED AND FOUND TO BE ELIGIBLE FOR MEDICAID, A REFERRAL IS GIVEN TO THE HOSPITAL'S MEDICAID OUTSTATION WORKER. THE OUTSTATION WORKER WILL VISIT THE PATIENT, AND BEGIN THE MEDICAID PROCESS.

Page 9

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.
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- 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
- 3. WHEN A PATIENT IS FOUND TO BE UNDERINSURED, (EXAMPLE IS A PATIENT WHO HAS MEDICARE ONLY) A REFERRAL IS MADE TO THE CHARITY CARE WORKER, AND THE SAME PROCESS IS FOLLOWED ABOVE.
- 4. THE PATIENT IS MONITORED FOR COMPLIANCE IN COMPLETING THE APPLICATION INCLUDING VISITING THE PATIENT'S HOME IF NECESSARY TO OBTAIN NECESSARY DOCUMENTATION TO COMPLETE THE APPLICATION.
- 5. ONCE THE PATIENT HAS BEEN APPROVED, THE CHARITY CARE DETERMINATION INFORMATION IS DOCUMENTED IN THE PATIENT'S REGISTRATION RECORD. PATIENT ACCESS MONITORS AND INSTRUCTS THE PATIENT WHEN THEIR CHARITY CARE APPLICATION IS DUE FOR RENEWAL.

ASIDE FROM INFORMING PATIENTS DURING THEIR REGISTRATION PROCESS, ALL OF CAPITAL HEALTH'S DUNNING STATEMENTS CONTAIN THE FOLLOWING LANGUAGE:

CAPITAL HEALTH SYSTEM, INC. IS COMMITTED TO PROVIDING CARE TO ALL

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
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- 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.

PATIENTS, REGARDLESS OF THEIR INSURANCE STATUS OR ABILITY TO PAY. UNDER CAPITAL HEALTH'S FINANCIAL ASSISTANCE AND CHARITY CARE PROGRAMS, THE PATIENT MAY BE ELIGIBLE TO RECEIVE FINANCIAL HELP THAT COVERS PART OR ALL OF THE PATIENT'S HOSPITAL BILL. IF THE PATIENT DOES NOT QUALIFY FOR EITHER OF THESE PROGRAMS, CAPITAL HEALTH CAN OFFER PROMPT PAYMENT DISCOUNTS AND DISCOUNTS FOR PATIENTS WHO HAVE BILLS THAT ARE A SIGNIFICANT FINANCIAL BURDEN TO THEM.

CAPITAL HEALTH SYSTEM, INC. ALSO PROVIDES, IN ENGLISH AND SPANISH, A

PHONE NUMBER FOR THOSE PATIENTS WHO CANNOT AFFORD TO PAY THEIR BILL AND
WOULD LIKE TO APPLY FOR FINANCIAL ASSISTANCE.

CAPITAL HEALTH SYSTEM, INC. HAS A RECORDED MESSAGE THAT IS PLAYED WHILE A CUSTOMER IS ON HOLD. IT REITERATES THE CAPITAL HEALTH SYSTEM INC. BELIEF THAT EVERYONE DESERVES QUALITY CARE, REGARDLESS OF THEIR ABILITY TO PAY. UNDER ITS FINANCIAL ASSISTANCE AND CHARITY CARE PROGRAMS, ELIGIBILITY TO RECEIVE FINANCIAL SUPPORT TO FULLY OR PARTIALLY COVER HOSPITAL COSTS IS OFFERED. IT ALSO STATES THAT FOR PATIENTS WHO DO NOT QUALIFY FOR EITHER

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
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- 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.

OF THESE PROGRAMS, CAPITAL HEALTH CAN OFFER PROMPT PAY AND OTHER
DISCOUNTS FOR PATIENTS WHO HAVE BILLS THAT ARE A SIGNIFICANT FINANCIAL
BURDEN TO THEM.

SCHEDULE H, PART VI; QUESTION 4

CAPITAL HEALTH PRIMARILY SERVES THE COMMUNITIES IN THE CITY OF TRENTON,

MERCER COUNTY AND PARTS OF BURLINGTON, MONMOUTH AND MIDDLESEX COUNTIES IN

NEW JERSEY AND BUCKS COUNTY IN PENNSYLVANIA. THERE ARE APPROXIMATELY

2,900,000 RESIDENTS WITHIN THE DEFINED PRIMARY AND SECONDARY SERVICE

AREA.

THE RACIAL MAKEUP OF MERCER COUNTY, WHICH INCLUDES TRENTON, THE STATE CAPITAL, IS 66.0% WHITE, 21.1% BLACK, AND 16.2% HISPANIC OR LATINO.

NEARLY 87.2% OF THE COUNTY'S RESIDENTS WHO ARE 25 YEARS OR OLDER

GRADUATED HIGH SCHOOL AND 38.2% HAVE A BACHELOR'S DEGREE. MEDIAN

HOUSEHOLD INCOME IN THE COUNTY WAS \$73,759 ACCORDING TO THE 2010 US

CENSUS.

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.
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- 6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report

THE RACIAL MAKEUP OF BURLINGTON COUNTY IS 74.7% WHITE, 17.5% BLACK, AND 7.3% HISPANIC OR LATINO. MORE THAN 91.4% OF BURLINGTON COUNTY RESIDENTS WHO ARE 25 YEARS OR OLDER GRADUATED HIGH SCHOOL AND 34.2% HAVE A BACHELOR'S DEGREE. MEDIAN HOUSEHOLD INCOME IN BURLINGTON COUNTY WAS \$78,229 ACCORDING TO THE 2010 US CENSUS.

THE RACIAL MAKEUP OF BUCKS COUNTY, PENNSYLVANIA IS 89.8% WHITE, 4.0% BLACK AND 4.1% HISPANIC OR LATINO. OF THOSE, 92.9% OF BUCKS COUNTY RESIDENTS WHO ARE 25 YEARS OR OLDER GRADUATED HIGH SCHOOL AND 35.1% HAVE A BACHELOR'S DEGREE. MEDIAN HOUSEHOLD INCOME IN BUCKS COUNTY WAS \$76,859 ACCORDING TO THE 2010 US CENSUS.

THE RACIAL MAKEUP OF MONMOUTH COUNTY IS 89.4% WHITE, 7.6% BLACK, AND 10.3% HISPANIC OR LATINO. MORE THAN 91.9% OF MONMOUTH COUNTY RESIDENTS WHO ARE 25 YEARS OR OLDER GRADUATED HIGH SCHOOL AND 40.3% HAVE A BACHELOR'S DEGREE. MEDIAN HOUSEHOLD INCOME IN COUNTY WAS \$84,746 ACCORDING TO THE 2010 US CENSUS.

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.
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- 6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE RACIAL MAKEUP OF MIDDLESEX COUNTY IS 62.8% WHITE, 11.0% BLACK, AND 19.5% HISPANIC OR LATINO. MORE THAN 88.8% OF MIDDLESEX COUNTY RESIDENTS WHO ARE 25 YEARS OR OLDER GRADUATED HIGH SCHOOL AND 39.8% HAVE A BACHELOR'S DEGREE. MEDIAN HOUSEHOLD INCOME IN COUNTY WAS \$79,442 ACCORDING TO THE 2010 US CENSUS.

SCHEDULE H, PART VI; QUESTION 5

THIS ORGANIZATION OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

- 1. THE ORGANIZATION PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY, INCLUDING CHARITY CARE, SELF-PAY, MEDICARE AND MEDICAID PATIENTS;
- 2. THE ORGANIZATION OPERATES AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;

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
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- 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.
- 3. THE ORGANIZATION MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;
- 4. CONTROL OF THE ORGANIZATION RESTS WITH ITS BOARD OF TRUSTEES; WHICH IS COMPRISED OF INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY; AND
- 5. SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE; PROGRAMS AND ACTIVITIES.

PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT
STATEMENT FOR ADDITIONAL INFORMATION ON HOW THE ORGANIZATION PROMOTES
COMMUNITY HEALTH.

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
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SCHEDULE H, PART VI; QUESTION 6

OUTLINED BELOW IS A SUMMARY OF THE ENTITIES WHICH COMPRISE THE CAPITAL HEALTH SYSTEM AND AFFILIATES.

NOT FOR PROFIT CAPITAL HEALTH SYSTEM AND AFFILIATES ENTITIES

CAPITAL HEALTH SYSTEM, INC.

CAPITAL HEALTH SYSTEM, INC. ("CHS") IS THE TAX-EXEMPT PARENT OF CAPITAL HEALTH SYSTEM AND AFFILIATES ("SYSTEM"). THIS INTEGRATED HEALTHCARE DELIVERY SYSTEM CONSISTS OF A GROUP OF AFFILIATED HEALTHCARE ORGANIZATIONS. THE SOLE MEMBER OR STOCKHOLDER OF EACH ENTITY IS EITHER CHS OR ANOTHER SYSTEM AFFILIATE CONTROLLED BY CHS. THE SYSTEM IS AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS IN THE STATE OF NEW JERSEY.

CAPITAL HEALTH SYSTEM IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE

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
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- 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

\$501(C)(3) AND AS A HOSPITAL UNDER IRC \$170(B)(1)(A)(I).

AS THE PARENT ORGANIZATION OF A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM IN MERCER COUNTY NEW JERSEY. CAPITAL HEALTH SYSTEM STRIVES TO CONTINUALLY DEVELOP AND OPERATE A MULTI-HOSPITAL HEALTHCARE SYSTEM WHICH PROVIDES SUBSTANTIAL COMMUNITY BENEFIT THROUGH THE PROVISION OF A COMPREHENSIVE SPECTRUM OF HEALTHCARE SERVICES TO THE RESIDENTS OF NEW JERSEY AND SURROUNDING COMMUNITIES. CAPITAL HEALTH SYSTEM, INC. ENSURES THAT ITS SYSTEM PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGINS OR ABILITY TO PAY. NO INDIVIDUALS ARE DENIED NECESSARY MEDICAL CARE, TREATMENT OR SERVICES. CAPITAL HEALTH SYSTEM, INC.'S ACTIVE HOSPITALS ARE CAPITAL HEALTH MEDICAL CENTER - HOPEWELL AND CAPITAL HEALTH REGIONAL MEDICAL CENTER. THE HOSPITALS OPERATE CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

1. PROVIDE MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY, INCLUDING CHARITY CARE, SELF-PAY, MEDICARE

Page 9

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

AND MEDICAID PATIENTS;

- 2. OPERATE AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN
- 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;
- 3. MAINTAIN AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS; AND
- 4. CONTROL RESTS WITH ITS BOARD OF TRUSTEES. THE BOARD IS COMPRISED OF INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY.
- 5. SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE, PROGRAMS AND ACTIVITIES.

CAPITAL HEALTH SYSTEM FOUNDATION, INC.

CAPITAL HEALTH SYSTEM FOUNDATION, INC. IS AN ORGANIZATION RECOGNIZED BY

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
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- 6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE \$501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE CODE \$509(A)(1).

THROUGH FUNDRAISING ACTIVITIES THE ORGANIZATION SUPPORTS THE CHARITABLE PURPOSES, PROGRAMS AND SERVICES OF CAPITAL HEALTH SYSTEM, INC.; A RELATED INTERNAL REVENUE CODE \$501(C)(3) TAX-EXEMPT ORGANIZATION, THAT PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY.

FOR PROFIT CAPITAL HEALTH SYSTEM AND AFFILIATES ENTITIES

BELLEVUE AVENUE MANAGEMENT, INC.

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS MERCER HOLDING CORPORATION.

THE ORGANIZATION IS LOCATED IN TRENTON, MERCER COUNTY, NEW JERSEY. THE

ORGANIZATION PROVIDES MANAGERIAL ADMINISTRATION AND SUPPORT.

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.
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- 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.

CAPITAL HEALTH SYSTEM CONDOMINIUM ASSOCIATION, INC.

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS CAPITAL HEALTH SYSTEM, INC.

THE ORGANIZATION IS LOCATED IN TRENTON, MERCER COUNTY, NEW JERSEY. THIS

ENTITY IS A HOMEOWNERS ASSOCIATION.

CAPITAL REGION INSURANCE COMPANY

A CONTROLLED FOREIGN CORPORATION OF CAPITAL HEALTH SYSTEM, INC. THE ORGANIZATION WAS FORMED AND OPERATES SOLELY IN CAYMAN ISLANDS.

MERCER HOLDING CORPORATION

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS CAPITAL HEALTH SYSTEM, INC.

THIS ENTITY IS THE SOLE OWNER OF ALL THE OUTSTANDING COMMON STOCK OF

BELLEVUE AVENUE MANAGEMENT, INC. AND IS INVOLVED IN VARIOUS ANCILLARY

HEALTHCARE RELATED ACTIVITIES.

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.
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- 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

STROKE AND CEREBROVASCULAR CENTER OF NEW JERSEY, P.C.

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS CAPITAL HEALTH SYSTEM, INC.

THE ORGANIZATION IS LOCATED IN TRENTON, MERCER COUNTY, NEW JERSEY. THIS

ENTITY PROVIDES MEDICAL SERVICES TO INDIVIDUALS.

SCHEDULE H, PART VI; QUESTION 7

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

SCHEDULE H, PART VI; QUESTION 8

THE ORGANIZATION HAS TWO HOSPITAL FACILITIES INCLUDED IN ONE FACILITY

REPORTING GROUP. THESE INCLUDE CAPITAL HEALTH MEDICAL CENTER - HOPEWELL

AND CAPITAL HEALTH REGIONAL MEDICAL CENTER, AS REFLECTED IN SCHEDULE H,

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
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PART V, SECTION A. PLEASE REFER TO OUR RESPONSES IN SCHEDULE H, PART VI,

QUESTION 1 ABOVE.

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" to Form 990, Part IV, line 23

► Attach to Form 990 ► See separate instructions.

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

OMB No 1545-0047

Name of the organization CAPITAL HEALTH SYSTEM, INC Employer identification number 22-3548695

Part	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 in Form			
	990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	First-class or charter travel Housing allowance or residence for personal use			
	Travel for companions Payments for business use of personal residence			
	Tax indemnification and gross-up payments Health or social club dues or initiation fees			
	Discretionary spending account Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to			
	explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all			
	directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line			
	1a ²	2		
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			
	X Compensation committee Written employment contract			
	X Independent compensation consultant X Compensation survey or study			
	X Form 990 of other organizations X Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing			
	organization or a related organization			
а	Receive a severance payment or change-of-control payment?	4a	Х	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
С	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		<u>X</u>
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any			
	compensation contingent on the revenues of			
а	The organization?	5a	х	-
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any			
	compensation contingent on the net earnings of			
а	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed]		!
	payments not described in lines 5 and 6? If "Yes," describe in Part III	7	Х	
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject			
	to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe			
	ın Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in			
	Regulations section 53 4958-6(c)?	9		

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

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 in 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.

					<u> </u>			
		(B) Breakdown of	of W-2 and/or 1099-MISC compensation	C compensation	(C) Retirement and	(D) Nontaxable	(E) Total of columns	(F) Compensation
(A) Name and Title	··	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	other deferred compensation	benefits	(B)(I)-(D)	reported as deferred in prior Form 990
LOUIS F DAMELIO MD	(3)	836,025.	7,500.	1,311.	3,051.	21,646.	869,533.	0
1 TRUSTEE	<u> </u>	0	b	0	0	0	 	0
AL MAGHAZEHE PHD FACHE	ε	1,005,297.	441,827.	29,023.	463,376.	17,517.	1,957,040.	0
2 TRUSTEE - PRESIDENT/CEO	(ii)	ე	b		0	0		0
SHANE F FLEMING CPA	Ξ	305,266.	29,063.	2,357.	15,893.	22, 686.	375, 265.	0
3 CHIEF FINANCIAL OFFICER	(ii)	5	b		D	0		0
EUGENE W GROCHALA	Ξ	391,953.	15,076.	22, 656.	67,619.	3,616.	500,920.	0
4 CHIEF INFORMATION OFFICER	Œ	C	O	р	d	0		0
STEPHEN A MILLER JD	()	201,317.	15,076.	1,962.	8,654.	20,049.	247,058.	0
5 CHIEF COMPLIANCE OFFICER	(E)	C			0	0		0
LARRY DISANTO	(1)	565,389.	217,060.	21,702.	318,820.	18,517.	1,141,488.	0
6 EXECUTIVE VICE PRESIDENT/COO	E	5	b		ט	0		0
ALEXANDER D GLADNEY ESQ	8	249,063.	24,295.	50,622.	D	7,863.	331,843.	0
7 GENERAL COUNSEL	(I)	, C			D	0	 	0
JOSHUA A EISENBERG MD	(i)	591,611.		1,917.	2,126.	24,116.	619,770.	0
8 CHIEF MEDICAL OFFICER	(E)	C	b		D	0	! ! !	0
MARGARET SULLIVAN	(1)	138,025.	268,238.	139,333.	473.	16,848.	562,917.	0
g VP, QUALITY RESOURCE MGMT	(II)	J	0		0	0		0
ROBERT REMSTEIN DO	(6)	385,221.	29,261.	4,071.	17,735.	. 666 '6	446,287.	0
10 VP, ACCOUNTABLE CARE	(ii)	ָרֵ כ	Ь	0	0	0	 	0
GREGORY N DADAMO] (s)	265,775.	79,501.	3,349.	56, 556.	2,263.	407,444.	0
11 VP, SUPPORT & PROFESSIONAL SVCS	(II)	ς	b	b	0	0		0
J SCOTT CLEMMENSEN	Ξ	245,749.	79,950.	22,066.	57,224.	18,122.	423, 111.	0
12 VP, HUMAN RESOURCES	(ii)	C	d	0	0	0		0
EILEEN M HORTON	Ξ	317,802.	23, 101.	2,938.	14,331.	18,543.	376,715.	0
13 VP, PATIENT SERVICES/CNO	(II)	C	0	0	0	0		0
NATHAN BOSK FACHE	Ξ	296,992	23,322.	19,765.	14,409.	20,037.	374, 525.	0
14 VP, AMBULATORY SERVICES	(II)	J		0	0	0		0
DENNIS DOOLEY	Ξ	232, 621.	70,033.	3,997.	50,339.	20,569.	377,559.	0
15 VP, PLANNING/VP, COMM & GOV'T	Ξ	ً د	0	0	0	0	0	0
ARLENE WALSH	Ξ	217,024.	15,076.	2,114.	8,899.	20,398.	263, 511.	0
16 VP, TRANSFORMATION	Ξ	J	0	0	0	0	b	0

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

For each individual whose compensation must be reported in 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)-(ii) 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

		/R) Breakdown of	of W-2 and/or 1099-MISC compensation	company				
(A) Name and Title		(I) Base compensation		(iii) Other reportable compensation	(c) Refrirement and other deferred compensation	(U) Nontaxable benefits	(E) lotal of columns (B)(I)-(D)	(F) Compensation reported as deferred in prior Form 990
ARLAN H MINTZ MD	ε	894,933.	164,923.	2,916.	0	17,349.	1,080,121.	0
1 PHYSICIAN	(II)	b	0		D	0		0
LEE M BUONO MD	Ξ	897,228.		270.	2,112.	15,537.	915,147.	
	Ξ				0	0	- 1	0
STEVEN A JOHNSON MD	Ξ	598,224.	114,167.	1,890.		25,422.	739,703	0
3 PHYSICIAN	(E)	5	0	0	0	0		0
GARY A TUMA MD	Ξ	608,603.	-	1,959.	0	21,393.	631,955.	0
4 PHYSICIAN	Ξ					0	 	0
JOSEPH E SHERRILL II MD	Ξ	545,962.	0	391.	O	11,662.	558,015.	0
5 PHYSICIAN	Ξ					i i i i		0
RONALD J GUY	Ξ	0	D	626,036.	0	7,594.	633, 630.	0
6 FORMER CFO	Ξ							0
JAN GABIN ESQ	Ξ	0	0	307,461.	0	16,996.	324,457.	0
7 FORMER GENERAL COUNSEL	€	1 1 1 1					\$ 1 1	0
LINDA DITE	(i)	27,237.	b	206,367.	0	13,852.	247,456.	0
8 FORMER VP, CLINICAL SERVICES	Ξ	0	D		0	0	 	0
	<u>(i)</u>	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				1		
6	Ξ							
	(3)	1						
10	Ξ							
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11	Ξ							
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12	(II)							
	Ξ							
13	Ξ							
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15	(E)							
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16	▣							
							Sche	Schedule J (Form 990) 2013

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Part III Supplemental Information

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

SCHEDULE J, PART I; QUESTION

("COMMITTEE"). THE COMMITTEE HAS ADOPTED A WRITTEN EXECUTIVE COMPENSATION PHYSICIANS, AND ANY OTHER OF THE ORGANIZATION'S SENIOR MANAGEMENT THE ORGANIZATION'S BOARD OF TRUSTEES HAS A BOARD COMPENSATION COMMITTEE COMMITTEE REVIEWS THE "TOTAL COMPENSATION" OF THE INDIVIDUALS WHICH IS COMPENSATION" OF SENIOR MANAGEMENT OF THE ORGANIZATION IS REASONABLE. BOTH QUALIFIED AND NON-QUALIFIED. THE COMMITTEE'S AGREEMENTS FOR THE COVERED EMPLOYEES AND DISINTERESTED PERSONS. THE AND OTHERS, INCLUDING THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL INTENDED TO INCLUDE BOTH CURRENT AND DEFERRED COMPENSATION AND ALL REVIEW IS DONE ON AT LEAST AN ANNUAL BASIS AND ENSURES THAT THE THE IT ALSO REVIEWS AND APPROVES EMPLOYMENT PHILOSOPHY WHICH IT FOLLOWS WHEN IT REVIEWS AND APPROVES OF OFFICER AND OTHER OFFICERS OF THE ORGANIZATION, COMPENSATION AND BENEFITS OF ALL DISINTERESTED PERSONS. BENEFITS, EMPLOYEE

THE ACTIONS TAKEN BY THE COMMITTEE ENABLE THE ORGANIZATION TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS FOR PURPOSES OF INTERNAL REVENUE CODE SECTION 4958 WITH RESPECT TO THE TOTAL COMPENSATION OF THE SENIOR

Page 3

Part III Supplemental Information

Complete this part to 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.

ACTIVITIES OF THE COMMITTEE IN ALL OF ITS REVIEWS, DELIBERATIONS AND EMPLOYEES AND DISINTERESTED PERSONS. THE THREE FACTORS WHICH MUST BE MANAGEMENT TEAM. REBUTTAL PRESUMPTION REQUIREMENTS HAVE GUIDED THE APPROVAL OF EXECUTIVE COMPENSATION ACTIONS FOR ALL OF THE COVERED SATISFIED IN ORDER TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS ARE THE FOLLOWING:

- 1. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY AN "AUTHORIZED ENTIRELY OF INDIVIDUALS WHO DO NOT HAVE A "CONFLICT OF INTEREST" WITH BODY" OF THE APPLICABLE TAX-EXEMPT ORGANIZATION WHICH IS COMPOSED RESPECT TO THE COMPENSATION ARRANGEMENT;
- 2. THE AUTHORIZED BODY OBTAINED AND RELIED UPON "APPROPRIATE DATA AS TO COMPARABILITY" PRIOR TO MAKING ITS DETERMINATION; AND
- 3. THE AUTHORIZED BODY "ADEQUATELY DOCUMENTED, THE BASIS FOR ITS DETERMINATION" CONCURRENTLY WITH MAKING THAT DETERMINATION

Page 3

Part III Supplemental Information

Complete this part to 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.

OF. THE COMMITTEE IS COMPRISED OF MEMBERS OF THE BOARD OF TRUSTEES EACH WHO ARE INDEPENDENT AND ARE FREE FROM ANY CONFLICTS OF INTEREST.

ALL DATA WAS WEIGHTED IN ARRIVING AT MARKET CONSENSUS FOR COVERED EMPLOYEE POSITIONS, IN ORDER TO ACCURATELY REFLECT NEIGHBORING STATES BASED ON APPROPRIATE THE COMMITTEE RELIED UPON DATA FROM COMPARABLE HEALTHCARE AND HOSPITAL IN ADDITION, SPECIFIC SALARY SURVEYS COVERING SIMILAR, REPRESENTATIVE HOSPITAL REVENUE, SERVICES, AND OVERALL FINANCIAL PERFORMANCE. PEERS IN NEW JERSEY AS WELL AS COMPENSATION DATA WAS USED. THE RELEVANT LABOR MARKET

PERFORMANCE JUSTIFICATION USED AS THE BASIS FOR AWARDING OF ALL INCENTIVE THESE ARE SUPPORTED BY THE WRITTEN DOCUMENTATION COVERING CONTEMPORANEOUS MINUTES ARE COMPILED AND APPROVED OF ALL COMMITTEE ALL COMPENSATION STUDIES AND PLAN DOCUMENTS, AS WELL AS DETAILED DELIBERATIONS. PROGRAMS

REBUTTAL PRESUMPTION ACTIVITIES OF THE COMMITTEE COVER ALL MEMBERS OF

Page 3 Schedule J (Form 990) 2013

Part III Supplemental Information

Complete this part to 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

PHYSICIANS AND OTHER DISINTERESTED PERSONS, ALL OF WHICH ARE SUBJECT TO SENIOR MANAGEMENT, AS WELL AS THE COMPENSATION AND CONTRACTS COVERING THE REVIEW AND APPROVAL OF THE COMMITTEE

THIS PLAN COMPLIES WITH MANAGEMENT AS A MEANS TO AID IN THEIR RETENTION, THE COMMITTEE UNDERTOOK AND ADHERES TO ALL RELATED REGULATIONS, WITH AN EMPHASIS ON IRC SECTIONS COMPETITIVE HEALTHCARE LABOR MARKET. THE PLAN PROVIDES SENIOR MANAGEMENT AN EXTENSIVE RESEARCH AND ANALYSIS OF ALTERNATIVE PROGRAMS, AND CREATED TOOL TO ASSIST IN THE RECRUITING OF SENIOR MANAGEMENT WITHIN THE HIGHLY BΕ THIS PLAN ALSO PROVIDES THE ORGANIZATION WITH AN ADDITIONAL BASED ON ACHIEVING SPECIFIED FINANCIAL PERFORMANCE PLAN", OR ဥ FORM OF LONG-TERM NON-QUALIFIED DEFERRED COMPENSATION RECOGNIZING THE NEED TO CONSIDER RETIREMENT PLANNING FOR ITS SENIOR WITH THE OPPORTUNITY TO QUALIFY FOR ANNUAL DEFERRED CONTRIBUTIONS TO AS THE "PERFORMANCE-BASED CAPITAL ACCUMULATION TARGETS AND MEETING ESTABLISHED CIRCUIT BEAKERS. RETIREMENT, 409A AND 457(F) AND APPROVED A (REFERRED "PBCAP"). PAID AT

Page 3

Part III Supplemental Information

Complete this part to 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

BASED UPON OTHER OBJECTIVE FACTORS DESIGNED TO ENSURE THAT REASONABLE AND OFFICER WITH ASSISTANCE FROM ORGANIZATION'S HUMAN RESOURCES DEPARTMENT IN CONJUNCTION WITH THE INDIVIDUAL'S JOB PERFORMANCE DURING THE YEAR AND SURVEY DATA FOR COMPARABLE POSITIONS, THE COMPENSATION AND BENEFITS OF CERTAIN OTHER INDIVIDUALS CONTAINED THIS FORM 990 ARE REVIEWED ANNUALLY BY THE PRESIDENT/CHIEF EXECUTIVE FAIR MARKET VALUE COMPENSATION IS PAID BY THE ORGANIZATION. OTHER PERSONNEL REVIEWS, EVALUATIONS, SELF-EVALUATIONS AND PERFORMANCE FEEDBACK MEETINGS. OBJECTIVE FACTORS INCLUDE MARKET INDIVIDUAL GOALS AND OBJECTIVES,

4 A SCHEDULE J, PART I; QUESTION

AS Ŋ THE FOLLOWING INDIVIDUALS RECEIVED A SEVERANCE PAYMENT DURING CALENDAR BOX MARGARET SULLIVAN, \$127,664; RONALD J. GUY, YEAR 2013 WHICH WAS INCLUDED IN EACH INDIVIDUAL'S 2013 FORM W-2, \$626,036; JAN GABIN, ESQ., \$307,461 AND LINDA DITE, \$206,367; TAXABLE MEDICARE WAGES:

Page 3

Part III Supplemental Information Schedule J (Form 990) 2013

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

SCHEDULE J, PART I; QUESTION 4B

AMOUNTS OUTLINED HEREIN WERE NOT INCLUDED IN THESE INDIVIDUAL'S 2013 FORM SECTION 457(F) PLAN (NON-QUALIFIED DEFERRED COMPENSATION PLAN) WHICH ARE INDIVIDUALS MAY NEVER ACTUALLY RECEIVE THIS UNVESTED BENEFIT AMOUNT. THE \$13,950; EUGENE W. GROCHALA, \$64,878; HORTON, \$12,320; NATHAN BOSK, FACHE, SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. ACCORDINGLY, INDIVIDUALS INCLUDES UNVESTED BENEFITS IN AN INTERNAL REVENUE CODE PH.D., FACHE, \$8,310; LARRY DISANTO, \$312,286; ROBERT THE DEFERRED COMPENSATION AMOUNT IN COLUMN C FOR THE FOLLOWING REMSTEIN, D.O., \$15,606; GREGORY N. D'ADAMO, \$53,001; J. SCOTT \$12,439; DENNIS DOOLEY, \$46,689 AND ARLENE WALSH, \$8,041. W-2, BOX 5 AS TAXABLE MEDICARE WAGES: AL MAGHAZEHE, FLEMING, CPA, CLEMMENSEN, \$53,300; EILEEN M. STEPHEN A. MILLER, J.D., \$456,551; SHANE F.

5A SCHEDULE J, PART I; QUESTION CERTAIN INDIVIDUALS INCLUDED IN SCHEDULE J, PART II RECEIVED INCENTIVE

COMPENSATION PAYMENTS DURING CALENDAR YEAR 2013 WHICH INCENTIVE

Part | Supplemental Information

Complete this part to 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.

INDIVIDUALS. PLEASE REFER TO THIS SECTION OF THE FORM 990, SCHEDULE J FOR COMPENSATION PAYMENTS WERE INCLUDED IN COLUMN'B (II) HEREIN AND IN EACH 5, AS TAXABLE MEDICARE WAGES. THESE INCENTIVE COMPENSATION PAYMENTS WERE BASED UPON A NUMBER OF FACTORS ORGANIZATION FOR PROFESSIONAL PHYSICIAN SERVICES RENDERED BY THESE INCLUDING PRODUCTIVITY, PERFORMANCE AND REVENUES COLLECTED BY THE THIS INFORMATION BY PERSON BY AMOUNT INDIVIDUAL'S 2013 FORM W-2, BOX

PART I; QUESTION 7 ٦ , SCHEDULE

TAXABLE MEDICARE WAGES. THESE INCENTIVE AWARDS WERE GIVEN PURSUANT TO THE AWARDS DURING CALENDAR YEAR 2013 WHICH INCENTIVE AWARDS WERE INCLUDED IN ORGANIZATION'S 2013 INCENTIVE COMPENSATION PLAN ("ICP"), APPROVED BY THE AS WELL CERTAIN INDIVIDUALS INCLUDED IN SCHEDULE J, PART II RECEIVED INCENTIVE PRE-ESTABLISHED 5, AS MEETING OR EXCEEDING SPECIFIC PERFORMANCE ON "CIRCUIT BREAKERS" BOX SYSTEM-WIDE AND BUSINESS UNIT PERFORMANCE CRITERIA AND METRICS, HEREIN AND IN EACH INDIVIDUAL'S 2013 FORM W-2, BOARD COMPENSATION COMMITTEE, BASED ON ACHIEVEMENT OF COLUMN B (II)

Page 3

Schedule J (Form 990) 2013

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

THE ICP IS AN EXTREMELY ROBUST INCENTIVE PLAN AND IS AN INTEGRAL

COMPONENT OF CAPITAL'S EXECUTIVE COMPENSATION PACKAGE. THE BOARD

COMPENSATION COMMITTEE USES THE ICP AS A MECHANISM TO REWARD PERFORMANCE

AGAINST ESTABLISHED KEY PERFORMANCE REQUIREMENTS, WHILE MAINTAINING

APPROPRIATE SAFEGUARDS. THE GOALS COVER FINANCIAL AND OPERATIONAL METRICS

AND ARE DEFINED EACH YEAR, BASED ON THE DESIRED CONCENTRATION REQUIRED BY

THE COMMITTEE. THE COMMITTEE UNDERTAKES A QUARTERLY REVIEW OF PERFORMANCE

TOWARDS ACHIEVEMENT OF EACH GOAL, WHICH ALLOWS THE BOARD TO MAINTAIN

COMPLETE KNOWLEDGE OF HOW KEY PROJECTS ARE BEING HANDLED AND TO MAKE

ADJUSTMENTS, IF NECESSARY.

PLEASE REFER TO THIS SECTION OF THE FORM 990, SCHEDULE J FOR THIS

INFORMATION BY PERSON BY AMOUNT.

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SCHEDULE L

(Form 990 or 990-EZ)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b

OMB No 1545-0047

2013

Department of the Treasury Internal Revenue Service ►II		ach to Form 9	90 or I	Form 9		e sepa	sa or 40b. rate instructions. s is at www.irs gov/fori	m990.		Ō	pen To specti	Public	
Name of the organization							En	nployer	identif	ication	numbe	er .	
CAPITAL HEALTH SYST									-354	8695	5		
Part I Excess Benefit Complete if the c	Transaction a rganization a	ns (section 5 inswered "Ye	01(c) s" on	(3) an Form	d section 501 990, Part IV	l (c)(4) , line 2	organizations only) 5a or 25b, or Form) 990-E	EZ, Pa	art V, I	line 40)b	
1 (a) Name of disqualifie	d person	(b) Relation			en disqualified	person	(c) Descr	iption	of tran	sactio	n		Correcte S N
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organization rep (a) Name of interested person	(b) Relationship	(c) Purpose of	(d) Lo	an lo or	(e) Origin	al	(f) Balance due	(g) In	default?	(h) Ap	proved		
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·			То	From				Yes	No	Yes	No	Yes	No
(1) ALEXANDER GLADNEY ESQ	OFFICER	RETENTION	<u> </u>	X	190,		95,000.	1	X	Х		X	
(2) SHANE F FLEMING CPA	OFFICER	RETENTION	ļ	Х	350,	000.	350,000.	ļ	Х	Х	ļ	X	
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Part III Grants or Ass Complete if the	istance Ben	efiting Inter	reste	d Per	sons.		445,000.	· <u> </u>		<u> </u>			
(a) Name of interested person		ip between intered the organization		c) Amou	unt of assistance	(d	i) Type of assistance		(e) l	Purpos	se of a	ssistand	æ:
(1)													
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(10) For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule L (Form 990 or 990-EZ) 2013

(9)

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28	Complete if the	organization ar	nswered "Yes'	on Form 990	. Part IV	 Ine 28a, 28b, or 28 	SC.
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(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	organ	anng of zation's nues?
				Yes	No
(1) MERCER MEDICAL ASSOCIATES, P.A	TRUSTEE, SUDHAKAR	209,167	MEDICAL SERVICES		х
(2) WILLIS OF NEW YORK, INC	TRUSTEE, FAM MEMBER CO	1,096,343	INSURANCE SERVICES		х
(3) RONA H REMSTEIN	SPOUSE OF OFFICER	117,519	EMPLOYEE		x
(4) BAHRAM MAGHAZEHE	BROTHER OF TRUSTEE/OFF	87,642	EMPLOYEE		Х
(5) KATHLEEN M SULLIVAN	DAUGHTER OF OFFICER	58,637	EMPLOYEE		х
(6) PEDIATRIX MEDICAL GROUP, P.A	TRUSTEE, AXELROD	500,000	MEDICAL SERVICES		х
(7)					
(8)				1	
(9)					
(10)					

Part V Supplemental Information

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

SCHEDULE L, PART IV

SAMUEL J. PLUMERI, JR. IS A TRUSTEE OF THE ORGANIZATION. THE ORGANIZATION UTILIZED THE SERVICES OF HIS FAMILY MEMBER'S COMPANY, WILLIS OF NEW YORK, INC., DURING 2013. TOTAL FEES PAID TO WILLIS OF NEW YORK, INC. IN 2013 WERE \$1,096,343. SERVICES WERE RENDERED AT FAIR MARKET VALUE RATES PURSUANT TO ARM'S LENGTH NEGOTIATIONS.

TELECHERY SUDHAKAR, M.D. IS A TRUSTEE OF THE ORGANIZATION. THE
ORGANIZATION UTILIZED THE SERVICES OF HIS COMPANY, MERCER MEDICAL
ASSOCIATES, P.A., DURING 2013. TOTAL FEES PAID TO MERCER MEDICAL
ASSOCIATES, P.A. IN 2013 WERE \$209,167. SERVICES WERE RENDERED AT FAIR
MARKET VALUE RATES PURSUANT TO ARM'S LENGTH NEGOTIATIONS.

RANDI A. AXELROD, M.D. IS A TRUSTEE OF THE ORGANIZATION. THE ORGANIZATION UTILIZED THE SERVICES OF HIS COMPANY, PEDIATRIX MEDICAL GROUP, P.A., DURING 2013. TOTAL FEES PAID TO PEDIATRIX MEDICAL GROUP, P.A. IN 2013 WERE \$500,000. SERVICES WERE RENDERED AT FAIR MARKET VALUE RATES PURSUANT TO ARM'S LENGTH NEGOTIATIONS.

SCHEDULE O (Form 990 or 990-EZ)

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.

OMB No 1545-0047

2013

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

CAPITAL HEALTH SYSTEM, INC

Employer identification number 22-3548695

FORM 990, PART X; BALANCE SHEET

THIS FORM 990 IS BEING AMENDED TO REFLECT CERTAIN BALANCE SHEET RECLASSIFICATIONS AND A CHANGE IN A RELATED SCHEDULE O ATTACHMENT.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

BACKGROUND

CAPITAL HEALTH SYSTEM, INC. ("CAPITAL HEALTH") OPERATES A MULTI-HOSPITAL HEALTHCARE SYSTEM WHICH PROVIDES SUBSTANTIAL COMMUNITY BENEFIT THROUGH THE PROVISION OF A COMPREHENSIVE SPECTRUM OF HEALTHCARE SERVICES TO THE RESIDENTS OF NEW JERSEY AND SURROUNDING COMMUNITIES. CAPITAL HEALTH IS RECOGNIZED BY THE IRS AS AN INTERNAL REVENUE CODE SECTION 501(C)(3)

TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, CAPITAL HEALTH PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. MOREOVER, THE HOSPITALS OPERATE CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

1) CAPITAL HEALTH PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUAL'S REGARDLESS OF ABILITY TO PAY;

- 2) CAPITAL HEALTH OPERATES EMERGENCY DEPARTMENTS AT BOTH OF ITS HOSPITAL CAMPUSES; REGIONAL AND HOPEWELL; WHICH ARE OPEN 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;
- 3) CAPITAL HEALTH MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;
- 4) CONTROL OF CAPITAL HEALTH RESTS WITH ITS BOARD OF DIRECTORS; WHICH IS COMPRISED OF INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY; AND
- 5) SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE, PROGRAMS AND ACTIVITIES.

WITH OVER A CENTURY OF SERVICE TO THE GREATER MERCER AND BUCKS COUNTY AREAS, CAPITAL HEALTH IS COMPRISED OF 494 BEDS, EMPLOYS APPROXIMATELY 4,500 INDIVIDUALS, AND GENERATES OVER 563 MILLION DOLLARS IN ANNUAL NET PATIENT SERVICE REVENUE. CAPITAL HEALTH REGIONAL MEDICAL CENTER AND CAPITAL HEALTH MEDICAL CENTER - HOPEWELL ARE SEPARATELY LICENSED ACUTE CARE HOSPITALS WITH 271 AND 223 BEDS; RESPECTIVELY.

CAPITAL HEALTH ALSO OPERATES A NEW KIND OF HEALTHCARE CENTER THAT PUTS FAMILY PHYSICIANS AND SPECIALISTS, STATE-OF-THE-ART TECHNOLOGIES, AND

SAME-DAY SURGICAL SERVICES ALL IN ONE LOCATION. CAPITAL HEALTH IN HAMILTON, LOCATED AT 1445 WHITEHORSE-MERCERVILLE ROAD, AND SPANNING 46,293 SQUARE FEET, CREATES A "MEDICAL MALL" WHERE PATIENTS CAN SEEK A HOST OF SERVICES SUCH AS OUTPATIENT SURGERY, RADIOLOGICAL TESTING AND SPECIALIZED CARE.

THE FAMILY HEALTH CENTER AT CAPITAL HEALTH IS LOCATED AT 433 BELLEVUE

AVENUE IN TRENTON. THE 14,000 SQUARE FOOT LOCATION HELPS TO REDUCE

PATIENT WAIT TIME AND EXPEDITE THE REGISTRATION PROCESS.

THE HENRY J. AUSTIN HEALTH CENTER-BELLEVUE LOCATED AT THE FAMILY HEALTH CENTER ALSO PROVIDES COMPREHENSIVE PRIMARY CARE FOR FAMILIES, INCLUDING EVALUATIONS AND SAME-DAY SICK APPOINTMENTS FOR ADULTS AND CHILDREN, AND PATIENTS HAVE ACCESS TO LOWER COST PRESCRIPTIONS, SOCIAL SERVICE AND PATIENT NAVIGATION.

CAPITAL HEALTH IS GUIDED BY ITS DEDICATION TO THE HEALTHCARE NEEDS OF THE COMMUNITIES THAT IT SERVES. THAT LEVEL OF DETERMINATION AND COMMITMENT IS THE VERY SOUL OF CAPITAL HEALTH. CAPITAL HEALTH PROVIDES HEALTHCARE SERVICES TO ALL PERSONS IN A NON-DISCRIMINATORY MANNER, REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGINS OR ABILITY TO PAY. MOREOVER, CAPITAL HEALTH PROVIDES HEALTHCARE SERVICES TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY, AS DEFINED BY THE NEW JERSEY STATE ATTORNEY GENERAL, WITHOUT CHARGE OR AT AMOUNTS LESS THAN ESTABLISHED RATES. CAPITAL HEALTH MAINTAINS RECORDS TO IDENTIFY AND

CAPITAL HEALTH SYSTEM, INC

Employer identification number

MONITOR THE AMOUNT OF CHARITY CARE IT PROVIDES. THESE RECORDS INCLUDE THE AMOUNT OF CHARGES FOREGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS CHARITY CARE POLICY.

MISSION STATEMENT

CAPITAL HEALTH IS COMMITTED TO PROVIDING COMPREHENSIVE, QUALITY
HEALTHCARE SERVICES, WHICH IMPROVE AND SUSTAIN THE HEALTH STATUS OF THE
RESIDENTS PRIMARILY IN CENTRAL NEW JERSEY AND LOWER BUCKS COUNTY,
PENNSYLVANIA. CAPITAL HEALTH ASSURES ACCESSIBLE, COMPASSIONATE HEALTHCARE
SERVICES THAT HONOR THE DIGNITY OF EVERY PERSON. CAPITAL HEALTH WILL BE A
LEADER IN DEFINING THE COMMUNITY'S HEALTHCARE NEEDS, IN PROVIDING
APPROPRIATE SOLUTIONS, AND DEVELOPING A COMPREHENSIVE CONTINUUM OF CARE
INCLUDING EDUCATION, PREVENTION, DISEASE MANAGEMENT AND RESTORATIVE
PROGRAMS.

AWARDS AND RECOGNITION

CAPITAL HEALTH HAS RECENTLY RECEIVED THE FOLLOWING AWARDS AND RECOGNITIONS:

- JOINT COMMISSION ADVANCED CERTIFICATION FOR COMPREHENSIVE STROKE
CENTER

CAPITAL HEALTH SYSTEM, INC

Employer identification number

- JOINT COMMISSION DISEASE SPECIFIC CERTIFICATION FOR HIV/AIDS
- JOINT COMMISSION DISEASE SPECIFIC CERTIFICATION FOR STROKE
- JOINT COMMISSION DISEASE SPECIFIC CERTIFICATION FOR RESPIRATORY
 DISTRESS IN PRETERM INFANTS

MAGNET RE-DESIGNATION

THE AMERICAN NURSES CREDENTIALING CENTER (ANCC) HAS RECOGNIZED CAPITAL HEALTH'S EXEMPLARY NURSING LEADERSHIP AND QUALITY PATIENT CARE BY AWARDING ITS MAGNET RECOGNITION FOR EXCELLENCE IN NURSING SERVICE. MAGNET STATUS IS THE HIGHEST LEVEL OF RECOGNITION THE ANCC CAN EXTEND TO A HEALTHCARE ORGANIZATION.

2013 AWARDS AND ACCREDITATIONS

- CAPITAL HEALTH MEDICAL CENTER-HOPEWELL WAS NAMED A 2012 TOP PERFORMER
ON KEY QUALITY MEASURES BY THE JOINT COMMISSION FOR EXEMPLARY PERFORMANCE
IN USING EVIDENCE-BASED PROCESSES TO IMPROVE CARE FOR STROKE, HEART
ATTACK, HEART FAILURE AND SURGICAL CARE.

CAPITAL HEALTH SYSTEM, INC

Employer identification number

- ONE OF ONLY TWO HOSPITALS IN THE COUNTRY RECERTIFIED WITH
 DISEASE-SPECIFIC CARE CERTIFICATION IN RESPIRATORY DISTRESS SYNDROME IN
 PRETERM INFANTS FROM THE JOINT COMMISSION.
- OUR MARJORIE G. ERNEST JOINT REPLACEMENT CENTER OF EXCELLENCE AT

 CAPITAL HEALTH MEDICAL CENTER-HOPEWELL RECEIVED DISEASE-SPECIFIC CARE

 CERTIFICATION FOR TOTAL JOINT HIP REPLACEMENT FROM THE JOINT COMMISSION.
- CAPITAL HEALTH REGIONAL MEDICAL CENTER WAS ONE OF THE FIRST TWO
 HOSPITALS IN NEW JERSEY TO RECEIVE ADVANCED CERTIFICATION AS A
 COMPREHENSIVE STROKE CENTER FROM THE JOINT COMMISSION.
- THE BRISTOL-MYERS SQUIBB TRAUMA CENTER AT CAPITAL HEALTH REGIONAL MEDICAL CENTER WAS REVERIFIED AS A LEVEL II TRAUMA CENTER BY THE COMMITTEE ON TRAUMA (COT) OF THE AMERICAN COLLEGE OF SURGEONS (ACS).
- COMPREHENSIVE CENTER FOR BREAST CARE WAS ACCREDITED BY THE NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS.
- CHEST PAIN CENTER ACCREDITATION FROM THE SOCIETY OF CARDIOVASCULAR PATIENT CARE (SCPC).

JOINT COMMISSION'S GOLD SEAL OF APPROVAL

Employer identification number

THE JOINT COMMISSION IS AN INDEPENDENT, NOT-FOR-PROFIT, NATIONAL BODY
THAT OVERSEES THE SAFETY AND QUALITY OF HEALTHCARE AND OTHER SERVICES
PROVIDED IN ACCREDITED ORGANIZATIONS. BY AWARDING CAPITAL HEALTH THEIR
GOLD SEAL OF APPROVAL, THE JOINT COMMISSION CONFIRMED THAT CAPITAL HEALTH
IMPROVED THE ACCURACY OF PATIENT IDENTIFICATION, IMPROVED THE
EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS, AND IMPROVED THE SAFETY
OF USING MEDICATIONS. IN ADDITION, THE JOINT COMMISSION CONFIRMED THAT
CAPITAL HEALTH REDUCED THE RISK OF HEALTHCARE-ASSOCIATED INFECTIONS,
ACCURATELY AND COMPLETELY RECONCILE MEDICATIONS ACROSS THE CONTINUUM OF
CARE, REDUCED THE RISK OF PATIENT HARM RESULTING FROM FALLS, ENCOURAGED
PATIENTS' ACTIVE INVOLVEMENT IN THEIR OWN CARE AS A PATIENT SAFETY
STRATEGY, AND CAPITAL HEALTH IDENTIFIED SAFETY RISKS INHERENT IN THE

STATEMENT FOR COMMUNITY HEALTH IMPROVEMENT & BENEFITS

TO PROMOTE WELLNESS, PREVENT ILLNESS, AND REMOVE BARRIERS THAT HINDER ACCESS TO HEALTHCARE BY WORKING HAND-IN-HAND WITH THE COMMUNITIES SERVED.

PRINCIPLES

- CAPITAL HEALTH BELIEVES THAT COMMUNITY HEALTH IMPROVEMENT IS ESSENTIAL

Employer identification number

TO THE CAPITAL HEALTH MISSION.

- CAPITAL HEALTH BELIEVES COMMUNITY-BASED COALITIONS ARE UNIQUELY
 QUALIFIED TO ACHIEVE COMMUNITY HEALTH GOALS, AND CAPITAL HEALTH VALUES
 PARTNERSHIPS WITH THEM.
- CAPITAL HEALTH VALUES EVIDENCE-BASED PRACTICES AND SEEKS TO MODEL EXCELLENCE IN COMMUNITY HEALTH PRACTICE BASED ON EVIDENCE.
- CAPITAL HEALTH BELIEVES IN APPLYING CONTINUOUS QUALITY IMPROVEMENT TO COMMUNITY HEALTH: MEASURING NEED, MATCHING RESOURCES TO NEED, MEASURING OUTCOMES, AND MAKING ADJUSTMENTS IN PROCESSES.

OPERATIONAL VALUES

- INTEGRITY: ADHERES TO AN APPROPRIATE AND EFFECTIVE SET OF CORE BELIEFS INCLUDING HONESTY AND SERVING THE GREATER GOOD. DOES NOT BLAME OTHERS FOR HIS OR HER OWN MISTAKES OR MISREPRESENT HIM OR HER FOR PERSONAL GAIN OR PROTECTION. PERCEIVED BY OTHERS AS A DIRECT, TRUTHFUL INDIVIDUAL AND IS WIDELY TRUSTED, WITH THE ABILITY TO PRESENT THE TRUTH IN AN APPROPRIATE AND HELPFUL MANNER.
- EXCELLENCE: PROVIDES THE MOST EFFICIENT AND EFFECTIVE WORK PROCESSES TO MEET THE NEEDS OF PATIENTS AND OTHER CUSTOMERS, WHICH LEADS TO THE

CAPITAL HEALTH SYSTEM, INC

Employer identification number

HIGHEST QUALITY SERVICES. MAKES SOUND DECISIONS BASED UPON KNOWLEDGE,
JUDGMENT, AND EXPERIENCE, AND IS SOUGHT OUT BY OTHERS FOR ADVICE AND
SOLUTIONS TO ISSUES AND PROBLEMS.

- COMPASSION: DEMONSTRATES CARING AND CONCERN FOR THE WELFARE OF OTHERS,
 ASSISTING WHEREVER NECESSARY. USES UNDERSTANDING AND INSIGHT WHEN DEALING
 WITH PATIENTS OR OTHER CUSTOMERS IN ALL ASPECTS OF CARE OR SERVICE
 DELIVERY.
- TEAMWORK: DISPLAYS A PROFESSIONAL AND COLLABORATIVE SPIRIT IN
 FULFILLING RESPONSIBILITIES AND ASSISTING OTHERS. HELPS TO CREATE AND
 MAINTAIN POSITIVE MORALE WITH HIS OR HER TEAM, SHARING IN SUCCESSES,
 WORKING THROUGH PROBLEMS. FOSTERS OPEN DIALOGUE, AND WORKS TOWARDS
 CREATING AN ATMOSPHERE WHERE OUTCOMES AND SUCCESS ARE BENEFICIAL TO THE
 TEAM AND/OR THE ORGANIZATION AT LARGE.

VISION-

CAPITAL HEALTH WILL BE THE PREMIER COMMUNITY-BASED HEALTHCARE PROVIDER IN NEW JERSEY. CAPITAL HEALTH WILL CONSTANTLY STRIVE TO SUSTAIN THE HIGHEST PROFESSIONAL QUALITY STANDARDS, TO EXCEED EXPECTATIONS OF THOSE SERVED AND TO PROMOTE A POSITIVE WORK ENVIRONMENT. CAPITAL HEALTH'S SUCCESS WILL BE BUILT UPON CARING, COMPASSION, CREATIVITY, INTEGRITY, RESPECT, SERVICE, AND TEAMWORK.

CAPITAL HEALTH SYSTEM, INC

Employer identification number

SERVICE CULTURE INITIATIVE

CAPITAL HEALTH IS DEDICATED TO HIGH QUALITY PERFORMANCE AND TO EXCEEDING CUSTOMER EXPECTATIONS WITHIN A SUPPORTIVE AND FRIENDLY ENVIRONMENT. EACH EMPLOYEE HAS A RESPONSIBILITY AND IS ACCOUNTABLE FOR PROVIDING OPTIMUM SATISFACTION TO THE PATIENTS AND THEIR FAMILIES, PHYSICIANS AND COWORKERS.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

SERVICE CULTURE INITIATIVE VISION STATEMENT

- CAPITAL HEALTH COMMITS TO THE NEEDS OF THE COMMUNITY SERVED. THROUGH EXCELLENT SERVICE AND CARE, CAPITAL HEALTH ACHIEVES SUCCESSFUL PATIENT OUTCOMES.
- CAPITAL HEALTH ADHERES TO A STANDARD OR POSITIVE BEHAVIOR. THIS MUST INCLUDE POSITIVE FIRST IMPRESSIONS, APPROPRIATE COMMUNICATION,

 PROFESSIONAL APPEARANCE AND THE REALIZATION THAT THEY ARE DEALING WITH PEOPLE'S LIVES.
- CAPITAL HEALTH CREATES AN ENVIRONMENT CONDUCIVE TO POSITIVE
 RELATIONSHIPS. BY HAVING EFFICIENT AND EFFECTIVE SYSTEMS, CAPITAL HEALTH

CAPITAL HEALTH SYSTEM, INC

Employer identification number

IMPROVES QUALITY CARE AND SERVICE DELIVERY.

- CAPITAL HEALTH ACCEPTS THE CHALLENGE OF SERVICE CULTURE IMPROVEMENT AS A BUSINESS STRATEGY. IT IS NOT ONLY THE NICE THING TO DO, BUT THE RIGHT THING TO DO TO ASSURE THE GROWTH OF CAPITAL HEALTH.
- CAPITAL HEALTH RECOGNIZES EXCELLENT SERVICE CULTURE PERFORMANCE.

FEATURED SERVICES

DIABETES SERVICES

DIABETES CARE AT CAPITAL HEALTH IS AN OUTPATIENT COMPREHENSIVE REFERRAL BASED DIABETES EDUCATION PROGRAM THAT EMPOWERS PATIENTS TO TAKE CONTROL IN THE SUCCESSFUL MANAGEMENT OF THEIR DISEASE. CAPITAL HEALTH'S EDUCATION MODEL, WHERE THE PATIENT IS THE CENTRAL PLAYER, IS WIDELY RECOGNIZED AS THE BEST MODEL TO USE TO HELP THE PATIENT ACHIEVE OPTIMAL HEALTH RELATED OUTCOMES. CAPITAL HEALTH WORKS CLOSELY WITH PRIMARY CARE PHYSICIANS WHO CONTINUE TO MONITOR EACH INDIVIDUAL'S MEDICAL PROBLEMS.

EMERGENCY SERVICES

Employer identification number

THE BRISTOL-MYERS SOUIBB TRAUMA CENTER, THE LEVEL II TRAUMA CENTER AT CAPITAL HEALTH - REGIONAL MEDICAL CENTER, IS ONE OF ONLY 10 DESIGNATED TRAUMA CENTERS IN NEW JERSEY. CAPITAL HEALTH PROVIDES COMPREHENSIVE CARE FROM THE TIME OF INJURY THROUGH REHABILITATION. THE TRAUMA CENTER MEETS HIGH NATIONAL STANDARDS FOR PATIENT CARE AND TEACHING. THE TRAUMA CENTER IS A NEW JERSEY STATE DESIGNATED TRAUMA CENTER. THE DESIGNATION PROCESS INVOLVES DETAILED REGULAR INSPECTIONS BY NATIONAL AND STATE ORGANIZATIONS TO ASSURE HIGH STANDARDS OF CARE. CAPITAL HEALTH IS THE REGIONAL REFERRAL CENTER FOR INJURED PATIENTS IN MERCER COUNTY AND ADJACENT PARTS OF SOMERSET, HUNTERDON, BURLINGTON, AND MIDDLESEX COUNTIES AS WELL AS NEARBY AREAS OF PENNSYLVANIA. DESIGNATED TRAUMA CENTERS CARE FOR SEVERELY INJURED PATIENTS AS WELL AS VICTIMS OF ACCIDENT TYPES KNOWN TO BE ASSOCIATED WITH A HIGH RISK FOR INJURY. TRAUMA PATIENTS INCLUDE PERSONS INVOLVED IN MOTOR VEHICLE CRASHES, FALLS, AND ASSAULTS WITH KNIVES, GUNS, OR BLUNT OBJECTS. TRAUMA CENTERS HAVE THE LATEST TECHNOLOGY AND EXPERIENCED STAFF AVAILABLE TO CARE FOR YOUR FAMILY MEMBER. BESIDES PROVIDING CARE TO THE INJURED, TRAUMA CENTERS ARE ALSO ACTIVE PARTNERS WITH THE COMMUNITY IN INJURY PREVENTION AND PUBLIC EDUCATION.

MATERNITY

FROM ROUTINE DELIVERIES TO HIGH-RISK NEEDS, CAPITAL HEALTH'S GREAT EXPECTATIONS PROGRAM PROVIDES A FULL RANGE OF PRENATAL, OBSTETRICAL, POSTPARTUM, AND NEONATAL CARE OPTIONS TO MAKE SURE YOUR NEW FAMILY HAS

CAPITAL HEALTH SYSTEM, INC

Employer identification number

THE GREATEST CHANCE FOR A HEALTHY BEGINNING. THE MATERNITY UNIT AT CAPITAL HEALTH REGIONAL MEDICAL CENTER IS MERCER COUNTY'S ONLY REGIONAL PERINATAL CENTER AND THE ONLY LEVEL III NEONATAL INTENSIVE CARE UNIT.

CAPITAL HEALTH IS THE ONLY HEALTHCARE PROVIDER IN THE REGION TO HAVE
IN-HOUSE COVERAGE BY OBSTETRICIANS, MIDWIVES, NEONATOLOGISTS, AND
ANESTHESIOLOGISTS 24 HOURS A DAY, SEVEN DAYS A WEEK. AND, CAPITAL HEALTH
WAS CHOSEN AS NEW JERSEY'S FIRST SITE TO HOUSE A MARCH OF DIMES FAMILY
SUPPORT PROGRAM. THE PROGRAM PROVIDES INFORMATION AND EMOTIONAL SUPPORT
TO FAMILIES OF CRITICALLY ILL NEWBORNS BEING CARED FOR IN THE NEONATAL
INTENSIVE CARE UNIT.

ALSO, COMPREHENSIVE CHILDBIRTH AND PARENT EDUCATION SERVICES ARE OFFERED TO HELP PREPARE INDIVIDUALS TO BE THE BEST PARENTS POSSIBLE BY TEACHING ABOUT THE PROCESS OF BIRTH AND HOW TO CARE FOR THEIR INFANTS.

INSTITUTE FOR NEUROSCIENCES

THE CAPITAL INSTITUTE FOR NEUROSCIENCES, SUPPORTED BY CAPITAL HEALTH HOSPITALS IN BOTH TRENTON AND HOPEWELL, AND WITH OUTPATIENT OFFICES IN THE MEDICAL OFFICE BUILDING ATTACHED TO CAPITAL HEALTH MEDICAL CENTER - HOPEWELL, HAS ADVANCED THE LEVEL OF CARE AVAILABLE TO PATIENTS IN THE REGION. PROVIDING COMPREHENSIVE, STATE-OF-THE-ART DIAGNOSTICS AND TREATMENTS FOR A WIDE RANGE OF MEDICAL CONDITIONS INVOLVING THE BRAIN,

SPINE AND NERVOUS SYSTEM, THE INSTITUTE'S HIGHLY TRAINED PHYSICIANS

INCLUDE BOARD-CERTIFIED AND FELLOWSHIP-TRAINED SPECIALISTS, AND AMONG
THEM ARE FOUR OF ONLY A VERY SELECT NUMBER OF DUAL-TRAINED NEUROSURGEONS
IN THE NATION. AT THE CAPITAL HEALTH INSTITUTE, PATIENTS BENEFIT FROM A
MULTI-DISCIPLINARY TEAM OF SPECIALISTS WHICH CAN INCLUDE NEUROLOGISTS,
NEUROSURGEONS, AND OTHER SPECIALIZED PHYSICIANS, AS WELL AS
ANESTHESIOLOGISTS, PHYSICIAN ASSISTANTS, CRITICAL CARE NURSES, NURSE
ANESTHETISTS, SPEECH PATHOLOGISTS, TECHNICIANS, PHYSICAL AND OCCUPATIONAL
THERAPISTS, SOCIAL WORKERS, AND OTHER CRITICAL TEAM MEMBERS WHO PROVIDE
AN OUTSTANDING CONTINUUM OF CARE FROM DIAGNOSIS TO TREATMENT AND RECOVERY
AT CAPITAL HEALTH. THE INSTITUTE, LED BY NEUROSURGEON DR.
EROLVEZNEDAROGLU, INCLUDES MANY SPECIALIZED CENTERS OF CARE INCLUDING THE
STROKE AND CEREBROVASCULAR CENTER OF NJ, KNOWN AS A CENTER OF EXCELLENCE
TO REFERRING PHYSICIANS AS WELL AS PATIENTS AND THEIR FAMILIES.

AMONG THE CONDITIONS TREATED:

- STROKE AND TRANSIENT ISCHEMIC ATTACKS
- CAROTID STENOSIS
- ANEURYSM
- ARTERIOVENOUS MALFORMATIONS (AVMS)
- CHIARI MALFORMATIONS
- TRAUMATIC BRAIN INJURY
- TUMORS OF THE BRAIN AND SPINE BOTH MALIGNANT AND BENIGN AND INCLUDING SCHWANNOMAS, MENINGIOMAS, NEUROFIBROMAS, PITUITARY, PINEAL, SKULL BASE,

CAPITAL HEALTH SYSTEM, INC

Employer identification number

GLIOMAS AND OTHERS

- SPINAL DISEASES AND INJURIES SUCH AS HERNIATED DISCS,

 SPONDYLOLISTHESIS, SPINAL COMPRESSION FRACTURES AND SPINAL VASCULAR

 MALFORMATIONS
- DEGENERATIVE DISEASES AND SPINAL TRAUMA
- NEUROLOGIC CONDITIONS INCLUDING DEMENTIA, MUSCLE AND MOVEMENT DISORDERS, NERVE DISORDERS AND HEADACHES
- MOVEMENT DISORDERS, PARKINSON'S, ESSENTIAL TREMOR, ATYPICAL PARKINSON'S (MULTISYSTEM ATROHY, PROGRESSIVE SUPRANUCLEAR PALSY, AND CORTICOBASILAR DEGENERATION), DYSTONIA, ATAXIA AND SPASTICITY
- PEDIATRIC NEUROLOGY, INCLUDING DEVELOPMENTAL DELAYS, AUTISM,
 NEUROMETABOLIC AND GENETIC DISORDERS, AND ATTENTION DEFICIT DISORDERS
- ACUTE AND CHRONIC PAIN, INCLUDING PAIN FROM SPINAL STENOSIS, NERVE DISORDERS, CANCER, FIBROMYALGIA, SCIATICA, MIGRAINES, TRIGEMINAL MEURALGIA, MYOFACIAL, SHINGLES AND OTHER CONDITIONS
- EPILEPSY
- MOVEMENT LIMITATIONS DUE TO STROKE, ARTHRITIS, INJURY, AMPUTATION, OR OTHER CONDITIONS

CENTER FOR DIGESTIVE HEALTH

THE CAPITAL HEALTH CENTER FOR DIGESTIVE HEALTH IS ADVANCING THE LEVEL OF CARE AVAILABLE TO PATIENTS IN THE REGION BY PROVIDING COMPREHENSIVE,

STATE-OF-THE-ART DIAGNOSTICS AND TREATMENTS FOR A WIDE RANGE OF MEDICAL

CONDITIONS INVOLVING THE ENTIRE DIGESTIVE SYSTEM ALL IN ONE LOCATION. THE CENTER'S HIGHLY TRAINED AND SPECIALIZED PHYSICIANS UTILIZE CUTTING-EDGE TECHNOLOGY TO DELIVER OUTSTANDING CARE.

THE CENTER'S MEDICAL DIRECTOR IS A FELLOWSHIP-TRAINED AND BOARD-CERTIFIED GASTROENTEROLOGIST WITH YEARS OF EXPERIENCE WHO HELPS PATIENTS AND THEIR REFERRING DOCTORS NAVIGATE THE CENTER AND ACCESS THE APPROPRIATE SPECIALIST OR SURGEON FOR THE ADVANCED TESTING OR CARE REQUIRED. THE CENTER'S MEDICAL STAFF INCLUDES THE REGION'S PRE-EMINENT MEDICAL EXPERT IN INTERVENTIONAL GASTROENTEROLOGY AND THERAPEUTIC ENDOSCOPY, WHO HAS UNMATCHED EXPERIENCE USING ADVANCED DIAGNOSTIC TECHNIQUES SUCH AS ENDOSCOPIC ULTRASOUND (EUS) AND NON-SURGICAL TREATMENTS SUCH AS ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP), RADIOFREQUENCY ABLATION (BARRX), ENDOSCOPIC MUCOSAL RESECTION (EMR), AND ENTERAL STENT PLACEMENT. IF SURGERY IS AN OPTION, THE CENTER HAS DIRECT ACCESS TO A ROSTER OF HIGHLY TRAINED LAPAROSCOPIC (MINIMALLY INVASIVE) SURGEONS, INCLUDING THE AREA'S ONLY HEPATOBILIARY SURGEON WHO SPECIALIZES IN ADVANCED LAPAROSCOPIC PROCEDURES OF THE LIVER, PANCREAS, AND BILE DUCTS.

CENTER FOR ONCOLOGY

CAPITAL HEALTH HAS CONSISTENTLY OFFERED PATIENTS A CLOSELY INTEGRATED
TEAM OF MEDICAL, SURGICAL, RADIATION, AND ALLIED CANCER SPECIALISTS WHO

USE THEIR KNOWLEDGE AND EXPERIENCE TO PROVIDE CUTTING-EDGE CANCER TREATMENT CLOSE TO HOME.

WHEN ONE CHOOSES CAPITAL HEALTH FOR CANCER CARE, ONE SELECTS BOARD

CERTIFIED PHYSICIANS WHO REMAIN WITH THE PATIENT FROM DIAGNOSIS THROUGH

TREATMENT. WORKING TOGETHER, CAPITAL HEALTH OFFERS A COMPASSIONATE

APPROACH TO ASSIST PATIENTS WITH EVERY ASPECT OF CANCER CARE, INCLUDING

SCREENING, DIAGNOSIS, TREATMENT, RECOVERY, AND SURVIVORSHIP.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

THE CAPITAL HEALTH CENTER FOR ONCOLOGY IS COMMITTED TO PROVIDING

COMPREHENSIVE QUALITY ONCOLOGY HEALTHCARE SERVICES, TO HELP IMPROVE AND

SUSTAIN THE HEALTH STATUS OF RESIDENTS LIVING PRIMARILY IN CENTRAL NEW

JERSEY AND LOWER BUCKS COUNTY. CAPITAL HEALTH STRIVES TO IMPROVE AND

EXTEND THE QUALITY OF LIFE FOR THE PATIENT WITH CANCER. THE CANCER CENTER

IS A LEADER IN DEFINING THE COMMUNITY'S CANCER CARE NEEDS BY PROVIDING

APPROPRIATE PLANS THROUGH A COMPREHENSIVE CONTINUUM OF CARE, WHICH

INCLUDES EDUCATION, PREVENTION, SCREENING, DIAGNOSIS, TREATMENT, SYMPTOM

MANAGEMENT, SUPPORTIVE CARE AND SURVIVORSHIP PROGRAMS. CAPITAL HEALTH'S

SUCCESS WILL BE BUILT UPON CARE, COMPASSION, CREATIVITY, INTEGRITY,

RESPECT, SERVICE, STATE-OF-THE-ART TECHNOLOGY AND MULTIDISCIPLINARY

TEAMWORK.

PEDIATRICS

Name of the organization

CAPITAL HEALTH SYSTEM, INC

Employer identification number

CAPITAL HEALTH MEDICAL CENTER - HOPEWELL IS HOME TO THE ONLY IN-PATIENT PEDIATRIC UNIT IN MERCER COUNTY. CAPITAL HEALTH'S PEDIATRIC EMERGENCY SERVICE IS COMPLETELY SEPARATE FROM THE ADULT EMERGENCY DEPARTMENT AND IS STAFFED BY PEDIATRIC SPECIALISTS. THE PEDIATRIC HOSPITALIST PROGRAM GIVES PEDIATRIC PATIENTS AND THEIR PHYSICIANS AROUND-THE-CLOCK ACCESS TO IN-HOUSE PEDIATRICIANS.

RADIOLOGY SERVICES

CAPITAL HEALTH HAS AN ABUNDANCE OF THE MOST STATE-OF-THE-ART RADIOLOGY

SERVICES IN THE REGION. AS THE REGION'S LEADER IN DIAGNOSTIC AND

TREATMENT TECHNOLOGY, CAPITAL HEALTH OFFERS FULL-TIME, ONSITE PET SCAN

TECHNOLOGY AND RECENTLY BECAME THE FIRST HOSPITAL IN THE COUNTRY TO OFFER

A MOLECULAR BREAST IMAGING DEVICE AT CAPITAL HEALTH MEDICAL REGIONAL

CENTER-HOPEWELL.

FULL-SERVICE IMAGING SUITES AT ALL CAPITAL HEALTH LOCATIONS BOAST THE MOST ADVANCED EQUIPMENT AVAILABLE, INCLUDING LOW DOSE, MULTI-SLICE DUAL ENERGY CT SCANNERS AND LARGE BORE MAGNETIC RESONANCE IMAGING (MRI)

MACHINES THAT FEATURES THE SHORTEST HIGH-FIELD MAGNET IN THE INDUSTRY RANGING FROM A 1.5 TO A 3.0 TESLA AND FUNCTIONAL MRI CAPABILITY.

SLEEP CENTER

CAPITAL HEALTH HAS BEEN PROVIDING COMPREHENSIVE EVALUATION AND TREATMENT FOR SLEEP RELATED PROBLEMS FOR MORE THAN 20 YEARS AND CAPITAL HEALTH WAS THE FIRST IN MERCER COUNTY. AT THE PRESENT TIME, CAPITAL HEALTH IS THE LARGEST FULLY ACCREDITED SLEEP CENTER IN MERCER AND BUCKS COUNTIES.

BETWEEN BOTH CAMPUSES, CAPITAL HEALTH OFFERS FOURTEEN PRIVATE ROOMS DEDICATED TO SLEEP TESTING FOR PATIENTS WHO HAVE A WIDE VARIETY OF PROBLEMS RELATED TO SLEEP AND WAKEFULNESS.

AS SLEEP CENTERS FULLY ACCREDITED BY THE AMERICAN ACADEMY OF SLEEP MEDICINE, CAPITAL HEALTH ENSURES THAT ALL PATIENTS TREATED AT CAPITAL HEALTH BENEFIT FROM A COMPLETE SLEEP EVALUATION AND INDIVIDUALIZED TREATMENT PLAN.

DEFINITION OF COMMUNITY AND POPULATION SERVED

CAPITAL HEALTH DEFINES ITS COMMUNITY AS THE CITY OF TRENTON, MERCER
COUNTY AND PARTS OF BURLINGTON, MONMOUTH, MIDDLESEX AND BUCKS COUNTIES.
WHILE IT WAS ONCE A CENTER FOR INDUSTRY IN THE LATE 1800'S AND EARLY
1900'S, TRENTON HAS SEEN DRAMATIC ECONOMIC DEVELOPMENT CHALLENGES OVER
THE YEARS. ACCORDING TO THE 2010 U.S. CENSUS, ITS MEDIAN HOUSEHOLD INCOME
WAS \$36,727, BY FAR THE LOWEST IN MERCER COUNTY. BASED ON A POPULATION OF
84,349, TRENTON ALSO HAS THE HIGHEST NUMBER AND PERCENTAGE OF MINORITIES

IN MERCER COUNTY WITH A PREDOMINANTLY AFRICAN-AMERICAN POPULATION OF 43,861 RESIDENTS OR 52.0 PERCENT. HISPANICS OR LATINOS OF ANY RACE CONSTITUTED 28,425 RESIDENTS OR 33.7 PERCENT, WHILE CAUCASIANS WERE NUMBERED AT 22,436 OR 26.6 PERCENT.

COMMUNITY BENEFITS PROGRAMS

OUTLINED BELOW ARE A NUMBER OF CAPITAL HEALTH COMMUNITY BENEFIT PROGRAMS.

THE INFORMATION IS NOT INTENDED TO BE ALL-INCLUSIVE BUT RATHER PROVIDES

ADDITIONAL INFORMATION THAT FURTHER DEMONSTRATES HOW CAPITAL HEALTH

BENEFITS THE SURROUNDING COMMUNITY IN FURTHERANCE OF ITS CHARITABLE

TAX-EXEMPT PURPOSES.

CAPITAL HEALTH CHILDBIRTH AND PARENT EDUCATION PROGRAM

BENEFIT ACTIVITY: PREPARED CHILDBIRTH CLASSES IN SPANISH LANGUAGE

THE CHILDBIRTH AND PARENT EDUCATION PROGRAM PROVIDES, FREE OF CHARGE, A FULL-DAY PREPARED CHILDBIRTH CLASS TO SPANISH-SPEAKING EXPECTANT PARENTS FROM THEIR COMMUNITY. THE CLASS IS HELD EVERY OTHER MONTH AND IS TAUGHT BY A CAPITAL HEALTH CERTIFIED CHILDBIRTH AND PARENT EDUCATOR WHO IS FLUENT IN SPANISH. CULTURALLY APPROPRIATE METHODS AND AUDIO-VISUAL MATERIALS ARE UTILIZED IN THE TEACHING OF THIS CLASS. PARTICIPANTS

RECEIVE FREE BREAKFAST AND LUNCH. PARTICIPANTS RECEIVE SPANISH LANGUAGE REFERENCE MATERIALS AND AN EXTENSIVE HANDBOOK. REFERRALS TO THIS CLASS COME FROM THE CAPITAL HEALTH, HEALTH START PRENATAL CLINIC, A COMMUNITY PARTNERSHIP WITH CUNA, AND BY WORD-OF-MOUTH.

LACTATION SERVICES

IN 2012, CAPITAL HEALTH MEDICAL CENTER-HOPEWELL WAS DESIGNATED AS A BABY FRIENDLY HOSPITAL, THE SECOND HOSPITAL IN NEW JERSEY TO ATTAIN THIS STATUS. AS A BABY FRIENDLY HOSPITAL, CAPITAL HEALTH FOCUSES ON THE ENTIRE OBSTETRIC POPULATION. IN 2013, CAPITAL HEALTH DEMONSTRATED AN OVERALL 82 PERCENT BREASTFEEDING INITIATION RATE AND A 57 PERCENT AVERAGE EXCLUSIVE BREASTFEEDING RATE. EXCLUSIVITY FOR BREASTFEEDING MOTHERS ONLY WAS HIGHER AT AN AVERAGE 66 PERCENT RATE.

CAPITAL HEALTH START CLINIC BREASTFEEDING RATES WERE COMPARABLE TO THE OVERALL OBSTETRIC POPULATION DUE TO ADDITIONAL EDUCATIONAL PROGRAMS AND ONE-TO-ONE SUPPORT WITH INCREASES IN SERVICES INCLUDING PRENATAL GROUP CENTERING AND COLLABORATIVE EFFORTS BETWEEN CAPITAL HEALTH AND SPECIFIC COMMUNITY ORGANIZATIONS DIRECTED TOWARD THIS VULNERABLE POPULATION.

FOCUSED PROGRAMS SUCH AS CHILDREN'S FUTURE AND WOMEN'S INFANTS AND CHILDREN (WIC) HAVE BEEN INSTRUMENTAL TO ITS DEMONSTRATED SUCCESS.

TRAUMA EDUCATION

Name of the organization

CAPITAL HEALTH SYSTEM, INC

Employer identification number

THE BRISTOL-MYERS TRAUMA CENTER AT CAPITAL HEALTH REGIONAL MEDICAL CENTER OFFERS FREE INJURY PREVENTION PROGRAMS TO MEMBERS OF THE COMMUNITY THAT INCLUDE PEDESTRIAN SAFETY, BICYCLE SAFETY, SEAT BELT SAFETY, PROPER USE OF CHILD SAFETY SEATS, AND HOME SAFETY.

CONNECTING WITH THE LATINO COMMUNITY

ENLACE ("LINK" IN SPANISH) IS A NAME FOR AN INNOVATIVE CAPITAL HEALTH
PROGRAM DESIGNED TO CREATE CONTACTS AND CONNECTIONS WITHIN THE LATINO
COMMUNITY. THROUGH ENLACE, CAPITAL HEALTH PROVIDES MEDICAL INTERPRETING
AND HAS TRANSLATED ALL VITAL MEDICAL DOCUMENTS AND ARE NOW DOING THE SAME
WITH PATIENT EDUCATION MATERIALS. ENLACE ALSO HELPS EDUCATE THE LATINO
COMMUNITY ABOUT AMERICAN CUSTOMS AND HEALTHCARE PRACTICES AND PROVIDES
CAPITAL HEALTH STAFF WITH INFORMATION ABOUT LATINO CULTURES. ANOTHER
PROGRAM, CUNA (WHICH IS SPANISH FOR "CRIB"), CONNECTS LATINO WOMEN WITH
PRE- AND POST-NATAL CARE, AND HELPS NEW MOTHERS OVERCOME LANGUAGE
BARRIERS TO BETTER UNDERSTAND HEALTH ISSUES. CUNA ALSO OFFERS HELP WITH
NUTRITION, COPING SKILLS AND EVEN BABYSITTING FOR OLDER CHILDREN.

COMMUNITY HEALTH EDUCATION

CAPITAL HEALTH'S COMMUNITY HEALTH EDUCATION PROGRAM IS DEDICATED TO
IMPROVING THE HEALTH AND WELL-BEING OF THE COMMUNITY, AS WELL AS TO THE
PREVENTION AND EARLY DETECTION OF DISEASE AMONG PEOPLE LIVING IN OUR
COMMUNITY. THESE GOALS ARE ACCOMPLISHED BY PROVIDING HEALTH EDUCATION AND
OTHER RELATED SERVICES TO THE GENERAL PUBLIC, AS WELL AS TO BUSINESS
ORGANIZATIONS. THESE SERVICES CONSIST OF THE SPEAKER'S BUREAU, HEALTH
FAIRS/HEALTH SCREENINGS, HEALTH EDUCATION LECTURE SERIES AND SUPPORT
GROUPS, HEALTH INFORMATION CENTER, WELLNESS SPA, AND A PARTNERSHIP WITH
THE MERCER COUNTY TOBACCO QUIT CENTER. PROGRAMS ARE HELD IN VARIOUS
LOCATIONS THROUGHOUT MERCER AND BUCKS COUNTIES, WITH TOPICS INCLUDING
DIABETES EDUCATION, PERIPHERAL VASCULAR DISEASE AWARENESS, HEALTHY
EATING, CANCER GENETICS, AND WOMEN'S HEALTH ISSUES.

THE COMMUNITY HEALTH EDUCATION PROGRAM PROVIDES A SERIES OF DIVERSE

HEALTH EDUCATION PROGRAMS, RELATED TO HEALTH MAINTENANCE, DISEASE

PREVENTION, EARLY DETECTION, GENERAL WELLNESS AND PERSONAL DEVELOPMENT. A

SCHEDULE OF THE PROGRAMS, SCREENINGS AND SUPPORT GROUPS MAY BE VIEWED

ONLINE AT: WWW.CAPITALHEALTH.ORG/EVENTS.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

COMMUNITY SPONSORSHIPS

CAPITAL HEALTH IS PROUD TO SPONSOR MANY LOCAL ORGANIZATIONS IN MERCER AND BUCKS COUNTIES THROUGH IN-KIND AND MONETARY DONATIONS. CAPITAL HEALTH

Name of the organization

CAPITAL HEALTH SYSTEM, INC

Employer identification number

SUPPORTS A VARIETY OF CIVIC AND CULTURAL ORGANIZATIONS THAT WORK TO IMPROVE THE WELLBEING OF THE COMMUNITY.

CONCLUSION

CAPITAL HEALTH IS A NON-PROFIT ORGANIZATION THAT HAS AN "OPEN DOOR"

POLICY. THIS POLICY MEANS THAT CAPITAL HEALTH PROVIDES NECESSARY BASIC

HOSPITAL CARE TO EVERYONE, REGARDLESS OF THEIR ABILITY TO PAY FOR THEIR

CARE.

CAPITAL HEALTH IS COMMITTED TO COMMUNITY OUTREACH AND EDUCATION, OFFERING NUMEROUS HEATH CARE RELATED PROGRAMS AND ACTIVITIES, INCLUDING COMMUNITY HEALTH FAIRS, HEALTH SCREENINGS, HEALTH EDUCATION AND MEDICAL LECTURES AND SEMINARS ANNUALLY. CAPITAL HEALTH IS PROUD OF THEIR MANY PARTNERSHIPS WITH LOCAL ORGANIZATIONS.

TO FURTHER SHOW HOW CAPITAL HEALTH IS COMMITTED TO BENEFITING ITS

COMMUNITY, CAPITAL HEALTH, IN NOVEMBER 2011, OPENED ITS \$530 MILLION

223-BED HOSPITAL IN HOPEWELL TOWNSHIP, NEW JERSEY TO REPLACE ITS EXISTING

FACILITY, CAPITAL HEALTH - MERCER, IN TRENTON, NEW JERSEY.

IN ADDITION, CAPITAL HEALTH REGIONAL MEDICAL CENTER IN TRENTON UNDERWENT

A COMPLETE RENOVATION. CAPITAL HEALTH OBTAINED A MORTGAGE LOAN THROUGH

THE FEDERAL HOUSING ADMINISTRATION WHICH ENABLED IT TO LOWER ITS COST OF

CREDIT. THIS WILL ALLOW CAPITAL HEALTH TO USE MORE OF ITS RESOURCES TO SERVE THE MEDICAL NEEDS OF ITS COMMUNITY.

CORE FORM, PART III; QUESTION 4D

EXPENSES INCURRED IN PROVIDING VARIOUS OTHER MEDICALLY NECESSARY
HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER
REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR
ABILITY TO PAY. PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT
STATEMENT INCLUDED IN SCHEDULE O.

CORE FORM, PART VI, SECTION B; QUESTION 11B

THE ORGANIZATION IS THE TAX-EXEMPT PARENT ENTITY OF CAPITAL HEALTH SYSTEM AND AFFILIATES ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. THE ORGANIZATION'S FEDERAL FORM 990 WAS PROVIDED TO EACH VOTING MEMBER OF ITS GOVERNING BODY (ITS BOARD OF TRUSTEES) PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE ("IRS"). IN ADDITION THE CAPITAL HEALTH SYSTEM, INC. COMPENSATION COMMITTEE PERFORMED A DETAILED REVIEW OF THE FEDERAL FORM 990 PRIOR TO PROVIDING IT TO EACH VOTING MEMBER OF ITS BOARD OF TRUSTEES. THE CAPITAL HEALTH SYSTEM, INC. BOARD OF TRUSTEES HAS DELEGATED TO THE COMPENSATION COMMITTEE THE RESPONSIBILITY TO OVERSEE AND COORDINATE THE FEDERAL FORM 990 PREPARATION, REVIEW AND FILING PROCESS FOR THE TAX-EXEMPT AFFILIATES OF THE SYSTEM.

AS PART OF THE ORGANIZATION'S FEDERAL FORM 990 TAX RETURN PREPARATION

PROCESS THE ORGANIZATION HIRED A PROFESSIONAL CPA FIRM WITH EXPERIENCE AND EXPERTISE IN BOTH HEALTHCARE AND NOT-FOR-PROFIT TAX RETURN PREPARATION TO PREPARE THE FEDERAL FORM 990. THE CPA FIRM'S TAX PROFESSIONALS WORKED CLOSELY WITH THE ORGANIZATION'S GENERAL COUNSEL, CHIEF FINANCIAL OFFICER, CHIEF COMPLIANCE OFFICER AND VARIOUS OTHER INDIVIDUALS OF THE SYSTEM TO OBTAIN THE INFORMATION NEEDED IN ORDER TO PREPARE A COMPLETE AND ACCURATE TAX RETURN.

THE CPA FIRM PREPARED A DRAFT FEDERAL FORM 990 AND FURNISHED IT TO THE ORGANIZATION'S INTERNAL WORKING GROUP, INCLUDING, BUT NOT LIMITED TO, THOSE INDIVIDUALS OUTLINED ABOVE, FOR THEIR REVIEW. THE ORGANIZATION'S INTERNAL WORKING GROUP AND OTHER INDIVIDUALS REVIEWED THE DRAFT FEDERAL FORM 990 AND DISCUSSED QUESTIONS AND COMMENTS WITH THE CPA FIRM. IN ADDITION, THE ORGANIZATION'S EXTERNAL INDEPENDENT COMPENSATION CONSULTING FIRM REVIEWED THE DRAFT FEDERAL FORM 990, PART VII AND SCHEDULE J. REVISIONS WERE MADE TO THE DRAFT FEDERAL FORM 990 WHERE NECESSARY AND A FINAL DRAFT WAS FURNISHED BY THE CPA FIRM TO THE ORGANIZATION'S INTERNAL WORKING GROUP AND VARIOUS OTHER INDIVIDUALS FOR FINAL REVIEW AND APPROVAL PRIOR TO PRESENTATION OF THE FEDERAL FORM 990 TO THE MEMBERS OF THE CAPITAL HEALTH SYSTEM, INC. COMPENSATION COMMITTEE. FOLLOWING THE COMPENSATION COMMITTEE'S REVIEW THE FINAL FEDERAL FORM 990 WAS PROVIDED TO EACH VOTING MEMBER OF THE ORGANIZATION'S GOVERNING BODY PRIOR TO FILING WITH THE IRS.

CORE FORM, PART VI, SECTION B; QUESTION 12

THE ORGANIZATION IS THE TAX-EXEMPT PARENT ENTITY OF CAPITAL HEALTH SYSTEM AND AFFILIATES ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. THE ORGANIZATION AND THE SYSTEM REGULARLY MONITOR AND ENFORCE COMPLIANCE WITH ITS CONFLICT OF INTEREST POLICY. ANNUALLY ALL MEMBERS OF THE BOARD OF TRUSTEES, OFFICERS AND SENIOR MANAGEMENT PERSONNEL ARE REQUIRED TO REVIEW THE EXISTING CONFLICT OF INTEREST POLICY AND COMPLETE A QUESTIONNAIRE. THE COMPLETED QUESTIONNAIRES ARE RETURNED TO THE ORGANIZATION AND BOTH THE SYSTEM'S GENERAL COUNSEL AND CHIEF COMPLIANCE OFFICER FOR REVIEW. THEREAFTER THE CHIEF COMPLIANCE OFFICER PREPARES A SUMMARY OF THE COMPLETED QUESTIONNAIRES WHICH CONTAINS INFORMATION DISCLOSED ON AN INDIVIDUAL BY INDIVIDUAL BASIS. THE SYSTEM'S CHIEF COMPLIANCE OFFICER THEN PRESENTS THIS SUMMARY TO THE SYSTEM'S FULL BOARD OF TRUSTEES FOR ITS REVIEW AND DISCUSSION. THIS SUMMARY IS UPDATED BY THE CHIEF COMPLIANCE OFFICER ON A QUARTERLY BASIS.

CORE FORM, PART VI, SECTION B; QUESTION 15

THE ORGANIZATION'S BOARD OF TRUSTEES HAS A BOARD COMPENSATION COMMITTEE

("COMMITTEE"). THE COMMITTEE HAS ADOPTED A WRITTEN EXECUTIVE COMPENSATION

PHILOSOPHY WHICH IT FOLLOWS WHEN IT REVIEWS AND APPROVES OF THE

COMPENSATION AND BENEFITS OF ALL OF THE ORGANIZATION'S SENIOR MANAGEMENT

AND OTHERS, INCLUDING THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL

OFFICER AND OTHER OFFICERS OF THE ORGANIZATION, PHYSICIANS, AND ANY OTHER

DISINTERESTED PERSONS. IT ALSO REVIEWS AND APPROVES EMPLOYMENT

AGREEMENTS FOR THE COVERED EMPLOYEES AND DISINTERESTED PERSONS. THE

COMMITTEE REVIEWS THE "TOTAL COMPENSATION" OF THE INDIVIDUALS WHICH IS

INTENDED TO INCLUDE BOTH CURRENT AND DEFERRED COMPENSATION AND ALL EMPLOYEE BENEFITS, BOTH QUALIFIED AND NON-QUALIFIED. THE COMMITTEE'S REVIEW IS DONE ON AT LEAST AN ANNUAL BASIS AND ENSURES THAT THE "TOTAL COMPENSATION" OF SENIOR MANAGEMENT OF THE ORGANIZATION IS REASONABLE.

THE ACTIONS TAKEN BY THE COMMITTEE ENABLE THE ORGANIZATION TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS FOR PURPOSES OF INTERNAL REVENUE CODE SECTION 4958 WITH RESPECT TO THE TOTAL COMPENSATION OF THE SENIOR MANAGEMENT TEAM. REBUTTAL PRESUMPTION REQUIREMENTS HAVE GUIDED THE ACTIVITIES OF THE COMMITTEE IN ALL OF ITS REVIEWS, DELIBERATIONS AND APPROVAL OF EXECUTIVE COMPENSATION ACTIONS FOR ALL OF THE COVERED EMPLOYEES AND DISINTERESTED PERSONS. THE THREE FACTORS WHICH MUST BE SATISFIED IN ORDER TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS ARE THE FOLLOWING:

- 1. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY AN "AUTHORIZED BODY" OF THE APPLICABLE TAX-EXEMPT ORGANIZATION WHICH IS COMPOSED ENTIRELY OF INDIVIDUALS WHO DO NOT HAVE A "CONFLICT OF INTEREST" WITH RESPECT TO THE COMPENSATION ARRANGEMENT;
- 2. THE AUTHORIZED BODY OBTAINED AND RELIED UPON "APPROPRIATE DATA AS TO COMPARABILITY" PRIOR TO MAKING ITS DETERMINATION; AND
- 3. THE AUTHORIZED BODY "ADEQUATELY DOCUMENTED THE BASIS FOR ITS DETERMINATION" CONCURRENTLY WITH MAKING THAT DETERMINATION.

THE COMMITTEE IS COMPRISED OF MEMBERS OF THE BOARD OF TRUSTEES EACH OF WHO ARE INDEPENDENT AND ARE FREE FROM ANY CONFLICTS OF INTEREST.

THE COMMITTEE RELIED UPON DATA FROM COMPARABLE HEALTHCARE AND HOSPITAL PEERS IN NEW JERSEY AS WELL AS NEIGHBORING STATES BASED ON APPROPRIATE REVENUE, SERVICES, AND OVERALL FINANCIAL PERFORMANCE. IN ADDITION, SPECIFIC SALARY SURVEYS COVERING SIMILAR, REPRESENTATIVE HOSPITAL COMPENSATION DATA WAS USED. ALL DATA WAS WEIGHTED IN ARRIVING AT MARKET CONSENSUS FOR COVERED EMPLOYEE POSITIONS, IN ORDER TO ACCURATELY REFLECT THE RELEVANT LABOR MARKET.

CONTEMPORANEOUS MINUTES ARE COMPILED AND APPROVED OF ALL COMMITTEE

DELIBERATIONS. THESE ARE SUPPORTED BY THE WRITTEN DOCUMENTATION COVERING

ALL COMPENSATION STUDIES AND PLAN DOCUMENTS, AS WELL AS DETAILED

PERFORMANCE JUSTIFICATION USED AS THE BASIS FOR AWARDING OF ALL INCENTIVE

PROGRAMS.

REBUTTAL PRESUMPTION ACTIVITIES OF THE COMMITTEE COVER ALL MEMBERS OF SENIOR MANAGEMENT, AS WELL AS THE COMPENSATION AND CONTRACTS COVERING PHYSICIANS AND OTHER DISINTERESTED PERSONS, ALL OF WHICH ARE SUBJECT TO THE REVIEW AND APPROVAL OF THE COMMITTEE.

RECOGNIZING THE NEED TO CONSIDER RETIREMENT PLANNING FOR ITS SENIOR

MANAGEMENT AS A MEANS TO AID IN THEIR RETENTION, THE COMMITTEE UNDERTOOK

AND EXTENSIVE RESEARCH AND ANALYSIS OF ALTERNATIVE PROGRAMS, AND CREATED AND APPROVED A FORM OF LONG-TERM NON-QUALIFIED DEFERRED COMPENSATION (REFERRED TO AS THE "PERFORMANCE-BASED CAPITAL ACCUMULATION PLAN", OR "PBCAP"). THIS PLAN ALSO PROVIDES THE ORGANIZATION WITH AN ADDITIONAL TOOL TO ASSIST IN THE RECRUITING OF SENIOR MANAGEMENT WITHIN THE HIGHLY COMPETITIVE HEALTHCARE LABOR MARKET. THE PLAN PROVIDES SENIOR MANAGEMENT WITH THE OPPORTUNITY TO QUALIFY FOR ANNUAL DEFERRED CONTRIBUTIONS TO BE PAID AT RETIREMENT, BASED ON ACHIEVING SPECIFIED FINANCIAL PERFORMANCE TARGETS AND MEETING ESTABLISHED CIRCUIT BEAKERS. THIS PLAN COMPLIES WITH AND ADHERES TO ALL RELATED REGULATIONS, WITH AN EMPHASIS ON IRC SECTIONS 409A AND 457(F).

THE COMPENSATION AND BENEFITS OF CERTAIN OTHER INDIVIDUALS CONTAINED IN THIS FORM 990 ARE REVIEWED ANNUALLY BY THE PRESIDENT/CHIEF EXECUTIVE OFFICER WITH ASSISTANCE FROM ORGANIZATION'S HUMAN RESOURCES DEPARTMENT IN CONJUNCTION WITH THE INDIVIDUAL'S JOB PERFORMANCE DURING THE YEAR AND IS BASED UPON OTHER OBJECTIVE FACTORS DESIGNED TO ENSURE THAT REASONABLE AND FAIR MARKET VALUE COMPENSATION IS PAID BY THE ORGANIZATION. OTHER OBJECTIVE FACTORS INCLUDE MARKET SURVEY DATA FOR COMPARABLE POSITIONS, INDIVIDUAL GOALS AND OBJECTIVES, PERSONNEL REVIEWS, EVALUATIONS, SELF-EVALUATIONS AND PERFORMANCE FEEDBACK MEETINGS.

CORE FORM, PART VI, SECTION C; QUESTION 19

THE ORGANIZATION'S FILED CERTIFICATE OF INCORPORATION AND ANY AMENDMENTS

CAN BE OBTAINED AND REVIEWED THROUGH THE STATE OF NEW JERSEY DEPARTMENT

Employer identification number

OF THE TREASURY.

CORE FORM, PART VII AND SCHEDULE J

THE ORGANIZATION DOES NOT COMPENSATE ITS BOARD MEMBERS FOR THEIR SERVICES
PERFORMED AS A TRUSTEE. ALL TRUSTEES ARE VOLUNTEERS. COMPENSATION AND
BENEFITS, WHERE APPLICABLE FOR CERTAIN MEMBERS, IS RELATED TO THE BOARD
MEMBER'S SERVICES PERFORMED AS A FULL-TIME EMPLOYEE OR INDEPENDENT
CONTRACTOR OF THE ORGANIZATION.

CORE FORM, PART VII, SECTION A, COLUMN B

THIS ORGANIZATION IS THE TAX-EXEMPT PARENT ENTITY OF CAPITAL HEALTH
SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM
("SYSTEM"). THE SYSTEM INCLUDES BOTH FOR-PROFIT AND NOT FOR-PROFIT
ORGANIZATIONS. CERTAIN BOARD OF TRUSTEE MEMBERS, OFFICERS AND/OR
DIRECTORS LISTED ON CORE FORM, PART VII AND SCHEDULE J OF THIS FORM 990
MAY HOLD SIMILAR POSITIONS WITH BOTH THIS ORGANIZATION AND OTHER
AFFILIATES WITHIN THE SYSTEM. THE HOURS SHOWN ON THIS FORM 990, FOR BOARD
MEMBERS WHO RECEIVE NO COMPENSATION FOR SERVICES RENDERED IN A NON-BOARD
CAPACITY, REPRESENT THE ESTIMATED HOURS DEVOTED PER WEEK FOR THIS
ORGANIZATION. TO THE EXTENT THESE INDIVIDUALS SERVE AS A MEMBER OF THE
BOARD OF TRUSTEES OF OTHER RELATED ORGANIZATIONS IN THE SYSTEM, THEIR
RESPECTIVE HOURS PER WEEK PER ORGANIZATION ARE APPROXIMATELY ONE HOUR.
THE HOURS REFLECTED ON PART VII OF THIS FORM 990, FOR BOARD MEMBERS WHO
RECEIVE COMPENSATION FOR SERVICES RENDERED IN A NON-BOARD CAPACITY, PAID

Employer identification number

OFFICERS AND KEY EMPLOYEES, REFLECT TOTAL HOURS WORKED PER WEEK ON BEHALF OF CAPITAL HEALTH SYSTEM; NOT SOLELY THIS ORGANIZATION.

CORE FORM, PART XI; QUESTION 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES INCLUDE:

- PENSION-RELATED CHANGES OTHER THAN NET PERIODIC PENSION COST; \$5,513,000.

CORE FORM, PART XII; QUESTION 2

THE TAXPAYER IS THE TAX-EXEMPT PARENT ENTITY OF A TAX-EXEMPT, INTEGRATED HEALTHCARE DELIVERY SYSTEM. AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF THE TAXPAYER AND ALL AFFILIATES FOR THE YEARS ENDED DECEMBER 31, 2013 AND DECEMBER 31, 2012; RESPECTIVELY AND ISSUED A CONSOLIDATED FINANCIAL STATEMENT WITH CONSOLIDATING SCHEDULES BY ENTITY. AN UNQUALIFIED OPINION WAS ISSUED EACH YEAR BY THE INDEPENDENT CPA FIRM. THE TAXPAYER'S AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND THE SELECTION OF AN INDEPENDENT AUDITOR.

CORE FORM, PART XII; QUESTION 3

THE ORGANIZATION IS THE TAX-EXEMPT PARENT ENTITY OF CAPITAL HEALTH SYSTEM AND AFFILIATES ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY

Name of the organization CAPITAL HEALTH SYSTEM, INC Employer identification number

SYSTEM. THE SYSTEM ENGAGED AN INDEPENDENT ACCOUNTING FIRM TO PREPARE AND ISSUE A SYSTEM WIDE CONSOLIDATED A-133 AUDIT. THIS ORGANIZATION WAS INCLUDED IN THE SYSTEM WIDE A-133 AUDIT.

CHS DEPARTMENTAL EIN LISTING

THE ORGANIZATION'S FEDERAL FORM 990 INCLUDES CERTAIN REVENUE RECEIVED AND EXPENSES INCURRED BY VARIOUS CAPITAL HEALTH SYSTEM, INC. RELATED PROGRAMS, DEPARTMENTS, ACTIVITIES AND CAPITAL HEALTH SYSTEM, INC. EMPLOYEES. REVENUE EARNED FROM THESE PROGRAMS AND ACTIVITES WAS RECEIVED BY CAPITAL HEALTH SYSTEM, INC. UTILIZING DIFFERENT FEDERAL IDENTIFICATION NUMBERS OTHER THAN 22-3548695. BELOW IS A LIST OUTLINING THE VARIOUS CAPITAL HEALTH SYSTEM, INC. PROGRAMS, DIVISIONS, DEPARTMENTS AND PHYSICIAN EMPLOYEES AND THEIR RESPECTIVE FEDERAL IDENTIFICATION NUMBERS:

CAPITAL ENDOCRINOLOGY	20-1730017
CAPITAL HEALTH CLINICAL CARDIOLOGY	26-3519972
CAPITAL SURGICAL ASSOCIATES	22-3680051
CHS - DR. SCHELL	22-2234088
CHS INSTITUTE FOR NEUROSCIENCES	26-0346624
CHS INSTITUTE FOR NEUROSCIENCES ONCOLOGY	46-0622985
CHS PATHOLOGY	45-4742151
FAMILY HEALTH CENTER	22-3796256
HAMILTON PHYSICIANS GROUP	22-3502175
HPG AT BORDENTOWN FAMILY MEDICAL	22-3502175

Schedule O	(Form	990	or 990-	EZ\ 2013

Page 2

Name of the organization	Employer identification number
CAPITAL HEALTH SYSTEM, INC	
HEART CARE SPECIALISTS AT CH	27-0309548
MERCER MATERNAL FETAL SPECIALTY GROUP	20-2886402
MULTISPECIALTY PROVIDER GROUP	22-3628075
STROKE & CEREBROVASCULAR CENTER OF NEW JERSEY	26-3519824
TRENTON NEUROSURGEONS ASSOCIATES	22-2035924
WEST TRENTON MEDICAL ASSOCIATES	20-4643360
PEDIATRIC HOSPITALIST	27-2627834
EMERGENCY PHYSICIANS	27-2232524
REHABILITATION MEDICINE	27-3421189
SPINE CENTER	27-3421008
PLASTIC SURGERY	27-4510784
PRIMARY CARE MOUNTAINVIEW	27-3945093
PRIMARY CARE PENNINGTON	27-3945093
PRIMARY CARE QUAKERBRIDGE	27-3945093
RADIATION ONCOLOGY	27-1366819
HOSPITALIST GROUP	45-1501476
ADVANCED SURGICAL ASSOCIATES	27-4742615
CENTER FOR DIGESTIVE HEALTH	45-2073374
COMPREHENSIVE SLEEP ASSOCIATES	45-2074032
CAPITAL WOMEN'S HEALTH CENTER	27-2715382
CAPITAL HEALTH CENTER FOR LIVER DISEASE	46-3152708

Name of the organization

CAPITAL HEALTH SYSTEM, INC

Employer identification number

ATTACHMENT 1

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

THE ORGANIZATION IS COMMITTED TO PROVIDING COMPREHENSIVE, QUALITY HEALTHCARE SERVICES WHICH IMPROVE AND SUSTAIN THE HEALTH STATUS OF THE RESIDENTS PRIMARILY IN CENTRAL NEW JERSEY AND LOWER BUCKS COUNTY.

THE ORGANIZATION ASSURES ACCESSIBLE, COMPASSIONATE HEALTHCARE

SERVICES THAT HONOR THE DIGNITY OF EVERY PERSON. THE ORGANIZATION

WILL BE A LEADER IN DEFINING THE COMMUNITY'S HEALTHCARE NEEDS, IN

PROVIDING APPPROPRIATE SOLUTIONS, AND DEVELOPING A COMPREHENSIVE

CONTINUUM OF CARE INCLUDING EDUCATION, PREVENTION, DISEASE MANAGEMENT

AND RESTORATIVE PROGRAMS. PLEASE REFER TO THE ORGANIZATION'S

COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O.

ATTACHMENT 2

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
TRENTON ANESTHESIOLOGY ASSOC P.O. BOX 15321 NEWARK, NJ 07192	MEDICAL	8,976,753.
SODEXO MANAGEMENT INC P.O. BOX 360170 PITTSBURGH, PA 15251-6170	MANAGEMENT	5,591,632.
ARAMARK MANAGEMENT SERVICES 12483 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	MANAGEMENT	4,677,831.
EMERGENCY MEDICAL ASSOCIATES OF NJ PA 3 CENTURY DRIVE PARSIPPANY, NJ 07054	MEDICAL	3,301,650.
CAPITAL HEALTH ADVANCE IMAGING P.O. BOX 223887 PITTSBURGH, PA 15251-2887	MEDICAL	3,227,198.

Schedule O (Form 990 or 990-EZ) 2013 Name of the organization		Page 2 Employer identification number
CAPITAL HEALTH SYSTEM, INC		
FORM 990, PART VIII - INVESTMENT INCOME	<u>E</u>	ATTACHMENT 3
DESCRIPTION	(A) (B) TOTAL RELATED OR REVENUE EXEMPT REVENUE	(C) (D) UNRELATED EXCLUDED BUSINESS REV. REVENUE
INTEREST AND DIVIDEND INCOME	2,714,422.	2,714,422.
TOTALS	2,714,422.	2,714,422.
	<u>A</u>	TTACHMENT 4
FORM 990, PART X - PREPAID EXPENSES AND	D DEFERRED CHARGES	
DESCRIPTION	BEGINNING BOOK VALUE	ENDING BOOK VALUE
PREPAID INSURANCE	18,232,763.	15,586,175.
TOTALS	18,232,763.	15,586,175.
FORM 990, PART X - SECURED MORTGAGES AND LENDER: FHA/GNMA MORTGAGE LOAN ORIGINAL AMOUNT: 755,874,500. INTEREST RATE: 5.770000 DATE OF NOTE: 01/01/2009 MATURITY DATE: 01/01/2037 BEGINNING BALANCE DUE		750,042,224. 750,042,224.
	MENT & RELATED CONSTRUCTION	
BEGINNING BALANCE DUE		2,966,226. 2,159,945.
		-

Schedule O (Form 990 or 990-EZ) 2013 Page 2 Name of the organization Employer identification number CAPITAL HEALTH SYSTEM, INC ATTACHMENT 5 (CONT'D) LENDER: KEY EQUIPMENT FINANCE, INC. INTEREST RATE: 3.080000 DATE OF NOTE: 10/11/2011 MATURITY DATE: 10/11/2016 SECURITY PROVIDED: LEASED EQUIPMENT PURPOSE OF LOAN: CYBERKNIFE ROBOTIC RADIOSURGERY SYSTEM BEGINNING BALANCE DUE 2,960,895. ENDING BALANCE DUE 2,346,325.

TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE

755,969,345.

754,548,494.

SCHEDULE R (Form 990)

Internal Revenue Service Name of the organization Department of the Treasury

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

▶ Attach to Form 990.

▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990. ▼ See separate instructions.

OMB No 1545-00

Open to Public

Employer Identification number 22-3548695

CAPITAL HEALTH SYSTEM, INC

Part I	Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.	nswered "Yes" on F	orm 990, Part IV,	line 33.		
	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary aclivity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)			:			
(2)						
(4)	(4)					
-(5)						
-(6)						

								i
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.	Complete if the organe to tax year.	anization answer	ed "Yes" on Fo	rm 990, Part IV,	line 34 because i	t had	
	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state	(d) Exempt Code section	(e) Public chanty status	(f) Direct controlling	(g) Section 512(b)(13) controlled	(b)(13) ed
					(CVC)		Yes	No.
_(1) CAPIT 750 B	(1) CAPITAL HEALTH SYSTEM FOUNDATION, INC 22-2230681 750 BRUNSWICK AVENUE TRENTON, NJ 08638	SUPPORT CHS	ρN	501(C)(3)	509 (A) (1)	CH SYSTEM	 	
(2)								
(3)								
(4)								
(5)								
(6)								
For Paper	For Paperwork Reduction Act Notice, see the Instructions for Form 990.					Schedule F	Schedule R (Form 990) 2013) 2013

JSA 3E1307 1 000

Part III Identific

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.

	<u> </u>		!	l	I	l	1	ŀ	ı
	(k) Percentage ownership								
	(J) General or managing partner?	Š							
	(I) General or managing partner?	Yes No							
	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)								
	fforms	^o N							
	(h) Olsproporforate albeators?	Yes							
	(g) Share of end-of- year assets								
lax year.	(f) Share of total income								
rmership during me	(e) Predominant income (related, unrelated, excluded from taken sections 512-514)								
ilealed as a pa	(d) Direct controlling entity								
เกเรสแดกร	(c) Legal domicile (state or foreign								
nore related orga	(b) Primary activity								
because it had one or more related organizations treated as a partitle snip during the tax year.	(a) Name, address, and EIN of related organization		(1)	(2)	(3)		(5)	(9)	$(ar{\iota})$

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. Part IV

				יווים נשני למוני				
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile	(c) (d) Legal domicle Direct controlling	(e) Type of entity	(f) Share of total	(g) Share of	(h) Percen-	(i) Section
		(state or foreign country)		(C corp, S corp, or trust)	псоте	end-of-year assets		512(b)(13) controlled entity?
							_	Yes No
(1) BELLEVUE AVENUE MANAGEMENT, INC								
446 BELLEVUE AVENUE TRENTON, NJ 08618	MANAGEMENT	ĹΝ	N/A	C CORP				×
(2) CAPITAL REGION INSURANCE COMPANY 98-0656385	ī							ļ
P.O. BOX 1085 KY1-1108 GRAND CAYMAN, CJ	FINANCIAL VEHICLE	CJ	CH SYSTEM	FOREIGN CORP	2,118,769	35,997,902 100 0000	100 0000	×
(3) MERCER HOLDING CORPORATION								
446 BELLEVUE AVENUE TRENTON, NJ 08618	HOLDING CO	ŊĊ	CH SYSTEM	C CORP	6, 122, 339	3,399,437 100 0000	100 0000	×
(4) STROKE & CEREBROVASCULAR CENTER OF NJ	-							
750 BRUNSWICK AVENUE TRENTON, NJ 08638	HEALTHCARE SVCS	ŊĴ	CH SYSTEM	C CORP	9,388,528	3,089,692 100 0000	100 0000	×
(5) TREMION NEUROLOGICAL SURGEONS ASSOCIATES 22-2035924	- 1							
3100 PRINCETON PIKE LAWRENCEVILLE, NJ 08648	HEALTHCARE SVCS	ĹΝ	CH SYSTEM	C CORP	0	0	0 100 0000	×
(9)								
(\overline{L})								
					•	-		

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Schedule R (Form 990) 2013

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 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?	lated organizations liste	ed in Parts II-V?	Yes
			×
 d Loans or loan guarantees to or for related organization(s) e Loans or loan guarantees by related organization(s) 			- X X X X X X X X X X X X X X X X X X X
f Dwidends from related organization(s)			-
g Sale of assets to related organization(s)			
h Purchase of assets from related organization(s)			
Exchange of assets with related organization(s)			- i-
b lease of facilities equipment or other sesate from related organization(s)			. ×
Performance of services or membership or fundraising sol			
m Performance of services or membership or fundraising solicitations by related organization(s)			E t
			×
p Reimbursement paid to related organization(s) for expenses			1 p
			1 1 × ×
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	s line, including covere	ed relationships and trans	transaction thresholds.
Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(a) Method of determining amount involved
(1) MERCER HOLDING CORPORATION	ı.	727, 533.	COST
(2) CAPITAL HEALTH SYSTEM FOUNDATION, INC.	U	9,002,463.	COST
(3) CAPITAL HEALTH SYSTEM FOUNDATION, INC.	0	302, 497.	COST
(4)			
(9)			
(9)			
JSA 3E1309 1 000			Schedule R (Form 990) 2013

Schedule R (Form 990) 2013

Unrelated Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 37. Part VI 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 domicie (stale or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under	(e) Are all partners section 501(c)(3) organizations?	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate aflocations?	<u> </u>	(1) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	Gen	(J) General or menaging partner?	(k) Percentage ownership
(1)			section 512-514)	Yes			Yes	2		Yes	No.	
(2)												
(3)												
(4)												
(5)												
(9)												
(7)												
(8)												
(6)		-										
(10)												
(11)					3							
(12)												
(13)												
(14)												
(15)												
(16)												
JSA									Sche	dule	R (Form	Schedule R (Form 990) 2013

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Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see

SCHEDULE R. PART V

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



RENTAL INCOME Yes No Did you actively participate in the operation of the activity during the tax year? TYPE OF PROPERTY: REAL RENTAL INCOME	Taxpayer's Name <u>CAPITAL HEALTH S</u>	STEM, INC								ing Number 8695
TYPE OF PROPERTY: REAL RENT'AL INCOME	DESCRIPTION OF PROPERTY									
REAL RENTAL INCOME OTHER INCOME: RENTAL INCOME 1,710,824. IOTAL GROSS INCOME 1,710,824. DEPRECIATION (SHOWN BELOW) LESS: Beneficiary's Portion LESS: Beneficiary's Porti	Yes No Did you act	ively participate in the	e operation	of the ac	tivity d	during the tax year?				
1,710,824 1,71	TYPE OF PROPERTY:									
RENTAL INCOME 1,710,824. TOTAL GROSS INCOME 1,710,824. DITHER EXPENSES: DEPRECIATION (SHOWN BELOW) LESS: Beneficiary's Portion LESS: Benefi	REAL RENTAL INCOM	ME					L			
1,710,824.	OTHER INCOME:								-	
DEPRECIATION (SHOWN BELOW) LESS: Beneficiary's Portion LES	RENTAL INCOME						1,71	0,82	4.	
DEPRECIATION (SHOWN BELOW) LESS: Beneficiary's Portion LES	TOTAL GROSS INCOME								1	.710.824
DEPRECIATION (SHOWN BELOW) LESS: Beneficiary's Portion AMORTIZATION LESS: Beneficiary's Portion DEPLETION LESS: Beneficiary's Portion LESS: Beneficiary's Portion DEPLETION LESS: Beneficiary's Portion LESS: Bene		<u> </u>	<u> </u>					<u> </u>	••	7 1 1 0 1 0 2 1 .
LESS: Beneficiary's Portion LESS: Beneficiary's Portion DEPLETION LESS: Beneficiary's Portion TOTAL EXPENSES TOTAL RENT OR ROYALTY INCOME (LOSS) Less Amount to Rent or Royalty Depreciation Depletion Investment Interest Expense Other Expenses Net Income (Loss) to Others Net Rent or Royalty Income (Loss) Deductible Rental Loss (if Applicable) SCHEDULE FOR DEPRECIATION CLAIMED (a) Description of property (b) Cost or (c) Date ACRS Bus (d) (e) (f) Bass for (g) Depreciation (h) (i) Life or (j) Depreciation (g) Depreciation (h) (i) Life or (j) Depreciation (g) Depreciation (h) (i) Life or (j) Depreciation (ii) Depreciation (iv) Depreciati										
LESS: Beneficiary's Portion LESS: Beneficiary's Portion DEPLETION LESS: Beneficiary's Portion TOTAL EXPENSES TOTAL RENT OR ROYALTY INCOME (LOSS) Less Amount to Rent or Royalty Depreciation Depletion Investment Interest Expense Other Expenses Net Income (Loss) to Others Net Rent or Royalty Income (Loss) Deductible Rental Loss (if Applicable) SCHEDULE FOR DEPRECIATION CLAIMED (a) Description of property (b) Cost or (c) Date ACRS Bus (d) (e) (f) Bass for (g) Depreciation (h) (i) Life or (j) Depreciation (g) Depreciation (h) (i) Life or (j) Depreciation (g) Depreciation (h) (i) Life or (j) Depreciation (ii) Depreciation (iv) Depreciati										
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	(a) Description of property	' '		ACRS	Bus		ın	1	or	
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JSA

3E7000 1 000 - 8621II U600

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER INCOME

RENTAL INCOME

1,710,824. 1,710,824.

8621II U600

RENT AND ROYALTY SUMMARY

PROPERTY	TOTAL INCOME	DEPLETION/ DEPRECIATION	OTHER EXPENSES	ALLOWABLE NET <u>INCOME</u>
RENTAL INCOME	1,710,824.			1,710,824.
TOTALS	1,710,824.			1,710,824.

SCHEDULE D (Form 1041)

Department of the Treasury Internal Revenue Service Capital Gains and Losses

► Attach to Form 1041, Form 5227, or Form 990-T.

► Use Form 8949 to list your transactions for lines 1b, 2, 3, 8b, 9 and 10.

Information about Schedule D and its separate instructions is at www.irs.gov/form1041.

OMB No 1545-0092

2013

Name of estate or trust Employer identification number CAPITAL HEALTH SYSTEM, INC 22-3548695 Note: Form 5227 filers need to complete only Parts I and II Short-Term Capital Gains and Losses - Assets Held One Year or Less See instructions for how to figure the amounts to enter on (h) Gain or (loss) (g) Adjustments the lines below (d) Proceeds (e) Cost Subtract column (e) to gain or loss from Form(s) 8949, Part I, line 2, column (g) from column (d) and This form may be easier to complete if you round off cents (sales pnce) (or other basis) combine the result with column (q) to whole dollars. 1a Totals for all short-term transactions reported on Form 1099-B for which basis was reported to the IRS and for which you have no adjustments (see instructions). However, if you choose to report all these transactions on Form 8949, leave this line blank and go to line 1b 1b Totals for all transactions reported on Form(s) 8949 Totals for all transactions reported on Form(s) 8949 Totals for all transactions reported on Form(s) 8949 Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts 5 Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2012 Capital Loss 6 Net short-term capital gain or (loss). Combine lines 1a through 6 in column (h) Enter here and on Long-Term Capital Gains and Losses - Assets Held More Than One Year See instructions for how to figure the amounts to enter on (g) Adjustments (h) Gain or (loss) Subtract column (e) to gain or loss from Form(s) 8949, Part II, line 2, column (g) from column (d) and Proceeds Cost This form may be easier to complete if you round off cents (sales price) (or other basis) combine the result with column (a) to whole dollars 8a Totals for all long-term transactions reported on Form 1099-B for which basis was reported to the IRS and for which you have no adjustments (see instructions). However, if you choose to report all these transactions on Form 8949, leave this line blank and go to line 8b 8b Totals for all transactions reported on Form(s) 8949 8,987,362. 8,987,362. with Box D checked.......... Totals for all transactions reported on Form(s) 8949 Totals for all transactions reported on Form(s) 8949 Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824 11 Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts. 12 13 14 14 Long-term capital loss carryover Enter the amount, if any, from line 14 of the 2012 Capital Loss 15 Net long-term capital gain or (loss). Combine lines 8a through 15 in column (h). Enter here and on 8,987,362. 16

For Paperwork Reduction Act Notice, see the Instructions for Form 1041.

Schedule D (Form 1041) 2013

Sche	dule D (Form 1041) 2013				Page 2
Pa	rt III Summary of Parts I and II		(1) Beneficiaries'	(2) Estate's	
	Caution: Read the instructions before completing this pa	rt	(see instr)	or trust's	(3) Total
17	Net short-term gain or (loss)	17			
18	Net long-term gain or (loss):				
а		18a			8,987,362.
b		18b			
С		18c			
19	• • • • • • • • • • • • • • • • • • • •	19			8,987,362.
Note	⊇: If line 19, column (3), is a net gain, enter the gain on Form 1041, line 4 on the first of t	or Fo	orm 990-T, Part I, line 4	a) If lines 18a and	19, column (2), are net
nece	ssary	et ioss	s, сотрієте Рап IV and	the Capital Loss	Carryover Worksheet, as
Pa	rt IV Capital Loss Limitation				·
20	Enter here and enter as a (loss) on Form 1041, line 4 (or Form 990-T, Pa	art I, li	ine 4c, if a trust), the sn	naller of	
а	The loss on line 19, column (3) or b \$3,000			20 ()
NOTE Loss	: If the loss on line 19, column (3), is more than \$3,000, or if Form 1041, p Carryover Worksheet in the instructions to figure your capital loss carryover	oage	1, line 22 (or Form 990	0-T, line 34), is a lo	ss, complete the Capital
Pa					
	n 1041 filers. Complete this part only if both lines 18a and 19 in colu		2) are dains or an a	mount is entered	in Port Lor Port II and
ther	e is an entry on Form 1041, line 2b(2), and Form 1041, line 22, is more	thar	n zero	mount is entered	III Fait I OI Fait II and
	tion: Skip this part and complete the Schedule D Tax Worksheet in the ir				
	ther line 18b, col (2) or line 18c, col (2) is more than zero, or				
	oth Form 1041, line 2b(1), and Form 4952, line 4g are more than zero				
Forr	n 990-T trusts. Complete this part only if both lines 18a and 19 ar	e gai	ins, or qualified divid	lends are include	d in income in Part I
	orm 990-T, and Form 990-T, line 34, is more than zero. Skip this part a	and c	omplete the Schedu	le D Tax Worksh	eet in the instructions
	her line 18b, col (2) or line 18c, col (2) is more than zero				<u></u>
21	Enter taxable income from Form 1041, line 22 (or Form 990-T, line 34	4)	. 21		
22	Enter the smaller of line 18a or 19 in column (2)				
	but not less than zero				
23	Enter the estate's or trust's qualified dividends				
	from Form 1041, line 2b(2) (or enter the qualified				
	dividends included in income in Part I of Form 990-T)				
24	Add lines 22 and 23				
25	If the estate or trust is filing Form 4952, enter the				
	amount from line 4g, otherwise, enter -0 ▶ 25		→		
26	Subtract line 25 from line 24. If zero or less, enter -0				
27	Subtract line 26 from line 21. If zero or less, enter -0-				
28	Enter the smaller of the amount on line 21 or \$2,450				
29	Enter the smaller of the amount on line 27 or line 28				
30	Subtract line 29 from line 28 If zero or less, enter -0 This amount is t			▶ 30	
31	Enter the smaller of line 21 or line 26				
32	Subtract line 30 from line 26		. 32		
33	Enter the smaller of line 21 or \$11,950				
34	Add lines 27 and 30		. 34		
35	Subtract line 34 from line 33 If zero or less, enter -0				
36	Enter the smaller of line 32 or line 35				
37	Multiply line 36 by 15%			▶ 37	
38	Enter the amount from line 31				
39	Add lines 30 and 36				
40					
41	Multiply line 40 by 20%		1 1	► 41	····
42	Figure the tax on the amount on line 27 Use the 2013 Tax Rate Schedule for E		i i		
42	and Trusts (see the Schedule G instructions in the instructions for Form 1041).				
43	Add lines 37, 41, and 42		·		
44	Figure the tax on the amount on line 21. Use the 2013 Tax Rate Schedule for E				
A E	and Trusts (see the Schedule G instructions in the instructions for Form 1041).			'obodula	
45	Tax on all taxable income. Enter the smaller of line 43 or line 44 his				
	G, line 1a (or Form 990-T, line 36)	• • •	 		ulo D /Farm 4044) 2515
				Scheu	ule D (Form 1041) 2013

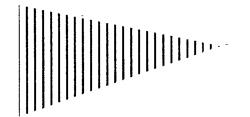
orm 8949 (2013) Name(s) shown on return. (Name and SSN or 1ax CAPITAL HEALTH SYSTEM, It		on no not required	if shown on other side)	l		achment Sequence No taxpayer identificat	
Most brokers issue their own substitute s he statement even if it is not reported to th he transactions for which basis was rep	he IRS Before orted to the I	re you check B RS Brokers ar	ox D, E, or F below re required to report	, determine whei t basis to the IRS	ther you receive I for most stock	d any statement(s you bought in 201) and, if so, 1 or later
Part II Long-Term. Transaction transactions, see page	ons involv	ing capital	assets you hel	d more than	one year ar	e long term.	For short-term
Note. You may aggree to the IRS and for whi you are not required to	gate all lo ich no adj	ustments o	r codes are req	juired. Enter i	the total dire		
ou must check Box D, E, or F beld a separate Form 8949, page 2, for emore of the boxes, complete as man X (D) Long-term transactions rep (E) Long-term transactions rep	each applicated on Footbed on Footbed on Footbed on Footbed on Footbed on Footbed	able box. If y h the same b orm(s) 1099- orm(s) 1099-	ou have more lo oox checked as y -B showing basis -B showing basis	ng-term transa ou need. was reported t	actions than w	rill fit on this pa	
(F) Long-term transactions not	reported t		m 1099-B	(e)	If you enter an a	ny, to gain or loss mount in column (g), le in column (f)	(h)
	(b) Date acquired Mo , day, уг)	(c) Date sold or disposed (Mo, day, yr)	(d) Proceeds (sales proce) (see instructions)	Cost or other basis See the Note below and see Column (e)		rate instructions.	Gain or (loss) Subtract column (e) from column (d) and combine the result
				in the separate instructions	Code(s) from instructions	Amount of adjustment	with column (g)
VARIOUS SECURITIES	/ARIOUS	VARIOUS	8,987,362.				8,987,362
				·			
	··- · · · · · · · · · · · · · · · · · ·						
			= -				
		-					
		_					
2 Totals. Add the amounts in colum (subtract negative amounts). Enterinctude on your Schedule D, line 8 checked), line 9 (if Box E above is (if Box F above is checked) ▶	er each tota Bb (if Box D	I here and above is	8,987,362.				8,987,362.

8,987,362. Note. If you checked Box D above but the basis reported to the IRS was incorrect, enter in column (e) the basis as reported to the IRS, and enter an adjustment in column (g) to correct the basis. See Column (g) in the separate instructions for how to figure the amount of the adjustment

CONSOLIDATED FINANCIAL STATEMENTS

Capital Health System, Inc. and Subsidiaries Years Ended December 31, 2013 and 2012 With Report of Independent Auditors

Ernst & Young LLP





Capital Health System, Inc. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2013 and 2012

Contents

Report of Independent Auditors	1
Consolidated Financial Statements	
Consolidated Balance Sheets	3
Consolidated Statements of Operations	4
Consolidated Statements of Changes in Net Assets	
Consolidated Statements of Cash Flows	
Notes to Consolidated Financial Statements	



Einst & Your di LLP 99 Whon Avenue South Motropalik P.O. Pox 751 Iselin, NJ (18830-047) Tel +1 732 516 4200 Fax -1 732 516 4429 ey com

Report of Independent Auditors

The Board of Directors Capital Health System, Inc.

We have audited the accompanying consolidated financial statements of Capital Health System, Inc. and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2013 and 2012, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of Capital Region Insurance Company (CRIC) a wholly-owned subsidiary, which statements reflect total assets of \$35,998,000 and \$37,866,000 as of December 31, 2013 and 2012, respectively, and total revenues of \$729,000 and \$1,913,000, for the years then ended. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for CRIC, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion.

An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of the other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Capital Health System, Inc. and Subsidiaries at December 31, 2013 and 2012, and the consolidated results of its operations, changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst + Young LLP

April 29, 2014

Capital Health System, Inc. and Subsidiaries

Consolidated Balance Sheets

	December 31 2013 2012				
Assets		(In The	usana		
Current assets: Cash and cash equivalents Short-term investments	\$	12,692 119,667	\$	14,278 126,294	
Assets whose use is limited – current portion Patient accounts receivable, net of allowance for doubtful accounts		3,432		3,967	
of \$38,643 in 2013 and \$41,568 in 2012		85,538		79,632	
Supplies		10,764		3,125	
Prepaid expenses and other current assets		13,718		18,659	
Total current assets		245,811		245,955	
Investments		6,522		7,980	
Assets whose use is limited – noncurrent portion		75,814		66,245	
Investment in joint ventures		2,115		3,035	
Deferred financing costs, net		12,599		13,527	
Property, plant, and equipment, net		746,436		805,700	
Other noncurrent assets	_	7,395		7,917	
	\$	1,096,692	\$	1,150,359	
Liabilities and net assets Current liabilities:					
Current portion of long-term debt	\$	6,395	\$	1,554	
Accounts payable		31,764		25,395	
Accrued expenses Accrued interest		39,412		41,604	
Estimated third-party payer settlements – current portion		3,606 2,510		3,606	
Total current liabilities		83,687		2,042 74,201	
·		-		74,201	
Long-term debt, excluding current portion		748,417		754,600	
Accrued pension Estimated third-party payer settlements – noncurrent portion and		_		3,336	
other long-term liabilities		42,659		57,908	
Total liabilities		874,763		890,045	
Commitments and contingencies					
Net assets:					
Unrestricted		212,470		243,256	
Temporarily restricted		2,567		9,211	
Permanently restricted		4,860		5,077	
Total Capital Health System net assets		219,897		257,544	
Non-controlling interest Total net assets including non-controlling interest		2,032 221,929		2,770	
Total net assets including non-controlling interest	<u> </u>	1,096,692	<u> </u>	260,314 1,150,359	
		1,070,072	Φ	1,100,009	

See accompanying notes

Consolidated Statements of Operations

	}	Year Ended December 31							
		2013	2012						
Unrestricted net assets:	(In Thousands)								
Revenue:			,						
Net patient service revenue	\$	583,194 \$	567,061						
Provision for bad debt		(43,199)	(40,418)						
Net patient service revenue, less provision for bad debts		539,995	526,643						
Other revenue		23,865	19,627						
Unrestricted contributions		234	141						
Total revenue		564,094	546,411						
Expenses:									
Salaries and wages		263,793	262,930						
Employee benefits		39,769	42,453						
Supplies and other expenses		201,315	196,956						
Interest		48,240	56,558						
Depreciation and amortization		63,735	61,970						
Total expenses prior to items below		616,852	620,867						
Loss from operations		(52,758)	(74,456)						
Investment income and realized gains and losses, net		14,755	13,412						
Other than temporary impairment of investments			(2,312)						
Loss on disposal of fixed assets		(1,209)	(2,096)						
Other			(3,168)						
Deficiency of revenue over expenses, before									
non-controlling interest		(39,212)	(68,620)						
Less: gain attributable to non-controlling interest		2,730	2,275						
Deficiency of revenue over expenses		(41,942)	(70,895)						
Net change in unrealized gains and losses on investments		3,290	6,915						
Additional paid-in capital		· _	11						
Redemptions		(498)	_						
Net assets released from restrictions for equipment		2,851	5,000						
Pension-related changes other than net periodic pension cost		5,513	(1,647)						
Decrease in unrestricted net assets	\$	(30,786) \$	(60,616)						

See accompanying notes.

Consolidated Statements of Changes in Net Assets

	Unrestricted		mporarily estricted	R	manently estricted Thousands)	I	controlling nterest	Total
Net assets at December 31, 2011	\$	303,872	\$ 13,461	\$	5,069	\$	2,908 \$	325,310
(Deficiency) excess of revenue over expenses Net change in unrealized gains		(70,895)			-		2,275	(68,620)
and losses on investments		6,915			_			6,915
Additional paid-in capital		11	_		_		_	11
Pension-related changes other than								• •
net periodic pension cost		(1,647)	_		_			(1,647)
Member distributions, net		_	-		_		(2,413)	(2,413)
Donor restricted contributions		_	1,494		8		_	1,502
Net assets released from restrictions								
for equipment		5,000	(5,000)		-		_	
Net assets released from restrictions for operations			(744)		_		_	(744)
(Decrease) increase in net assets		(60,616)	(4,250)		8		(138)	(64,996)
Net assets at December 31, 2012		243,256	9,211		5,077		2,770	260,314
(Deficiency) excess of revenue over expenses		(41,942)	_		_		2,730	(39,212)
Net change in unrealized gains		2 200						2 200
and losses on investments		3,290	_		_		_	3,290
Redemptions Pension-related changes other than		(498)	_				_	(498)
net periodic pension cost		5,513						5,513
Member distributions, net		3,313	_		_		(3,468)	(3,468)
Donor restricted contributions		_	1,025		48		(5,400)	1,073
Net assets released from restrictions			1,025		-10			1,075
for equipment		2,851	(2,851)		_		_	_
Net assets released from restrictions		_,	(-,,					
for operations		_	(5,083)				_	(5,083)
Transfers		_	265		(265)		_	· · · ·
Decrease in net assets		(30,786)	(6,644)		(217)		(738)	(38,385)
Net assets at December 31, 2013	\$	212,470	\$ 2,567	\$	4,860	\$	2,032 \$	221,929

See accompanying notes

Consolidated Statements of Cash Flows

		Year Ended December 31 2013 2012					
Cook Same Co.		(In The	ousand	ds)			
Cash flows from operating activities	•	(20.205)	Φ.	(64.000)			
Decrease in net assets Adjustments to reconcile decrease in net assets to net cash provided by (used in)	\$	(38,385)	\$	(64,996)			
operating activities.							
Depreciation and amortization		63,735		61,970			
Amortization of deferred financing fees		928		852			
Net change in unrealized gains and losses on investments		(3,290)		(6,915)			
Loss on disposal of fixed assets		1,209		2,096			
Pension-related changes other than net periodic pension cost		(5,513)		1,647			
Member distributions related to non-controlling interest		3,468		2,413			
Changes in operating assets and liabilities:							
Patient accounts receivable, net		(5,906)		(13,067)			
Supplies		(7,639)		474			
Prepaid expenses and other current assets		4,941		1,769			
Other noncurrent assets		522		5,724			
Accounts payable		6,369		(12,228)			
Accrued expenses		(2,192)		(11,092)			
Accrued pension		2,177		283			
Accrued interest				3,596			
Estimated third-party payer settlements and other long-term liabilities		(14,781)		6,262			
Net cash provided by (used in) operating activities		5,643		(21,212)			
Cash flows from investing activities							
Net (purchases) sales of assets whose use is limited		(7,098)		11,660			
Net sales of investments		9,439		40,905			
Investment in joint ventures		(2,548)		(1,808)			
Cash proceeds from sale of property and equipment		7,947		4,125			
Purchases of property and equipment, net		(13,414)		(76,744)			
Net cash used in investing activities		(5,674)		(21,862)			
Cash flows from financing activities		(, ,		` , ,			
Proceeds from long-term debt				44 249			
Payments of capital leases		(1,555)		44,348 (2,311)			
Payments of long-term debt		(1,333)		(5,833)			
Refund of mortgage insurance premium		_		2,905			
Net cash (used in) provided by financing activities		(1,555)		39,109			
Net decrease in cash and cash equivalents		(1,586)		(2.065)			
Cash and cash equivalents at beginning of year		14,278		(3,965)			
Cash and cash equivalents at origining of year Cash and cash equivalents at end of year	<u>\$</u>		\$	18,243			
Cash and Cash equivalents at the OI year	<u></u>	12,692	Þ	14,278			
Noncash investing and financing transactions	æ	212	¢				
Assets acquired under capitalized lease obligations		213					
Supplemental disclosures of cash flow information Cash paid for interest expense	\$	47,312	\$	52,110			
•		· · · · · · · · · · · · · · · · · · ·		,			

Notes to Consolidated Financial Statements

December 31, 2013 (Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies

Capital Health System, Inc. (Capital Health), a New Jersey nonprofit corporation, consists of four operating divisions: Capital Health Regional Medical Center (Regional), Capital Health at Mercer (Mercer), Capital Health – Hamilton (Hamilton), and Capital Health Medical Center – Hopewell (Hopewell). Regional is a separately licensed acute care hospital with 271 licensed beds, located in Trenton, New Jersey. Mercer ceased operations as a separately licensed acute care hospital on November 6, 2011 but remained open as a satellite emergency department (SED) licensed under Regional. Capital Health sold the Mercer campus on August 29, 2013. The SED ceased operations on December 17, 2013. Also on November 6, 2011, Hopewell commenced operations as a separately licensed acute care hospital with 223 licensed beds, located in Hopewell Township, New Jersey. Hamilton is an ambulatory care facility located in Hamilton, New Jersey and licensed under Hopewell. Capital Health is the sole member of Capital Health Foundation (the Foundation), a nonprofit corporation. Capital Health is also the sole shareholder of two for-profit corporations: Mercer Holding Corporation (Mercer Holding) and Capital Region Insurance Company (CRIC).

Mercer Holding owns 100% of the capital stock of Bellevue Avenue Management, Inc. (Bellevue), a for-profit company which provides management services; 100% of the capital stock of Oasis Spa at Hopewell, LLC (Oasis Spa), a for-profit company which provides spa services at Hopewell; 100% of the capital stock of Capital Health Accountable Care Organization Limited Liability Company (ACO), a for-profit Company with no activity in 2013; and 50% of the capital stock of Capital Imaging Ventures, LLC (Capital Imaging Ventures), a for-profit company which has a 50% ownership in a radiology joint venture. Mercer Holding has a 43.64% ownership interest in Hamilton Surgery Center, LLC (Hamilton Surgery Center) and majority control of the Board of Directors. Additionally, Mercer Holding had an 80% ownership interest and majority control of the Board of Directors of Hopewell Surgery Center, LLC (Hopewell Surgery Center) as of December 31, 2012. On January 18, 2013, Mercer Holding purchased the remaining ownership interest in Hopewell Surgery Center and became its sole member. On February 15, 2013, Hopewell Surgery Center ceased operations as a separately licensed ambulatory surgical center and was dissolved in September 2013. Hamilton Surgery Center and Hopewell Surgery Center (collectively, the Surgery Centers) and Capital Imaging Ventures are consolidated in the accompanying consolidated financial statements. Mercer Holding accounts for the noncontrolling interests in the Surgery Centers and Capital Imaging Ventures in accordance with Accounting Standards Codification (ASC) 810, Consolidation.

CRIC is a captive insurance company formed under the laws of the Cayman Islands, which provides professional and general liability coverage for Capital Health and its employees.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Capital Health System Condominium Association, Inc. (the Association) is a nonprofit corporation that provides maintenance, preservation and control of the common areas within Hopewell. Capital Health is grantor of the Association and has majority control of its Board of Trustees. As such, the Association is consolidated in the accompanying consolidated financial statements.

Stroke and Cerebrovascular Center of New Jersey, P.C. (SCNJ) is a professional service corporation which operates a medical practice specializing in cerebrovascular and neurosurgical services at Capital Health. An employed physician of Capital Health is currently the sole shareholder of SCNJ. Capital Health has control over the appointment of shareholders and directors in SCNJ, and as such, SCNJ is consolidated in the accompanying consolidated financial statements.

A summary of significant accounting policies of Capital Health follows:

Principles of Consolidation

The consolidated financial statements include the accounts of Capital Health, the Foundation, Mercer Holding, the Association, SCNJ, and CRIC. All intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes, such as estimated allowance for doubtful accounts, estimated settlements with third-party payors, professional liability insurance and pension benefit assets (liabilities), and disclosures of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the amounts of revenue and expenses reported during the period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates and assumptions.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly-liquid instruments with a maturity of three months or less when purchased, excluding assets whose use is limited by board designation, debt and trust agreements or other arrangements and those held in the investment portfolio.

Patient Accounts Receivable and Net Patient Service Revenue

Patient accounts receivable results from health care services provided by Capital Health. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts. The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, and includes estimated retroactive revenue adjustments due to future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are provided and adjusted in future periods, as adjustments become known, or as years are no longer subject to such audits, reviews and investigations (see Note 3).

Investments

Short-term investments are readily marketable and not subject to donor restriction. Investments include amounts under donor restrictions.

Investments in equity securities (including mutual funds) with readily determinable fair values and all investments in debt securities (including mutual funds) are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, other than temporary impairments of investments, and interest and dividends) are included in the deficiency of revenue over expenses, unless the income or loss is restricted by donor or law. Net change in unrealized gains and losses on investments,

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

except for those unrealized losses which are deemed to be other than temporary impairments, are excluded from the deficiency of revenue over expenses. The fair value of marketable investments is determined by reference to quoted market prices.

Nonmarketable investments are defined as nontraditional, not readily marketable asset classes. Nonmarketable investment holdings consist of private mutual funds of funds (the Funds). The valuation of the Funds is determined by the investment managers or general partners (see below). Individual investment holdings within the private mutual funds primarily include investments in market-traded securities. However, values for nonmarketable securities held by the Funds, where readily available fair values do not exist. may be based on estimates determined by the fund managers based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Capital Health's units of account are valued based on monthly net asset values (NAV) as published and reported to qualified investors and used for the basis for trades. NAV approximates fair value. The investments may indirectly expose Capital Health to securities lending, short sales of securities, and trading in futures and forwards contracts, options and other derivative products. While these financial instruments may contain varying degrees of risk, Capital Health's risk with respect to such transactions is limited to its capital balance in the investment. Funds are available and can be divested within 65 days from the tender deadline. The financial statements of the Funds are audited annually by independent auditors, although the timing for reporting the results of such audits does not coincide with Capital Health's annual financial statement reporting. At December 31, 2013, Capital Health has no future commitments to invest in nonmarketable investments. Capital Health sold a portion of its investment in the Funds subsequent to year end December 31, 2012 and as such, unrealized losses of \$2,312 for the year ended December 31, 2012 were deemed to be other than temporarily impaired. Unrealized gains and losses on the Funds are excluded from the deficiency of revenue over expenses in 2013.

Assets Whose Use is Limited

Assets whose use is limited includes investments held by CRIC (see Note 4), restricted investments for collateral, restricted cash for guarantees, investments held under debt agreements and investments held under a supplemental retirement plan. Assets whose use is limited are recorded at fair value determined by reference to quoted market prices.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Supplies

Supplies are carried at the lower of cost, determined on the first-in, first-out method, or market.

Deferred Financing Costs

Deferred financing costs include the costs of obtaining financing and are amortized over the period the obligation is outstanding using the effective interest method. Deferred financing fees are reported net of accumulated amortization of \$4,090 and \$3,255 at December 31, 2013 and 2012, respectively.

During 2012, Capital Health incurred \$107 of deferred financing costs associated with private offering statements in connection with the Hopewell Surgery Center. Accumulated amortization was \$107 and \$14 at December 31, 2013 and 2012, respectively.

During 2012, Capital Health received a refund of \$3,090 related to overpayment of mortgage insurance premiums to the U.S. Department of Housing and Urban Development (HUD). Such costs, including \$2,905 which were previously capitalized, were written-off during 2012.

Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost, except those acquired by gift or bequest which are recorded at their fair value established at date of contribution.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. The estimated lives range from two to forty years.

Capital Health continually evaluates whether later events and circumstances have occurred that indicate that the remaining estimated useful life of long-lived assets may warrant revision or that the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, Capital Health uses an estimate of the related undiscounted operating income over the remaining life of the long-lived asset, or determines the fair value of the long-lived asset in measuring whether the long-lived asset is recoverable.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Guarantees

Capital Health provides guarantees in relation to certain joint ventures and other agreements (see Note 9) and accounts for such guarantees under the provisions of ASC 460, *Guarantees*.

Estimated Professional Liabilities

Insurance reserves represent estimated unpaid losses and loss adjustment expenses. Such amounts are established using management's estimates on the basis of claims records and an independent actuarial review and include an amount for the adverse development of reported claims. Adjustments to the estimate of the liability for losses are reflected in earnings in the period in which the adjustment is determined. The insurance reserves are based on estimates and, while management believes that the amount is adequate, the ultimate liability may vary significantly from the amount provided.

Classification of Net Assets

Capital Health separately accounts for and reports upon donor restricted and unrestricted net assets. Unrestricted net assets are not externally restricted for identified purposes by donors or grantors. Resources arising from the results of operations or assets set aside by the Board of Directors are not considered to be donor restricted. Temporarily restricted net assets are those whose use is temporarily limited by the donor. Permanently restricted net assets have been restricted by donors to be maintained by Capital Health in perpetuity.

When a donor restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations as other revenue, if intended for operations, or after deficiency of revenue over expense, if intended for capital purposes. Income earned from temporarily restricted net assets is included in investment income and realized gains and losses, net, unless the income is restricted by the donor, in which case it is added to temporarily restricted net assets. Income earned from permanently restricted net assets is not subject to donor restriction and is, therefore, included in the consolidated statements of operations as investment income and realized gains and losses, net.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Capital Health follows the requirements of the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as it relates to its permanently restricted contributions and net assets, as enacted by the State of New Jersey in 2009. Capital Health expends the income distributed from the related assets according to donor stipulations.

Advertising Costs

Capital Health expenses advertising costs as incurred. Total amounts charged to advertising expense during the years ended December 31, 2013 and 2012 were approximately \$3,304 and \$1,508, respectively.

Deficiency of Revenue Over Expenses

The consolidated statements of operations include deficiency of revenue over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from deficiency of revenue over expenses, include the net change in unrealized gains and losses on investments (excluding those considered to be other than temporary), pension-related changes other than net periodic pension cost, additional paid-in capital, gain attributable to non-controlling interest and net assets released from restrictions for equipment.

Transactions deemed by management to be ongoing, major or central to the provision of health care services are reported within loss from operations.

Functional Expenses

All operating expenses incurred by Capital Health were related to the provision of health care services.

Income Taxes

Capital Health and the Foundation are nonprofit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Foundation is classified with public charity status of 170(b)(1)(A)(vi) under Section 501(c)(3) of the Code. These entities are also exempt from state and local income taxes. Mercer Holding and SCNJ are taxable

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

entities; amounts provided for federal and state and local income taxes are included in the accompanying consolidated financial statements. However, such amounts are not material for disclosure. The Association is a New Jersey nonprofit association, with no taxable income recorded during 2013 or 2012. CRIC is not subject to taxes on income or gains under Section 6 of the Cayman Islands tax concessions law (revised). Therefore, no provision for taxes has been made in the accompanying consolidated financial statements.

Pension Plan

Capital Health's policy is to fund amounts as necessary on an actuarial basis to provide assets sufficient to meet the benefits to be paid to plan members in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

Capital Health recognizes in its consolidated balance sheets an asset for its defined benefit pension plan's overfunded status or a liability for the Plan's underfunded status, measures the Plan's assets and obligations that determine its funded status as of the end of its fiscal year, and recognizes changes in the funded status of the Plan in changes in unrestricted net assets in the year in which the changes occur (see Note 10).

Reclassifications

Certain reclassifications have been made to the 2012 amounts previously reported in order to conform to the current year presentation.

2. Charity Care

Capital Health provides care to patients who meet certain criteria defined by the New Jersey Department of Health (DOH) without charge or at amounts less than established rates. Because Capital Health does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Capital Health's records identify and monitor the level of charity care it provides and include the amount of charges forgone for services and supplies furnished. DOH allows retroactive application for charity care up to two years from the date of service.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

2. Charity Care (continued)

The costs of charity care is derived from both estimated and actual data. The estimated cost of charity care includes the direct and indirect cost of providing such services and is estimated utilizing Capital Health's ratio of cost to gross charges, which is then multiplied by the gross uncompensated charges associated with providing care to charity patients. Charity care provided, at cost, during 2013 and 2012 totaled approximately \$62,129 and \$57,617, respectively.

Capital Health receives payments from the New Jersey Health Care Subsidy Funds for charity care and such amounts totaled approximately \$29,170 and \$28,864 for the years ended December 31, 2013 and 2012, respectively.

3. Net Patient Service Revenue

Patient Accounts Receivable and Net Patient Service Revenue

Capital Health recognizes accounts receivable and patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered (see description of third-party payor payment programs below). For uninsured patients that do not qualify for charity care, Capital Health recognizes revenue on the basis of discounted rates under Capital Health's self-pay patient policy. Under the policy for self-pay patients, a patient who has no insurance and is ineligible for any government assistance program has his or her bill reduced to the amount which would be billed to a commercially insured patient. Previously, uncollectible amounts for such patients were recorded as the provision for bad debt.

Patient service revenue for the year ended December 31, 2013, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	 2013		2012	_
Third party payors	\$ 554,034	\$	544,379	
Self-pay	29,160		22,682	
Total payors	\$ 583,194	\$	567,061	_

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

3. Net Patient Service Revenue (continued)

Deductibles and copayments under third-party payment programs with third-party payor amounts above are the patients responsibility and Capital Health considers these amounts in its determination of the provision for bad debts based on collection experience. Accounts receivable are also reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, Capital Health analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, Capital Health analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, Capital Health records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Capital Health's allowance for doubtful accounts totaled \$38,643 and \$41,568 at December 31, 2013 and 2012, respectively. The allowance for doubtful accounts for self-pay patients was approximately 36% and 39% of self-pay accounts receivable as of December 31, 2013 and 2012. Overall, the total of self-pay discounts and write-offs has not changed significantly for the year ended December 31, 2013. Capital Health has not experienced significant changes in write-off trends and has not changed its charity care policy for the years ended December 31, 2013 and 2012.

Third Party Payment Programs

Capital Health has agreements with third-party payors that provide for payment for services rendered at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

3. Net Patient Service Revenue (continued)

Medicare: Hospitals are paid for most Medicare inpatient and outpatient services under the national prospective payment system and other methodologies of the Medicare program for certain other services. Federal regulations provide for certain adjustments to current and prior years' payment rates, based on industry-wide and hospital-specific data. Medicare cost reports of Capital Health have been audited and settled for years through 2007, except for 2005, at December 31, 2013.

Medicaid: Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under cost-based and fee schedule methodologies. Capital Health is reimbursed for outpatient services at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicaid fiscal intermediary. The Medicaid cost reports of Capital Health for years through 2007, except for 2005, have been audited and settled at December 31, 2013.

Other Third Party Payors: Capital Health also has entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to Capital Health under these agreements includes prospectively determined rates per discharge or days of hospitalization and discounts from established charges.

Net patient service revenue was increased by approximately \$6,956 and \$4,957 for the years ended December 31, 2013 and 2012, respectively, for net adjustments and settlements related to prior years. Included in the \$4,957 increase in net patient service revenue for the year ended December 31, 2012 was approximately \$3,058 related to the settlement of the Budget Neutrality Appeal.

Capital Health has appealed certain items in audited cost reports. The outcome of these appeals is uncertain and, therefore, potential revenue associated with these appeals is not included within the accompanying consolidated statements of operations.

Capital Health has provided for certain amounts which are expected to be repaid in relation to a Medicare supplemental payment referred to as disproportionate share, under which Capital Health is paid additional funds based on the number of Medicaid and similar patients it serves. The disproportionate share formula and the requirements for inclusion of certain types of patient days are extremely complex. The underlying data for the formula has been subject to state-wide

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

3. Net Patient Service Revenue (continued)

evaluations by the national and regional administrators of the federal Medicare and New Jersey Medicaid programs in recent years. In 2009, amounts related to cost report years 2001 through 2004 were settled by Medicare. Beginning in August 2010, certain data related to cost report years 2005 through 2007 was required to be resubmitted by hospitals state-wide. As part of this resubmission process in 2010, Capital Health reviewed and revised the applicable data to be in conformity with management's interpretation of the disproportionate share formula requirements. Data for cost report years 2005 through 2007 and analysis for similar revisions for cost report years through 2012, and the impact on the estimated disproportionate share calculations from any resulting data revisions, are reviewed regularly by management of Capital Health. In 2013, Medicare settled cost reports for years 2006 and 2007. Capital Health believes that adequate provision has been made for this issue; however, the resubmitted data and subsequent years' information are subject to review in the future by the national and regional administrators of the Medicare and Medicaid programs.

Revenue from the Medicare and Medicaid programs accounted for approximately 26% and 25% of Capital Health's net patient service revenue for the years ended December 31, 2013 and 2012, respectively.

There are various proposals at the federal and state levels that could, among other things, significantly reduce payment rates or modify payment methods. The ultimate outcome of these proposals and other market changes, including the potential effects of heath care reform that has been enacted by the federal government, cannot presently be determined. Future changes in the Medicare and Medicaid programs and any reduction of funding could have an adverse impact on Capital Health.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Capital Health believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that could have a material adverse effect on its financial statements. Noncompliance with such laws and regulations could result in fines, penalties and exclusion from such programs.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

3. Net Patient Service Revenue (continued)

State Subsidy Funds

The New Jersey Health Care Subsidy Funds were established for various purposes, including the distribution of charity care payments to hospitals statewide.

The following is a summary of subsidy revenue included in net patient service revenue:

	 2013	 2012		
Charity care	\$ 29,170	\$ 28,864		
Hospital relief	5,514	5,463		
Mental health	 958	957		
	\$ 35,642	\$ 35,284		

Capital Health expects to receive approximately \$14,768 in Charity Care subsidies for distributions scheduled through June 30, 2014. Charity Care subsidies subsequent to June 30, 2014 are presently unknown. Effective January 1, 2014, the State of New Jersey replaced the Hospital Relief Subsidy Fund with a new payment mechanism referred to as the Delivery System Reform Incentive Payment Pool-(the Pool). The Pool is available to certain-hospitals that are able to establish performance improvement activities in one of eight specified clinical improvement areas. Capital Health's application with the State of New Jersey to participate in the Pool has been approved. Management anticipates it will receive approximately the same level of funding from the Pool in 2014 as compared to Hospital Relief subsidies in 2013.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

4. Assets Whose Use is Limited

Assets whose use is limited consist of the following:

	Decer	nbei	· 31
	 2013		2012
Restricted investments for collateral	\$ 12,089	\$	16,461
Restricted cash for guarantees (see Note 9)	818		1,545
Assets held under supplemental retirement plan	7,717		5,984
Assets held under debt agreement	27,893		15,386
Assets held by CRIC (see Note 15)	30,729		30,836
Total assets whose use is limited	 79,246		70,212
Less: assets whose use is limited – current portion	 3,432		3,967
	\$ 75,814	\$	66,245

Assets held under debt agreements are maintained for the following purposes:

	December 31					
			2012			
Mortgage reserve fund	\$	24,461	\$	11,419		
Mortgage insurance premium		3,432		3,459		
Escrow of condominium sale proceeds		-		508		
	\$	27,893	\$	15,386		

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

4. Assets Whose Use is Limited (continued)

Capital Health's gross unrealized losses and fair value of individual securities, classified as assets whose use is limited, aggregated by investment category, which have been in a continuous unrealized loss position less than 12 months and greater than 12 months at December 31, 2013 and 2012 are as follows:

						Decemb	er 31	I, 2013					
		ess than T	ve Months		Twelve Months or Longer				Total				
			1	Unrealized				Unrealized		<u> </u>	Unrealized		
	F	air Value		Losses	1	Fair Value		Losses		Fair Value		Losses	
Fixed income securities (1 security) Mutual funds – fixed income securities	\$	1,512	\$	(71)	\$	3,037	\$	(17)	\$	4,549	\$	(88)	
(2 funds)		255		(3)		209		(26)		464		(29)	
Total	\$	1,767	\$	(74)	\$	3,246	\$	(43)	\$	5,013	\$	(117)	
		December 31, 2012 Less than Twelve Months Twelve Months or Longer							Total				
		Unrealized					•	Unrealized				Unrealized	
	F	air Value		Losses		Fair Value		Losses		Fair Value		Losses	
Fixed income securities (1 security) Mutual funds – fixed	\$	-	\$	-	\$	2,934	\$	(16)	\$	2,934	\$	(16)	
income securities - (1 fund) Mutual funds – equity		269		(3)		_		-		269		(3)	
securities (1 fund)		239		(7)				_		239		(7)	
Total	\$	508	\$	(10)	\$	2,934	\$	(16)	\$	3,442	\$	(26)	

At December 31, 2013 and 2012, the unrealized losses of approximately \$117 and \$26, respectively, were not deemed to be other than temporary based on Capital Health's ability and intent to hold the funds until recovery.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

5. Investments

Investments consist of the following:

	December 31						
		2013		2012			
Cash and cash equivalents	\$	5,263	\$				
Mutual funds – fixed income securities		57,101		53,063			
Mutual funds – equity securities		62,081		54,388			
Private mutual funds		1,665		26,739			
Accrued interest		79		84			
Total investments		126,189		134,274			
Less short-term investments		119,667		126,294			
	\$	6,522	\$	7,980			

Investment income, included within investment income and realized gains and losses, net, consists of the following:

	Y	Year Ended December 31								
	- +	2013		2012						
Interest and dividend income Net realized gains	\$	3,944 10,811	\$	3,798 9,614						
Total investment income		14,755	\$	13,412						

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

5. Investments (continued)

At December 31, 2013 and 2012, unrealized losses of approximately \$1,357 and \$214, detailed below, were not deemed to be other than temporary based on Capital Health's ability and intent to hold the funds until recovery.

						Decembe	r 31	, 2013					
	L			e Months	Tw	velve Mon	ths	or Longer		Total			
		Fair Value	U	nrealized Losses	F	air Value	U	nrealized Losses	I	air Value	Ţ	Inrealized Losses	
Private mutual funds (3 funds) Mutual funds- fixed income securities	\$	981	\$	(50)	\$	245	\$	(19)	\$	1,226	\$	(69)	
(21 funds)		5,695		(639)		15,610		(649)		21,305		(1,288)	
Total	\$	6,676	\$	(689)	\$	15,855	\$	(668)	\$	22,531	\$	(1,357)	
	L	Less than Twelve Months Fair Unrealized			December 31, 2012 Twelve Months or Longer Unrealized					Total Unrealized			
		Value		Losses	F	air Value		Losses	<u>F</u>	air Value		Losses	
Private mutual funds (3 funds) Mutual funds- fixed income securities	\$		\$	-	\$	1,196	\$	(99)	\$	1,196	\$	(99)	
(3 funds) Mutual funds- equity		14,642		(106)		291		(8)		14,933		(114)	
securities (1 fund)						208		(1)		208		(1)	
Total	\$	14,642	\$	(106)	\$	1,695	\$	(108)	\$	16,337	\$	(214)	

At December 31, 2012, unrealized losses of \$2,312 were determined to be other than temporarily impaired. No such impairment existed at December 31, 2013.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

6. Fair Value Measurements

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A three-level hierarchy for fair value measurements exists based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument.
- Level 3 inputs to the valuation methodology are unobservable and significant to the fair value measurement.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

6. Fair Value Measurements (continued)

The following tables present the financial instruments carried at fair value by caption on the consolidated balance sheet based on the valuation hierarchy defined above (excludes accrued interest):

	December 31, 2013								
		Level 1		Level 2		Level 3	Total		
Assets									
Cash and cash equivalents	\$	12,692	\$	_	\$	- \$	12,692		
Assets whose use is limited:							•		
Cash and cash equivalents		818		_		_	818		
Assets held by CRIC (see Note 15):									
Equity securities		-		14,051		_	14,051		
Fixed income		_		16,678		-	16,678		
Investments restricted for collateral:							•		
Mutual funds - fixed income securities		12,089		_		_	12,089		
Assets held under supplemental retirement plan:							•		
Mutual funds – fixed income securities		2,894		_		_	2,894		
Mutual funds – equity securities		1,153		_		_	1,153		
Investment contract with insurance company		_		3,670		_	3,670		
Assets held under debt agreement		27,893				_	27,893		
Total assets whose use is limited		44,847		34,399		_	79,246		
Investments.							,		
Cash and cash equivalents		5,263		_		_	5,263		
Mutual funds – fixed income securities		57,101		_		_	57,101		
Mutual funds – equity securities		62,081		_	-		62,081		
Private mutual funds				1,665		_	1,665		
Total investments		124,445		1,665		_	126,110		
Total assets at fair value	\$	181,984	\$	36,064	\$	- \$	218,048		
Pension assets									
Mutual funds – fixed income securities	\$	52,347	\$		e	•	F2 247		
Mutual funds – fixed income securities Mutual funds – equity securities	J	17,629	J	_	\$	- \$	52,347		
		17,029		7 722		-	17,629		
U.S. government securities Private mutual funds		_		7,732		_	7,732		
	•	60.076	•	4,125	•		4,125		
Total pension assets at fair value	<u>\$</u>	69,976	\$	11,857	<u>\$</u>	<u> </u>	81,833		

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

6. Fair Value Measurements (continued)

				Decemb	er 31	1, 2012	
		Level 1		Level 2		Level 3	Total
Assets							
Cash and cash equivalents	\$	14,278	\$	_	\$	- \$	14,278
Assets whose use is limited							,
Cash and cash equivalents		1,545		_		_	1,545
Assets held by CRIC (see Note 15):							,
Equity securities		_		14,174		-	14,174
Fixed income		_		16,662		_	16,662
Investments restricted for collateral:							,
Mutual funds - fixed income securities		16,461		_			16,461
Assets held under supplemental retirement plan:		•					,
Mutual funds - fixed income securities		3,159		_		_	3,159
Mutual funds – equity securities		2,328		_		-	2,328
Investment contract with insurance company		_		497		-	497
Assets held under debt agreement		15,386		_		_	15,386
Total assets whose use is limited		38,879		31,333	•		70,212
Investments:				,			,
Cash and cash equivalents				-		_	_
Certificate of deposit		-		_		_	-
Mutual funds - fixed income securities		53,063		_		_	53,063
Mutual funds – equity securities		54,388		_		_	54,388
Private mutual funds		_		26,739			26,739
Total investments	-	107,451		26,739	-		134,190
Total assets at fair value	\$	160,608	\$	58,072	\$		218,680
Pension assets		_			_		-
Mutual funds – fixed income securities	\$	55,262	\$		æ	•	55.262
Mutual funds – equity securities	Ф	18,230	Þ	_	\$	- \$	55,262
U.S. government securities		10,230		8,654		_	18,230
Private mutual funds				,			8,654
Total pension assets at fair value	•	72 402	<u> </u>	3,952	•		3,952
rotal pension assets at fair value	<u>\$</u>	73,492		12,606	\$		86,098

The carrying value of long-term debt approximates fair value at December 31, 2013 and 2012. The fair value is based upon discounted cash flow analyses. Fair value of FHA/GNMA debt is classified as Level 1 of the valuation hierarchy, while the fair value of capital leases is classified as Level 2.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

7. Pledges Receivable

Pledges receivable, which are due from individuals, businesses and civic organizations and are uncollateralized, consist of the following:

	December 31			31
		2013		2012
Pledges receivable within one year	\$	1,707	\$	1,843
Pledges receivable greater than one year		847		2,445
Pledges receivable, gross		2,554		4,288
Allowance for uncollectible pledges		(232)		(391)
Discount on pledges, with rates ranging from 0.73% to				, ,
2.56%		(240)		(374)
Total pledges receivable, net		2,082		3,523
Less pledges receivable, net – current portion (included				
in prepaid expenses and other current assets)		1,707		1,843
Pledges receivable, net – noncurrent (included in other				
noncurrent assets)	\$	375	\$	1,680

8. Property, Plant and Equipment

Property, plant and equipment consists of the following:

	December 31		
	 2013		2012
Land	\$ 48,620	\$	48,620
Land improvements	34,396		34,373
Buildings, leasehold improvements and fixed equipment	738,127		738,298
Major movable equipment	 224,888		218,506
	1,046,031		1,039,797
Accumulated depreciation and amortization	_(303,030)		(240,097)
	743,001		799,700
Construction in progress	3,435		6,000
Property, plant, and equipment, net	\$ 746,436	\$	805,700

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

8. Property, Plant and Equipment (continued)

Depreciation expense for the years ended December 31, 2013 and 2012 was \$62,365 and \$61,820, respectively.

On November 6, 2011, the Regional Perinatal Center project at Regional (RPC) and the project at Hopewell (collectively, the Project) were substantially complete, and Hopewell began operating as a separately licensed acute care hospital. As of the same date, Mercer ceased operations as a separately licensed acute care hospital, but remained open as a satellite emergency department (SED) licensed under Regional. The SED ceased operations on December 17, 2013.

Major moveable equipment includes assets held under capital lease obligations of \$9,820 and \$6,877 at December 31, 2013 and 2012, respectively, net of accumulated amortization of \$4,061 and \$2,691, respectively, as of those dates.

9. Long-Term Debt

Long-term debt consists of the following:

	December 31			31
		2013		2012
FHA/GNMA \$755,875 Taxable Insured Mortgage Loan Capital lease obligations with interest rates ranging	\$	750,042	\$	750,042
from 3.95% to 9.08% payable monthly and quarterly		4,770		6,112
		754,812		756,154
Less current portion		6,395		1,554
-	\$	748,417	\$	754,600

On April 7, 2009, Capital Health closed on a \$755,875 mortgage insured by HUD through the Federal Housing Administration's (FHA's) Section 242 Hospital Mortgage Insurance Program. The proceeds of this financing were used to: 1) fund the construction of a 223 bed hospital in Hopewell Township, New Jersey that replaced Mercer; 2) fund the construction of the RPC at Regional; 3) defease Capital Health's NJHCFFA Series 1997, Series 2003A and Series 2003B bonds; 4) repay a \$45,000 line of credit with a bank; and 5) pay financing costs related to the transaction.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

9. Long-Term Debt (continued)

Escrow accounts were established with the bond trustee and escrow agent for all three series of bonds. From the proceeds in the escrow accounts, the escrow agent: 1) redeemed the Series 1997 bonds on July 1, 2009; 2) redeemed the Series 2003A bonds on July 1, 2013; and 3) redeemed the Series 2003B bonds on May 7, 2009. The total par value of these bonds outstanding at April 7, 2009 was \$157,195. The total amount placed in escrow to defease the Series 1997, 2003A and 2003B bonds was \$172,314. At December 31, 2012, amounts outstanding and held in escrow related to the Series 2003A Bonds were \$83,611. This escrow account was closed in July 2013.

Financing from the FHA Section 242 Hospital Mortgage Insurance Program provided \$755,875. Capital Health was required to provide an equity contribution of \$124,506, which was provided by final endorsement of the mortgage loan on September 20, 2012. At the initial closing, the debt had a fixed interest rate of 7.83%, and no principal was due on the loan until February 2012. At final endorsement of the loan, the mortgage note was amended effective September 1, 2012 with interest rates of 7.83% from April 7, 2009 through July 31, 2012, 5.77% from August 1, 2012 through July 31, 2014, 6.80% from August 1, 2014 through July 31, 2018 and 6.77% from August 1, 2018 through maturity date of January 1, 2037. Under the terms of the amended mortgage note, interest only was due and payable on the first day of each month on the outstanding balance of principal up to and including January 1, 2012. The following table outlines the principal and interest payments due and payable on the first day of each month for the remainder of the loan's term:

February 1, 2012-August 1, 2012	\$ 5,749
September 1, 2012-August 1, 2014 (interest only)	3,606
September 1, 2014-August 1, 2018	5,440
September 1, 2018- January 1, 2037	5,428

The mortgage note is collateralized by a security interest and a mortgage on substantially all of the property, plant and equipment at the Regional, Hopewell and Hamilton campuses. Interest costs resulting from the portion of debt related to construction was capitalized accordingly.

As of December 31, 2013 and 2012, Capital Health had outstanding letters of credit totaling \$4,002 related to various aspects of the Project. No amounts have been drawn at December 31, 2013 and 2012. The letters of credit expire throughout 2014.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

9. Long-Term Debt (continued)

Also in connection with the Project, Capital Health was required to provide a security interest in and lien on certain of its investments as collateral. As of December 31, 2013 and 2012, \$12,089 and \$16,461 of investments were pledged as collateral for the outstanding letters of credit. These investments are included in assets whose use is limited as of December 31, 2013 and 2012.

As of December 31, 2013 and 2012, Capital Health had outstanding letters of credit totaling \$5,456 and \$5,406, respectively, related to vendor arrangements. No amounts have been drawn on the letters of credit at December 31, 2013 and 2012. The letters of credit expire throughout 2014 and automatically renew for a term of one year.

Under the terms of the mortgage loan, Capital Health is required to maintain certain financial ratios and comply with other restrictive covenants as described in the respective agreements. At December 31, 2013 and 2012, Capital Health was in compliance with the financial ratio requirements described in the agreements, with the exceptions of the debt service coverage ratio and the equity financing ratio, of which Capital Health was not in compliance at December 31, 2013 and 2012. The non compliance noted above did not result in an event of default of the related debt.

Scheduled payments on long-term debt and capital lease obligations at December 31, 2013, net of interest, are as follows:

	FF	IA/GNMA	•	Capital Lease	Total
		<u> </u>		1301130	 10111
2014	\$	4,800	\$	1,595	\$ 6,395
2015		15,067		1,599	16,666
2016		16,124		1,576	17,700
2017		17,256			17,256
2018		18,487		_	18,487
Thereafter		678,308		-	678,308
Total long-term debt	\$	750,042	\$	4,770	\$ 754,812

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

9. Long-Term Debt (continued)

As of December 31, 2012, the radiology joint venture had a line of credit with a bank of \$1,500 which bears interest at LIBOR plus 2.06% and was due on demand. Capital Health had guaranteed this line of credit. The line of credit was paid off in 2013. The radiology joint venture has a loan of \$1,298, of which \$1,238 is outstanding at December 31, 2013. Capital Health has guaranteed \$818 of this at December 31, 2013. In addition, Capital Health guaranteed a \$2,000 loan of the radiology joint venture of which \$45 was outstanding at December 31, 2012. This loan was paid off in 2013.

These guarantees, which total approximately \$818 and \$1,545 at December 31, 2013 and 2012, respectively, are included in other long-term liabilities and investment in joint ventures in the accompanying consolidated balance sheets.

10. Retirement Plans

Capital Health has a non-contributory defined benefit pension plan and a defined contribution plan that operate under Section 403(b) of the Internal Revenue Code. Both plans cover substantially all of its employees. The benefits are based on years of service and compensation. Capital Health's funding policy provides that payments to the defined benefit pension plan shall be equal to the minimum funding requirement of ERISA plus additional amounts, which may be approved by Capital Health. In 2013 and 2012, Capital Health incurred \$629 and \$4,893, respectively, in pension expense for employer contributions to the defined contribution plan, which is included in employee benefits expense in the accompanying consolidated statements of operations.

As noted in Note 1, Capital Health recognizes in its consolidated balance sheets an asset, for the defined benefit plan's overfunded status, or a liability, for the plan's underfunded status; measures the defined benefit plan's assets and obligations that determine funded status as of the end of the its fiscal year; and recognizes the periodic change in the funded status of the defined benefit plan as a component of changes in unrestricted net assets in the year in which the change occurs.

Amounts that are recognized as a component of other changes in unrestricted net assets will be subsequently recognized as a component of net periodic pension.

Capital Health froze its defined benefit pension plan as of December 31, 2007.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

10. Retirement Plans (continued)

Included in unrestricted net assets is unrecognized actuarial loss at December 31, 2013 and 2012 of \$14,050 and \$19,563, respectively, which has not yet been recognized in net periodic pension cost. At December 31, 2013 Capital Health has a defined benefit asset of \$2,244 which is reported within other noncurrent assets in the accompanying consolidated balance sheet.

The unrecognized actuarial loss included in unrestricted net assets at December 31, 2013 and expected to be recognized in net periodic pension cost during the year ending December 31, 2014 is approximately \$1,011.

The following table sets forth the funded status of the plan at December 31, 2013 and 2012 and the amounts recognized in the consolidated financial statements:

	 2013	2012
Change in benefit obligation		-
Benefit obligation, beginning of year	\$ 89,434	\$ 85,451
Interest cost	2,685	3,378
Actuarial (gain) loss	(6,699)	5,939
Benefits paid	(2,022)	(1,908)
Settlement gain	(3,809)	(3,426)
Benefit obligation, end of year	 79,589	89,434
Change in plan assets		
Fair value of plan assets, beginning of year	86,098	84,045
Actual return on plan assets	1,567	7,387
Benefits paid and settlement gain	(5,832)	(5,334)
Fair value of plan assets, end of year	 81,833	86,098
Funded status	\$ 2,244	\$ (3,336)

The net periodic pension (benefit) cost includes the following components:

		2013	 2012
Interest cost	\$	2,685	\$ 3,378
Expected return on plan assets		(4,435)	(4,708)
Recognized actuarial loss		1,011	864
Settlement loss		672	749
Periodic pension (benefit) cost	\$	(67)	\$ 283

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

10. Retirement Plans (continued)

The benefit obligations represent the projected and accumulated benefit obligation.

The following assumptions were used in determining the benefit obligations and net periodic benefit cost:

	2013	2012
Weighted-average assumptions used to determine benefit		
obligations at December 31:		
Discount rate	4.25%	3.23%
Weighted-average assumptions used to determine net		
periodic benefit cost for the years ended December 31:		
Discount rate	3.23%	4.28%
Expected long-term return on plan assets	5.50%	6.00%

Expected long-term rate of return on plan assets assumption:

The expected long-term rate of return on plan assets assumption of 5.5% was selected using the "building block" approach described by the Actuarial Standards Board in Actuarial Standards of Practice No. 27 – Selecting Economic Assumptions for Measuring Pension Obligations. Based on Capital Health's investment policy for the pension plan in effect as of the beginning of the fiscal year, a best estimate range was determined for both the real rate of return (net of inflation) and for inflation based on historical 30-year period rolling averages. An average inflation rate within the range equal to 4.0% was selected and added to the real rate of return range to arrive at a best estimate.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

10. Retirement Plans (continued)

Capital Health's pension plan weighted-average asset allocations at December 31, 2013 and 2012 by asset category are as follows:

	Plan Assets at December 31		
	2013	2012	
Mutual funds – equity securities	22%	21%	
Mutual funds – fixed income securities	64	64	
U.S. government securities	9	10	
Other	5	5	
	100%	100%	
Capital Health expects to pay future benefits as follows:			
2014	\$	6,666	

2014	\$ 6,666
2015	6,294
2016	6,160
2017 -	6,661
2018	5,328
2019-2023	28,350

Capital Health's investment policies and strategies for plan assets include allocations of a diversified portfolio of equity investments, fixed income securities and cash equivalents. Though these assets are long-term in nature, a reasonable amount of liquidity should be maintained.

Capital Health does not expect to contribute to its defined benefit pension plan in 2014.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

11. Concentration of Credit Risk

Capital Health grants credit without collateral to its patients, most of whom are local residents of the greater Trenton metropolitan area and are insured under third-party payer agreements. Concentrations of net accounts receivable from patients and third-party payers were as follows:

	December 31		
	2013	2012	
Medicare	23%	31%	
Medicaid	4	3	
Commercial and managed care	55	53	
Blue Cross	15	10	
Self-pay	3	3	
	100%	100%	

12. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

		- Decer 2013	nber	1ber 31 2012	
Health care services	\$	1,233	\$	5,385	
Education		508		292	
Equipment		585		3,198	
Charity care		64		54	
Other		177		282	
	\$	2,567	\$	9,211	

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

12. Temporarily and Permanently Restricted Net Assets (continued)

Net assets were released from restrictions for the following purposes:

	Ye	Year Ended December 31			
		2013		2012	
Equipment	\$	2,851	\$	5,000	
Health care services		4,473		182	
Education		354		79	
Charity care		12		69	
Other		244		414	
	\$	7,934	\$	5,744	

Changes in donor endowment funds for the years ended December 31, 2013 and 2012 consisted of the following:

	Unrestricted		Permanently Restricted	
Endowment funds at December 31, 2012 Investment return on endowments Contributions Appropriations Endowment funds at December 31, 2013	\$ 1,946 510 - (1,776) \$ 680		\$	5,077 - 48 (265) 4,860
	Unrestricted			
	_ U !	arestricted		rmanently estricted

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

12. Temporarily and Permanently Restricted Net Assets (continued)

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires Capital Health to retain as a fund of perpetual duration. Deficiencies of this nature are reported in unrestricted net assets. Individual donor-restricted endowment funds with deficiencies will retain future income and appreciation to restore the required fair value of the assets. There were no such deficiencies as of December 31, 2013 and 2012.

13. School of Nursing

In accordance with the U.S. Department of Education accounting requirements, disclosure of the school of nursing individual revenue and expenses follows:

	Yea	Year Ended December 31				
	2	2013		2012		
Total revenue	\$	_	\$	362		
Total expenses		_		481		
Expenses over revenues	\$		\$	(119)		

The School of Nursing ceased operations during 2012.

14. Contingencies

Various lawsuits and claims arising in the normal course of operations are pending or are in appeal against Capital Health. Such lawsuits and claims are either specifically covered by insurance or are not material. While the outcome of these lawsuits cannot be determined at this time, management believes that any loss which may arise from Capital Health's actions will not have a material adverse effect on the consolidated financial position or consolidated results of operations.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

15. Professional Liability Insurance

Capital Health purchased first dollar claims made insurance coverage prior to April 5, 2003 through a commercial carrier. Under this program, the professional and general liabilities were insured under two policies. A "package policy" covered those risks related to Capital Health's general and professional liability as well as certain employed physicians. A "master physician policy" covered all other physicians for whom Capital Health provided coverage. The master physician policy also included an automatic tail provision. In addition to the two primary policies mentioned above, Capital Health purchased umbrella and excess insurance on a claims-made basis.

As of April 5, 2003, Capital Health purchased coverage for its professional and general liability exposures through CRIC. The reinsurance purchased by CRIC covers, on a claims-made basis, both new occurrences and any incident that occurred prior to April 5, 2003 that was unknown to Capital Health as of that date. For the insurance coverage year May 1, 2012 to May 1, 2013 CRIC insures Capital Health for its professional liability in the amount of \$42,000 per claim and \$46,000 in the annual aggregate, of which \$40,000 per claim and \$40,000 in the annual aggregate is ceded to "A" rated reinsurers. CRIC, therefore, retains professional liability losses of \$2,000 per claim and \$6,000 in the annual aggregate. During the same insurance coverage year, CRIC insures Capital Health for its general liability in the amount of \$41,000 per claim and \$46,000 in the annual aggregate, of which \$40,000 per claim and \$40,000 in the annual aggregate is ceded to "A" rated insurers. CRIC, therefore, retains general liability losses of \$1,000 per claim and \$6,000 in the annual aggregate.

At December 31, 2013 and 2012, CRIC has recorded an estimated reserve for claims of \$17,581 and \$22,240, respectively, included in other long-term liabilities within the accompanying consolidated balance sheets, which includes an estimate for claims incurred but not reported. These undiscounted reserves are not offset by estimates of reinsurance claims. Estimated receivables for reinsurance recoveries recorded by CRIC of \$4,548 and \$5,971 at December 31, 2013 and 2012, respectively, are included in other noncurrent assets within the accompanying consolidated balance sheets.

Liabilities arising from incidents which occurred prior to April 5, 2003 which were known to Capital Health are the responsibility of Capital Health. At December 31, 2013 and 2012, Capital Health has calculated estimates of approximately \$5,637 and \$5,279, respectively, which have been discounted at 3% based upon an actuarial valuation, for these incidents and has recorded them in other long-term liabilities in the accompanying consolidated balance sheets.

Notes to Consolidated Financial Statements (continued)

(Dollars In Thousands)

16. Electronic Health Records

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement, or upgrade certified EHR technology. In subsequent years, providers must demonstrate meaningful use of such technology to qualify for additional Medicaid incentive payments. Hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

Capital Health uses a grant accounting model to recognize revenue for the Medicare and Medicaid EHR incentive payments. Under this accounting policy, EHR incentive payment revenue is recognized when the System is reasonably assured that the EHR meaningful use criteria for the required period of time were met and that the grant revenue will be received. EHR incentive payment revenue totaling \$483 (Medicaid) and \$2,851 (Medicare) for the year ended December 31, 2013 and \$1,931 (Medicaid) and \$3,435 (Medicare) for the year ended December 31, 2012, are included in other revenue in the accompanying consolidated statements of operations. Income from Medicare incentive payments is subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated. Additionally, Capital Health's attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

17. Subsequent Events

Capital Health's management has evaluated subsequent events from December 31, 2013 through April 29, 2014, which is the date the consolidated financial statements were issued.

EY | Assurance | Tax | Transactions | Advisory

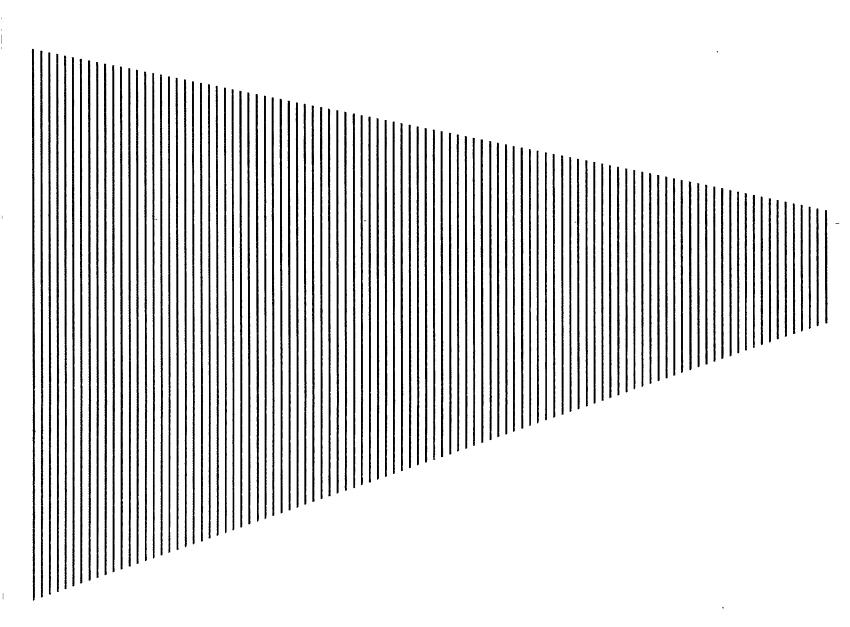
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2012 MERCER COUNTY, NJ COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

SUBMITTED TO: GREATER MERCER PUBLIC HEALTH PARTNERSHIP



NOVEMBER 2012

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This report was written by a mobilized group of geographically broad Mercer County constituents, facilitated, compiled and prepared by:



Health Resources in Action

Advancing Public Health and Medical Research

in cooperation with the Greater Mercer Public Health Partnership and Community Advisory Board thanks to the supportive funding from the Robert Wood Johnson Foundation New Jersey Health Initiatives.

ACKNOWLEDGEMENTS

Dear Healthy Community,

This is a community written strategic plan dedicated to reviving our community's health, right here, right now. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort. Our success is dependent upon moving from plan to action. Necessarily, the plan is fluid as it is executed by multiple community partners working together to achieve the goals, and must be adjusted and revised as conditions and key factors that influence plan execution change. In order to move from plan to action, we will need to address the following key questions:

- 1. Specific tasks: what will be done and by whom?
- 2. Timeframe: when will it be done?
- 3. Available resources: what specific funds and/or resources are available for specific activities?

It took an extensive list of partners to develop this Community Health Improvement Plan. People from all over Mercer County generously dedicated their time to uncover community health needs and priorities. Overall, this was a highly participatory process involving multiple perspectives: regional, cultural, linguistic, generational, geographical, and environmental, to name a few! As project director for our Healthy Future, I am very humbled by this dedication and commitment to health and wellbeing. Further, I am in awe of the strength of the many individuals who have supported this effort: citizens, parents, students, retirees, and our friends currently seeking employment. In the absence of their support we would have looked through a narrower lens. In addition, we have the great fortune to have received support from regional organizations in terms of dedicating their talented people, facilities and other resources to support the development of this strategic plan. It is my hope that the appended list reflects the majority of devoted affiliates, knowing full well that by simply creating the list, there is potential for omissions especially given that supporters join the efforts of this project continually.

I wish to also express thanks to the Robert Wood Johnson New Jersey Health Initiatives for its generous support which provided Mercer County's Health Improvement Plan with the necessary resources to allow us a greater chance of success. Finally, I appreciate those dedicated people who kept it real not only by making this plan happen, but for the positive impact they have on humanity every day: the Greater Mercer Public Health Partnership, the Community Advisory Board, and Health Resources in Action, Inc.

Mercer County offers a wealth of assets, the most critical of all is its people -- our community members who have given a tremendous outpouring of support to ensure that our community is a healthy one by the U.S. Center for Disease Control's definition: "A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."

Sincerely,

Antonia Lewis, Project Director, GMPHP

EXECUTIVE SUMMARY

Improving the health of a community is critical for not only enhancing residents' quality of life but also supporting their future prosperity. To this end, the Greater Mercer Public Health Partnership (GMPHP)—a collaborative of 14 area non-profit organizations, including four hospitals (Capital Health Medical Center- Hopewell, Princeton HealthCare System, Robert Wood Johnson University Hospital-Hamilton, St. Lawrence Rehabilitation Center), nine local health departments representing all thirteen municipalities in Mercer County, and the United Way —is leading a comprehensive community health planning effort to measurably improve the health of greater Mercer County, NJ residents.

Funded through the Robert Wood Johnson Foundation's New Jersey Health Initiatives, the Community Health Improvement Planning process includes two major components:

- 1. A community health assessment (CHA) to identify the health-related needs and strengths of greater Mercer County, and
- 2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across the County.

The full report presents the Community Health Improvement Plan (CHIP), which was developed using the key findings from the CHA to inform discussions and select the following data driven priority health issues, goals, and objectives:

Goal 1: lmpro	ove access to quality mental health and substance abuse prevention, treatment ecovery services for all persons while reducing the associated stigma.
Objective 1.1:	By January 2016, incorporate mental health and substance abuse services and education into 25% of primary care settings.
Objective 1.2:	By January 2016, increase awareness and utilization of existing mental health and substance abuse services among adolescents, young adults, and seniors by 25%.
Objective 1.3:	By January 2016, increase the number of mental health professionals in areas of highest need in Mercer County to achieve optimal recommended ratios of 4,500:1.
Objective 1.4:	By January 2016, increase the number of evidence-based educational programs in Mercer County that address prevention of mental illness and substance abuse among adolescents, young adults, and seniors.

10 45 ELLEVIEW, 1945	
Goal 2: Ilmaro	we the health and well-being of the community by advocating for sustainable
	y lifestyle choices.
Objective 2.1:	By September 2014, increase the number of children in daycare settings, schools (K-
	12) and afterschool programs who meet the Healthy New Jersey physical activity guidelines.
Objective 2.2:	By June 2014, increase the number transportation options for seniors and people who
	are disabled that will increase their access to safe places for physical activity (e.g., public parks, gyms). (cross reference with Transportation priority)
Objective 2.3:	By June 2014, provide guidelines for and educate the community on all aspects of healthy eating and active living, (specifically in areas of economic hardship).
Objective 2.4:	By August 2015, increase the number of school age children in Mercer County that have access to healthy food and beverage choices in school cafeterias to 100%.
Objective 2.5:	By January 2016, increase the percent of Mercer County employers that have implemented evidence-based worksite wellness initiatives by 25%.
Objective 2.6:	By January 2016, implement a minimum of 4 new policies that result in an increase in
	access to healthy foods and beverages in the community. [Note: the original 2.6
	objective from the planning session (which addressed Complete Streets) was integrated into the Complete Streets objective under Priority 4: Transportation.]
	A STATE OF THE STA
Goal 3: Engag	e the community to prevent and reduce chronic disease incidence and
morbi	dity (e.g., cancer, diabetes, heart disease, asthma).
Objective 3.1:	By January 2015, increase by 25% the number of people and venues in areas of
	greatest disparity who have access to information about the continuum of chronic disease services (i.e., prevention, treatment, maintenance).
Objective 3.2:	By January 2016, increase by 25% the number of health care providers who are
	engaged and aware of evidence-based practices and existing social services (see Objective 1.2).
Objective 3.3:	By January 2016, increase the number of chronic disease patients educated on and
	adherent to their medication regimen.
	THE THE PROPERTY OF THE PARTY O
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ise the overall health and wellbeing of Mercer County residents by enhancing affordable, accessible options for people to move easily and freely within and
与高级的 医眼中毒性坏疽	en communities in Mercer County.
Objective 4.1:	By January 2016, increase by 15% the existing miles of shared roads, safe walk ways,
Obj. at a a	and bike paths within Mercer County.
Objective 4.2:	By January 2016, research organizations currently addressing community development master plan transportation issues and develop strategies for
	improvement.
Objective 4.3:	By January 2016, promote the adoption of at least one sustainable, municipal, built
	environment policy in Mercer County that improves safety and increases opportunity for physical activity.
Objective 4.4:	By January 2016, increase by 30% viable, environmentally safe, public transportation
	options across communities and to and from parks.

The CHIP is not intended to be a static report. It is intended to focus and guide the beginning of a continuous health improvement process that will monitor and evaluate health priorities and system changes in an ongoing manner. The Mercer County CHIP provides an approach that is structured and specific enough to guide decisions, but flexible enough to respond to new health challenges. Its inclusive process represents a framework for all stakeholders.

Mercer County Community Health Improvement Plan

INTRODUCTION/BACKGROUND

Improving the health of a community is critical for not only enhancing residents' quality of life but also supporting their future prosperity. To this end, the Greater Mercer Public Health Partnership (GMPHP)—a collaborative of 14 area non-profit organizations, including four hospitals (Capital Health Medical Center- Hopewell, Princeton HealthCare System, Robert Wood Johnson University Hospital-Hamilton, St. Lawrence Rehabilitation Center), eight local health departments (Ewing, Hamilton, Lawrence, Hopewell, Montgomery, Princeton, East Windsor, and West Windsor), and the United Way —is leading a comprehensive community health planning effort to measurably improve the health of greater Mercer County, NJ residents.

Funded through the Robert Wood Johnson Foundation's New Jersey Health Initiatives, the Community Health Improvement Planning process includes two major components:

- 1. A community health assessment (CHA) to identify the health-related needs and strengths of greater Mercer County, and
- A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across the County.

This report presents the Community Health Improvement Plan (CHIP), which was developed using the key findings from the CHA to inform discussions and determine health priority areas.

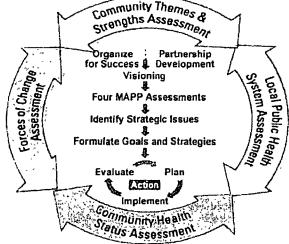
Moving from Assessment to Planning

Similar to the process for the Community Health Assessment (CHA), the CHIP utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.^{1, 2} See Figure 1.

¹ www.uwgmc.org/CHA)

² MAPP, a comprehensive, planning process for improving health, is a strategic framework that local public health departments across the country have utilized to help direct their strategic planning efforts. MAPP is comprised of four distinct assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/ evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/





To develop a shared vision and plan for improved community health, and help sustain implementation efforts, the Mercer County assessment and planning process engaged multi-sector community organizations, community members, community hospitals and Local Public Health System Partners (LPHS) through different avenues:

- a) In 2011, The Greater Mercer Public Health Partnership (GMPHP) was formed as the decision-making leadership body for the CHIP. In January 2012, the GMPHP hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a research partner to provide strategic guidance and facilitation of the CHA-CHIP process, to collect and analyze data, and to develop the report deliverables.
- b) The Community Advisory Board (CAB) was established in January 2012 to guide and offer feedback on the CHA and CHIP processes. The CAB is comprised of approximately 60 individuals who represent the local community in all its diverse aspects: business, education, communications, transportation, health and wellness, faith-based groups, civic and government, vulnerable populations (disabled, seniors, etc.), and other organizations and specialized areas.

GMPHP led the assessment and planning process by uniting community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, such as education, housing, local government, and social services. The community has been engaged in focus groups and interviews during the comprehensive data collection effort of the Community Health Assessment. Public events and media were used to further reach out to the community to broadcast and solicit feedback on the CHA findings and the CHIP priorities and strategies. In July 2012, the CHA report was distributed to the GMPHP and CAB for their review and feedback, and then to the community through a Town Hall Meeting attended by 200 community leaders. The larger community has been involved through continuous communications and meetings to discuss the importance of this planning process and to form working groups. On September 19, 2012, a summary of the CHA findings was presented to the CHIP Workgroups for review and refinement, serving as the official launching point of the CHIP. The CHIP Workgroups, comprised of 50 community leaders and organizations, represented broad and diverse sectors of the community. During the two planning sessions that followed, the Workgroups discussed key issues and themes from which priority health issues were identified and developed the goals, objectives and strategies for the CHIP.

I. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan that outlines priority health issues for a defined community, and how these issues will be addressed, to ultimately improve the community's health. A CHIP is intended to serve as a vision for the community's health and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP aims to:

- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

B. Going from Plan to Action

A CHIP is designed to be a broad, strategic framework for community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors — private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens — can unite to improve the health and quality of life for all people who live, work, and play in Mercer County.

The next phase of the CHIP will involve broad implementation of the strategies and action plan identified in the CHIP, and monitoring/evaluation of the CHIP's output and outcome indicators.

II. DEVELOPMENT OF THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

A. Community Engagement

Greater Mercer Public Health Partnership (GMPHP) led the planning process for Mercer County and oversaw all aspects of the CHIP development, including the establishment of Working Groups to flesh out details for identified health priorities. The GMPHP and the CAB continued from the Assessment Phase to the Planning Phase, guiding all aspects of planning and offering expert input on plan components.

CHIP Workgroup members were recruited from a large participation database of those individuals who had been involved in the focus groups, interviews, the Healthy Future Town Hall community meeting, and who represented broad and diverse sectors of the community.

B. Development of Data-Based Community Identified Health Priorities

A summary of the CHA findings was presented to the Workgroup members for further discussion. The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

- Access
- **Chronic Disease**
 - Cardiovascular
 - Cancer
 - **Diabetes**
 - Asthma
 - **Environmental factors**
- **Economic Equity**
- **Healthy Eating/Active Living**
 - Nutrition and Exercise
- Housing

- Maternal & Child Health
- Mental Health
 - Stress
 - Depression
 - **Obesity / Overweight**
- **Oral Health**
- Reproductive Health
- **Substance Abuse**
 - Prescription medicine
 - **Narcotics**
- Alcohol
- **Transportation**

The group was invited to offer feedback on and list additional priorities for the CHA to be included in the prioritization process.

Facilitators used a multi-voting process to identify the four most important public health issues for Mercer County from the list of major themes identified from the CHA. Each participant received four dots to apply to their top four public health priorities, after reviewing, discussing, and agreeing upon a common set of selection criteria, and grouping/categorizing areas of focus (e.g., transportation/built environment):

Political will exists to support change Community cares about it Key area of need (based on data)

- Size: Many people affected
- Trend: Getting worse
- Seriousness: Deaths, hospitalizations, disabilities
- Causes: Can identify root causes/social determinants
- Research/evidence-based

Achievable/Easy short term wins Resources available or likely Outcomes are measurable Can demonstrate progress **Community Based Strategies**

The results of the multi-voting process are as follows:

Priority	Total # of Votes
Mental Health	23
Substance Abuse	15
Healthy Eating/Active Living	23
Obesity/Overweight	17
3 Chronic Disease	17
Transportation/Built Environment	15
Access	14
Youth and Seniors	14

Based on the results of the multi-voting exercise, the workgroup participants agreed to combine Mental Health with Substance Abuse, and Obesity/Overweight with Healthy Eating/Active Living and ultimately agreed upon the following four health priority areas for the CHIP:

- 1. Mental Health and Substance Abuse
- 2. Healthy Eating and Active Living
- 3. Chronic Disease
- 4. Transportation

The group also suggested that Access and Youth and Seniors be added to Continuity of Care and Health Education/Literacy as cross cutting strategies for each of the CHIP priorities, as appropriate. Transportation was the identified priority aimed at addressing a social determinant of health inequity in Mercer County.

C. Development of the CHIP Strategic Components

The two half day planning sessions on September 19 and September 20, 2012 were facilitated by 2-person teams comprised of the Community Advisory Board and external consultants from HRiA facilitated the working groups on both days to develop draft goals, objectives, strategies, output and outcome indicators, and potential partners/resources for each of the four priority areas. HRiA provided sample evidence based strategies that were identified from the Community Guide to Preventive Services, County Health Rankings, and the National Prevention Strategy prior to the strategy setting session.

The GMPHP, CAB and HRiA consultants reviewed the draft output from the planning sessions and edited material for clarity, consistency, and inclusion of evidence base. Their feedback was incorporated into the final versions of the CHIP contained in this report.

D. Relationship Between the CHIP and other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Mercer County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP development process identified potential partners and resources wherever possible.

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the community health improvement plan meets the requirements for hospitals as per the section 501(r)(3)(B) of the Internal Revenue Code³, and fulfills the required prerequisites for local public health departments to earn accreditation, which indicates that the agency is meeting national Public Health Accreditation Board⁴ standards. Following the guidelines of the National Association of County and City Health Officials (NACCHO)⁵, the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact.

III. STRATEGIC ELEMENTS OF THE CHIP

Vision

A Healthy Future in Mercer County will require communities to work together across sectors – geographic, gender, generational, cultural, educational, and financial – for a healthy community where all citizens can be assured they are getting what they need to not just survive, but to flourish, economically, physically, environmentally, socially and politically.

Goals, Objectives, Strategies, Key Partners, and Output/Outcomes Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether your efforts are making a difference. Output and Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies.

The following pages outline the Goals, Objectives, Strategies, Potential Output and Outcome Indicators, and Potential Partner/Resources for the four health priority areas outlined in the CHIP. Please see Appendix B for a glossary of terms used in the CHIP.

2012 Mercer County Community Health Improvement Plan (CHIP)

http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act

⁴ http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/

⁵ http://www.naccho.org/topics/infrastructure/CHAIP/accreditation-preparation.cfm

A. Priority One: Mental Health and Substance Abuse

Substance use and mental health were considered interrelated, growing concerns for which the current prevention and treatment services do not sufficiently address community needs, particularly among youth. Current treatment and prevention programs do exist, but the demand exceeds the number of providers or even number of beds currently available. Youth substance use, particularly related to alcohol, marijuana, and prescription drugs, was an issue raised among a range of residents, including parents, those who work with youth, and teens themselves. The social norm was that some substances such as marijuana, alcohol, and prescription drugs were not considered dangerous among youth and thus were becoming more popular. The lack of programs for youth and concerned loved ones, social stigma in talking about substance abuse problems in the community, and complexity of addiction were all identified as contributors to this problem. Additionally, in community conversations many noted that the issues of substance abuse and mental health are intricately intertwined, which makes addressing these issues more challenging.

A dominant health concern for Mercer County residents was mental health. Focus group members and interviewees reported rising rates of depression and other mental health issues among people in the region and closely connected these to substance use, the economic downturn, and the region's achievement culture. Hospital admission rates for mental and behavioral health indicate that admissions indeed have been rising over the last several years from 4.9 per 1,000 population in 2006 to 7.8 admissions per 1,000 population in 2010.⁶ While hospital admission for mental health is more extreme, many residents noted that mental health conditions are pervasive and stigma presents a barrier.

Alcohol and marijuana are the substances cited as most often used by area high school students, 60.4% and 27.3% of Mercer County high school students reported using these respective substances in the past year. In 2010, there were 2,787 admissions in Mercer County to treatment facilities for alcohol and other drugs. Among these admissions, alcohol and heroin/other opiates were the leading causes of admission, with 34.8% and 31.1% of admissions respectively. Approximately 18% of admissions were due to marijuana. This distribution was similar to what was seen in past years, although slightly more admissions were due to cocaine in 2008 (15%) than in 2009 or 2010 (both approximately 11%). Among those 25 years and under, heroin and marijuana are the leading drugs for treatment. While treatment admissions are a promising sign of people seeking help, in 2009 the County experienced 41 deaths related to substance abuse.

Youth respondents reported that parental and community expectations create substantial stress for students, leading some to abuse substances or become depressed. Youth mental health data for Mercer County were not available; however, according to the New Jersey High School Youth Risk Behavior Survey, 12.9% of students reported seriously considering

⁶ Hospital admission data for both mental disease and disorders and alcohol/drug use or alcohol/drug-induced mental disorders. Data are for all hospitals within Mercer County. N.J. Department of Human Services, Division of Mental Health Services, Mental Health Subsidy Allocation, 2011; U.S. Census Bureau, 2010 Census as cited in County Health Profiles 2012-Mercer County. Health Research and Educational Trust of New Jersey.

New Jersey High School Risk and Protective Factor Survey, 2008. NOTE: Sample sizes at the county level may be small, so it is important to interpret data with caution.

⁸ New Jersey Drug and Alcohol Abuse Treatment. Substance Abuse Overview, 2010. Mercer County.

attempting suicide, while 10.9% made a plan about how they would attempt suicide. Several adult focus group participants also discussed how the economic recession exacerbates depression. In 2011, there were 24 deaths by suicide in the County. The area saw a steep rise in suicides in 2008, a difficult economic year nationwide and locally.

Goal 1: Improve; access to quality mental health and substance abuse prevention; treatment and recovery services for all persons while reducing the associated stigma.

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Objective 1:1: By lanuary 2016, incorporate mental health and substance abuse services and education into 25% of primary care settings.

Evidence-based Strategies:

- 1.1.1: Coordinate with institutions of higher learning to ensure that mental health and substance abuse training is included in the curriculum during undergraduate medical and paramedical studies to ensure adequate supply of trained primary care professionals. (Year 1)
- 1.1.2: Identify local primary health care settings that are willing to develop their team with the requisite skills and competencies to identify mental disorders and substance abuse; provide basic medication and psychosocial interventions; undertake crisis interventions; refer to specialists where appropriate; and provide education and support to patients and families. (Year 1 and 2)
- 1.1.3: Develop an effective referral system between primary health-care and secondary mental health and substance abuse facilities for instances when more severe cases need to be referred to specialists. (Year 1)
- 1.1.4. Provide current mental health and substance abuse resource information to area PCP's. (Year 1)

Outcome Indicators for Objective 1.1:

- Increase in number of primary care practitioners (PCP's) that provide mental health and substance abuse screening and treatment services
- Increase in number of primary care practitioners (PCP's) that refer mental health and substance abuse screening and treatment services
- Increase in mental health screenings and substance abuse screenings by PCP's
- Increase in number of mental health and substance abuse providers embedded in PCP settings
- Increase in the number of PCP's aware of available mental health and substance abuse services.

⁹ Centers for Disease Control and Prevention (CDC). New Jersey High School Youth Risk Behavior Survey Data.
Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

Goal 1: Improve access to quality mental health and substance abuse prevention, treatment and recovery/services for all persons while reducing the associated stigma.

Objective 1:2: By January 2016, increase awareness and utilization of existing mental health and substance abuse services among adolescents, young adults, and seniors by 25%.

Evidence-based Strategies:

- 1.2.1: Enhance existing website(s) and improve point of entry that includes easily accessible information and resources for all human services provided in Mercer County. (Year 1)
- 1.2.2: Develop and implement a culturally and linguistically appropriate media campaign that addresses stigma, is directed at the community, that drives people to the website and that also increase their awareness and use of available mental health and substance abuse services. (Year 1-3)
- 1.2.3: Develop and distribute targeted educational materials for youth and parents for dissemination throughout the school systems using conventional and social media distribution methods (e.g., Facebook, Twitter, texting, etc.). (Year 1-3)
- 1.2.4: Develop and distribute targeted educational materials for seniors for dissemination throughout senior centers, clinics, hospitals, and primary care settings. (Year 1-3)

Outcome Indicators for Objective 1.2:

- Increase in number of clients accessing mental health and substance abuse services
- Increase in number of community members who are aware of mental health and substance abuse services
- Increase by 5% the number of inpatient services available
- Increase by 10% the number of outpatient treatment services available
- Increase the timeliness of providing inpatient and outpatient treatment services
- Increased awareness in community about available resources

- Goal 1: Improve access to quality mental health and substance abuse prevention, freatment and recovery services for all persons while reducing the associated stigma.
- Objective 1.3: By January 2016, increase the number of mental health professionals in areas of highest need in Mercer County to achieve optimal recommended ratios of 4,500:1.10

Evidence-based Strategies:

- 1.3.1: Review existing assessments to determine existing number of mental health and substance abuse providers in Mercer County and number who accept Medicare/Medicaid. (Year 1)
- 1.3.2: Based on assessment results, develop a plan for addressing mental health and substance abuse provider short fall in areas of highest need and for vulnerable populations (uninsured/under insured). (Year 1&2)
- 1.3.3: Invest in mental health and substance abuse providers through increased resources for training, new incentives for medical personnel for providing mental health care to all patients, and support for individuals who choose to provide mental health and substance abuse services in underserved areas. (Year 2&3)
- 1.3.4: Collaborate with placement departments at training entities to place new clinicians with current mental health and substance abuse providers and within other settings (community based organizations, schools, senior care, places of worship) as determined by 1.3.1. (Year 2&3)

Outcome Indicators for Objective 1.3:

- Increase the number of mental health providers to be aligned with the optimal ratio
- Increase in mental health and substance abuse providers who accept Medicare/Medicaid and other insurance.

 $^{^{10}\,}http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaguidelines.html$

Goal 1: Improve accessito quality mental health and substance abuse prevention, treatment and recovery services for all persons while reducing the associated stigma.

Objective: 1.4: By January 2016, increase the number of evidence-based educational programs in Mercer County that address prevention of mental illness and substance abuse among adolescents, young adults, and seniors.

Evidence-based Strategies:

- 1.4.1 Identify evidence-based programs targeted towards youth and seniors on mental health and substance abuse issues that most impact each target population (i.e., anxiety, substance abuse, addiction, depression, social isolation). (Year 1)
- 1.4.2: Disseminate information about local programs to schools, primary care physicians, senior centers, health clinics, adult care facilities, and non-profit organizations serving homebound seniors and the homeless.
- 1.4.3: Partner with schools, community-based organizations, employers, and faith-based organizations to implement new programs.¹¹
- 1.4.4: Work with media to promote programs available for target populations.

Outcome Indicators for Objective 1.4:

- Increase in the number of community members with knowledge about mental health and substance abuse prevention and early intervention programs
- Increase the number of community members participating in prevention programs

National Registry of Effective Programs and Practices http://www.rmccorp.com/public/projectpage aspx?ProjectNum=170&Category=Alcohol%2C+tobacco%2C+and+other+drug+prevention+and+treatment

Goal 1: Improve access to quality mental health and substance abuse prevention, treatment

and recovery services for all persons while reducing the associated stigma

Partners/Resources for Mental Health and Substance Abuse

- County government
- Division of Mental Health and Substance Abuse
 - Foundation support
 - Robert Wood Johnson Foundation
 - Princeton Area Community
 Foundation
 - Janssen
- Bristol Myers Squibb
- Physicians
- Local Advisory Committee on Alcoholism Drug Abuse
- Public Health Training Center at University of Medicine and Dentistry
- School districts
- School Based Youth Services Program (SBYSP)
- The Center for Family, Community and Social Justice (CFCSJ, Inc.)
- Millhill Child and Family Development (outpatient services)
- HTIPS Adolescent Center
- Corner House
- Rutgers
- Thomas Edison College
- The College of New Jersey
- Princeton University
- Rider
- Mercer County Community College
- Womanspace
- Providers
- Trenton Stakeholders
- Faith-based groups (churches, seminary)
- Meals on Wheels
- County nutrition sites
- Assisted Living Communities

- Hospitals
- National Alliance on Mental Illness
- County Mental Health Board
- Department of Administrative Service
- Department of Education
- Department of Health
- County Office on Addiction Services
- SACs Student Assistance Counselors
- Trenton Health Team
- Mercer County Hispanic Association
- Latin American Family Alliance
- NEED baseline data on mental health
- Hispanic-American Medical Association (HAMA)
- Association for the Advancement of Mental Health (AAMH)
- HealthyLivingPrinceton.org
- Jewish Family and Children Services (JCFA)
- Better Beginnings UEEC
- Healthcare Quality Strategies, Inc. (HQSI)
- Catholic Charities
- EAP Employee Assistance programs
- Mercer Council on Alcoholism and Drug Addiction
- Governor's Council on Alcohol and Drug Addiction/Municipal Alliances
- Children's Interagency Coordinating Council
- Local Council on Alcoholism and Drug Addiction
- Nestkeepers
- Municipal Alliances
- Governor's Council on Alcoholism and Drug Addiction
- Children's Interagency Coordinating Council
- NestKeepers.org
- Central Jersey Family Health Consortium (CJFHC) Perinatal Addiction Prevention Project

B. Priority Two: Healthy Eating/Active Living

As with the rest of the country and state, issues around physical activity, healthy eating, and obesity are issues for Mercer County residents. The data supports that these issues are still considered critical given that the related chronic conditions of heart disease, cancer, and diabetes are the leading causes of morbidity and mortality. Of particular concern was the anecdotal evidence related to the increase in childhood obesity—an issue that will have even more severe health and cost repercussions in the future as the younger generation transitions to adulthood. While Mercer County has many grocery stores, parks, and recreational facilities, concerns were related to the accessibility and affordability of these outlets. The high cost of healthier foods, limited transportation to services, fees for recreational facilities, and difficulty around walking within some communities due to traffic, crime and lack of sidewalks were cited as challenges related to these issues. Therefore ensuring equitable resources for living and active life and eating healthy requires a comprehensive approach, in that multiple sectors, including health care, education, public works, transportation, local government, and the business community, needed to collaborate together to make an impact on current conditions.

Similar to trends nationwide, issues around obesity—particularly healthy eating and physical activity—are important health concerns in the area that are associated with prevalent chronic conditions such as heart disease and diabetes. Statistics indicate that Mercer County residents have similar behaviors to residents statewide. More than 70% of Mercer County and NJ residents reported eating fruits and vegetables fewer than five times per day (the recommended guideline), while approximately 25% indicated that they get no physical activity, according to the Behavioral Risk Factor Surveillance Survey¹².

The obesity epidemic is getting worse. Nationally, childhood obesity has tripled in the last 30 years. In New Jersey, the percentage of residents who are obese has risen from 14% in 1995 to 24% in 2010.¹³ The childhood obesity data for Mercer County is unreported. The adult obesity rate in Mercer County in 2009 was slightly higher (25.0%) than that of New Jersey overall (24.7%).

13 http://www.state.nj.us/health/newsletter/documents/october 2011 newsletter.pdf accessed 11/12

¹² Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention as cited in County Health Rankings, 2012

- Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.
- Objective 2.1: By September 2014, increase the number of children in daycare settings, schools (K-12) and afterschool programs who meet the Healthy New Jersey.

 physical activity guidelines. 14

Evidence-based Strategies:

- 2.1.1: Clearly define the issue of childhood obesity, and present it to parents, school administrators and key stakeholders to ensure support for increasing physical activity during the school day. (Year 1)
- 2.1.2: Identify and implement 3 evidence based approaches to increasing physical activity among school aged-children. (Examples include increasing the amount of time children engage in physical education and recess, instituting a walking school bus initiative, implementing Safe Routes to Schools). (Year 1)

Outcome Indicators for Objective 2.1:

- Increase in the of preschool, elementary, middle and high schools that have policies that require the recommended amount of physical activity during the school day (K-12)
- Decrease the % of youth that report a BMI >= to 30
- Increase the # of youth who say they were physically active during the school day
- Increase in physical activity in after school programs

¹⁴ http://health.gov/paguidelines/pdf/paguide.pdf

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Goal 2: : Improve the health and well being of the community by advocating for sustainable healthy lifestyle choices:

Objective 2:2: By June 2014 increase the number transportation options for seniors and people who are disabled to increase their access to safe places for physical activity (e.g., public parks, gyms). (cross reference with Transportation priority)

Evidence-based Strategies:

- 2.2.1: Assess current needs and transportation resources for seniors/disabled with respect to access to safe places for physical activity.
- 2.2.2: Identify and recruit a volunteer pool that can assist in transporting seniors and persons with disabilities to places where they can safely exercise. (Year 1)
- 2.2.3: Identify organizations that can provide vans and/or buses that can be used to transport target populations. (Year 1-3)
- 2.2.4: Identify local business to donate canes, walkers, snacks, and funding for gas. (Year 1-3)
- 2.2.5: Evaluate use of transportation services by target populations and promote among key leaders as rationale for long term sustainability. (Year 3)

Outcome Indicators for Objective 2.2:

- Increase in number of senior citizens and persons with disabilities who have access to safe places to be physically active
- Increase in the utilization rates of gyms and parks by seniors and persons with disabilities

Objective 2.3: By June 2014, provide guidelines for and educate the community on all aspects of healthy eating and active living, (specifically in areas of economic hardship).

Evidence-based Strategies:

- 2.3.1: Establish partnerships with key community groups especially those with resources/focus on healthy eating and active living (e.g., area businesses, , faith-based organizations, childcare centers, and assisted living centers, and other agencies) in an effort to work more collaboratively to implement healthy eating and active living community events. (Year 1)
- 2.3.2: Create centralized website for volunteers, mission, partnerships, events, and basic information on nutrition, fitness, and overall health and well-being that is appropriate for a variety of cultures, languages and literacy levels. (Year 1)
- 2.3.3: Host at least two county-wide events at community based centers and/or parks (Lock-in/field-day) and include vendors for nutrition and active living education. (Year 1-3)

Outcome Indicators for Objective 2.3:

- · Increase # of county residents using bike/walking paths or other recreational facilities
- Increase in # of county residents that participate in county wide healthy eating and active living events
- Increase in general well-being and quality of life of county residents
- Database of volunteers

Goal 2: Improve the health and well-being of the community by advocating for sustainable healthyllifestyle choices

Objective 2.4: By August 2015, increase the number of school age children in Mercer County that have access to healthy food and beverage choices in school cafeterias to 100%.

Evidence-based Strategies:

- 2.4.1: Educate students on the "Healthy Plate" concept through placemats, servicing trays, posters in cafeterias, and health and physical education classes. (Year 1)
- 2.4.2: Develop and implement a policy that restricts the availability of heavily sweetened beverages in schools. (Year 1)
- 2.4.3: Develop and implement a policy that requires schools to serve only non-fat, 1%, soy, rice, or almond milk in schools. (Year 1)
- 2.4.4: Develop and implement a policy that requires providing at least one serving of fresh fruits and vegetables during each meal. (Year 1)
- 2.4.5: Ensure availability of fresh drinking water throughout the day. (Year 1)
- 2.4.6: Increase fresh vegetable selections including implementation of salad bars. (Year 2)
- 2.4.7: Develop and implement a policy that requires schools to eliminate trans fats from all processed foods and snacks. (Year 3)
- 2.4.8: Work with school food service vendors to ensure that they provide healthier menu options. (Year 1)
- 2.4.9: Increase the utilization of school breakfast programs. (Year 1)

Outcome Indicators for Objective 2.4:

- Increase # schools in compliance with Healthy Plate Program (e.g., placemats, trays, posters)
- Increase # of healthy food and beverage policies established
- Increase in fruit and vegetable consumption
- Increase in consumption of water in schools
- Elimination of trans fats in school foods and snacks

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Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices:

Objective 2.5: By January 2016, increase the percent of Mercer County employers that have implemented evidence based worksite wellness initiatives by 25%.

Evidence-based Strategies:

- 2.5.1: Assess and compile current work place health and wellness programs to establish a resource of existing initiatives and examples. (Year 1)
- 2.5.2: Design and implement a plan to raise awareness and educate employers on the benefits of employee worksite wellness initiatives. (Year 1)
- 2.5.3: Recruit a minimum of 10 employers who are interested in implementing a comprehensive worksite wellness initiative. (Year 1)
- 2.5.4: Facilitate employers' implementation of evidence-based worksite wellness programs that include: health risk assessments, physical activity component, nutrition, mental health, alcohol and drug abuse, tobacco cessation and Employee Assistance Program. (Year 1)
- 2.5.5: Design and implement a recognition program for employer participation. (Year 2)

Outcome Indicators for Objective 2.5:

- Increase % of employers who participate in a worksite wellness program
- Increase % of employees who participate in a workplace program that is offered

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Goal 2 Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.

Objective 2.6: By January 2016, implement a minimum of 4 new policies that result in an increase in access to healthy foods and beverages in the community. 15

Evidence-based Strategies:

- 2.6.1: Work with local/county/state governments to create/use (existing) incentives to attract healthy food retailers and full service grocery stores into underserved communities (e.g., tax incentive, food license).
- 2.6.2: Implement a healthy vending machine policy that results in the removal of sodas/sweetened beverages and candy from vending machines in state and county facilities.
- 2.6.3: Work with local farmers to increase the number of Farmer's Markets and advocate for farmfriendly policies (e.g., farm to school and farm to worksite initiatives) in Mercer County.
- 2.6.4: Develop and implement an incentive based program that encourages local restaurants to provide healthy menu options that are labeled with calorie counts.
- 2.6.5: Pilot a Healthy Corner Store initiative in communities with limited access to fresh fruits and vegetables.
- 2.6.6: Partner with industrial landlords to create micro-farms inside abandoned buildings to address "food desert" issues.

Outcome Indicators for Objective 2.7:

- Increase in new food stores/outlets that provide healthy food options in previously underserved areas
- Increase in % of people who have access to healthy food choices
- Increase in the # of existing food stores/restaurants that have increased sales of healthy foods
- Increase % of locations (municipal buildings, senior centers) that have implemented healthy food options/healthy vending machines
- Increase # of farmers markets in county
- Increase # of healthy corner stores in county
- Increase in # of farm friendly policies

¹⁵ The original 2.6 objective from the planning session (which addressed Complete Streets) was moved from this priority area to the Complete Streets objective under Priority 4. Transportation.]

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Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices

Partners/Resources for Healthy Eating and Active Living

- T.R.A.D.E.
- Robert Wood Johnson Foundation
- Michelle Obama's Lets Move Initiative and local models
- Economic Development Authority
- Chamber of Commerce
- Health Food Stores
- Food Policy Council
- Aquatic Programs
- Child Care Center
- St. Lawrence Rehabilitation Center
- Senior Center
- Child Adult Food Program (Better Beginnings)
- Child Care Referral and resources
- Rise
- Nutritionists and Assoc.
- Community Food Pantries
- Add partners cut from 2.3.1
- School boards
- Mercer County Parks and Recreation
- Local recreation departments
- Restaurants
- Food pantries
- Physicians
- Department of Education
- Department of Health
- ShapingNJ

- Women Infants and Children (WIC)
- HealthyLivingPrinceton.org
- HealthyLivingMercer.org
- Sports Medicine
- School Superintendents
- PCORE
- Pediatric Council (Mercer County)
- Physicians
- School Boards
- Local junior leagues
- Harvest Routes
- Meals on Wheels
- Pediatric Council on
- Research & Education, Inc.
- Department of Travel and Tourism
- Grocery Stores
- Farmers Markets
- YWCA's and YMCA's
- Wellness and Fitness Centers
- "Suppers" Program
- Healthy Bones Program for Seniors
- Mercer County Park Commission
- Local Rec Depts.
- Local restaurants
- Local farmers
- Hospitals
- "Walk this Way" program

C. Priority Three: Chronic Disease

When asked about health concerns in their communities, many residents cited chronic diseases, specifically cancer, heart (cardiovascular) disease, diabetes, and asthma. Physicians reported seeing an increase in chronic disease co-morbidities along with mental illness and substance abuse. While EMT focus group respondents reported that it seemed like chronic disease patients were being discharged prematurely from the hospital and then not managing their conditions adequately, thus being at-risk for re-admittance. Numerous participants pointed to the rising obesity epidemic as being a concern for potentially increasing rates of chronic disease.

Heart disease was the leading cause of inpatient hospitalization among Mercer County adult patients 18-64 years old (2.95 per 1,000 population) Heart disease was followed by asthma (0.88 per 1,000) and diabetes (0.86 per 1,000) in Mercer County. Heart disease was also the leading cause of hospitalization in Mercer County (36.68 per 1,000) for the elderly (aged 65 and older). The second leading cause of inpatient hospitalization for the elderly in Mercer County was for stroke (20.11 per 1,000 population) followed by fractures (10.59 per 1,000)¹⁶.

Cancer is the second leading cause of death in New Jersey and in Mercer County, the incidence rates for most cancers is higher in Mercer County than for the state. The all-site cancer incidence rate in Mercer County has slightly increased from 2003 to 2009 from 572.1 per 100,000 population to 589.3¹⁷, whereas there has been a decrease in overall cancer mortality during that same time period¹⁸. Cancers with the highest incidence rates include prostate and breast, while lung and prostate cancer are the leading causes of cancer deaths.

Diabetes and asthma were the most prevalent chronic conditions, with 9.1% and 7.4% reporting currently having been diagnosed with these diseases¹⁹.

New Jersey Department of Health and Senior Services, Office of Health Care Quality Assessment, Data analyses conducted with 2010 Uniform Billing (UB) Hospitalization data, NJ Discharge Data Collection System (NJDDCS). Analyses conducted using ICD-9 codes, primary diagnosis only. Rates standardized to U.S. Census 2010 Population for Mercer County, by municipality, and by age.

¹⁷ State of New Jersey Department of Health and Senior Services, New Jersey Cancer Registry, 2003-2009

State of New Jersey Department of Health and Senior Services, New Jersey Cancer Registry, 2000-2007
 Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data.
 Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010.

- Goal 3: Engage the community to prevent and reduce chronic disease incidence and morbidity (e.g. fcancer diabetes; heart disease; asthma).—
- Objective 3.1: By January 2015, increase by 25% the number of people and venues in areas of greatest disparity who have access to information about the continuum of chronic disease services (i.e., prevention treatment, maintenance).

Evidence-based Strategies:

- 3.1.1: Work with local coalitions, public health offices, health care facilities, and associations to disseminate information about chronic disease and promote the importance of screenings. (Year 1)
- 3.1.2: Develop or use existing evidence-based curriculum with local health care professionals and agencies to design programs for specific underserved target populations/audience. (Year 1)
- 3.1.3: Identify and partner with organizations that have mobile units to bring services to the communities with limited access to health screenings (e.g., mammography mobiles, blood pressure mobiles). (Year 1-2)
- 3.1.4: Work with recognized state and private agencies, and health care professionals and associations, to educate, teach and provide compliance and prevention tools. (Year 2-3)

Outcome Indicators for Objective 3.1:

- Increase in # of people served from underserved population groups
- Decrease in % existing vulnerable groups in ER use, re-admittance to hospital
- Increase in # of organizations/venues providing services in areas of need
- Decrease in disparity between underserved groups and overall Mercer County

- Goal 3: Engage the community to prevent and reduce chronic disease incidence and morbidity (e.g., cancer: diabetes; heart disease, asthma).
- Objective 3:2: By January 2016, increase by 25% the number of health care providers who are engaged and aware of evidence-based practices and existing social services (see Objective 1.2).

Evidence-based Strategies:

- 3.2.1: Advocate for health care training programs to include chronic disease management and mandatory rotation to post-acute venues of care. (Year 2)
- 3.2.2: Advocate with the legislature and Division of Consumer Affairs to expand their policy on the scope of practice for Nurse Practitioners and Physicians Assistants, to push for multi-state reciprocity of licensure, and to allow for direct access to the community by NPs and PAs. (Year 2)
- 3.2.3: Encourage the medical society and specialty boards to adopt a uniform set of evidence-based practices to be used by the profession. (Year 3)
- 3.2.4: Develop and disseminate a county-wide referral database that can be utilized by professionals and community members to ensure that individuals are sent to the appropriate location. (Year 1)
- 3.2.5: Recruit five physician ambassadors, five nurse ambassadors and five social workers and/or mental health practitioners to develop an advisory council that will be tasked with developing a plan to help patients become more adherent resulting in better health outcomes. (Year 1)
- 3.2.6: Link mental health and substance abuse providers with the chronic disease providers.

Outcome Indicators for Objective 3.2:

- Track # of referrals to social services from Electronic Medical Records
- Increase the # of providers participating in workshops/programs and receiving CME/CEU credits
- Increase the # of mental health providers integrated into chronic disease management venues
 of care.

Goal 3: Engage the community to prevent and reduce chronic disease incidence and morbidity (e.g. cancer diabetes; heart disease) asthma).

Objective 3.3: By January 2016, increase the number of chronic disease patients educated on and adherent to their medication regimen.

Evidence-based Strategies:

- 3.3.1: Using a patient focused, team-based approach, create information tools for all health care providers (including pharmacists, social workers, discharge planners, etc.) that promote treatment adherence. (Year 1)
- 3.3.2: Utilize new technologies and information systems to monitor treatment adherence (e.g., callin services, tele-health, mobile apps (e.g., Aetna), cell phone reminders, med boxes). (Year 1-2)
- 3.3.3: Expand existing community initiatives including peer counselors to educate patients and encourage adherence. (Year 2)
- 3.3.4: Create and implement marketing campaign to general public (partnering with pharmaceuticals and Health Insurance companies). (Year 1-3)
- 3.3.5: Advocate to pharmaceutical companies to make more generic drugs available and to ensure more appropriate use of the branded drugs already available. (Year 2)

Outcome Indicators for Objective 3.3:

- Decrease in #of heart attacks, heart disease prevalence, diabetes, asthma
- Track prescription refills of medications from pharmacies what was picked up, what was refilled?
- Self-reported surveys of patients on adherence

Outcome Indicators for Overarching Goal:

- % decrease in incidence chronic diseases
- Decrease in emergency room use, hospitalizations and re-admittance for chronic disease
- Increase in the number of patient centered providers

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Goal 3: Engage the community to prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).

Partners/Resources for Priority Area

- Centers for Disease Control
- Schools (Medical)
- NJ Department of Health
- Department of Environmental Protection
- Local Health Departments
- Local Boards of Health
- Insurance Companies
- Hospitals

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- Hospital/association NJ
- NJ Case Management Society of America
- HQSI Healthcare Quality Strategies, Inc.
- Pharmaceutical companies
- NJ Health Information Exchange
- Medical Association
- St. Lawrence Rehabilitation Center

- NJ Hospital Association
- Institute of Medicine
- Physicians
- Community based organizations (outreach)
- Island Peer Review Organization (IPRO)
- CPHQ NJ Certified Professional Healthcare Quality
- National Transitions of Care Organization (NTOCC)
- Greater Trenton Coalition
- NJ Pharmacists (?association)
- NJ State Nurses Association
- NJ Division of Consumer Affairs
- Planned Parenthood

D. Priority Four: Transportation

Residents repeatedly discussed that their communities had limited walkability and a lack of public transportation services, resulting in an environment which has affected some residents' quality of life, stress level, and ease of accessing services. In many communities, transportation or walkability was discussed as a critical issue. Mercer County's suburban and rural areas have a lower density area and residents are more reliant on their cars. For those who do not have a car, it is difficult to walk to needed services due to distance and lack of infrastructure for pedestrians. Public transportation was discussed as being unreliable and limited. For vulnerable populations such as the elderly, youth and lower income, these limited transportation options have a severe impact on their time, ease of getting to employment, scheduling and maintaining appointments, or fulfilling errands in their daily lives. These discussions repeatedly identified the interconnections between transportation and its challenges to maintaining good health. As Mercer County's population grows, particularly among the elderly, the issue of transportation will become even more critical to address. These challenges are exacerbated during times of emergency crises, such as the recent hurricanes, given fuel restrictions, and homebound and relocated residents.

Goal 4: Increase the overall health and wellbeing of Mercer County, residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.

Objective 4.1: By January 2016, increase by 15% the existing miles of shared roads, safe walkways, and blke paths within Mercer County.

Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe; affordable accessible options for people to move easily and freely within and between communities in Mercer County:

Evidence-based Strategies:

- 4.1.1: Identify and link existing bicycle and pedestrian groups, for the purpose of developing partnerships, understanding existing plans, and developing an inventory of the existing bike paths, foot paths and lanes. (Year 1)
- 4.1.2: Analyze projects that are planned for the near future and identify any gaps or safety concerns in the plans for shared road/bike path and pedestrian network. (Year 1)
- 4.1.3: Identify funding sources to make network improvements or additions, and/or advocate including network improvements in existing roadway construction projects. (Year 2)
- 4.1.4: Lobby policy makers for inclusion of specific critical segments in road improvement projects. (Year 3)

Outcome Indicators for Objective 4.1:

- Increase in miles of safe foot paths/walkways
- Increase in miles of bike lanes/paths
- Increase in # of future road improvement projects that include bike lanes, sidewalks and bike paths

Objective 4.2: By January 2016, research organizations currently addressing community development master plan transportation issues and develop strategies for improvement.

Evidence-based Strategies:

- 4.2.1: Review and evaluate appropriate sections of all municipal, county and state community development master plans for health impact in order to modify/enhance existing laws and policies regarding sidewalks, bike lanes, walking trails and mode of movement throughout communities. (Year 1)
- 4.2.2: Contact transportation-related agencies that may have relevant data, research and resources available to identify needs (e.g., Transportation Management Association (TMA), Trail groups). (Year 1)
- 4.2.3: Identify and mobilize key stakeholders within each municipality who have the authority to address community connectivity needs that include all modes of movement (e.g., planners, engineers, elected officials). (Year 2)
- 4.2.4: Collaborate with organizations and individuals who can help to advocate to local governments to address transportation gaps including pedestrian, bike and vehicular issues (via resolutions, ordinances and planning policies). (Year 2-3)
- 4.2.5: Develop awareness campaign to promote all modes of transportation currently available. (Year 3)

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Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.

Outcome Indicators for Objective 4.2:

- # of community development master plans reviewed
- # of strategies developed
- Implementation of awareness campaign
- List of transportation-related agencies and key stakeholders

Objective 4:3: By January 2016, promote the adoption of at least one sustainable, municipal, built environment policy in Mercer County that improves safety and increases opportunity for physical activity.

Evidence-based Strategies:

- 4.3.1: Review evidence-based policies that have been successfully implemented in other communities (Complete Streets, Safe Passage, sidewalks/streetlights, and traffic calming measures.) (Year 1)
- 4.3.2: Identify one successful community model for Mercer County and use as the basis for developing a plan. (Year 1)
- 4.3.3: Convene local affected businesses ,home owners , tenants, school PTAs, and other community stakeholders to identify and target areas of greatest need and solicit their comments/ideas regarding a plan. (Year 1)
- 4.3.4: Review area accident and crime rate/incidents in focus area to develop solutions. (Year 1)
- 4.3.5: Review engineering lay vs. complete street concept in focus area with environment impact. (Year 1)
- 4.3.6: Identify resources from objective 4.2 and other available funding. (Year 1)
- 4.3.7: Adopt suitable policy to support transportation needs identified. (Year 2)

Outcome Indicators for Objective 4.3:

- # of policies adopted
- Decrease in crime and accidents in targeted areas

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Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe) affordable; accessible options for people to move easily and freely within and between communities in Mercer, County.

Objective 4.4: By January 2016, increase by 30% viable, environmentally safe, public transportation options across communities and to and from parks.

Evidence-based Strategies:

- 4.4.1: Partner with area and regional hospitals to verify and address the need for a shuttle service for communities where there is limited transportation.
- 4.4.2: Partner with DOT to implement recommended projects; address the need for a high-speed bus line along major and feeder routes to reduce congestion, pollution, stress and accidents; and leverage their investment/grant/funding sources.
- 4.4.3: Expand existing overpass serving the retail centers along busy highways to include a protected passenger walking lane with guard rail, thus reducing auto traffic on the highway and encouraging people to increase their physical activity.
- 4.4.4: Introduce public forums through libraries to disseminate information on public transportation projects and invite public input.
- 4.4.5: Identify and secure funding to expand existing service and routes for seniors and people with disabilities to accommodate weekends, early morning , evenings, late night and trip lengths over ten miles with special attention to portions of Mercer County with limited transportation.
- 4.4.6: Work with emergency management responders to improve and enhance transit options during crisis response.

Outcome Indicators for Objective 4.4:

- Increase in the # of safe walkways around busy retail areas
- A shuttle service and/or transit options established for outlier communities
- High speed bus lines along major highway and feeder routes

Partners/Resources for Priority Area

- TMA (Transportation Management)
- Police Departments
- "Free Wheelers"
- "Lawrence-Hopewell Trail"
- Parks and Recreation
- Environmental Commissions
- Grassroots Environmental Advocates
- Mercer County TRADE Transportation
- Conservation Groups
- Boy Scouts/Girl Scouts
- Rutgers Co-Op Extension

- NJ Transit
- "Ride Provide"
- Cycling groups
- Running Groups
- Community Associations
- School Districts
- Education Department
- Emergency Management Responders
- Sustainable Regional Organizations
- Princeton Futures
- ARC Mercer
- Hospitals

IV. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. To finalize this strategic framework, GMPHP, CAB and community participants will revise and refine the suggested activities and timelines drafted by workgroup members to complete the action plans for the CHIP. As part of the action planning process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Mercer County.

Appendices

APPENDIX A: COMMUNITY HEALTH IMPROVEMENT PLAN PARTNERS

A large number of diverse community stakeholders representing multiple areas

Better Beginnings Day Care Center

Bristol Myers Squibb

Capital Health Medical Center at Hopewell

Catholic Charities

Central Jersey Family Health Consortium (CJFHC)

City of Trenton Division of Health

Corner House

Creative Marketing Group

Educational Testing Services

Enable

Family Service Organization

Grace N Rogers School

Hamilton Township Senior Center

Health Resources in Action

Hightstown Board of Health

HiTops

Hopewell Township Health Department

Hopewell Township Police Department

Hopewell Valley Regional School District

Horizon Healthcare Innovations

Hygeia Consulting Group

Interfaith Caregivers of Greater Mercer County

Janssen Pharmaceutica

Lawrence Township Health Department

National Alliance on Mental Illness of Mercer County

M J Scott DO & Assoc. Inc

Mercer County Community College

Mercer Council on Alcoholism and Drug Addiction

Mercer County Board of Freeholders

Mercer County Division of Public Health

Mercer County - Economic Development

Mercer County TRADE Transportation

Mercer County Park Commission

Mercer County Veteran Services

Mid-Jersey Chamber of Commerce

Mill Hill Child Development Center

New Jersey Health Care Quality Institute

P.E.I Kids

Princeton Community Housing

Princeton Medical Group PA

Princeton Township Health Department

Robbinsville Senior Center

RWJ Hamilton Hospital

Robert Wood Johnson Foundation New Jersey Health Initiatives

St Lawrence Rehabilitation Center

State of NJ Department of Health

Terhune Orchards

Terra Momo Restaurant Group

The College of New Jersey

Thomas Edison State College

Trenton Funeral Home

United Way of Greater Mercer County

University of Medicine and Dentistry of New Jersey

University Medical Center of Princeton at Plainsboro

Visiting Nurses Association Home Care of Mercer County

West Windsor Township Health Department

West Windsor Township Senior Center

West Windsor Waterworks

YMCA of Hamilton

YMCA of Trenton

A large number-of people have helped guide the development of the community health assessment and health improvement plan. If there are any omissions, or you have an interest in becoming a part of this movement, please let us know.

APPENDIX B: GLOSSARY OF CHIP TERMS

Priority Areas - broad issues that pose problems for the community

Goals - identify in broad terms how the efforts will change things to solve identified problems

Objectives - measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

Strategies - action-oriented phrases to describe how the objectives will be approached

Output Indicators - specific deliverables that are the result of the completion of the strategies and actions taken

Outcome Indicators - the changes that occur at the community level as a result of completion of the strategies and actions taken



Community Health Improvement Plan

Making the City of Trenton
The Healthiest City in New Jersey:
Creating a Culture of Health

Trenton, New Jersey

January 2014

Acknowledgments

We wish to acknowledge the Robert Wood Johnson Foundation, through its New Jersey Health Initiatives, for funding the Community Health Needs Assessment for the six zip codes of Trenton.

We also wish to recognize The Nicholson Foundation for its operating support of the Trenton Health Team, which has enabled us to improve health care access, outcomes, and delivery of services while lowering system costs.

We are deeply grateful for the contributions of hundreds of anonymous community members who shared their views and concerns through one-on-one interviews and forums.

We are also indebted to our many partners who are working alongside us to improve the health of the Trenton community. Our partners are listed at the back of this report; we apologize for any inadvertent omissions.

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Executive Summary

The Trenton Health Team (THT) has completed a comprehensive, data-informed Community Health Needs Assessment (CHNA), in which Trenton residents played a key role in identifying and articulating the city's top health priorities. THT, a collaborative of the city's two hospitals, St. Francis Medical Center and Capital Health; its only Federally Qualified Health Center, Henry J. Austin Health Center; and the city government's Department of Health & Human Services, partnered with 29 community and social service agencies across Trenton to develop one CHNA for the city as a whole.

CHIP Priorities

Within the overarching priority of poverty, the CHNA process identified five health priorities that require community-wide attention and focus:

- Health Literacy & Disparities
- Safety & Crime
- Obesity & Healthy Lifestyles
- Substance Abuse & Behavioral Health
- Chronic Disease: Diabetes, Hypertension, and Cancer

These were chosen from a longer list of issues that had been derived using health data from THT partner organizations and public sources. These data were shared with the community, whose input was the key driver in selecting our priority areas. During THT's unique community engagement efforts, hundreds of Trenton residents and THT members talked in over 300 individual interviews and 30 forums held in places of worship, community organizations, and public facilities. Priorities emerged as residents shared their personal stories, their fears, their frustrations, and their health and life challenges, in discussions guided by THT professionals.

Results of the CHNA, which were presented in a number of public forums and are available for download via the THT website¹, were used to drive the development of our Community Health Improvement Plan (CHIP), which includes realistic, measurable goals to address the emerging priorities uncovered by the CHNA. Each CHNA health priority was assigned to a community leader who will lead that priority's improvement initiative, guided by the CHIP Steering Team.

As noted in the CHNA, Trenton's health challenges are numerous. Some of those challenges, while beyond the scope of the current CHNA and therefore not a primary focus of the CHIP, bear mentioning in order to fully understand the picture of health in Trenton. Additional factors impacting health outcomes in the city include:

- HIV/AIDS and Hepatitis C
- Teen pregnancy and poor birth outcomes

¹ http://www.trentonhealthteam.org/tht/TrentonCommunityHealthNeedsAssessmentJuly2013.pdf

- Sexually transmitted diseases
- Lead poisoning
- Other chronic conditions such as asthma
- Transportation

Efforts are currently under way to address these issues, which may ultimately overlap with some of our CHIP initiatives. While they will not be our primary focus, THT supports the efforts and will participate in collaboration with organizations that are working to address them. Among these are Planned Parenthood of the Mercer Area, HiTOPS, Children's Futures, Isles, Inc., and the City of Trenton. We will continue to acknowledge the impact of these issues, as applicable, while we focus on the emerging priorities identified by our quantitative data and community engagement efforts.

Also noted as a limitation of the CHNA is the transience of the Trenton population, which means our data snapshot may not exactly reflect the situation on any given day. Population mobility also presents a challenge in tracking outcomes of the CHIP, as individuals and families move within and beyond the community's geography. It is our goal, however, to demonstrate quantifiable improvement on key targets using the most accurate measures available to us. We anticipate that the Trenton Health Information Exchange, launched and maintained by THT as of January 2014, will be a valuable resource in this endeavor.

Overarching Goals and Objectives

Targets for improvement over the three-year period of the CHIP have been set, relating to each of the priority areas. While these targets have been set with the recognition that further improvements will be needed to align with national norms, achieving them will begin to address the current disparities. It should be noted that strategies for cultural competency and the removal of barriers will be a necessary and integral component for all priority areas. Our success in this regard will depend upon strong partnerships with appropriate community agencies throughout the city. Our targets include the following:

- Engage city providers in health literacy and cultural competency trainings and secure commitments to adopt best practices in this area
- Reduce the violent crime rate
- Reduce the obesity rate for children and adults
- Adopt substance abuse and mental health screenings city wide, expanding the SBIRT program and expanding available services for behavioral health
- Reduce the adult diabetes rate and improve self-management of the disease
- Include smoking cessation counseling at all of the city's seven clinics
- Increase routine screenings for cancers, especially for lung, prostate, breast, and colorectal cancer

It is also worth noting that our CHIP goals and objectives support and align with the NJ Department of Health Strategic Plan, 2012-2015, and *Partnering for a Healthy New Jersey:* New Jersey Chronic Disease Prevention and Health Promotion Plan, 2013-2018. In each of these plans there is an emphasis on public-private partnerships and collaboration,

community engagement, culturally appropriate communication, effective use of data, fostering prevention and wellness strategies, and promoting early detection and self-management of chronic disease.

Priority Area Goals and Objectives

Within the overarching CHIP goals, specific objectives and strategies have been developed, with primary goals and strategies for each priority area as follows:

	Priority Area 1: Health Literacy & Disparities
Goal 1.1	Increase access for everyone to accurate and actionable health
	information; support lifelong learning to promote good health
1.1.1	By July 2014, each member organization of the Community Advisory Board
	will commit to developing a plan to incorporate best-practice health literacy
	standards for both communication strategies and printed outreach and
	educational materials.
1.1.2	By September 2014, establish a relationship to support NJPHK's efforts to
	embed information regarding CHNA priorities and CHIP goals into school
	health curriculum at all grade levels (also Obesity & Healthy Lifestyles).
Goal 1.2	Deliver person-centered health information and services
1.2.1	By July 2014, engage with faith-based and other community organizations
	to develop a plan to conduct cultural competency trainings at primary care
	clinics and behavioral health providers throughout the city.
1.2.2	By September 2014, convene from among the Community Advisory Board
	partners, those individuals serving in community outreach positions
	(including the roles of peer leader, community ambassador, patient
	navigator, health advocate, <i>Promotora</i> , or Community Health Worker) to
	share best practices and align strategies around CHIP goals.
1.2.3	By July 2015, develop and provide an educational program focusing on
	access to care and care disparities for physicians and other providers

Goal 2.1	Reduce street-level violence by implementing the Trenton Violence Reduction Strategy (TVRS), an evidence-based, public health approach
2.1.1	By March 2014, begin conducting call-ins to confront gang members and violent offenders and offer them the choice to accept social service interventions and an alternate lifestyle or face lengthy jail time.
2.1.2	By July 2014, develop a highly specific, data-informed plan for building community and agency capacities to incorporate and promote violence reduction strategies.
Goal 2.2	Increase residents' perceptions of safety
2.2.1	By January 2014, conduct task force activities, thereby increasing police presence in identified "hot spot" areas.
2.2.2	By March 2014, reduce criminal presence by beginning program of long- term incarcerations for repeat offenders who refuse positive interventions.

	Priority Area 3:: Obesity & Healthy Eifestyles
Goal 3.1	Increase residents' access to and consumption of healthy foods
3.1.1	By April 2014, obtain letters of commitment from THT's Community Advisory Board to support the Trenton Healthy Food Network, building on existing initiatives such as NJPHK (http://www.njhealthykids.org/) and Shaping NJ (http://www.shapingnjcommunity.org/).
3.1.2	By July 2014, work with Capital Health to refine and develop additional strategies for its Delivery System Reform Incentive Payment (DSRIP) program, which is focused on reducing obesity.
3.1.3	By July 2015, seek funding to expand Healthy Corner Stores initiative to add four or more participating stores distributed on the basis of need.
Goal 3.2	Increase access to and practice of physical activity
3.2.1	By May 2014, re-establish collaboration among public departments and agencies such as the City of Trenton Recreation Department, TPD, and schools to ensure that physical fitness activities are available regularly at public parks and community centers.
3.2.2	By September 2014, craft organizational wellness policies for THT partners and promote adoption of similar policies in Trenton schools, public and private agencies, and workplaces by July 2015.

Goal 4.1	Priority Area 4: Substance Abuse & Behavioral Health Expand screening and improve referral to quality behavioral treatment services, including reducing cultural barriers for behavioral health treatment
4.1.1	By July 2014, expand the SBIRT program to all city clinics and emergency rooms and develop a plan for including adolescents; by July 2015, expand SBIRT to non-clinical settings such as Rescue Mission and TASK.
4.1.2	By September 2015, develop a pilot "transitional" outpatient clinic model designed to divert emergency room visits to more appropriate settings for care, and improve patient engagement in treatment programs.
4.1.3	By July 2016, re-establish detoxification programming within the Trenton geography.
Goal 4.2	Improve access to and utilization of prevention services
4.2.1	By January 2014, work with Mercer County Prevention Coalition, Trenton Municipal Alliance, and the County Comprehensive Plan to coordinate and expand knowledge of available prevention resources.
4.2.2	By July 2015, develop "ready access" scheduling at behavioral health providers and develop resources for helping individuals pay for medications.

Prio	rity Area 5: (Chronic Disease: Diabetes: Hypertension: and Cancer
Goal 5.1	Improve disease management for diabetes and hypertension (HTN) by adopting evidence-based practice guidelines in each of the city's clinics
5.1.1	By July 2014, implement a self-management tool for diabetes and HTN at each site.
5.1.2	By July 2014, work with St. Francis Medical Center to refine and develop additional strategies for its DSRIP program, which is focused on diabetes care and prevention.
5.1.3	By September 2014, have self-management goals for 60% of established patients with diagnosis of diabetes/HTN at all clinic sites.
Goal 5.2	Expand cancer screenings for the community by facilitating a partnership with NJCEED (Cancer Education and Early Detection)
5.2.1	By July 2014, establish a process that will result in referrals for cancer screening by primary care practitioners or NJCEED.
5.2.2	By July 2014, provide a navigator model of care at each site that will assure confirmation of appropriate screening services for clients.
5.2.3	By July 2015, identify GI specialist referral resources for patients with abnormal colorectal screenings.

Introduction

Our Health Priorities

The Trenton Health Team (THT), in collaboration with its community partners, recently completed a comprehensive, data-informed Community Health Needs Assessment (CHNA) in which Trenton residents played a key role in identifying and articulating the city's top health priorities. Within the overarching priority of poverty, the CHNA has identified five health priorities that require community-wide attention and focus. These are:

- 1. Health Literacy & Disparities
- 2. Safety & Crime
- 3. Obesity & Healthy Lifestyles
- 4. Substance Abuse & Behavioral Health
- 5. Chronic Disease: Diabetes, Hypertension, and Cancer

As noted in the CHNA, Trenton's health challenges are numerous. Some of those challenges, while beyond the scope of the current CHNA and therefore not a primary focus of the CHIP, bear mentioning in order to fully understand the picture of health in Trenton. Additional factors impacting health outcomes in the city include:

- HIV/AIDS and Hepatitis C
- Teen pregnancy and poor birth outcomes
- Sexually transmitted diseases
- Lead poisoning
- Other chronic conditions such as asthma
- Transportation

Efforts are currently under way to address these issues, which are extremely important and may ultimately overlap with some of our CHIP initiatives. While they will not be our primary focus, THT supports the efforts and will participate in collaboration with organizations that are working to address them. Among these are Planned Parenthood of the Mercer Area, HiTOPS, Children's Futures, Isles, Inc., and the City of Trenton. We will continue to acknowledge the impact of these issues, as applicable, while we focus on the emerging priorities identified by our quantitative data and community engagement efforts.

Developing Our CHIP Strategies

The next, all-important step is to take the identified needs and, with continued community engagement, drive plans to address them. This is the goal of our Community Health Improvement Plan (CHIP), which we envision as a living document that will guide our efforts over the next three years.

To adequately address the five health priority areas identified in the CHNA, the THT executive leadership created workgroups by reaching out to its Community Advisory Board (CAB) for volunteers to provide leadership in each of the five health priority areas. The

CAB collaborated with workgroup leaders to identify Trenton city residents with relevant interests and expertise to participate. One of the THT executive leaders was also assigned to each of the five workgroups, with additional THT staff as resources.

Each workgroup held a series of meetings, which were convened with the purpose of developing goals, objectives, and strategies to provide measurable improvements related to their particular CHNA priority. A summary of those discussions was then reviewed and refined by the THT Executive Committee and leaders of the workgroups, with the goal of creating consensus regarding those objectives and strategies that could create the most meaningful impact on the health of the community within the three-year time frame of the CHIP. The resulting goals, objectives, and strategies are summarized in this document, along with the organizations that will have primary responsibility for implementation in each category.

We are grateful to all our workgroup members and community partners, whom we have listed in Appendix A, for their thoughtful participation in the CHIP development process and for their continued engagement in its implementation. Together, we can move towards our vision of making Trenton the healthiest city in the State of New Jersey.

Vision and Values

The vision of the Trenton Health Team (THT) is to make Trenton the healthiest city in the state. Our mission is to transform healthcare for the city through a committed partnership with the community, with a continued focus is on the triple aim of improved patient experience, improved patient outcomes, and lower healthcare costs.

We recognize that this is an ambitious undertaking – one that can be accomplished <u>only</u> through the committed partnership of the entire community. The collaborative structure of THT, which brings former competitors together to address major health concerns in a coordinated way, has already shown dramatic results, including significant reductions in inappropriate and costly use of emergency departments, increased access to primary care, integration of behavioral services into primary care, and establishment of a system for improved efficiencies through shared data via the Trenton Health information Exchange (HIE).

Community Health Status

The Challenges and Our Priorities

As described in the CHNA, the challenges for Trenton are enormous, including low income and educational levels, high unemployment, poor housing conditions, inadequate transportation, limited access to fresh food sources, high levels of crime and homelessness, plus chronic disease and health disparities. Pervasive poverty and concerns for safety are issues that cannot be ignored when seeking to improve health outcomes for the community. Indeed, violence is a serious public health concern beyond the direct physical harm to its victims.

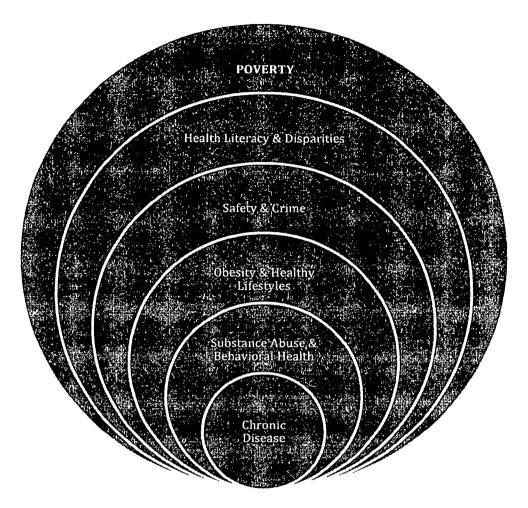
In developing the CHNA, a long list of needs was generated using quantitative data. From that list, community residents identified these needs as the top health concerns in Trenton:

- Health Literacy and Disparities Obstacles to building health knowledge and communicating about health affect many aspects of care. For example, many foreign-born residents struggle to adapt to a different healthcare system in a new country. Diverse and complex language barriers also impact health literacy in Trenton, where over 35 percent of the population speaks a language other than English in the home.
- **Safety and Crime** –Trenton's rate of violent crime in 2010 was 4.5 times higher than in New Jersey as a whole. At least two of Trenton's 11 gangs operate within the city's schools. Decreased numbers of police officers, ongoing gang activity and poverty all fuel Trenton's high crime rate.
- Obesity/Healthy Lifestyles Nearly half of the city's children even those as young as three to five years old are obese. Trenton has been identified as a food desert, due to lack of access to healthy foods. Poor food options and limited places to play have taken a toll on Trenton's children. Hunger is also an issue, with 17 percent of Trenton households regularly lacking enough food to eat.
- Substance Abuse/Behavioral Health Fifty-five percent of the 2012 Mercer County substance abuse treatment admissions were cases from Trenton. Emergency departments are overrun by patients with substance abuse issues. Cultural and socioeconomic disparities result in a hesitancy to seek mental health services.
- Chronic Disease Trenton residents have high rates of diabetes, hypertension, and cancer. Sixteen percent of the city's residents were diabetic in 2009. Heart disease and cancer are two of the three leading causes of death in Mercer County. Unmanaged chronic illness leads to acute, costly, avoidable emergencies.

Addressing the Social Determinants of Health

Because health is about much more than the treating of symptoms or isolated body parts, our success depends on our ability to address the underlying issues, often called the social determinants of health, within our target geography. Hence our ongoing efforts to engage with public and private agencies, corporate and non-profit entities, educators and social service providers, policy makers, and individuals who care about the wellbeing of the greater Trenton area.

These overlapping issues are reflected in our CHIP priorities, described above and depicted in the stacked Venn diagram below to illustrate their interdependence and causal relationship. These priorities undergird the selection of our implementation strategies, all of which call for a team effort from the medical, social service, environmental, behavioral, and educational sectors. They also call for the collaboration of public/ governmental and private entities, including businesses and non-profit organizations.



This CHIP represents input from the full range of our partners, but is also designed to continue as a blueprint for building partnerships and collaborative strategies around the realization of our shared vision for a healthy and vibrant Trenton community. As noted previously, there are significant health issues that extend beyond these priorities. However, we believe that a strategic focus on these critical areas will generate meaningful improvements to population health in the Trenton community and, through increased knowledge and access to information and services, will have a positive impact on many of the issues that are not being directly targeted.

While we understand that the issues are complex and the solutions will not be easy, we have developed goals and objectives that will move the needle and improve the outcomes for a vast number of our residents. We believe that Dr. Lavizzo-Mourey, CEO of the Robert Wood Johnson Foundation, is correct in stating that "Our zip code may be more important to our health than our genetic code." Therefore, we want to make sure that residents of the six zip codes of Trenton have the promise of a bright future. Through collaborative efforts, we are aiming to improve health and health outcomes for the community by working to ensure access to high-quality healthcare services and supports while also bolstering educational, social, and economic opportunities for the community.

Priority Area 1: Health Literacy & Disparities

Workgroup membership: Francis E. Blanco (Executive Director, Living Hope Empowerment Center), M. Carolyn Daniels, DHSc (NJ Department of Health), Patricia Fizer (Fizer Dental), Ruth Perry, MD (THT Executive Leadership), Harry Reyes, LPC, LCADC (Deputy Director, NJ Department of Human Services/DMHAS), Carol Rogers (Tour Guide Liaison, NJ Office Legislative Services), Yvette Graffie-Cooper (Epidemiologist, City of Trenton Department of Health and Human Services), Kendall Watson (THT Support Staff)

The Health Literacy & Disparities (HLD) workgroup was led by M. Carolyn Daniels, Executive Director of the Office of Minority and Multicultural Health, New Jersey Department of Health. Accountability for implementation of strategies related to this priority will be with THT in cooperation with the NJ Department of Health and community and faith-based organizations in the Trenton geography.

Background and Rationale

Numerous factors were considered in determining HLD as one of the five priority health areas. Poverty, which is more than 25 percent in Trenton, was a primary consideration for designating all priority areas. Poverty has a significant impact on one's education, employment, housing and homelessness, plus access to vital services – all of which are considered social determinants of health as identified by Healthy People 2020.²

Because Trenton has a significant non-English speaking population, including immigrants and refugees from all over the world (35.4 percent speak a language other than English in the home), there are cultural, linguistic, and educational barriers that must be overcome. In addition, Trenton is a majority-minority city, with approximately 50 percent African American and over 30 percent Hispanic/ Latino. Both of these minority groups have statistically higher rates of obesity and chronic disease, including diabetes, heart disease, and cancer. Key findings in the 2013 Health Disparities report from the CDC³ are particularly relevant for Trenton:

- Cardiovascular disease is the leading cause of death in the United States, with non-Hispanic black adults at least 50% more likely to die prematurely of heart disease or stroke than their non-Hispanic white counterparts.
- The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other or mixed races than among Asians and non-Hispanic whites.
 Prevalence is also higher among adults without college degrees and those with lower household incomes.

² U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (2nd ed.) [with Understanding and Improving Health (vol. 1) and Objectives for Improving Health (vol. 2)]. Washington, DC: U.S. Government Printing Office. Healthy People.Gov.2020. http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx http://www.cdc.gov/media/releases/2013/p1121-health-disparities.html

This disparity holds true for Trenton, where adult obesity is an alarming 39 percent, diabetes is 16 percent, and heart disease is a leading cause of death. Many Trenton residents do not prioritize cardiovascular preventive care due to disparities in insurance, lack of access to multicultural health professionals, distrust of medical professionals, and decreased overall awareness of lifestyle and health practices that increase risk of heart disease. In addition, many residents forego cancer screenings due to fear or a lack of information or insurance.

Health literacy can be improved through linguistically and culturally competent education and services, and improved access to primary and specialty care. Addressing health literacy, which may be defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions," is essential to reducing health disparities.

Key Findings and Assumptions

Basic assumptions can be made about health literacy and the overall impact on the healthcare system.⁵

- Health literacy is a major public health issue and can be substantiated by extensive data.
- The association between health literacy and health outcomes is supported by an evidence base.
- The issues of limited health literacy exceed individual limitations and therefore should also be extended and recognized as a healthcare and health information systemic problem.
- Hidden costs associated with system changes should be weighed and considered as costs associated with interventions to improve health literacy.

Poor health outcomes drive cost in all healthcare/health information systems and, as noted previously, contribute to the high prevalence of health disparities noted among minority populations. As supported by the HLD literature review, one component of health literacy, namely, health-related print literacy, can significantly mediate racial/ethnic disparities. It is important to make this correlation so as not to forget that health disparities continue to drive poor outcomes for racial and ethnic populations.

⁴ Institute of Medicine of the National Academies. A prescription to end confusion [Internet] Washington, DC: The Institute; 2004. [cited 10 Sept 2013]. http://www.iom.edu/Reports/2004/Health-Literacy-A-Prescription-to-End-Confusion.aspx.

⁵ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. National Action Plan to Improve Health Literacy. Section 3.Goal 7. [Internet] Washington, DC: http://www.health.gov/communication/HLActionPlan/pdf/Health_Lit_Action_Plan_Summary.pdf.

⁶ Annals of Family Medicine. The Contribution of Health Literacy to Disparities in a Self-Rated Health Status and Preventive Health Behaviors in Older Adults. http://www.medscape.com/viewarticle/703457 4.

Recommendations of the HLD Workgroup

The HLD workgroup has recommended the adoption of the *National Action Plan to Improve Health Literacy*⁷ as a blueprint so that health literacy principles are interwoven throughout the CHIP. The *Plan* seeks to engage organizations, professionals, policymakers, communities, individuals, and families in a linked, multi-sector effort to improve health literacy. The *Plan* is based on the principles that (1) everyone has a right to health information that helps them make informed decisions and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life. The *Plan* also includes key strategies, with the following examples being most applicable to THT and its partner organizations:

Developing and Disseminating Health and Safety Information

- Participate in ongoing training in health literacy that focuses on improving clear communication and information design practices.
- Involve members of the target population—including persons with limited health literacy—in planning, developing, implementing, disseminating, and evaluating health and safety information.
- Ensure that health and safety information is culturally and linguistically appropriate and motivating. Issue plain language guidance for the development of all public health and safety information.
- Build networks with community and faith-based organizations, social service
 agencies, and nontraditional partners—such as foster care services, poison control
 centers, and literacy service providers— to deliver health and safety information to
 and through different points in the community.
- Leverage technology and electronic health tools to deliver health information and services at the time, in the place, and in the multiple formats people need and want.
- Promote health literacy improvement efforts through professional and advocacy organizations.
- Create documents that demonstrate best practices in clear communication and information design.
- Ensure that all consumer health communication—including applications, benefits materials, rights and responsibilities, letters, and health and wellness information—incorporate health literacy principles.

Strategies for Print, Audiovisual, and Electronic Media

- Report consistent, clear messages with action steps for health promotion and disease prevention.
- Use local, community, and ethnic media to raise awareness of health information and services in the community and overcome barriers to care.
- Tell stories about the impact of poor-quality health information and services on people and organizations in the community.

⁷ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. National Action Plan to Improve Health Literacy. Section 3.Goal 7. [Internet] Washington, DC: http://www.health.gov/communication/HLActionPlan/pdf/Health_Lit_Action_Plan_Summary.pdf.

Strategies for Employers

- Develop workplace policies that increase and improve health information and services for employees and their families.
- Ensure that information and services are culturally and linguistically appropriate.
- Provide training, tools, and resources for employees to improve their health information-seeking and decision-making skills.

Strategies for Health Care Executives

- Train all staff, including executives and support staff, in the principles of health literacy and Culturally and Linguistically Appropriate Services (CLAS).
- Remove informational barriers and create a welcoming, easy-to-navigate, shamefree environment by using such methods as well-designed signage and offering assistance with forms.
- Encourage employees to take advantage of continuing education opportunities to improve communication and CLAS skills. (The HLD workgroup recommends the Think Cultural Health Website-https://www.thinkculturalhealth.hhs.gov/ for online CLAS standards training).
- Provide incentives to encourage employees to use good communication practices.

Action Steps

Based on the HLD workgroup recommendations, THT has committed itself to raising awareness of the need for culturally competent communication and delivery of services across its member organization and collaborating agencies. The CHIP Steering Committee has embraced two primary goals, with related objectives and strategies as follows:

	PilonyArea E-Health Iteracy& Disparities
Goal 1.1	Increase access for everyone to accurate and actionable health
	information; support lifelong learning to promote good health
- 1.1.1	By July 2014, each member organization of the Community Advisory Board-
	(CAB) will commit to developing a plan to incorporate best-practice health
	literacy standards for both communication strategies and printed outreach
	and educational materials
	CAB to identify specific programs and projects affected by limited
	health literacy
	THT to identify materials and resources that are available through
	government agencies and foundation websites to support activities
	and educational efforts, e.g.,
	http://www.state.nj.us/health/omh/culturalcompetency.shtml
	http://www.cdc.gov/minorityhealth/internships/opportunities.html
	HLD workgroup to select most relevant and valuable materials for
	distribution through partner organizations and develop activities
	that can improve effectiveness
1.1.2	By September 2014, establish a relationship to support NJPHK's efforts to
1.1.2	
	embed information regarding CHNA priorities and CHIP goals into school
	health curriculum at all grade levels (also Obesity & Healthy Lifestyles)

學的學例	Priority Area:1: Health Literacy & Disparities 神界是學學學學		
	 Work with NJPHK and school district liaison to coordinate meetings 		
	with appropriate school/district personnel		
	 Identify opportunities in the curriculum and key elements that can 		
	be interwoven within the class structures		
Goal 1.2	Deliver person-centered health information and services		
1.2.1	By July 2014, engage with faith-based and other community organizations		
	to develop a plan to conduct cultural competency trainings at primary care		
	clinics and behavioral health providers throughout the city		
	Through CAB, identify needs pertaining to cultural issues		
	HLD workgroup to select/design trainings based upon issues that		
	have been identified		
1.2.2	By September 2014, convene from among the CAB partners, those		
	individuals serving in community outreach positions (including the roles of		
	peer leader, community ambassador, patient navigator, health advocate,		
	Promotora, or Community Health Worker) to share best practices and align		
	strategies around CHIP goals		
	 Based upon CAB needs assessment regarding cultural competency, 		
	conduct workshops 2-3 times per year and establish networks of		
	community workers for ongoing learning and sharing of best		
	practices and resources		
	Develop programming to empower community workers to address		
	issues related to healthy lifestyles and particular diseases (e.g.,		
	diabetes, heart disease) that are priorities for the Trenton		
	community		
1.2.3	By July 2015, develop and provide an educational program focusing on		
	access to care and care disparities for physicians and other providers		
	Using knowledge gained through CAB assessment and community		
-	workshops, develop training agenda for physicians and providers		
	 Make arrangements for expert presenter(s), venues, etc. 		
	Present trainings and gather participant feedback		
12 Yes			
	(at least 80%) will sign covenants regarding use of culturally competent		
	ons, including availability of translations, design for appropriate reading		
	levels, and commitment to staff trainings. Numbers of individuals trained will be tracked		
and participa	nts surveyed for perceived quality.		
	Partners and Resources		
ł –	nt of Health, including Office of Minority and Multicultural Health; City of		
Trenton Department of Health and Human Services; Trenton Public Schools' telephonic			
interpretation services; Horizon Foundation, through health literacy grants to THT, Millhill			
•	nily Development Center, and Children's Futures; RWJF through NJHI grant to		
El Centro for	health literacy within Latino community		



Workgroup membership: James Brownlee (THT Leadership and City of Trenton Health Department), Alexis Durlacher (Trenton Police Department), Grady Griffin (Chief of Trenton Emergency Medical Services), Jerome Harris (Shiloh CDC)

The Safety & Crime workgroup was led by Alexis Durlacher, a detective in the Office of Police Director, Trenton Police Department (TPD). Accountability for this priority will be with TPD, supported by THT plus Rutgers University-Camden and the College of New Jersey (TCNI) for data and research.

Background and Rationale

The area of Safety & Crime is a critical social determinant of health and has a profound impact on all the other areas that have been identified as priorities for the CHIP. A biochemical relationship exists between crime and health, as safety concerns cause toxic stress leading to subsequent emotional, mental, and physical issues and disparities beginning in childhood and throughout adult life.⁸

Through the CHIP, we are seeking to reduce the rates of crime through an evidence-based approach to curtailing gang activity and street-level violence, which will be a centerpiece of our strategy for this priority area. Funding has been secured by TPD to launch the Trenton Violence Reduction Strategy (TVRS), a comprehensive model that blends the best elements of two existing evidence-based policing strategies: Boston Ceasefire and Chicago Ceasefire (now CURE). The goals of TVRS are to change the criminogenic behavior of a targeted population of gang members identified by the TPD, mobilize social service and outreach workers into neighborhoods experiencing high levels of criminal activity, work with individuals and families to reduce violence, and provide needed job training, life skills and other aid to at-risk teens, young adults, and families as an alternative to engaging in criminal behavior.

One of the key pillars of TVRS is its reliance on experts engaging in research and sharing their knowledge to inform practices on the ground. It emphasizes the importance of ongoing information gathering, data analysis, assessment, evaluation, and training. An interdisciplinary group of faculty experts from TCNJ and Rutgers-Camden (including former advisors to the current U.S. Attorney General and the former Governor of New Jersey) will oversee the research efforts.

The analysts will examine crime statistics, economic data, social service information, an analysis of the physical environment, qualitative information of individuals residing in target communities as well as other relevant figures. Dr. Louis Tuthill of Rutgers

⁸ Centers for Disease Control and Prevention findings on associations between adverse childhood experience (ACEs) and later-life health and well-being: http://www.cdc.gov/ace/

University-Camden is currently analyzing TPD crime data. Dr. Tuthill has a long history of working with local, tribal, and Federal law enforcement agencies to develop deterrent strategies. TCNJ will provide monitoring and analysis of grant outcomes relative to the social service interventions.

The chosen focus areas for year one of TVRS are Donnelly Homes and Spring Street. This was determined through parallel analysis by the TPD and the Department's Violent Enterprise Source Targeting (VEST) group, coupled with an understanding of the location of important services. In taking a targeted approach, TVRS is moving social service resources and agents who can have an impact on reducing violence directly to where they are most needed. This is similar to the way law enforcement focuses resources on hot spots. We want to drive offenders away from a life of gang and criminal behavior by providing directed "alternative ladders of opportunity" to them.

Geographic focus areas for subsequent years will be determined based on outcomes and continued data analysis. The goal is not to implement a program that will have a moderate impact for a modest period. The purpose of TVRS is to enable agencies and the community to collaborate and continue their work together in a strategic, focused, scientific, and purposeful manner. After addressing the violent crime that is currently plaguing the City of Trenton, we aim to mobilize similar community and academic resources to address other tertiary factors or crimes that can contribute to violence and victimization. These include intimate partner violence, closed indoor recreational spaces, juvenile delinquency, and truancy. By addressing these factors, we create sustainability for the effort while continuing to have an indirect, positive impact on street level violence.

In addition to TVRS, the City has announced plans to hire more police officers in each of the next few years, which will be an important support for crime prevention efforts. We are also working to provide increased security in public spaces in a way that will promote positive community engagement and perceptions of safety. These efforts overlap with and are described in more detail in the section on Priority Area 3: Obesity & Healthy Lifestyles.

Key Findings and Assumptions

Among the key findings of the CHNA regarding crime and safety are the following:

- Trenton's crime index is significantly higher than that of New Jersey, the US and neighboring municipalities in Mercer County. For example, New Jersey averaged 1,154 offenses known to law enforcement per 100,000 population; Trenton averaged 3,169 on the same scale. The rate is around ten-fold lower, in some cases more, in every neighboring municipality in the county.
- Decreases in the number of city police officers, increases in the number of vacant homes and high rates of gang activity fuel Trenton's high crime rates, along with declining business and poverty.
- Trenton is one of six New Jersey towns with multiple gangs of more than 100 members, with 11 total reported gangs comprising around 5,325 members and two

to four of these gangs present in the city's schools. About 45 percent of Trenton parents feel that their neighborhoods are somewhat or very unsafe due to crime.

Recommendations of the Safety & Crime Workgroup

As described above, the central recommendation of the Safety & Crime workgroup was adoption of the TVRS, which includes three categories for collaborative activity:

- 1. Law enforcement
- 2. Social services/outreach and education
- 3. Research and data analysis through area institutions of higher education

This cross-sector collaboration is a hallmark of the TVRS approach and a vital characteristic of the model. Another distinctive feature is its inclusion of families and its holistic approach in providing services to individuals who choose to engage in the process of turning their lives around. Another key component is its reliance on data, including the ongoing collection of performance and process measures and the use of focus groups and regular data analysis to track changes.

Action Steps

Based on the Safety & Crime workgroup recommendations, the CHIP Steering Committee has embraced two primary goals, with related objectives and strategies as follows:

	Priority Area'2: Safety & Grime 👢 🚎 👙 👙 🐉
Goal 2.1	Reduce street-level violence by implementing the Trenton Violence
	Reduction Strategy (TVRS), an evidence-based, public health approach
	to crime reduction
2.1.1	By March 2014, begin conducting call-ins to confront gang members and
	violent offenders and offer them the choice to accept social service
	interventions and an alternate lifestyle or face lengthy jail time
	Begin provision of wraparound services for offenders and families
	who choose to break with the past and turn their lives around
	Pursue federal prosecutions for non-repentant perpetrators
2.1.2	By July 2014, develop a highly specific, data-informed plan for building
	community and agency capacities to incorporate and promote violence
	reduction strategies
	Work with Rutgers-Camden to complete data-mapping and analysis
	for crime hot spots
	 Work with TCNJ and Bonner Fellows to develop mobile phone apps
	and online system for reporting low-level crimes
Goal 2.2	Increase residents' perceptions of safety
2.2.1	By January 2014, conduct task force activities, thereby increasing police
	presence in identified "hot spot" areas
	 Investigate funding to install security cameras at strategic locations

	Priority Area 2:: Safety & Grime W 1 Conduct ongoing analysis of crime data and program participant outcomes, including metrics tied to educational and job development efforts
2.2.2	By March 2014, reduce criminal presence by beginning program of long-term incarcerations for repeat offenders who refuse positive interventions TCNJ Bonner Fellows to conduct resident surveys in focus areas (Donnelly Homes and Spring Street) regarding safety concerns and perceptions; to be followed up for comparison in subsequent years Monitor reporting of crimes by residents as an indicator of increased confidence in law enforcement
Matrice	

Regular monitoring of crime data and performance outcomes for participating offenders relative to educational and job development efforts (e.g., GED completion, avoidance of further criminal activity, placement and persistence in internships and positions of employment). Specific measurements will be developed by higher education partners in collaboration with social service providers.

Partners and Resources

Trenton Police Department, including the newly established Police Chaplaincy Program; TCNJ, including Bonner Fellows and Trenton Policy and Prevention Board; Rutgers University-Camden; Trenton Council of Civic Associations; social service providers (TBA based upon results of bidding process)

Priority Area 3: Obesity & Healthy Lifestyles

Workgroup membership: Andrew Carten* (CityWorks), Janet Heroux (Shaping NJ), Connie Polonsky (NJ Prevention Network), Francis Blanco* (Living Hope Empowerment Center), Susan Jones* (Henry J. Austin Health Center), Jerome Harris* (Shiloh CDC), Elyse Pivnick* (Isles), Marissa Davis* and Shannon O'Connor* (New Jersey Partnership for Healthy Kids/NJPHK), Michelle Kennedy (Rutgers University)
*also member of the NJPHK steering committee

The Obesity & Healthy Lifestyles workgroup was led by Elyse Pivnick, Vice President of Environment and Community Health Programs at Isles, Inc. Accountability for implementation will be with THT and NIPHK.

Background and Rationale

The area of obesity and healthy lifestyles is one that has been in the national spotlight in recent years, due to the alarming increase in obesity, both among adults and children. As described in the CHNA, the problem in Trenton is significant, with rates of obesity that exceed both the national norm and the rates of neighboring communities.

Because of the scope and seriousness of the obesity issue, much work is being done within the region and, rather than "reinvent the wheel" for this CHIP, the Obesity & Healthy Lifestyles workgroup consolidated and reviewed the goals and objectives from five separate obesity/healthy lifestyle plans that include Trenton: Greater Mercer Community Health Plan, Community Transformation Project of New Jersey Prevention Network, Shaping NJ, New Jersey Partnership for Healthy Kids (NJPHK), and NJ Chronic Disease Plan. There was agreement that we should build on existing work by selecting goals and objectives from these plans that best meet Trenton's needs, assuming some modifications. Final recommendations were drawn from five categories:

- Healthy food access
- Increased physical activity
- Crime and safety (partnership with that workgroup)
- Workplace
- Childcare

Key Findings and Assumptions

As noted in the CHNA, crime is intrinsically linked with health in the realm of obesity and sedentary lifestyles. The lack of physical activity exhibited by many Trenton residents partially stems from feeling unsafe in their neighborhoods and subsequently not using sidewalks and parks in the city for exercise. This issue, in combination with a lack of access to healthy food in Trenton, has created an unhealthy environment fueling the city's obesity

⁹ http://www.state.ni.us/health/newsletter/documents/sept_2012.pdf

epidemic, with approximately 39 percent of Trenton residents being obese, compared to 19.7 percent in Mercer County and 23.7 percent in New Jersey as a whole.¹⁰

Supermarkets are considered the healthiest option of all available food outlets, yet are the least accessible. The lack of access to supermarkets coincides with disparities experienced by various racial/ethnic groups and those of low socio-economic status. Because of the paucity of supermarkets, Trenton has been deemed a "food desert," which is defined as an urban neighborhood where fresh fruit and vegetables are scarce and obesity and diabetes are correspondingly common.¹¹

The lowest rates for being overweight or obese in the U.S. are found where people have easy access to supermarkets and grocery stores. Those who live farther away from grocery stores than from convenience stores or limited service restaurants have significantly higher rates of premature death from diabetes. Overall, most Trenton area supermarkets are inaccessible without a car, representing a major disparity. Many residents do not own cars and, while public transportation in the city is unreliable, it is also costly.

Income disparities also play into access to healthy food and subsequently impact health. The Food Trust, a nonprofit organization started in Philadelphia, found that obesity rates in New Jersey are over 35 percent higher for those earning less than \$15,000 a year when compared to those earning \$50,000 or above. ¹²

The combination of issues related to safety and crime, a lack of transportation, economic challenges, limited knowledge regarding nutrition and inadequate availability of fresh produce all combine to drive Trenton's high rates of obesity and related chronic diseases. Our goals in the CHIP are to focus on several key areas that can begin to have a positive impact on these interrelated factors.

Recommendations of the Obesity & Healthy Lifestyles Workgroup

There was consensus regarding the following recommendations:

- Reestablish the functions of the city's recreation department, which lost its entire staff soon after Mayor Mack took office. These functions include programs of physical activity at community centers and parks, park maintenance, park security, and safe routes to parks and centers.
- Pursue the creation of joint-use agreements between school district and City of Trenton that would allow opening of school parks outside of school hours and including weekends.
- Reestablish a partnership among police commissioner, school superintendent, and City of Trenton to address security problems.

¹⁰ Centers for Disease Control and Prevention, Adult Obesity Facts, Behavioral Risk Factor Surveillance System 2011, Retrieved from http://www.cdc.gov/obesity/data/adult.html#baseline

¹¹ New Jersey Department of Law & Public Safety, Division of State Police, Intelligence Section, Gangs in New Jersey, Municipal Law Enforcement Response to the 2010 NJSP Gang Survey. Retrieved from http://www.njsp.org/info/pdf/gangs in nj 2010 pdf

¹² Fitzgerald, B. (2012). More Cash Coming to Help Eliminate New Jersey's Food Deserts, NJ Spotlight. Retrieved from http://www.nispotlight.com/stories/12/0104/0034/

- Expand the Healthy Corner Store initiative of NJPHK, which has been working with The Food Trust to provide new refrigerators and display apparatus to four stores where the owners agreed to sell more healthy food items and to feature the healthy items prominently in their stores.
- Increase the availability of fresh produce at Trenton food pantries either through new partnerships or grants.
- Expand the number of urban gardens by adding plots at schools, in parks, and in other public spaces.
- Offer cooking classes in publicly available spaces such as neighborhood schools, community and senior centers, and area churches. Classes are needed because many residents do not know how to prepare fresh foods.

Also discussed as possible strategies were the adoption of zoning regulations that would limit approval of new fast food establishments or prescribe a minimum distance between them and a policy that gives restaurants an incentive to feature healthy food items and to post calories of all menu items. These may be pursued through the newly established Trenton Healthy Food Network.

Action Steps

Based on the Obesity & Healthy Lifestyles workgroup recommendations, the CHIP Steering Committee has embraced two primary goals, with related objectives and strategies as follows:

THE PART A	》是如 Priority Area 3: Obesity & Healthy Lifestyles (中央) (中央)
Goal 3.1	Increase access to and consumption of healthy foods
3.1.1	By April 2014, obtain letters of commitment from THT's Community
	Advisory Board to support the Trenton Healthy Food Network, building on
-	existing initiatives such as NJPHK (http://www.njhealthykids.org/) and
	Shaping NJ (http://www.shapingnjcommunity.org/)
	Present information and a letter for adoption at the CAB meeting on
	April 28 th
	 THT Executive Committee and CAB members to promote efforts
	within their respective organizations, including especially those with
	food pantries and provision of meals to community members
3.1.2	By July 2014, work with Capital Health to refine and develop additional
	strategies for its Delivery System Reform Incentive Payment (DSRIP)
	program, which is focused on reducing obesity
	 CH to present progress report for discussion at THT Executive
	Committee meetings in May – June
	 Refinements/new strategies to be presented to CAB at July meeting
3.1.3	By July 2015, seek funding to expand Healthy Corner Stores initiative to add
	four or more participating stores distributed on the basis of need
	 NJPHK/Trenton Healthy Food Network to conduct assessment of
	existing corner stores and determine locations of need and interest

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	PriorityAreas, Obesity&HealthyBirestyles
	 Representatives from THT, Isles, and NJPHK to develop a list of
	funding prospects, develop outreach and solicitation plans, and
	submit proposals for consideration
Goal 3.2	Increase access to and practice of physical activity
3.2.1	By May 2014, re-establish collaboration among public departments and
	agencies such as the City of Trenton Recreation Department, TPD, and
	schools to ensure that physical fitness activities are available regularly at
	public parks and community centers (THT to serve as convener)
	 Establish regular meetings and representation across key agencies
	 Confirm plans to provide safe corridors to and from schools and
	expand security at parks and recreational facilities
	 Monitor effectiveness through levels of usage and resident feedback
3.2.2	By September 2014, craft organizational wellness policies for THT partners
	and promote adoption of similar policies in Trenton schools, public and
	private agencies, and workplaces by July 2015
	 THT and Obesity workgroup to identify materials and resources that
	are available through government agencies and foundation websites
	to support policy development
	 Workgroup to develop recommendations for distribution through
	and adoption by partner organizations
	 THT to work through the THT Executive Committee to facilitate
	partner buy-in and implementation
	 Engage the Chamber of Commerce to encourage adoption within the
	business community (July 2015)
	Metrics

Numbers and success of healthy corner stores will be tracked. Levels of access to parks and recreation centers will be monitored (e.g., increased hours of operation, program offerings, etc.). NJPHK, in partnership with Rutgers University, is monitoring the BMI of students in Trenton public schools; heights and weights will be collected and analyzed for academic years 2013-14 and 2015-16.

Partners and Resources

NJ Department of Health, including Shaping NJ; City of Trenton, including TPD and Department of Health; Trenton Public Schools; NJPHK partners; Trenton Healthy Food Network; NJ Prevention Network; CAB members, including Trenton Council of Civic Associations, Visiting Nurse Association of Mercer County, TASK, HomeFront, faith community, Capital Health; and Rutgers University

Priority Area 4: Substance Abuse & Behavioral Health

Workgroup membership: Mary Gay Abbott-Young (CEO, Rescue Mission of Trenton), Marygrace Billek (Director, Mercer County Department of Human Services), Dr. Gary Brown (Chair, Department of Psychiatry Capital Health Regional Medical Center), Jill Claudio (Screening Director, Capital Health), Ann Dorocki (Chief of Addiction Services, Mercer County), Chris Freeman (Clinician, Catholic Charities), Leslie Karpf (Vice President, Greater Trenton Behavioral Healthcare), Michele Madiou (Mental Health Administrator, Mercer County), Cynthia Oberkofler (CEO, Millhill Child and Family Development Center), Anita Porbeni (THT, SBIRT Program Coordinator), Jennifer Priest (Social Worker, Henry J. Austin Health Center), Jeffery Robbins (Executive Director, Family Guidance Center), Barbara Sprechman (Prevention Coalition Coordinator, Mercer Council on Alcoholism and Drug Abuse), Dawn J. Tuminaro, LSW (Emergency Room Social Worker, St. Francis Medical Center), Kendall Walton (THT Support)

The Substance Abuse & Behavioral Health (SA/BH) workgroup was led by Marygrace Billek, Director of Human Services for Mercer County. Accountability for implementation will be with THT, its corporate partners, and the Mercer County Department of Human Services.

Background and Rationale

The top three issues, as revealed in every behavioral health assessment for the community, are safety, cultural competence, and access. The SA/BH workgroup undertook a careful review of the CHNA and strongly supports the finding that safety and crime is the number one health crisis for residents of the City of Trenton. Issues of substance abuse and behavioral health are inextricably linked with safety and crime. Additional behavioral health challenges for Trenton include a shortage of medication providers – there are not enough generally or in Trenton specifically. Issues with dually diagnosed patients are very common, with more than one-third of those who come into Trenton emergency rooms having substance abuse issues. The need for addressing co-occurring treatment is very important. The current delivery system puts a burden on patients to find an outpatient provider and they struggle with wait times and waiting lists.

Key Findings and Assumptions

During one-on-one interviews and community forums in the CHNA process, the problems associated with substance abuse emerged as a recurring theme. It is of interest to note that the concerns were focused on drug use by high school students, as well as concerns for personal safety. While the THT grant for Screening, Brief Intervention and Referral to Treatment (SBIRT) is a valuable resource, including screening for co-occurring issues using the Mental Health Screening Form III,¹³ it does not currently screen adolescents and has

¹³ http://www.omh.ny.gov/omhweb/resources/providers/co_occurring/adult_services/screening.html

not yet been fully ramped up across the city – limitations we plan to address in the year ahead.

Addressing SA/BH issues is complicated by enormous housing and transportation needs. Many of the most frequent ER users (who are disproportionately affected by SA/BH issues) are homeless, many are undocumented, and there are increasing numbers of children represented. Additional complicating factors are cultural. Minority populations are very unlikely to seek and receive mental health services. Between the stigma associated with mental illness and inadequate screening by primary care practitioners, identification is often missed. For those fortunate enough to have received an intervention for an acute episode, the lack of follow-through with discharge plans and delays in the initiation of community-based follow-up services frequently result in a re-admission.¹⁴ The faith-based community can be an important resource, but engagement and training are needed.

Another key issue that emerged in discussions with the CHIP Screening Committee is the need for detoxification services within the community. Currently, the only services are a long distance from Trenton and referrals may be cumbersome, resulting in loss of valuable time and motivation. Hospital ERs are then obligated to accommodate intoxicated patients, but are penalized for inappropriate use of the facility. Patients would be better served at lower cost in a setting that is designed for this purpose. It was agreed that addressing this issue should be a priority of the CHIP.

Recommendations of the SA/BH Workgroup

Key recommendations of the SA/BH workgroup include the following:

- Deconstruct silos and increase collaborative efforts across organizations
 - Adopt an integrative model
 - Have one coordinated way of getting into treatment and having patients' needs met
 - o Use warm hand-offs to other service providers/organizations
 - Engage/train culturally competent navigators and liaisons who are available to come to the consumer
 - o Schedule at least 5-6 visits as follow-up to appointments
 - Have THT members participate on Mercer County Prevention Coalition and the Trenton Municipal Alliance Committee
- Address issues of prevention and access
 - o Coordinate/provide transportation
 - Engage the faith-based community in developing ways to offer educational and culturally competent programming and de-stigmatize behavioral health issues
 - Work to remove economic barriers, including funding/insurance coverage for medications and prescribers
 - o Arrange for resources to be available for childcare during treatment

¹⁴ Healthy New Jersey 2010, Center for Health Statistics, Office of the State Epidemiologist, Public Health Services, New Jersey Department of Health & Senior Services. Retrieved from http://www.state.ni.us/health/chs/hnj2010u05/hnj2010u05.pdf

- Work for more flexibility with regulatory bodies
- Expand SBIRT screenings into more settings (planned expansion into ERs in January, 2014) and add a tool and process for screening adolescents (e.g., CRAFFT, which was developed by the Center for Adolescent Substance Abuse Research and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse. CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions.¹⁵)

Action Steps

Based on the SA/BH workgroup recommendations, the CHIP Steering Committee has embraced two primary goals, with related objectives and strategies as follows:

	Prilority Area;4: Substance Abuse & Behavioral Health
Goal 4.1	Expand screening and improve referral to quality behavioral
	treatment services, including reducing cultural barriers for behavioral
	health treatment
4.1.1	 By July 2014, expand SBIRT program to all city clinics and emergency rooms and develop a plan for including adolescents; by July 2015, expand SBIRT to non-clinical settings such as Rescue Mission and TASK Develop MOUs with each agency regarding screening processes, resources, and referrals for treatment Conduct training for staff in Motivational Interviewing and screening procedures Work with NJPJK and schools regarding a plan for targeting adolescents
	Collect data and monitor outcomes
4.1.2	By September 2015, develop a pilot "transitional" outpatient clinic model
	 designed to divert emergency-room visits-to-more appropriate settings for care, and improve patient engagement in treatment programs THT leadership and SA/BH workgroup to determine issues, options, and opportunities to develop pilot
	 County Department of Human Services to coordinate outreach to potential service providers
4.1.3	 By July 2016, re-establish detoxification programming within the Trenton geography THT and SA/BH workgroup to convene meetings with City agencies, hospitals, and behavioral health collaborative to identify needs and obstacles, and explore possible locations for program THT and City to develop plan for acquiring and readying facility County Department of Human Services to coordinate outreach to potential service providers

¹⁵ http://www.ceasar-boston.org/clinicians/crafft.php

	ு Priority Area 4: Substance Abuse & Behavioral Health	
Goal 4.2	Improve access to and utilization of prevention services	
4.2.1	By January 2014, work with Mercer County Prevention Coalition, Trenton	
	Municipal Alliance, Trenton Prevention Policy Board, and the County	
	Comprehensive Plan to coordinate and expand knowledge of available	
	prevention resources	
	 THT representative to attend TPPB and TMAC meetings and report 	
	back to CAB	
	 CAB members to share and disseminate information within and 	
	through respective organizations	
4.2.2	By July 2015, develop "ready access" scheduling at behavioral health	
	providers and develop resources for helping individuals pay for medications	
	 THT leadership to work with behavioral health collaborative to 	
	develop plans for each agency to adopt scheduling system that has	
	been successfully implemented at HJAHC and hospital clinics	
Metrics		

SBIRT metrics will be tracked, including numbers screened, numbers of brief interventions and brief treatments conducted, numbers referred to treatment, and numbers of patients who follow-through on referrals. Initial screening will be used as "baseline" data, and subsequent screenings, which are done annually, as "follow-up" data. In this way, providers can ascertain practice-based evidence to determine if brief intervention services are promoting positive patient behavior changes. Implementation of transitional pilot and detoxification programming will be measured against numbers continuing to use ER for this purpose. Baseline wait times for behavioral services will be measured against wait times after adoption of "ready access" scheduling.

Partners and Resources

THT corporate partners, behavioral and social service providers, including Catholic Charities Diocese of Trenton, Family Guidance Center, Greater Trenton Behavioral Healthcare, Millhill Child and Family Development Center, Rescue Mission of Trenton, Trenton Area Soup Kitchen, etc.); NJ Division of Mental Health and Addiction Services; Mercer County Department of Human Services, including Mercer Council on Drug and Alcohol Addiction and Trenton Municipal Alliance, TPPB, SBIRT grant to THT.

Priority Area 5: Chronic Disease: Diabetes, Hypertension, and Cancer

Workgroup Membership: Kemi Alli, MD (Chief Medical Officer, HJAHC), Jerome Harris (Shiloh CDC), Laura Hernandez-Paine, MSW (Director of CDPC, NJ Division of Family Health Services), Carol McAloon, RN, MSN (St. Francis Medical Center), Peri Nearon, MPA (Director of External Affairs and Strategic initiatives, NJ Division of Family Health Services), Robert Remstein, DO, MBA (THT leadership and Vice President for Accountable Care, Capital Health), Christy Stephenson, RN, MBA (Interim CEO/President, St. Francis Medical Center)

The Chronic Disease Workgroup was led by Carol McAloon. Accountability for implementation will be with the THT Executive Committee and corporate partners.

Background and Rationale

Chronic disease is a major health concern for the population of Trenton, with particular challenges due to diabetes, heart disease, and cancer – all of which occur within the community at higher than the nationally or regionally normal rates.

Diabetes is a disease that, if left uncontrolled and untreated, can lead to significant morbidity and mortality, including diseases of the heart and circulatory system, nervous system, eyes and kidneys. The disease has close links to hypertension, obesity, and heart disease to name just a few. It is one of the leading causes of hospitalization in the U.S. ¹⁶ The total percentage of adults with diagnosed diabetes in 2010 was just over six percent in the U.S. and a little over eight percent in New Jersey. Comparatively, in 2009 just over nine percent of Mercer County residents and 16 percent of Trenton residents were diabetic. Individuals who do not achieve good control of their diabetes are more prone to short-term complications that can reduce the quality of life, increase chances of death and increase the overall cost of healthcare. The populations most at risk for diabetes are all represented to a significant degree in Trenton: those who are over the age of 45, minority populations (especially African Americans and Latinos) and persons who are obese. With the demographics and health disparities of Trenton, there is reason to believe that many diabetics in the community are not receiving the recommended interventions.

Heart disease is the leading cause of death of men and women in the United States and is one of the top three causes of death in Mercer County. The risk of dying from cardio-vascular disease is double for African American men compared to white men. This disparity is most pronounced in the 45 to 64 year age group.¹⁷ Hypertension, diabetes, and high cholesterol play a role in the reason for this disparity, according to an article

¹⁶ Centers for Disease Control and Prevention, Diabetes Fact Sheet, 2009. Retrieved from http://www.cdc.gov/diabetes/pubsestimates9.htm

¹⁷ Healthy New Jersey 2010, Center for Health Statistics, Office of the State Epidemiologist, Public Health Services, New Jersey Department of Health & Senior Services. Retrieved from http://www.state.nj.us/health/chs/hnj2010u05/hnj2010u05.pdf

published by Health Power for Minorities (a nationally unique minority health improvement organization).¹⁸

Cancer is the third leading cause of death in Mercer County. Four sites represent over 50 percent of all new cancers and 48 percent of all cancer deaths. These are: lung, prostate, breast, and colorectal cancers. Early detection is the key to best survival rates. As is the case with other chronic diseases, cancer detection and treatment in Trenton is fraught with issues of disparity. From 2000 forward, the rate of advanced stage of breast cancer in African American women increased from 99 to 108 per 100,000 women. According to the 2011 National Healthcare Disparities Report, the benchmark of 79 cases per 100,000 has been achieved by both White and Latino women; African American women are moving away from the benchmark.

Key Findings and Assumptions

Unmanaged chronic illness leads to acute, costly, avoidable emergencies. Trenton residents have higher rates of chronic illnesses than Mercer County as a whole, the state of New Jersey, and the nation. The most significant chronic diseases in Trenton are diabetes, cardiovascular disease, and cancer. Co-pays for services (ranging from \$10 to \$80 per encounter) limit access and prevent early detection and effective management of chronic diseases. Through its innovative structure and collaborative approach, THT has been able to increase access to primary care, improve care coordination among providers, and reduce the avoidable and costly use of emergency services. This model will be central in addressing the continuing and complex challenges of chronic disease in the city.

Recommendations of the Chronic Disease Workgroup

Key recommendations of the Chronic Disease workgroup involve the adoption and implementation of consistent, evidence-based practices throughout the city, coupled with educational efforts aimed at increased screenings for cancer and improved self-management of chronic conditions.

Action Steps

Based on the Chronic Disease workgroup recommendations, THT will work to ensure that best-practices for addressing these chronic diseases will be used in all clinic locations. The CHIP Steering Committee has embraced two primary goals, with related objectives and strategies as follows:

¹⁸ http://www.healthpowerforminorities.com

¹⁹ American Cancer Society, New Jersey & New York. The Cancer Burden in New Jersey, 2012. Retrieved from http://www.acscan.org/ovc images/file/action/states/nj/NJ_Cancer_Burden_Report_2012.pdf

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Goal 5.1	Improve disease management for diabetes and hypertension (HTN) by
	adopting evidence-based practice guidelines in each of the city's clinics
5.1.1	By July 2014, implement a self-management tool for diabetes and HTN at
	each site
	 Clinic sites to select and implement a self-management tool for
	diabetes and HTN (e.g., Stanford's Chronic Disease Self-Management Program or CDSMP)
	THT to implement and monitor outcomes of GoMo mobile
	application funded through Horizon Foundation for diabetes
	management, with view towards broader adoption
	Develop plan and implement training on self-management tool for
	staff at each site
5.1.2	By July 2014, work with St. Francis Medical Center to refine and develop
	additional strategies for its Delivery System Reform Incentive Payment
	(DSRIP) program, which is focused on diabetes care and prevention
	 SFMC to present progress report for discussion at THT Executive
	Committee meetings in May – June
	 Refinements/new strategies to be presented to CAB at July meeting
5.1.3	By September 2014, have self-management goals for 60% of established
	patients with diagnosis of diabetes/HTN at all clinic sites
	 An established patient will be defined as any patient with two or
	more medical visits in the previous 12 months, with second or later
	visit falling after June 2014 and the adoption of the self-management
	tool.
Goal 5.2	Expand cancer screenings for the community by facilitating a
	partnership with NJCEED (Cancer Education and Early Detection)
5.2.1	By July 2014, establish a process that will result in referrals for cancer
	screening by primary care practitioners or NJCEED
}	THT, through its corporate partners, will deliver education for
	providers regarding process and eligibility for referral to NJCEED
5.2.2	By July 2014, provide a navigator model of care at each site that will assure
	confirmation of appropriate screening services for clients
	THT, through its corporate partners, will agree upon a navigator
	model and deliver education for providers regarding its system-wide
	adoption
	Numbers of screenings and outcomes will be tracked through the Trenton HIE
5.2.3	By July 2015, identify GI specialist referral resources for patients with
	abnormal colorectal screenings
	 Workgroup to conduct assessment of resources and make
	recommendations to THT Executive Committee
	THT to disseminate information through partners

Priority Area 5: Chronic Disease: Diabetes, Hypertension, and Cancer of

Metrics

- Best practice metrics will be implemented in all clinics located in the city
- 80% of diabetics in the self-management program will have their HgA1c measured two times within a 12-month period of time, at least 90 days apart
- 80% of patients with HTN in the self-management program will have at least three blood pressure measurements within a 12-month period
- 50% of patients in self-management program (CDSMP) will demonstrate a blood pressure measurement in control (<140/90) for their most recent reading
- Numbers of patients screened for cancer will be tracked and compared from year to year, with data entered in the Trenton HIE
- 90% of patients 18 years and older will be screened for tobacco use and will receive tobacco cessation intervention (cessation counseling and/or pharmacological intervention) if a tobacco user within 24 months of most recent visit

Partners and Resources

THT corporate partners (CH, SFMC, HJAHC, City of Trenton Department of Health); NJ Department of Health, including NJCEED and Chronic Disease Department; Planned Parenthood Association of the Mercer Area; Visiting Nurse Association of Mercer County; Shiloh CDC as lead agency for Mercer County NJCEED and Horizon Foundation grantee for Chronic Disease Self-Management Project; Horizon Foundation grant to THT for deployment of GoldMobile technology for diabetes self-management

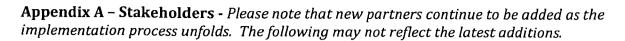
Next Steps

With adoption of this Community Health Improvement Plan by the THT Community Advisory Board (CAB) and Executive Committee, the document is being shared broadly through partner agencies and organizations working to address health and related issues throughout the six zip codes of Trenton. Implementation will be coordinated and monitored by THT, through its CAB and Executive Committee, with workgroup leaders and members providing critical on-the-ground program direction, support, and feedback. Funding sources are being identified to support implementation of the CHIP and its priority areas.

We view this as a living document and encourage the ongoing engagement of partner organizations and community residents through CAB meetings, workgroups, and collaborations that focus on the CHIP priorities and concerns.

Conclusion

We recognize the enormity of the task ahead of us, but also acknowledge the dedication and thoughtful contributions of countless individuals who have come together to shape this effort and who work tirelessly on behalf of the residents of Trenton. With continued collaboration, communication, and an unwavering eye on outcomes, we can advance our vision of making Trenton the healthiest city in the state of New Jersey.



Trenton Health Team Community Advisory Board





















