



See a Social Security Number? Say Something!  
Report Privacy Problems to <https://public.resource.org/privacy>  
Or call the IRS Identity Theft Hotline at 1-800-908-4490



## CHANGE IN ACCOUNTING PERIOD

Form 990

## Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2015

Open to Public  
InspectionDepartment 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](http://www.irs.gov/form990).

A For the 2015 calendar year, or tax year beginning

01/01/2016, and ending

06/30/2016

<input checked="" type="checkbox"/> Check if applicable <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES			D Employer identification number 90-0779828	
	Doing business as			E Telephone number (609) 569-7040	
	Number and street (or P O box if mail is not delivered to street address) 2500 ENGLISH CREEK AVENUE			Room/suite	
	City or town, state or province, country, and ZIP or foreign postal code EGG HARBOR TOWNSHIP, NJ 08234			G Gross receipts \$ 407,201,268.	
	F Name and address of principal officer LORI S. HERNDON 2500 ENGLISH CREEK AVE EGG HARBOR TOWNSHIP, NJ 08234			H(a) Is this a group return for subordinates? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)( ) (insert no) 4947(a)(1) or 527			H(b) Are all subordinates included? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
J Website ► <a href="http://WWW.ATLANTICARE.ORG">WWW.ATLANTICARE.ORG</a>			If "No," attach a list (see instructions)		
K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ►			L Year of formation 1897 M State of legal domicile NJ		

## Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities THE ORGANIZATIONS ARE COMMITTED TO IMPROVING THE HEALTH AND WELL-BEING OF THE RESIDENTS OF NJ BY PROVIDING QUALITY, PATIENT-CENTERED HEALTHCARE SERVICES.			
	2 Check this box ► <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets			
	3 Number of voting members of the governing body (Part VI, line 1a)	3	16.	
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	11.	
	5 Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	0.	
	6 Total number of volunteers (estimate if necessary)	6	279.	
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	113,785.	
	b Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
	8 Contributions and grants (Part VIII, line 1h)	MAY 15 2017	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	1,39,251,831.	11,736,742.	
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1731,458,599.	376,686,696.	
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	29,884,566.	15,088,144.	
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,583,127.	2,382,344.		
	803,178,123.	405,893,926.		
Revenue	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	16,736,065.	507,689.	
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.	
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	337,147,665.	163,753,835.	
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.	
	b Total fundraising expenses (Part IX, column (D), line 25) ►	0.		
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	368,596,617.	172,730,539.	
	18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	722,480,347.	336,992,063.	
19 Revenue less expenses Subtract line 18 from line 12	80,697,776.	68,901,863.		
Expenses	Beginning of Current Year	End of Year		
	20 Total assets (Part X, line 16)	1,136,752,943.	1,191,534,890.	
	21 Total liabilities (Part X, line 26)	617,731,208.	644,679,970.	
	22 Net assets or fund balances Subtract line 21 from line 20	519,021,735.	546,854,920.	

## Part II Signature Block

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

Sign Here	Signature of officer <i>Walter Greiner</i>		Date 5/10/17
	► <i>WALTER GREINER, CFO</i> Type or print name and title		
Paid Preparer Use Only	Print/Type preparer's name SCOTT J MARIANI	Preparer's signature <i>Scott J. Mariani</i>	Date 5/8/2017
	Firm's name ► WITHUMSMITH+BROWN, PC		Check <input type="checkbox"/> if self-employed PTIN P00642486
	Firm's address ► 200 JEFFERSON PARK SUITE 400 WHIPPANY, NJ 07981-1070		Firm's EIN ► 22-2027092
			Phone no 973-898-9494
May the IRS discuss this return with the preparer shown above? (see instructions) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			

Form 990 (2015)

**Part III Statement of Program Service Accomplishments**Check if Schedule O contains a response or note to any line in this Part III  X

1 Briefly describe the organization's mission:  
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?  Yes  X No  
If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services?  Yes  X No  
If "Yes," describe these changes on Schedule O

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

4a (Code \_\_\_\_\_) (Expenses \$ 48,786,306 including grants of \$ 0.) (Revenue \$ 44,544,797.)  
EXPENSES INCURRED BY ATLANTICARE REGIONAL MEDICAL CENTER IN  
PROVIDING MEDICALLY NECESSARY GENERAL MEDICINE SERVICES TO ALL  
INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE,  
COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY.

---



---



---



---

4b (Code \_\_\_\_\_) (Expenses \$ 34,093,118 including grants of \$ 0.) (Revenue \$ 34,007,026.)  
EXPENSES INCURRED BY ATLANTICARE REGIONAL MEDICAL CENTER IN  
PROVIDING MEDICALLY NECESSARY CARDIOLOGY/CARDIAC SURGERY SERVICES  
TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF  
RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY.

---



---



---



---

4c (Code \_\_\_\_\_) (Expenses \$ 33,793,714 including grants of \$ 0.) (Revenue \$ 47,838,619.)  
EXPENSES INCURRED BY ATLANTICARE REGIONAL MEDICAL CENTER IN  
PROVIDING MEDICALLY NECESSARY ORTHOPEDIC SERVICES TO ALL  
INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE,  
COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY.

---



---



---



---

**4d Other program services (Describe in Schedule O)**

(Expenses \$ 186,670,492. including grants of \$ 507,689.) (Revenue \$ 250,296,254.)

**4e Total program service expenses ► 303,343,630.**

**Part IV Checklist of Required Schedules**

1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A. . . . .

2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? . . . . .

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 . . . . .

4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II. . . . .

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. . . . .

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. . . . .

7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II. . . . .

8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III . . . . .

9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV . . . . .

10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V. . . . .

11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable

a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI . . . . .

b Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII . . . . .

c Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII. . . . .

d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX. . . . .

e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X

f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X . . . . .

12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII . . . . .

b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional . . . . .

13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E. . . . .

14a Did the organization maintain an office, employees, or agents outside of the United States? . . . . .

b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV. . . . .

15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV . . . . .

16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV . . . . .

17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions). . . . .

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 . . . . .

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 . . . . .

	Yes	No
1	X	
2	X	
3		X
4	X	
5		X
6		X
7		X
8		X
9		X
10	X	
11a	X	
11b		X
11c	X	
11d		X
11e	X	
11f		X
12a		X
12b	X	
13		X
14a		X
14b	X	
15		X
16		X
17		X
18	X	
19		X

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

20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H. . . . .  
 b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .

21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II. . . . .

22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III. . . . .

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 . . . . .

24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a . . . . .  
 b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .  
 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? . . . . .  
 d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .

25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I . . . . .  
 b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I . . . . .

26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II . . . . .

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 . . . . .

28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)  
 a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . .  
 b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . .  
 c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV . . . . .

29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M. . . . .

30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M . . . . .

31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I. . . . .

32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II . . . . .

33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I . . . . .

34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 . . . . .

35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? . . . . .  
 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 . . . . .

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 . . . . .

37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI . . . . .

38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O

	Yes	No
20a	X	
20b	X	
21	X	
22		X
23		X
24a		X
24b		
24c		
24d		
25a		X
25b		X
26		X
27		X
28a		X
28b		X
28c		X
29	X	
30		X
31		X
32		X
33		X
34	X	
35a	X	
35b	X	
36		X
37		X
38	X	

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V 

1a Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. **1a** 0.

b Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. **1b** 0.

c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? **1c**

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** 0.

b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **2b**

*Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).* **3a** X

b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O. **3b** X

4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? **4a** X

b If "Yes," enter the name of the foreign country ► **4b**

See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)

5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? **5a** X

b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? **5b** X

c If "Yes" to line 5a or 5b, did the organization file Form 8886-T? **5c**

6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? **6a** X

b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? **6b**

7 Organizations that may receive deductible contributions under section 170(c).

a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? **7a** X

b If "Yes," did the organization notify the donor of the value of the goods or services provided? **7b** X

c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? **7c** X

d If "Yes," indicate the number of Forms 8282 filed during the year. **7d**

e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? **7e** X

f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? **7f** X

g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? **7g**

h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? **7h**

8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? **8**

9 Sponsoring organizations maintaining donor advised funds.

a Did the sponsoring organization make any taxable distributions under section 4966? **9a**

b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? **9b**

10 Section 501(c)(7) organizations. Enter

a Initiation fees and capital contributions included on Part VIII, line 12. **10a**

b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. **10b**

11 Section 501(c)(12) organizations. Enter

a Gross income from members or shareholders. **11a**

b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them). **11b**

12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? **12a**

b If "Yes," enter the amount of tax-exempt interest received or accrued during the year. **12b**

13 Section 501(c)(29) qualified nonprofit health insurance issuers.

a Is the organization licensed to issue qualified health plans in more than one state? **13a**

*Note. See the instructions for additional information the organization must report on Schedule O*

b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans. **13b**

c Enter the amount of reserves on hand. **13c**

14a Did the organization receive any payments for indoor tanning services during the tax year? **14a** X

b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O. **14b**

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

### Section A. Governing Body and Management

1a Enter the number of voting members of the governing body at the end of the tax year . . . . . **1a** 16  
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

1b Enter the number of voting members included in line 1a, above, who are independent . . . . . **1b** 11

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? . . . . .

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? . . . . .

4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . .

5 Did the organization become aware during the year of a significant diversion of the organization's assets? . . . . .

6 Did the organization have members or stockholders? . . . . .

7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . . . .  
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . .

8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:

a The governing body? . . . . .

b Each committee with authority to act on behalf of the governing body? . . . . .

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 . . . . .

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

10a Did the organization have local chapters, branches, or affiliates? . . . . .  
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? . . . . .

11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? . . . . .  
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 . . . . .  
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? . . . . .  
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done . . . . .

13 Did the organization have a written whistleblower policy? . . . . .

14 Did the organization have a written document retention and destruction policy? . . . . .

15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?

a The organization's CEO, Executive Director, or top management official . . . . .  
b Other officers or key employees of the organization . . . . .  
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)

16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? . . . . .  
b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? . . . . .

### Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ► NJ,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply  
 Own website  Another's website  Upon request  Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ►  
WALTER A. GREINER 2500 ENGLISH CREEK AVE EGG HARBOR TWP, NJ 08234 (609)569-7040

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

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

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

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

- List all of the organization's current officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid

- List all of the organization's current key employees, if any See instructions for definition of "key employee "

• List the organization's five current highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

- List all of the organization's former officers, key employees, 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.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Or Individual Trustee	Institutional Trustee	Officer	Key Employee	Highest Compensated	Former			
(1) KENNETH R. STEINBERG - CHAIRMAN - TRUSTEE	1.00 0.	X		X				0.	0.	0.
(2) DAVID GODDARD - VICE CHAIRMAN - TRUSTEE	1.00 0.	X		X				0.	0.	0.
(3) FRANCINE GOLDSTEIN - SECRETARY - TRUSTEE	1.00 0.	X		X				0.	0.	0.
(4) MANUEL APONTE - TREASURER - TRUSTEE	1.00 0.	X		X				0.	0.	0.
(5) BLAIR A. BERGEN, M.D. - TRUSTEE	55.00 0.	X						0.	0.	0.
(6) JOHN B. BULGER, M.D. - TRUSTEE	55.00 0.	X						0.	0.	0.
(7) DAVID CARR, PH.D. - TRUSTEE	1.00 0.	X						0.	0.	0.
(8) MATHEW D. FINKELSON, D.M.D. - TRUSTEE	1.00 0.	X						0.	0.	0.
(9) CRAIG GLICK, M.D. - TRUSTEE	1.00 0.	X						0.	0.	0.
(10) LORI S. HERNDON - TRUSTEE-ARMC PRES/CEO-EVP SYS	55.00 0.	X		X				0.	0.	0.
(11) ROSALIND KINCAID - TRUSTEE	1.00 0.	X						0.	0.	0.
(12) ALDALBERTO LOPEZ - TRUSTEE	1.00 0.	X						0.	0.	0.
(13) EDELYN L. MILLER - TRUSTEE	55.00 0.	X						0.	0.	0.
(14) PATRICIA RICH-TUOHY - TRUSTEE	1.00 0.	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		Or director	Individual trustee	Institutional trustee	Officer	Key employee	Highest compensated			
( 15) PRIYESH THAKKAR, D.O. TRUSTEE	1.00 0.		X					0.	0.	0.
( 16) FRANCIS WREN, M.D. TRUSTEE	1.00 0.		X					0.	0.	0.
( 17) BENJAMIN ZELTNER, ESQ. CHAIRMAN - TRUSTEE	1.00 0.		X		X			0.	0.	0.
( 18) PACIFICO AGNELLINI, ESQ. VICE CHAIRMAN - TRUSTEE	1.00 0.		X		X			0.	0.	0.
( 19) FATEN DIB TREASURER - TRUSTEE	1.00 0.		X		X			0.	0.	0.
( 20) JOHN BECHER, D.O. TRUSTEE	1.00 0.		X					0.	0.	0.
( 21) MICHAEL CONNOR, ESQ. TRUSTEE	1.00 0.		X					0.	0.	0.
( 22) STOWELL FULTON TRUSTEE	1.00 0.		X					0.	0.	0.
( 23) THOMAS GLENN, III TRUSTEE	1.00 0.		X					0.	0.	0.
( 24) GARY HANSEN TRUSTEE	1.00 0.		X					0.	0.	0.
( 25) GARY L. HILL TRUSTEE	1.00 0.		X					0.	0.	0.
<b>1b Sub-total</b>							►	0.	0.	0.
<b>c Total from continuation sheets to Part VII, Section A</b>							►	0.	0.	0.
<b>d Total (add lines 1b and 1c)</b>							►	0.	0.	0.

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 ► 0.

3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual . . . . .

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual . . . . .

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person . . . . .

	Yes	No
3		X
4		X
5		X

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ► 0.		

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		<input type="checkbox"/> Director	<input type="checkbox"/> Individual trustee	<input type="checkbox"/> Institutional trustee	<input type="checkbox"/> Officer	<input type="checkbox"/> Key employee	<input type="checkbox"/> Highest compensated			
( 26) ROBERT HORDES	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 27) DEE W. KASSIS, R.N.	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 28) LARRY KAUFMAN, M.D.	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 29) RANDOLPH C. LAFFERTY, ESQ.	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 30) CORENLIUS MCPEAK	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 31) ALVIN ONG, M.D.	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 32) TRACY SANTORO	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 33) CAROLINE TILL	1.00									
TRUSTEE	0.	X						0.	0.	0.
( 34) DAVID P. TILTON	55.00									
TRUSTEE - PRESIDENT/CEO	0.	X	X					0.	0.	0.
( 35) DOMINIC S. MOFFA	55.00									
TRUSTEE - VICE CHAIR/EVP SYS	0.	X	X					0.	0.	0.
( 36) WALTER A. GREINER	55.00									
TRUSTEE - TREASURER/SVP & CFO	0.	X	X					0.	0.	0.
<b>1b Sub-total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>										

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 ► 0.

3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual . . . . .

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual . . . . .

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person . . . . .

	Yes	No
3	X	
4	X	
5	X	

**Section B. Independent Contractors**

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Officer	Individual trustee	Institutional trustee	Key employee	Highest compensated			
( 37) JAMES P. NOLAN, JR., CPA SVP & CFO (TERM 2/1/16)	55.00 0.			X			0.	0.	0.
( 38) DONNA MICHAEL-ZIEREIS, ESQ. VP GENERAL COUNSEL	55.00 0.			X			0.	0.	0.
( 39) MARGARET A. BELFIELD CHIEF OPERATING OFFICER - ARMC	55.00 0.			X			0.	0.	0.
( 40) CHRISTOPHER A. SCANZERA VP/CHIEF INFORMATION OFFICER	55.00 0.			X			0.	0.	0.
( 41) MARILOUISE VENDITTI, M.D. CHIEF MEDICAL OFFICER	55.00 0.			X			0.	0.	0.
( 42) RICHARD D. LOVERING SR VP HUMAN RESOURCES & OD	55.00 0.			X			0.	0.	0.
( 43) JOAN MARRY BRENNAN SR VP QUALITY & PERFORM EXCEL	55.00 0.			X			0.	0.	0.
( 44) TERRI LU SCHIEDER VP CLINICAL DEV. & INTEGRATION	55.00 0.			X			0.	0.	0.
( 45) ROBYN O. BEGLEY VP NURSING/CNO	55.00 0.			X			0.	0.	0.
( 46) CHARISSE FIZER VP CLINICAL OPS & AMB SERVICES	55.00 0.			X			0.	0.	0.
( 47) RENE A. ZANELOTTI-BUNTING VP MARKETING (TERM 3/5/16)	55.00 0.			X			0.	0.	0.
<b>1b Sub-total</b>									
<b>c Total from continuation sheets to Part VII, Section A</b>									
<b>d Total (add lines 1b and 1c)</b>									

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 ► 0.

	Yes	No
3		X
4		X
5		X

**Section B. Independent Contractors**

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations	
		Or director	Individual trustee	Institutional trustee	Officer	Key employee				
( 48) IRA R. PEEZICK VP STRATEGIC PLAN (TERM 1/2/16)	55.00 0.			X				0.	0.	0.
( 49) HAK J. KIM VP FINANCIAL PLANNING	55.00 0.			X				0.	0.	0.
( 50) JOSEPH J. MCCARTHY, CPA VP FINANCIAL OPERATIONS	55.00 0.			X				0.	0.	0.
( 51) BARBARA YOUNG CORP. DIRECTOR SUPPLY CHAIN	55.00 0.			X				0.	0.	0.
( 52) JATIN MOTIWAL VP PHYSICIAN PRACTICE ADMIN	55.00 0.			X				0.	0.	0.
( 53) JULIA DREW EXECUTIVE DIRECTOR	55.00 0.			X				0.	0.	0.
( 54) CHRISTOPHER C. APGAR DIRECTOR OF FINANCE	55.00 0.			X				0.	0.	0.
( 55) MICHAEL J. SAYNISCH SENIOR DIRECTOR	55.00 0.			X				0.	0.	0.
( 56) LOYAL M. OWNES SENIOR DIRECTOR - CLINICAL	55.00 0.			X				0.	0.	0.
( 57) SAMANTHA A. KILEY EXECUTIVE DIRECTOR	55.00 0.			X				0.	0.	0.
( 58) STEVEN M. BLUMBERG SVP EXECUTIVE DIRECTOR	55.00 0.			X				0.	0.	0.
<b>1b Sub-total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>										

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 ► 0.

	Yes	No
3		X
4		X
5		X

3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual . . . . .

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual . . . . .

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person . . . . .

**Section B. Independent Contractors**

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

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

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

**Part VIII Statement of Revenue**Check if Schedule O contains a response or note to any line in this Part VIII. 

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>					
1a Federated campaigns . . . . .	1a				
b Membership dues . . . . .	1b				
c Fundraising events . . . . .	1c	306,410.			
d Related organizations . . . . .	1d	507,689.			
e Government grants (contributions) . . .	1e	10,358,991.			
f All other contributions, gifts, grants, and similar amounts not included above .	1f	563,652.			
g Noncash contributions included in lines 1a-1f \$		58,163.			
h Total. Add lines 1a-1f . . . . . ►		11,736,742			
<b>Program Service Revenue</b>					
2a NET PATIENT SERVICE REVENUE	Business Code				
	541900	367,870,585	367,870,585.		
b OTHER HEALTHCARE RELATED REVENUE		8,816,111.	8,702,326.	113,785.	
c					
d					
e					
f All other program service revenue . . . . .					
g Total. Add lines 2a-2f . . . . . ►		376,686,696.			
<b>Other Revenue</b>					
3 Investment income (including dividends, interest, and other similar amounts). <b>ATTACHMENT 2</b> . . . . . ►		15,243,953			15,243,953.
4 Income from investment of tax-exempt bond proceeds [3] ►		27			27.
5 Royalties . . . . . ►		0			
6a Gross rents . . . . .	(i) Real	(ii) Personal			
	3,224,132.				
b Less rental expenses . . . . .	843,970				
c Rental income or (loss) . . . . .	2,380,162				
d Net rental income or (loss) . . . . . ►		2,380,162			2,380,162.
7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
b Less cost or other basis and sales expenses . . . . .		155,836			
c Gain or (loss) . . . . .		-155,836			
d Net gain or (loss) . . . . . ►		-155,836.			-155,836
8a Gross income from fundraising events (not including \$ 306,410. of contributions reported on line 1c) See Part IV, line 18 . . . . .	ATCH 4				
b Less direct expenses . . . . .	a 307,536				
c Net income or (loss) from fundraising events. . . . . ►	b 307,536	0			
9a Gross income from gaming activities See Part IV, line 19 . . . . .	ATCH 5 ►				
b Less direct expenses . . . . .	a				
c Net income or (loss) from gaming activities. . . . . ►	b	0.			
10a Gross sales of inventory, less returns and allowances . . . . .	a				
b Less cost of goods sold . . . . .	b				
c Net income or (loss) from sales of inventory. . . . . ►		0.			
<b>Miscellaneous Revenue</b>	<b>Business Code</b>				
11a TELEPHONE	517000	2,182.			2,182
b					
c					
d All other revenue . . . . .					
e Total. Add lines 11a-11d . . . . . ►		2,182			
12 Total revenue See instructions . . . . . ►		405,893,926.	376,572,911	113,785.	17,470,488

**Part IX Statement of Functional Expenses**

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

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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A) Total expenses</b>	<b>(B) Program service expenses</b>	<b>(C) Management and general expenses</b>	<b>(D) Fundraising expenses</b>
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 . . . . .	507,689.	507,689.		
2 Grants and other assistance to domestic individuals See Part IV, line 22 . . . . .	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16 . . . . .	0.			
4 Benefits paid to or for members . . . . .	0.			
5 Compensation of current officers, directors, trustees, and key employees . . . . .	0.			
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	0.			
7 Other salaries and wages . . . . .	125,060,264.	112,554,238.	12,506,026.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	8,194,792.	7,375,313.	819,479.	
9 Other employee benefits . . . . .	20,976,546.	18,878,891.	2,097,655.	
10 Payroll taxes . . . . .	9,522,233.	8,570,010.	952,223.	
11 Fees for services (non-employees) . . . . .				
a Management . . . . .	1,309,053.	1,178,148.	130,905.	
b Legal . . . . .	136,600.	122,940.	13,660.	
c Accounting . . . . .	8,403.	7,563.	840.	
d Lobbying . . . . .	0.			
e Professional fundraising services See Part IV, line 17. . . . .	0.			
f Investment management fees . . . . .	0.			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) . . . . .	4,693,581.	4,224,223.	469,358.	
12 Advertising and promotion . . . . .	401,383.	361,245.	40,138.	
13 Office expenses . . . . .	28,923,859.	26,031,473.	2,892,386.	
14 Information technology . . . . .	532,058.	478,852.	53,206.	
15 Royalties . . . . .	0.			
16 Occupancy . . . . .	7,049,856.	6,344,870.	704,986.	
17 Travel . . . . .	222,572.	200,315.	22,257.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0.			
19 Conferences, conventions, and meetings . . . . .	506,809.	456,128.	50,681.	
20 Interest . . . . .	1,421,269.	1,279,142.	142,127.	
21 Payments to affiliates . . . . .	0.			
22 Depreciation, depletion, and amortization . . . . .	17,141,212.	15,427,091.	1,714,121.	
23 Insurance . . . . .	3,631,988.	3,268,789.	363,199.	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O) . . . . .				
a MEDICAL SUPPLIES . . . . .	53,509,597.	48,158,637.	5,350,960.	
b PHYSICIAN FEES . . . . .	28,190,274.	25,371,247.	2,819,027.	
c ADMINISTRATIVE FEES . . . . .	11,374,530.	10,237,077.	1,137,453.	
d PURCHASED SERVICES . . . . .	8,805,274.	7,924,747.	880,527.	
e All other expenses . . . . .	4,872,221.	4,385,002.	487,219.	
25 Total functional expenses. Add lines 1 through 24e	336,992,063.	303,343,630.	33,648,433.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ► <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0.			

**Part X Balance Sheet**

		(A) Beginning of year		(B) End of year
Assets				
1	Cash - non-interest-bearing	3,515,166.	1	32,056,950.
2	Savings and temporary cash investments	7,571,404.	2	9,063,294.
3	Pledges and grants receivable, net	5,630,058.	3	3,458,465.
4	Accounts receivable, net	57,286,795.	4	78,955,459.
5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees			
	Complete Part II of Schedule L	0.	5	0.
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.
7	Notes and loans receivable, net	0.	7	0.
8	Inventories for sale or use	11,458,616.	8	11,370,277.
9	Prepaid expenses and deferred charges	7,274,446.	9	8,773,350.
10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	1002602078.		
b	Less accumulated depreciation	550,311,874.	10c	452,290,204.
11	Investments - publicly traded securities	443,957,314.	11	0.
12	Investments - other securities See Part IV, line 11	0.	12	0.
13	Investments - program-related See Part IV, line 11	562,595,487.	13	568,101,226.
14	Intangible assets	225,491.	14	255,785.
15	Other assets See Part IV, line 11	37,238,166.	15	27,209,880.
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	1,136,752,943.	16	1,191,534,890.
Liabilities				
17	Accounts payable and accrued expenses	94,954,240.	17	94,824,857.
18	Grants payable	0.	18	0.
19	Deferred revenue	2,249,323.	19	2,203,196.
20	Tax-exempt bond liabilities	224,258,011.	20	224,300,000.
21	Escrow or custodial account liability Complete Part IV of Schedule D	0.	21	0.
22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
23	Secured mortgages and notes payable to unrelated third parties	24,802,698.	23	24,400,188.
24	Unsecured notes and loans payable to unrelated third parties	0.	24	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 of Schedule D	271,466,936.	25	298,951,729.
26	<b>Total liabilities.</b> Add lines 17 through 25	617,731,208.	26	644,679,970.
Net Assets or Fund Balances				
	Organizations that follow SFAS 117 (ASC 958), check here ► <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
27	Unrestricted net assets	482,615,365.	27	512,969,438.
28	Temporarily restricted net assets	34,842,584.	28	32,274,012.
29	Permanently restricted net assets	1,563,786.	29	1,611,470.
	Organizations that do not follow SFAS 117 (ASC 958), check here ► <input type="checkbox"/> and complete lines 30 through 34.			
30	Capital stock or trust principal, or current funds		30	
31	Paid-in or capital surplus, or land, building, or equipment fund		31	
32	Retained earnings, endowment, accumulated income, or other funds		32	
33	<b>Total net assets or fund balances</b>	519,021,735.	33	546,854,920.
34	<b>Total liabilities and net assets/fund balances</b>	1,136,752,943.	34	1,191,534,890.

---

Form 990 (2015)

Form 990 (2015)

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI 

1 Total revenue (must equal Part VIII, column (A), line 12) . . . . .	1 405,893,926.
2 Total expenses (must equal Part IX, column (A), line 25) . . . . .	2 336,992,063.
3 Revenue less expenses Subtract line 2 from line 1 . . . . .	3 68,901,863.
4 Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	4 519,021,735.
5 Net unrealized gains (losses) on investments . . . . .	5 8,018,287.
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 -49,086,965.
10 Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) . . . . .	10 546,854,920.

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII 

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? . . . . . If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2a	X
2b Were the organization's financial statements audited by an independent accountant? . . . . . If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2b	X
2c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	X
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .	3a	X
3b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	X

Form 990 (2015)

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

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

► Attach to Form 990 or Form 990-EZ.

► Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2015**

Open to Public  
Inspection

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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

The organization is not a private foundation because it is (For lines 1 through 11, check only one box.)

- 1  A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
- 2  A school described in section 170(b)(1)(A)(ii). (Attach Schedule E (Form 990 or 990-EZ) )
- 3  A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii).
- 4  A medical research organization operated in conjunction with a hospital described in section 170(b)(1)(A)(iii). Enter the hospital's name, city, and state \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in section 170(b)(1)(A)(iv). (Complete Part II )
- 6  A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v).
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in section 170(b)(1)(A)(vi). (Complete Part II )
- 8  A community trust described in section 170(b)(1)(A)(vi). (Complete Part II )
- 9  An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See section 509(a)(2). (Complete Part III )
- 10  An organization organized and operated exclusively to test for public safety See section 509(a)(4).
- 11  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See section 509(a)(3). Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g
  - a  **Type I** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
  - b  **Type II** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
- f Enter the number of supported organizations ..... 1
- g Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>ATTACHMENT 1</b>						
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

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

Schedule A (Form 990 or 990-EZ) 2015

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants") . . . . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
4 Total. Add lines 1 through 3 . . . . .						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) . . . . .						
6 Public support. Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
7 Amounts from line 4 . . . . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources . . . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on . . . . .						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) . . . . .						
11 Total support. Add lines 7 through 10 . . . . .						
12 Gross receipts from related activities, etc (see instructions) . . . . .					12	
13 First five years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here . . . . . ►						<input type="checkbox"/>

**Section C. Computation of Public Support Percentage**

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) . . . . .	14	%
15 Public support percentage from 2014 Schedule A, Part II, line 14 . . . . .	15	%
16a 33 1/3% support test - 2015. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization . . . . . ►		<input type="checkbox"/>
b 33 1/3% support test - 2014. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization . . . . . ►		<input type="checkbox"/>
17a 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ►		<input type="checkbox"/>
b 10%-facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ►		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ►		<input type="checkbox"/>

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose . . . . .						
3 Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
6 Total. Add lines 1 through 5 . . . . .						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons . . . . .						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b . . . . .						
8 Public support. (Subtract line 7c from line 6) . . . . .						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
9 Amounts from line 6 . . . . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources . . . . .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 . . . . .						
c Add lines 10a and 10b . . . . .						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on . . . . .						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) . . . . .						
13 Total support. (Add lines 9, 10c, 11, and 12) . . . . .						
14 First five years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here . . . . . ► <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f)) . . . . .	15	%
16 Public support percentage from 2014 Schedule A, Part III, line 15 . . . . .	16	%

**Section D. Computation of Investment Income Percentage**

17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f)) . . . . .	17	%
18 Investment income percentage from 2014 Schedule A, Part III, line 17 . . . . .	18	%
19a 33 1/3% support tests - 2015. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
b 33 1/3% support tests - 2014 If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ► <input type="checkbox"/>		

**Part IV Supporting Organizations**

(Complete only if you checked a box in line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
1	X	
2		X
3a		X
3b		
3c		
4a		X
4b		
4c		
5a		X
5b		
5c		
6		X
7		X
8		X
9a		X
9b		X
9c		X
10a		X
10b		

1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in **Part VI** how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain

2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in **Part VI** how the organization determined that the supported organization was described in section 509(a)(1) or (2)

3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below

b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in **Part VI** when and how the organization made the determination

c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in **Part VI** what controls the organization put in place to ensure such use

4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below

b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in **Part VI** how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations

c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in **Part VI** what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes

5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in **Part VI**, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document)

b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?

c Substitutions only. Was the substitution the result of an event beyond the organization's control?

6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in **Part VI**.

7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)

8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)

9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in **Part VI**.

b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in **Part VI**.

c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in **Part VI**.

10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer 10b below

b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings)

**Part IV Supporting Organizations (continued)**

11 Has the organization accepted a gift or contribution from any of the following persons?

- A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?
- A family member of a person described in (a) above?
- A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in **Part VI**.

Yes	No
11a	X
11b	X
11c	X

**Section B. Type I Supporting Organizations**

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

2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in **Part VI** how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization

Yes	No
1	X
2	X

**Section C. Type II Supporting Organizations**

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

Yes	No
1	

**Section D. All Type III Supporting Organizations**

1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?

2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in **Part VI** how the organization maintained a close and continuous working relationship with the supported organization(s)

3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in **Part VI** the role the organization's supported organizations played in this regard

Yes	No
1	X
2	X
3	X

**Section E. Type III Functionally-Integrated Supporting Organizations**

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

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

2 Activities Test Answer (a) and (b) below.

- Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in **Part VI** identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities
- Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in **Part VI** the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement

Yes	No
2a	
2b	

3 Parent of Supported Organizations Answer (a) and (b) below.

- Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in **Part VI**.
- Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in **Part VI** the role played by the organization in this regard

Yes	No
3a	
3b	

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount		Current Year	
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)			

Schedule A (Form 990 or 990-EZ) 2015

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

<b>Section D - Distributions</b>		<b>Current Year</b>
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in Part VI) See instructions.	
7	<b>Total annual distributions.</b> Add lines 1 through 6	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9	Distributable amount for 2015 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	
<b>Section E - Distribution Allocations (see instructions)</b>		
		<b>(i) Excess Distributions</b>
		<b>(ii) Underdistributions Pre-2015</b>
		<b>(iii) Distributable Amount for 2015</b>
1	Distributable amount for 2015 from Section C, line 6	
2	Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)	
3	Excess distributions carryover, if any, to 2015	
a		
b		
c		
d	From 2013 . . . . .	
e	From 2014 . . . . .	
f	<b>Total of lines 3a through e</b>	
g	Applied to underdistributions of prior years	
h	Applied to 2015 distributable amount	
i	Carryover from 2010 not applied (see instructions)	
j	Remainder Subtract lines 3g, 3h, and 3i from 3f	
4	Distributions for 2015 from Section D, line 7	\$
a	Applied to underdistributions of prior years	
b	Applied to 2015 distributable amount	
c	Remainder Subtract lines 4a and 4b from 4	
5	Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)	
6	Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)	
7	<b>Excess distributions carryover to 2016 Add lines 3 and 4c</b>	
8	Breakdown of line 7	
a		
b		
c	Excess from 2013 . . . . .	
d	Excess from 2014 . . . . .	
e	Excess from 2015 . . . . .	

Schedule A (Form 990 or 990-EZ) 2015

Schedule A (Form 990 or 990-EZ) 2015

**Part VI** **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information (See instructions).

## SCHEDULE A, PART I

THE PUBLIC CHARITY STATUS REFLECTED ON SCHEDULE A, PART I IS FOR ATLANTICARE REGIONAL MEDICAL CENTER, THE LARGEST SUBORDINATE ORGANIZATION INCLUDED IN THE GROUP EXEMPTION RULING AND IN THIS CONSOLIDATED GROUP FORM 990. OUTLINED BELOW IS THE PUBLIC CHARITY STATUS FOR ALL OTHER ORGANIZATIONS INCLUDED IN THE GROUP EXEMPTION:

ATLANTICARE BEHAVIORAL HEALTH, INC.; SCHEDULE A, PART I, LINE 7, INTERNAL REVENUE CODE SECTION 509(A)(1) PUBLIC CHARITY;

ATLANTICARE FOUNDATION; SCHEDULE A, PART I, LINE 7, INTERNAL REVENUE CODE SECTION 509(A)(1) PUBLIC CHARITY;

ATLANTICARE HEALTH ENGAGEMENT, INC.; SCHEDULE A, PART I, LINE 11, INTERNAL REVENUE CODE SECTION 509(A)(3) PUBLIC CHARITY;

ATLANTICARE HEALTH SERVICES, INC.; SCHEDULE A, PART I, LINE 9, INTERNAL REVENUE CODE SECTION 509(A)(2) PUBLIC CHARITY;

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION; SCHEDULE A, PART I, LINE 11, INTERNAL REVENUE CODE SECTION 509(A)(3) PUBLIC CHARITY; AND

INFOSHARE, INC.; SCHEDULE A, PART I, LINE 11, INTERNAL REVENUE CODE SECTION 509(A)(3) PUBLIC CHARITY. INFOSHARE, INC. FILED A CERTIFICATE OF DISSOLUTION WITH THE STATE OF NEW JERSEY ON MARCH 18, 2016 AND IS NO

**Part VI** **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

LONGER IN EXISTENCE.

ATTACHMENT 1

SCHEDULE A, PART I - INFORMATION ABOUT SUPPORTED ORGANIZATIONS

(I) NAME OF SUPPORTED ORGANIZATION	(II) EIN	(III) TYPE OF ORGANIZATION	(IV) YES NO	(V) AMOUNT OF SUPPORT	(VI) OTHER SUPPORT AMOUNT
ATLANTICARE REGIONAL MEDICAL CENTER	80-0834222	03	X	0.	0.

TOTAL AMOUNT OF SUPPORT

**SCHEDULE C**  
(Form 990 or 990-EZ)**Political Campaign and Lobbying Activities**

OMB No 1545-0047

**2015****Open to Public  
Inspection**Department of the Treasury  
Internal Revenue Service**For Organizations Exempt From Income Tax Under section 501(c) and section 527**

► Complete if the organization is described below. ► Attach to Form 990 or Form 990-EZ.  
► Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

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

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

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

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

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

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

Name of organization	Employer identification number
ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES	90-0779828

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

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

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

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

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

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

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

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

Schedule C (Form 990 or 990-EZ) 2015

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

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

**B** Check ►  if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a	Total lobbying expenditures to influence public opinion (grass roots lobbying) . . . . .														
b	Total lobbying expenditures to influence a legislative body (direct lobbying) . . . . .														
c	Total lobbying expenditures (add lines 1a and 1b) . . . . .														
d	Other exempt purpose expenditures . . . . .														
e	Total exempt purpose expenditures (add lines 1c and 1d) . . . . .														
f	Lobbying nontaxable amount Enter the amount from the following table in both columns														
<table border="1"> <tr> <td>If the amount on line 1e, column (a) or (b) is:</td> <td>The lobbying nontaxable amount is:</td> </tr> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g	Grassroots nontaxable amount (enter 25% of line 1f) . . . . .														
h	Subtract line 1g from line 1a If zero or less, enter -0- . . . . .														
i	Subtract line 1f from line 1c. If zero or less, enter -0- . . . . .														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? . . . . .	<input type="checkbox"/> Yes	<input type="checkbox"/> No												

4-Year Averaging Period Under section 501(h)

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

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

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

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

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

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

**Part IV** Supplemental Information

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

SEE PAGE 4

---



---



---



---



---



---



---



---



---

**Part IV** Supplemental Information (continued)

## SCHEDULE C, PART II-B, LINE 11

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM") WHICH INCLUDES ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM"). AH SYSTEM ENGAGES IN LOBBYING EFFORTS ON BEHALF OF ALL AFFILIATES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990.

DURING THE SHORT-PERIOD ENDED JUNE 30, 2016, AH SYSTEM PAID \$50,000 TO OUTSIDE INDEPENDENT LOBBYING FIRMS TO ENGAGE IN LOBBYING ACTIVITIES PERFORMED ON BEHALF OF AH SYSTEM AND ALL AFFILIATES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990.

IN ADDITION, ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC"), A TAX-EXEMPT HOSPITAL WITHIN THE SYSTEM AND AFFILIATE OF AH SYSTEM, IS A MEMBER OF THE NEW JERSEY HOSPITAL ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION AND THE NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION WHICH ALL ENGAGE IN LOBBYING EFFORTS ON BEHALF OF THEIR MEMBER HOSPITALS. DURING THE SHORT-PERIOD ENDED JUNE 30, 2016, AH SYSTEM PAID THE DUES TO THESE ORGANIZATIONS ON BEHALF OF ARMC, A PORTION OF WHICH HAS BEEN ALLOCATED TO LOBBYING ACTIVITES PERFORMED ON BEHALF OF AH SYSTEM ALL AFFILIATES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. THIS ALLOCATION AMOUNTED TO \$42,187 DURING THE SHORT PERIOD ENDED JUNE 30, 2016.

THE TOTAL AMOUNT OF LOBBYING EXPENDITURES MADE BY AH SYSTEM, \$92,187, ON

**Part IV** Supplemental Information (continued)

BEHALF OF ALL AFFILIATES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 IS REPORTED ON AH SYSTEM'S FORM 990 (FEIN: 22-3265213), SCHEDULE C, PART II-B FOR THE SHORT-PERIOD ENDED JUNE 30, 2016.

**SCHEDULE D**  
(Form 990)Department of the Treasury  
Internal Revenue Service  
Name of the organization**Supplemental Financial Statements**► Complete if the organization answered "Yes" on Form 990,  
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

► Attach to Form 990.

► Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2015**Open to Public  
Inspection

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number  
90-0779828**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 6

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year . . . . .		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year) . . . . .		
4 Aggregate value at end of year . . . . .		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? . . . . .	<input type="checkbox"/>	Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? . . . . .	<input type="checkbox"/>	Yes <input type="checkbox"/> No

**Part II Conservation Easements.**

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)	<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education) <input type="checkbox"/> Preservation of a historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.	<input type="checkbox"/> Held at the End of the Tax Year
a Total number of conservation easements . . . . .	2a
b Total acreage restricted by conservation easements . . . . .	2b
c Number of conservation easements on a certified historic structure included in (a) . . . . .	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register . . . . .	2d
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►	
4 Number of states where property subject to conservation easement is located ►	
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►	
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$	
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements	

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 8

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items
(i) Revenue included in Form 990, Part VIII, line 1 . . . . . ► \$
(ii) Assets included in Form 990, Part X . . . . . ► \$
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items.
a Revenue included in Form 990, Part VIII, line 1 . . . . . ► \$
b Assets included in Form 990, Part X . . . . . ► \$

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

Schedule D (Form 990) 2015

JSA

5E1268 1 0000

4608KZ U600

SHORT-PERIOD

PAGE 37

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

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

a  Public exhibition  
 b  Scholarly research  
 c  Preservation for future generations

d  Loan or exchange programs  
 e  Other \_\_\_\_\_

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

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

	Amount
1c	
1d	
1e	
1f	

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

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

**Part V Endowment Funds.**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance . . . . .	36,406,370.	30,211,265.	27,823,172.	22,645,492.	22,759,161.
b Contributions . . . . .		15,000,000.	14,380,409.	5,695,000.	4,093,000.
c Net investment earnings, gains, and losses . . . . .		-20,698.	-11,000.	56,000.	29,000.
d Grants or scholarships . . . . .					
e Other expenditures for facilities and programs . . . . .	2,520,888.	8,784,197.	11,981,316.	573,320.	4,235,669.
f Administrative expenses . . . . .					
g End of year balance . . . . .	33,885,482.	36,406,370.	30,211,265.	27,823,172.	22,645,492.

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

a Board designated or quasi-endowment ►        %

b Permanent endowment ► 5.0000 %

c Temporarily restricted endowment ► 95.0000 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

(i) unrelated organizations . . . . .  
 (ii) related organizations . . . . .

Yes	No
3a(i)	X
3a(ii)	X

b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? . . . . .

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

**Part VI Land, Buildings, and Equipment.**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land . . . . .		31,682,188.		31,682,188.
b Buildings . . . . .		516,386,136.	199,674,575.	316,711,561.
c Leasehold improvements . . . . .		69,339.		69,339.
d Equipment . . . . .		427,477,798.	347,795,858.	79,681,940.
e Other . . . . .		26,986,617.	2,841,441.	24,145,176.

Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c). . . . . ► 452,290,204.

**Part VII Investments - Other Securities.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other . . . . .		
(A) . . . . .		
(B) . . . . .		
(C) . . . . .		
(D) . . . . .		
(E) . . . . .		
(F) . . . . .		
(G) . . . . .		
(H) . . . . .		
<b>Total (Column (b) must equal Form 990, Part X, col (B) line 12) ►</b>		

**Part VIII Investments - Program Related.**

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

(a) Description of investment ATTACHMENT 1	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) POOLED INVESTMENTS	4,090,147.	FMV
(2) CASH & CASH EQUIVALENTS;		
(3) LIMITED USE	28,007,924.	FMV
(4) CASH - RESTRICTED - BROKERAGE		
(5) FUNDS; CURRENT	116,363.	FMV
(6) CASH - RESTRICTED; NON-CURRENT		FMV
(7) OTHER INVESTMENTS	4,125,105.	FMV
(8) BOARD DESIGNATED INVESTMENTS	516,634,674.	FMV
(9) TRUSTEE HELD ASSETS UNDER DEBT		
<b>Total (Column (b) must equal Form 990, Part X, col (B) line 13) ►</b>	568,101,226.	

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total. (Column (b) must equal Form 990, Part X, col (B) line 15) . . . . . ►</b>	

**Part X Other Liabilities.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO AFFILIATES	
(3) ESTIMATED THIRD-PARTY PAYOR	
(4) SETTLEMENTS	65,764,135.
(5) OTHER LIABILITIES	90,215,427.
(6) ACCRUED INTEREST PAYABLE	569,123.
(7) ACCRUED RETIREMENT BENEFITS	142,403,044.
(8) DUE TO AFFILIATES	
(9) (JOINT & SEVERAL LIABILITIES)	224,300,000.
<b>Total (Column (b) must equal Form 990, Part X, col (B) line 25) ►</b>	523,251,729.

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

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.**  
 Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.**  
 Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

**Part XIII Supplemental Information.**

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

**SCHEDULE D, PART V, QUESTION 4**

RESTRICTED FUNDS ARE USED TO SUPPORT THE CHARITABLE ACTIVITIES AND

PROGRAMS OF THE ORGANIZATION AND ITS AFFILIATES.

**Part XIII Supplemental Information (continued)**ATTACHMENT 1SCHEDULE D, PART VIII - INVESTMENTS - PROGRAM RELATED

<u>DESCRIPTION</u>	<u>BOOK VALUE</u>	<u>COST OR FMV</u>
AGREEMENT		FMV
PERMANENTLY RESTRICTED		
ENDOWMENT FUND	1,501,077.	FMV
ACCRUED INTEREST; LIMITED USE		FMV
ALTERNATIVE INVESTMENTS;		
LIMITED USE	10,362,213.	FMV
BENEFICIAL INTEREST IN		
ATLANTICARE FOUNDATION	3,263,723.	FMV
<b>TOTALS</b>	<b><u>568,101,226.</u></b>	

**SCHEDULE F  
(Form 990)****Statement of Activities Outside the United States**

OMB No. 1545-0047

**2015****Open to Public  
Inspection**Department of the Treasury  
Internal Revenue Service

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

► Attach to Form 990.

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

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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

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

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

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN			PROGRAM SERVICES	FINANCIAL VEHICLE	7,030,035.
(2) EAST ASIA AND THE PACIFIC			INVESTMENTS		5,351,307.
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total. . . . .					12,381,342
b Total from continuation sheets to Part I . . . . .					
c Totals (add lines 3a and 3b)					12,381,342

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

Schedule F (Form 990) 2015

JSA  
5E1274 1 000

4608KZ U600

SHORT-PERIOD

PAGE 42

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

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

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

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

Schedule F (Form 990) 2015

**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)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

**Part IV Foreign Forms**

1 Was the organization a US 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 US Transferor of Property to a Foreign Corporation (see Instructions for Form 926). . . . .  Yes  No

2 Did the organization have an interest in a foreign trust during the tax year? If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a US Owner (see Instructions for Forms 3520 and 3520-A, do not file with Form 990). . . . .  Yes  No

3 Did the organization have an ownership interest in a foreign corporation during the tax year? If "Yes," the organization may be required to file Form 5471, Information Return of US Persons With Respect to Certain Foreign Corporations (see Instructions for Form 5471). . . . .  Yes  No

4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621). . . . .  Yes  No

5 Did the organization have an ownership interest in a foreign partnership during the tax year? If "Yes," the organization may be required to file Form 8865, Return of US Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865). . . . .  Yes  No

6 Did the organization have any operations in or related to any boycotting countries during the tax year? If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, do not file with Form 990). . . . .  Yes  No

**Part V Supplemental Information**

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

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

Department of the Treasury  
Internal Revenue Service

**Supplemental Information Regarding Fundraising or Gaming Activities**

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

► Attach to Form 990 or Form 990-EZ.  
► Information about Schedule G (Form 990 or 990-EZ) and its Instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047

**2015**

Open to Public  
Inspection

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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

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

a <input type="checkbox"/>	Mail solicitations	e <input type="checkbox"/>	Solicitation of non-government grants
b <input type="checkbox"/>	Internet and email solicitations	f <input type="checkbox"/>	Solicitation of government grants
c <input type="checkbox"/>	Phone solicitations	g <input type="checkbox"/>	Special fundraising events
d <input type="checkbox"/>	In-person solicitations		

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

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

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
1		Yes	No			
2						
3						
4						
5						
6						
7						
8						
9						
10						
<b>Total</b>						

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

..... ►

.....

.....

.....

.....

.....

.....

.....

.....

.....

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

	(a) Event #1 GALA (event type)	(b) Event #2 (event type)	(c) Other events (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts . . . . .	613,946.		613,946.
	2 Less Contributions . . . . .	306,410.		306,410.
	3 Gross income (line 1 minus line 2). . . . .	307,536.		307,536.
Direct Expenses	4 Cash prizes . . . . .			
	5 Noncash prizes . . . . .			
	6 Rent/facility costs . . . . .	200,556.		200,556.
	7 Food and beverages . . . . .			
	8 Entertainment . . . . .	21,825.		21,825.
	9 Other direct expenses . . . . .	85,155.		85,155.
	10 Direct expense summary Add lines 4 through 9 in column (d) . . . . .			307,536.
	11 Net income summary Subtract line 10 from line 3, column (d) . . . . .			

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

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

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

a Is the organization licensed to conduct gaming activities in each of these states? . . . . .  Yes  No  
b If "No," explain: \_\_\_\_\_

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? . . . . .  Yes  No  
b If "Yes," explain: \_\_\_\_\_

Schedule G (Form 990 or 990-EZ) 2015

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

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

13 Indicate the percentage of gaming activity conducted in

a The organization's facility . . . . .  13a %

b An outside facility . . . . .  13b %

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

Name ► \_\_\_\_\_

Address ► \_\_\_\_\_

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

b If "Yes," enter the amount of gaming revenue received by the organization ► \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ► \$ \_\_\_\_\_.

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

Name ► \_\_\_\_\_

Address ► \_\_\_\_\_

## 16 Gaming manager information

Name ► \_\_\_\_\_

Gaming manager compensation ► \$ \_\_\_\_\_

Description of services provided ► \_\_\_\_\_

Director/officer       Employee       Independent contractor

## 17 Mandatory distributions

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

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

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

**SCHEDULE H**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

OMB No 1545-0047

**2015**

**Open to Public  
Inspection**

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

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .  
b If "Yes," was it a written policy? . . . . .  
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year  
 Applied uniformly to all hospital facilities       Applied uniformly to most hospital facilities  
 Generally tailored to individual hospital facilities

3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year  
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:  
 100%     150%     200%     Other \_\_\_\_\_ %  
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care. . . . .  
 200%     250%     300%     350%     400%     Other 500.0000 %  
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care

4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .  
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?  
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .  
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .  
6a Did the organization prepare a community benefit report during the tax year? . . . . .  
b If "Yes," did the organization make it available to the public? . . . . .

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

	Yes	No
1a	X	
1b	X	
3a	X	
3b	X	
4	X	
5a	X	
5b	X	
5c		X
6a	X	
6b	X	

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1) . . . . .		3057	11,265,787.	12,660,399.		0
b Medicaid (from Worksheet 3, column a) . . . . .		23885	71,853,015.	52,696,367.	19,156,648.	6.23
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d Total Financial Assistance and Means-Tested Government Programs . . . . .		26942	83,118,802.	65,356,766.	19,156,648.	6.23
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4) . . . . .	14	23259	1,277,281.	77,483.	1,199,798.	.39
f Health professions education (from Worksheet 5) . . . . .	1		3,274,870.	1,916,846.	1,358,024.	.44
g Subsidized health services (from Worksheet 6) . . . . .	4	4945	6,328,147.	1,634,884.	4,693,263.	1.53
h Research (from Worksheet 7) . . . . .	1		156,227.	17,495.	138,732.	.05
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .	1		238,756.		238,756.	.08
j Total. Other Benefits . . . . .	21	28204	11,275,281.	3,646,708.	7,628,573.	2.49
k Total Add lines 7d and 7j. . . . .	21	55146	94,394,083.	69,003,474.	26,785,221.	8.72

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

JSA 5E1284 1000  
4608KZ U600

Schedule H (Form 990) 2015

SHORT-PERIOD

PAGE 50

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

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

**Part III** **Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15? . . . . .

2 Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount. . . . .

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit . . . . .

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

	Yes	No
1	X	
2	7,876,318.	
3	31,457.	

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) . . . . .

6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .

7 Subtract line 6 from line 5 This is the surplus (or shortfall) . . . . .

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used

Cost accounting system  Cost to charge ratio  Other

5	95,973,922.
6	111,807,639.
7	-15,833,717.

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? . . . . .

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

9a	X
9b	X

<b>Part IV</b> <b>Management Companies and Joint Ventures</b> (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)				
(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

**Part V Facility Information****Section A Hospital Facilities**

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

How many hospital facilities did the organization operate during the tax year? 2

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

Facility reporting group	Other (describe)						
		Licensed hospital	General medical & surgical	Critical access hospital	Teaching hospital	Children's hospital	ER-24 hours
1		X	X	X	X	X	
2		X	X	X	X	X	
3							
4							
5							
6							
7							
8							
9							
10							

**Part V Facility Information (continued)****Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group ARMCLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1-2**Community Health Needs Assessment**

1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .

2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .

3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . .  
If "Yes," indicate what the CHNA report describes (check all that apply).

a  A definition of the community served by the hospital facility

b  Demographics of the community

c  Existing health care facilities and resources within the community that are available to respond to the health needs of the community

d  How data was obtained

e  The significant health needs of the community

f  Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

g  The process for identifying and prioritizing community health needs and services to meet the community health needs

h  The process for consulting with persons representing the community's interests

i  Information gaps that limit the hospital facility's ability to assess the community's health needs

j  Other (describe in Section C)

4 Indicate the tax year the hospital facility last conducted a CHNA 20 16

5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .

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

b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .

7 Did the hospital facility make its CHNA report widely available to the public? . . . . .  
If "Yes," indicate how the CHNA report was made widely available (check all that apply)

a  Hospital facility's website (list url): WWW.ATLANTICARE.ORG/COMMUNITY

b  Other website (list url) WWW.BACHARACH.ORG

c  Made a paper copy available for public inspection without charge at the hospital facility

d  Other (describe in Section C)

8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .

9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16

10 Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .

a If "Yes," (list url) WWW.ATLANTICARE.ORG/COMMUNITY

b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .

11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed

12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .

b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .

c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$   

	Yes	No
1	X	
2	X	
3	X	
5	X	
6a	X	
6b	X	
7	X	
8	X	
10	X	
10b	X	
12a	X	
12b		

**Part V Facility Information (continued)****Financial Assistance Policy (FAP)****Name of hospital facility or letter of facility reporting group** ARMC

Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP

13  a Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000 % and FPG family income limit for eligibility for discounted care of 500.0000 %

b Income level other than FPG (describe in Section C)

c Asset level

d Medical indigency

e Insurance status

f Underinsurance status

g Residency

h Other (describe in Section C)

14 Explained the basis for calculating amounts charged to patients? . . . . .

15 Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):

a Described the information the hospital facility may require an individual to provide as part of his or her application

b Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application

c Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process

d Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications

e Other (describe in Section C)

16 Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)

a The FAP was widely available on a website (list url) ATLANTICARE.ORG/PLS

b The FAP application form was widely available on a website (list url) ATLANTICARE.ORG/PLS

c A plain language summary of the FAP was widely available on a website (list url) ATLANTICARE.ORG/PLS

d The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)

e The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)

f A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)

g Notice of availability of the FAP was conspicuously displayed throughout the hospital facility

h Notified members of the community who are most likely to require financial assistance about availability of the FAP

i Other (describe in Section C)

**Billing and Collections**

17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? . . . . .

18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP.

a Reporting to credit agency(ies)

b Selling an individual's debt to another party

c Actions that require a legal or judicial process

d Other similar actions (describe in Section C)

e None of these actions or other similar actions were permitted

	Yes	No
13	X	
14	X	
15	X	
16	X	
17	X	

## Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group ARMC

19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	Yes	No
If "Yes," check all actions in which the hospital facility or a third party engaged		19	X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

## Policy Relating to Emergency Medical Care

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

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

22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .	23	X
If "Yes," explain in Section C			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .	24	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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

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

IN 2013, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT IN COLLABORATION WITH BACHARACH INSTITUTE FOR REHABILITATION, WHICH IS ALSO LOCATED IN ATLANTIC COUNTY, NEW JERSEY. IN ADDITION TO A REVIEW OF PRIMARY AND SECONDARY DATA SOURCES, BOTH PARTIES ENSURED THAT THEY RECEIVED FEEDBACK FROM COMMUNITY LEADERS THROUGH FORMAL MEETINGS WHERE FINDINGS WERE SHARED FOR VALIDATION AND INPUT. COMMUNITY RESIDENT FEEDBACK WAS ALSO COLLECTED THROUGH A SERIES OF FOCUS GROUPS WHICH WERE CONDUCTED IN FOUR DISTINCT COMMUNITIES WITHIN THE COUNTY, SOMERS POINT, HAMMONTON, GALLOWAY, AND ATLANTIC CITY. ADDITIONAL EFFORTS WERE TAKEN TO ENSURE THAT ALL MEMBERS OF OUR COMMUNITY; INCLUDING MINORITY AND UNDERSERVED MEMBERS WERE INCLUDED AS PART OF THESE FEEDBACK SESSIONS. A FOLLOW-UP IMPLEMENTATION STRATEGY WAS ALSO DRAFTED IN 2013 TO DOCUMENT HOW ATLANTICARE WAS GOING TO MEET THE COMMUNITY'S IDENTIFIED NEEDS. IN THE YEARS 2014 AND 2015, ATLANTICARE RELEASED INTERIM REPORTS DETAILING ITS PROGRESS IN MEETING THESE IDENTIFIED COMMUNITY NEEDS. ATLANTICARE REGIONAL MEDICAL CENTER RELEASED AN UPDATED COMMUNITY HEALTH NEEDS ASSESSMENT IN 2016.

## SCHEDULE H, PART V, SECTION B, QUESTIONS 6A &amp; 6B

IN 2013, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT IN COLLABORATION WITH BACHARACH INSTITUTE FOR REHABILITATION, WHICH IS A TAX-EXEMPT TERTIARY CARE

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FACILITY LOCATED IN ATLANTIC COUNTY, NEW JERSEY. ATLANTICARE CONTINUES TO WORK WITH ITS COMMUNITY PARTNERS TO FIND SOLUTIONS FOR ALL IDENTIFIED COMMUNITY NEEDS. TO DATE, AT LEAST ONE STRATEGY PER COMMUNITY NEED HAS BEEN IDENTIFIED AND CONTINUED IMPLEMENTATION AND REVISIONS OF PROPOSED STRATEGIES ARE ONGOING.

AN UPDATED COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPILED AND PUBLICLY RELEASED IN 2016. THIS WAS COMPLETED INDEPENDENT OF BOTH A HOSPITAL AND COMMUNITY PARTNER, AND CAN BE FOUND ON ATLANTICARE'S WEBSITE AT [WWW.ATLANTICARE.ORG/COMMUNITY](http://WWW.ATLANTICARE.ORG/COMMUNITY).

GIVEN RECENT CHANGES IN OUR LOCAL COMMUNITY MANY OF THE PRIORITIES IN OUR ASSESSMENT WERE REPRIORITIZED BY OUR LOCAL RESIDENTS, WITH ISSUES SUCH AS SAFETY, DRUG AND ALCOHOL ADDICTION, MENTAL HEALTH, AND FOOD INSECURITY RISING TO THE TOP OF THE COMMUNITY'S NEEDS AS PERCEIVED BY OUR RESIDENTS. ATLANTICARE IS ACTIVELY SEEKING OUT PARTNERSHIPS TO BETTER UNDERSTAND THE ROOT CAUSES OF THESE SOCIAL DETERMINANTS OF HEALTH. IT IS ALSO WORKING WITH THESE PARTNERS TO IDENTIFY OPPORTUNITIES TO ACCELERATE OR SUPPORT ONGOING EFFORTS TO MAKE A GREATER IMPACT AND IMPROVE THE HEALTH OF OUR COMMUNITY.

SCHEDULE H, PART V, SECTION B, QUESTION 11

IN 2013, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS INITIAL REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") IN COLLABORATION WITH

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

BACHARACH INSTITUTE FOR REHABILITATION, WHICH IS ALSO LOCATED IN ATLANTIC COUNTY, NEW JERSEY. IT AGAIN ASSESSED THE COMMUNITY IN 2016, WITH A REPORT PUBLISHED DURING 2016. IN ADDITION TO A REVIEW OF PRIMARY AND SECONDARY DATA SOURCES, ATLANTICARE ENSURED THAT FEEDBACK FROM COMMUNITY LEADERS THROUGH FORMAL MEETINGS WHERE FINDINGS WERE SHARED FOR VALIDATION AND INPUT WAS OBTAINED. COMMUNITY RESIDENT FEEDBACK WAS ALSO COLLECTED THROUGH A SERIES OF FOCUS GROUPS AND THROUGH THE IMPLEMENTATION OF A RESIDENT SURVEY. ADDITIONAL EFFORTS WERE TAKEN TO ENSURE THAT ALL MEMBERS OF OUR COMMUNITY; INCLUDING MINORITY AND UNDERSERVED MEMBERS, WERE INCLUDED AS PART OF THESE FEEDBACK EFFORTS.

COMMUNITY NEEDS THAT EMERGED FROM THIS ASSESSMENT WERE REVIEWED AND WERE PRIORITIZED FOR GREATER ORGANIZATIONAL SUPPORT IN ORDER TO ADDRESS. NEEDS THAT WERE IDENTIFIED IN THE 2016 CHNA INCLUDED COMMUNITY SAFETY; ADDICTIONS/MENTAL HEALTH SERVICES; FOOD INSECURITY/ACCESS TO HEALTHY FOODS; AND INFRASTRUCTURE SUPPORT. THESE HAVE SHIFTED SINCE OUR PREVIOUS SURVEY AS A RESULT OF RECENT CASINO CLOSURES, THE DOWNTURN OF THE HOUSING MARKET, AND THE LACK OF AVAILABLE JOBS IN OUR LOCAL ECONOMY. OUR COMMUNITY IS ALSO FACING A SIGNIFICANT RISE IN DRUG USE, SPECIFICALLY OPIOIDS, AND THE CRIME THAT CORRESPONDS WITH DRUG USE. AN UPDATED IMPLEMENTATION STRATEGY HAS BEEN ADOPTED TO SHARE OUR PROGRESS ON PREVIOUSLY STATED NEEDS, AND TO INCORPORATE OUR ACTIONS TO THOSE NEW NEEDS WHICH HAVE EMERGED AS COMMUNITY PRIORITIES. WEAVED INTO OUR IMPLEMENTATION STRATEGY IS THE UNDERSTANDING THAT, IN ORDER TO HAVE A GREATER IMPACT ON OUR COMMUNITY, MORE FORMALIZED PARTNERSHIPS NEED TO BE

**Part V Facility Information (continued)**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility

ESTABLISHED WITH OUR LOCAL SOCIAL SERVICE AND GOVERNMENT AGENCIES TO  
DEVELOP A MORE COMPREHENSIVE APPROACH TO MEETING THE STATED NEEDS OF OUR  
COMMUNITY.

HOSPITALS ARE NOT REQUIRED TO, NOR CAN THEY RESPOND TO ALL UNMET NEEDS IN  
THE COMMUNITY. ANY NEEDS NOT ADDRESSED BY THE APPROVED IMPLEMENTATION  
STRATEGY ARE EITHER ALREADY BEING ADDRESSED BY OTHER AGENCIES WITHIN THE  
HOSPITAL'S SERVICE AREA OR HAVE BEEN DEEMED TO NOT BE A VIABLE USE OF  
EXISTING RESOURCES. UNMET NEEDS AND THE COMMUNITY PARTNERS WHO IMPACT  
THESE WILL CONTINUE TO BE MONITORED AND ASSESSED ANNUALLY TO ENSURE THAT  
ATLANTICARE REMAINS AGILE AND RESPONSIVE TO THE NEEDS WHICH HAVE THE  
LARGEST IMPACT ON THE HEALTH OF OUR COMMUNITY.

## SCHEDULE H, PART V, SECTION B, QUESTION 22D

ATLANTICARE REGIONAL MEDICAL CENTER INSTITUTED A SELF-PAY DISCOUNT POLICY  
THAT LIMITS CHARGES FOR MEDICAL SERVICES TO AN AMOUNT NOT TO EXCEED THE  
LESSER OF THE CALCULATED AMOUNTS GENERALLY BILLED UNDER IRC §501(R)(5) OR  
115% OF THE APPLICABLE MEDICARE REIMBURSEMENT RATE FOR ALL QUALIFIED  
UNINSURED PATIENTS WHO ARE NOT ELIGIBLE FOR EXISTING STATE, FEDERAL AND  
LOCAL PROGRAMS.

SCH H H, PART V, SECT B, Q'S 3J, 7D, 13B, 13H, 15E, 16I, 18D, 19D, 20E, 21C, 21D, 23, 24

NOT APPLICABLE.

**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? 12

Name and address	Type of Facility (describe)
1 ARMC CANCER CARE/FACULTY PRACTICE 2500 ENGLISH CREEK AVE, BUILDING 400 EGG HARBOR TOWNSHIP NJ 08234	CANCER CARE INSTITUTE, IMAGING CENTER AND GYNECOLOGY/ONCOLOGY
2 ARMC SATELLITE EMERGENCY DEPARTMENT 219 NORTH WHITE HORSE PIKE HAMMONTON NJ 08037-2014	SATELLITE EMERGENCY DEPARTMENT
3 ARMC FACULTY PRACTICE 1925 PACIFIC AVENUE ATLANTIC CITY NJ 08401	CARDIAC DIAGNOSTIC, SURGERY GROUP, HOSPITALISTS, PSYCH AND TRAUMA
4 ARMC THE CANCER CARE INSTITUTE 106 COURT HOUSE SOUTH DENNIS RD. BLD 200 CAPE MAY COURT HOUSE NJ 08210	CANCER CARE INSTITUTE, LAB, PHARMACY, SURGERY CENTER/ONCOLOGY
5 ARMC ADULT PARTIAL CARE SERVICES 400 CHRIS GAUPP DRIVE GALLOWAY NJ 08205	BEHAVIORAL HEALTH CLINIC
6 ATLANTICARE HEALTHPLEX 1401 ATLANTIC AVENUE ATLANTIC CITY NJ 08401	CLINIC, SPECIALTY CARE CLINIC, RADIOLOGY, LAB, SCC, INFECT. DISEASE, POST ACUTE CARE
7 ATLANTICARE PHARM/SPECIALTY CARE CLINIC 54 WEST JIMMIE LEEDS ROAD GALLOWAY NJ 08205-9401	PHARMACY, SPECIALTY CARE
8 CHILD PARTIAL HOSPITALIZATION 6010 BLACK HORSE PIKE EGG HARBOR TOWNSHIP NJ 08234	ADOLESCENT BEHAVIORAL HEALTH
9 ARMC WOUND HEALING CENTER 2500 ENGLISH CREEK AVE BLDG 700, STE 701 EGG HARBOR TOWNSHIP NJ 08234	WOUND CARE
10 ARMC PREADMISSION TESTING 2500 ENGLISH CREEK AVENUE, BLDG. 200 EGG HARBOR TOWNSHIP NJ 08234	PREADMISSION TESTING

Schedule H (Form 990) 2015

**Part V Facility Information (continued)****Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**  
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 ARM C WOUND HEALING CENTER 219 N. WHITE HORSE PIKE HAMMONTON NJ 08037	WOUND CARE
2 ATLANTICARE COMMUNITY PHARMACY 65 W. JIMMIE LEEDS ROAD POMONA NJ 08240-9102	PHARMACY
3	
4	
5	
6	
7	
8	
9	
10	

Schedule H (Form 990) 2015

**Part VI Supplemental Information**

Provide the following information

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

**PART I, LINE 3C**

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 2015 POVERTY GUIDELINES (DEPARTMENT OF HEALTH AND SENIOR SERVICES). FPG ARE INCLUDED IN THE CRITERIA FOR DETERMINING ELIGIBILITY FOR CHARITY AND DISCOUNTED CARE.

**SCHEDULE H, PART I; QUESTION 6**

SINCE 2012, THE ORGANIZATION HAS BEEN PARTICIPATING IN A DATA COLLECTION AND SHARING EXERCISE WITH THE NEW JERSEY HOSPITAL ASSOCIATION ("NJHA") TO PUBLICLY REPORT COMMUNITY BENEFITS DERIVED FROM COMMUNITY HOSPITALS AND HEALTH SYSTEMS. ATLANTICARE CONTINUES TO CONTRIBUTE TO THIS EFFORT BY SPECIFICALLY REPORTING ALL OF ITS PROGRAMMING AND SERVICES THAT ARE DEEMED A BENEFIT TO OUR SERVICE AREA. ATLANTICARE'S COMMUNITY BENEFIT INFORMATION IS A PART OF THE AGGREGATE DATA THAT IS REPORTED ANNUALLY BY NJHA.

**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; QUESTION 7G**

SUBSIDIZED HEALTH SERVICES INCLUDE NICU, PRENATAL, PALLIATIVE CARE, RNS  
VAN SERVICE, BREAST HEALTH, PSYCHIATRIC INTERVENTION PROGRAM, HIV  
COUNSELING AND OUTPATIENT DIALYSIS. THOSE PROGRAMS ARE IDENTIFIED AS  
NEEDS IN THE COMMUNITY AND ARE SUBSIDIZED BY EXTERNAL AND INTERNAL FUNDS.

**SCHEDULE H, PART I, QUESTION 7**

THE ORGANIZATION UTILIZED MCKESSON'S COST ACCOUNTING SYSTEM TO ESTIMATE  
COSTS.

**SCHEDULE H, PART III, SECTION A; QUESTION 4**

BAD DEBT EXPENSE WAS CALCULATED USING THE PROVIDERS' BAD DEBT EXPENSE  
FROM ITS AUDITED FINANCIAL STATEMENTS, ADJUSTED FOR SELF-PAY CONTRACTUAL  
ALLOWANCES MULTIPLIED BY ITS COST TO CHARGE RATIO. ATLANTICARE REGIONAL  
MEDICAL CENTER IS AN AFFILIATE WITHIN GEISINGER HEALTH SYSTEM FOUNDATION

**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 CHINAs 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 AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM

("SYSTEM"). GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES ("GHS")

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 CONSOLIDATED FINANCIAL STATEMENTS OF GEISINGER HEALTH SYSTEM

FOUNDATION AND AFFILIATES.

CHARITY CARE

GHS PROVIDES SERVICES TO ALL PATIENTS REGARDLESS OF ABILITY TO PAY. IN

ACCORDANCE WITH GHS'S POLICY, A PATIENT IS CLASSIFIED AS A CHARITY

PATIENT BASED ON INCOME ELIGIBILITY CRITERIA. GHS ALSO PROVIDES FREE CARE

TO PATIENTS THAT EITHER DO NOT PURSUE CHARITY CARE ELIGIBILITY OR ARE

OTHERWISE DETERMINED TO BE IN NEED. BECAUSE GHS DOES NOT PURSUE

COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT

REPORTED AS REVENUE.

**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

ADDITIONALLY, GHS SPONSORS OTHER CHARITABLE PROGRAMS THAT PROVIDE  
SUBSTANTIAL BENEFIT TO THE BROADER COMMUNITY. SUCH PROGRAMS INCLUDE  
SERVICES TO THE NEEDY AND ELDERLY POPULATION REQUIRING SPECIAL SUPPORT,  
VARIOUS CLINICAL OUTREACH PROGRAMS, AND HEALTH EDUCATION AND PROMOTION.

SCHEDULE H, PART III, SECTION B; QUESTION 8

MEDICARE COSTS WERE DERIVED FROM THE MEDICARE COST REPORT AND THE COST  
ACCOUNTING SYSTEM.

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

THE ORGANIZATION FEELS 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

**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

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 INDIVIDUAL'S 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  
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 §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

**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

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.

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

**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

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.

**COMMUNITY BENEFIT STANDARD**

IN 1969, THE IRS ISSUED REVENUE RULING 69-545, WHICH "REMOVE[D]" 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

**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

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 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

**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

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

AVAILABLE TO ALL QUALIFIED PHYSICIANS.

MEDICARE UNDERPAYMENTS AND BAD DEBT ARE COMMUNITY BENEFIT AND ASSOCIATED

COSTS ARE INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I.

THE AMERICAN HOSPITAL ASSOCIATION ("AHA") FEELS 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

**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

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 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

**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

"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 THE 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.

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

**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

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 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

**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.

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  
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

PATIENTS RECEIVE A STATEMENT AFTER RECEIVING SERVICES. IF CONTACTING THE  
ORGANIZATION REGARDING THEIR INABILITY TO PAY, PATIENTS IMMEDIATELY WILL  
BE REFERRED TO AN INTERNAL FINANCIAL ASSISTANCE COUNSELOR. THIS

**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

INDIVIDUAL WILL SCREEN THE PATIENT TO DETERMINE IF THE PATIENT IS

ELIGIBLE FOR CHARITY CARE OR THE STATE MEDICAID PROGRAM.

SCHEDULE H, PART VI; QUESTION 2

IN ADDITION TO THE INTERNAL REVENUE CODE SECTION 501(R) COMMUNITY HEALTH NEEDS ASSESSMENT INFORMATION OUTLINED IN THE FORM 990, SCHEUDLE H, PART V, SECTION B, ATLANTICARE REGIONAL MEDICAL CENTER PARTICIPATES IN A COUNTY WIDE COMMUNITY NEEDS ASSESSMENT IN CONJUNCTION WITH THE ATLANTIC COUNTY DIVISION OF PUBLIC HEALTH WHICH OCCURS ON A REGULARLY SCHEDULED BASIS. ATLANTICARE REGIONAL MEDICAL CENTER ALSO RECEIVES COMMUNITY NEEDS ASSESSMENT INFORMATION FROM LOCAL AGENCIES SUCH AS THE UNITED WAY WHICH WE UTILIZE IN OUR PLANNING PROCESS. ANOTHER TOOL THAT IS USED BY ATLANTICARE REGIONAL MEDICAL CENTER TO IDENTIFY COMMUNITY NEEDS ARE THE CUSTOMER FOCUS GROUPS THAT ARE HELD BY OUR MARKETING DEPARTMENT.

ATLANTICARE REGIONAL MEDICAL CENTER UPDATED THE NEEDS ASSESSMENT IN 2016.

**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 VI; QUESTION 3

ALL PATIENTS ARE INFORMED REGARDING THE AVAILABILITY OF CHARITY CARE.

THIS IS ACCOMPLISHED THROUGH POSTED SIGNS AND WRITTEN NOTICES PROVIDED AT THE TIME OF REGISTRATION IN BOTH ENGLISH AND SPANISH IN THE EMERGENCY DEPARTMENT AND ADMISSIONS AREAS. ATLANTICARE REGIONAL MEDICAL CENTER WILL ASSIST ANY PATIENT INTERESTED IN APPLYING BY PLACING THEM IN CONTACT WITH THE APPROPRIATE PERSONNEL IN THE COMPANY'S REGISTRATION OR BUSINESS OFFICE.

## SCHEDULE H, PART VI; QUESTION 4

ATLANTICARE REGIONAL MEDICAL CENTER PROVIDES URGENT AND EMERGENT HEALTHCARE SERVICES TO ALL INDIVIDUALS AND ALSO PROVIDES ELECTIVE PROCEDURES TO APPROXIMATELY 430,000 MEMBERS IN THE SOUTH JERSEY COMMUNITY IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, CREED, AGE, SEX, LIFESTYLE OR ABILITY TO PAY. THE PRIMARY SERVICE AREAS ARE ATLANTIC COUNTY (COMPRISED OF 16 ZIP CODES IN CENTRAL AND EASTERN

**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

ATLANTIC COUNTY) AND SOUTHERN OCEAN COUNTY (TUCKERTON ZIP CODE ONLY). THE REGIONAL SERVICE IS COMPRISED OF ATLANTIC COUNTY RSA (REMAINING ZIP CODES), CAPE MAY COUNTY RSA AND SOUTHERN OCEAN COUNTY RSA (LONG BEACH ISLAND, MANAHAWKIN AND WEST CREEK).

SCHEDULE H, PART VI; QUESTION 5

ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS A TAX-EXEMPT ORGANIZATION LOCATED IN ATLANTIC CITY, NEW JERSEY. IT IS AN AFFILIATE MEMBER OF THE GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES, HAVING JOINED THE ENTERPRISE IN OCTOBER OF 2015. AH SYSTEM IS THE SOLE CORPORATE MEMBER OF VARIOUS HEALTHCARE RELATED ORGANIZATIONS, THE MAJORITY OF WHICH ARE TAX-EXEMPT ENTITIES (COLLECTIVELY "ATLANTICARE"). PLEASE REFER TO FORM 990, SCHEDULE O, WHICH CONTAINS THE AH SYSTEM'S COMMUNITY BENEFIT STATEMENT AND SUMMARY OF ALL ENTITIES WHICH COMPRISE ATLANTICARE FOR FURTHER INFORMATION ON HOW THE ORGANIZATION'S HOSPITALS AND OTHER HEALTHCARE FACILITIES FURTHER ATLANTICARE'S CHARITABLE TAX-EXEMPT PURPOSES BY PROMOTING THE HEALTH OF THE COMMUNITY AND MEET THE CRITERIA

**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

OUTLINED IN REVENUE RULING 69-545.

SCHEDULE H, PART VI; QUESTION 6

ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS A TAX-EXEMPT ORGANIZATION LOCATED IN ATLANTIC CITY, NEW JERSEY. IT IS AN AFFILIATE MEMBER OF THE GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES, HAVING JOINED THE ENTERPRISE IN OCTOBER OF 2015. AH SYSTEM IS THE SOLE CORPORATE MEMBER OF VARIOUS HEALTHCARE RELATED ORGANIZATIONS, THE MAJORITY OF WHICH ARE TAX-EXEMPT ENTITIES (COLLECTIVELY "ATLANTICARE"). PLEASE REFER TO FORM 990, SCHEDULE O, WHICH CONTAINS THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

THE FOLLOWING ARE THE NOT FOR-PROFIT ATLANTICARE HEALTHCARE SYSTEM, INC. ENTITIES.

ATLANTICARE HEALTH SYSTEM, INC.

=====

**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

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

ATLANTICARE HEALTH SYSTEM, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C) (3) AND AS A SUPPORTING ORGANIZATION PURSUANT TO INTERNAL REVENUE CODE §509(A) (3).

AH SYSTEM ENSURES THAT ITS SYSTEM PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OF ABILITY TO PAY. NO INDIVIDUALS ARE DENIED NECESSARY MEDICAL CARE, TREATMENT OR SERVICES. AH SYSTEM IS THE SOLE CORPORATE

**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.

MEMBER OF ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC"); A HOSPITAL

PROVIDING COMPREHENSIVE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES.

ARMC OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS

REVENUE RULING 69-545:

1. PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY, INCLUDING CHARITY CARE, SELF-PAY, MEDICARE AND MEDICAID PATIENTS;
2. OPERATES AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;
3. MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;
4. CONTROL OF IT RESTS WITH ITS BOARD OF TRUSTEES AND THE BOARD OF TRUSTEES OF ATLANTICARE HEALTH SYSTEM, INC. BOTH BOARDS ARE COMPRISED OF INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY;

**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

AND

5. SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND  
AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE; PROGRAMS AND  
ACTIVITIES.

ATLANTICARE REGIONAL MEDICAL CENTER

=====

ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC") IS A 593-BED NON-PROFIT  
ACUTE CARE MEDICAL CENTER LOCATED IN ATLANTIC CITY, ATLANTIC COUNTY, NEW  
JERSEY. ARMC IS RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS AN INTERNAL  
REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS  
CHARITABLE PURPOSES, ARMC 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,  
ARMC OPERATES CONSISTENTLY WITH THE CRITERIA OUTLINED IN IRS REVENUE  
RULING 69-545.

**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.

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION

=====

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT ORGANIZATION  
IS AN ORGANIZATION RECOGNIZED BY 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)(3).

ATLANTICARE BEHAVIORAL HEALTH, INC.

=====

ATLANTICARE BEHAVIORAL HEALTH, INC. IS AN ORGANIZATION RECOGNIZED BY 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). THE ORGANIZATION PROVIDES MEDICALLY NECESSARY  
HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER

**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

REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR

ABILITY TO PAY.

ATLANTICARE BEHAVIORAL HEALTH, INC. MANAGES A 34-BED ACUTE CARE PSYCHIATRIC FACILITY IN ATLANTIC COUNTY, NEW JERSEY AND OPERATES 26 LOCATIONS THROUGHOUT THE REGION. THE ORGANIZATION PROVIDES INPATIENT, PARTIAL HOSPITALIZATION, AND INTENSIVE OUTPATIENT PROGRAMS FOR ADULTS AND OLDER ADULTS DIAGNOSED WITH PSYCHIATRIC AND DUAL DISORDERS. ATLANTICARE BEHAVIORAL HEALTH, INC. IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION FOR HEALTHCARE ORGANIZATIONS.

ATLANTICARE FOUNDATION

=====

ATLANTICARE FOUNDATION, INC. IS AN ORGANIZATION RECOGNIZED BY 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).

**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

THROUGH FUNDRAISING ACTIVITIES THE ORGANIZATION SUPPORTS THE CHARITABLE PURPOSES, PROGRAMS AND SERVICES OF ATLANTICARE REGIONAL MEDICAL CENTER; 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.

ATLANTICARE HEALTH ENGAGEMENT, INC.

=====

ATLANTICARE HEALTH ENGAGEMENT, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C) (3).

THE ORGANIZATION IS PRIMARILY AN AMBULATORY CARE NETWORK THAT REACHES BEYOND ATLANTICARE REGIONAL MEDICAL CENTER TO ADDRESS THE HEALTH AND WELLNESS NEEDS FOR THE REGIONALS RESIDENTS THROUGHOUT ALL STAGES OF

**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.

LIFE.

ATLANTICARE HEALTH SERVICES, INC.

=====

ATLANTICARE HEALTH SERVICES, INC. IS AN ORGANIZATION RECOGNIZED BY 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) (2).

THE ORGANIZATION IS PRIMARILY AN AMBULATORY CARE NETWORK THAT REACHES BEYOND ATLANTICARE REGIONAL MEDICAL CENTER TO ADDRESS THE HEALTH AND WELLNESS NEEDS FOR THE REGIONS RESIDENTS THROUGHOUT ALL STAGES OF LIFE.

ATLANTICARE PHYSICIAN GROUP, P.A.

=====

ATLANTICARE PHYSICIAN GROUP, P.A. IS AN ORGANIZATION RECOGNIZED BY THE

**Part VI Supplemental Information**

Provide the following information

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

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) (3) .

THE ORGANIZATION PROVIDES SERVICES OUTSIDE OF THE HOSPITAL ATMOSPHERE TO  
SPECIALIZE IN PREVENTIVE CARE AND IN DIAGNOSING AND TREATING VARIOUS  
ILLNESSES.

INFOSHARE, INC.

=====

INFOSHARE, INC. IS AN ORGANIZATION RECOGNIZED BY 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) (3) .

THE ORGANIZATION IS THE INFORMATION TECHNOLOGY FIRM OF ATLANTICARE  
REGIONAL MEDICAL CENTER. AND, AS SUCH, SUPPORTS ALL OTHER ATLANTICARE  
HEALTH SYSTEM, INC. AFFILIATES TO ACHIEVE MAXIMUM RESULTS THROUGH THE USE

**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

OF INFORMATION TECHNOLOGY. THIS ENTITY WAS DISSOLVED ON MARCH 18, 2016.

THE FOLLOWING ARE THE FOR PROFIT ATLANTICARE HEALTHCARE SYSTEM, INC.

ENTITIES:

ATLANTICARE ASSURANCE ALLIANCE, INC.

=====

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS AH SYSTEM. THE ORGANIZATION  
PROVIDES BENEFITS RELATED TO MALPRACTICE LIABILITY INSURANCE TO ITS  
MEMBERS.

ATLANTICARE HEALTH SOLUTIONS, INC.

=====

A FOR-PROFIT ENTITY WHOSE SOLE SHAREHOLDER IS AH SYSTEM. THE ENTITY IS AN  
ACCOUNTABLE CARE ORGANIZATION FOR ATLANTICARE HEALTH SYSTEM.

**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

ATLANTICARE SURGERY CENTER, L.L.C.

=====

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP LOCATED IN EGG HARBOR TOWNSHIP, ATLANTIC COUNTY, NEW JERSEY. THE ORGANIZATION PROVIDES HEALTHCARE SERVICES TO INDIVIDUALS.

COOPERATIVE HEALTHCARE SERVICES OF SOUTH JERSEY, L.L.C.

=====

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP OWNED BY ATLANTICARE HEALTH SYSTEM, INC. THE ORGANIZATION PROVIDES HEALTHCARE SERVICES TO INDIVIDUALS.

ENGLISH CREEK ASSURANCE, LTD.

=====

A CONTROLLED FOREIGN CORPORATION BY ATLANTICARE HEALTH SYSTEM, INC. THE

**Part VI Supplemental Information**

Provide the following information

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

ORGANIZATION WAS FORMED AND OPERATES SOLELY IN BERMUDA.

SOUTH JERSEY ONCOLOGY PROPERTIES, L.L.C.

=====

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP WITH A PERCENTAGE OWNED BY ATLANTICARE HEALTH SERVICES, INC. THE ORGANIZATION PROVIDES HEALTHCARE SERVICES TO INDIVIDUALS.

SCHEDULE H, PART III, SECTION B; QUESTION 7

NOT APPLICABLE. THE ENTITY AND RELATED PROVIDER ORGANIZATIONS ARE LOCATED IN NEW JERSEY. NO COMMUNITY BENEFIT REPORT IS FILED WITH THE STATE OF NEW JERSEY.

**SCHEDULE I**  
(Form 990)

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

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

► Attach to Form 990.

Department of the Treasury  
Internal Revenue Service

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES  
Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER  
1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION  
2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

OMB No 1545-0047

**2015**

**Open to Public  
Inspection**

► Information about Schedule I (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

Name of the organization

ATLANTICARE REGIONAL MEDICAL CENTER

1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401

(2) ATLANTICARE FOUNDATION

2500 ENGLISH CREEK AVE

(3) 22-2148992 501 (C) (3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

**Part I General Information on Grants and Assistance**

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

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

**Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.** Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) ATLANTICARE REGIONAL MEDICAL CENTER 1925 PACIFIC AVENUE ATLANTIC CITY, NJ 08401	21-0634549	501 (C) (3)	132,689.				PROGRAM SUPPORT
(2) ATLANTICARE FOUNDATION 2500 ENGLISH CREEK AVE	22-2148992	501 (C) (3)	375,000				PROGRAM SUPPORT
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

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

5E1288 1 000  
4 608 KZ U600

SHORT-PERIOD

Schedule I (Form 990) (2015)

**Part III Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.

Part III can be duplicated if additional space is needed.

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

**Part IV Supplemental Information.** Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SCHEDULE I, PART I; QUESTION 2

GRANTS ARE MONITORED BY THE ORGANIZATION'S FINANCE PERSONNEL THROUGH THE UTILIZATION OF COST CENTERS AND OTHER INFORMATION; INCLUDING WRITTEN DOCUMENTATION AND RECEIPTS.

**SCHEDULE M**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Noncash Contributions**

OMB No. 1545-0047

**2015**

**Open To Public  
Inspection**

- Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- Attach to Form 990.
- Information about Schedule M (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art . . . . .				
2 Art - Historical treasures . . . . .				
3 Art - Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods. . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes. . . . .				
8 Intellectual property . . . . .				
9 Securities - Publicly traded . . . . .				
10 Securities - Closely held stock . . . . .				
11 Securities - Partnership, LLC, or trust interests . . . . .				
12 Securities - Miscellaneous . . . . .				
13 Qualified conservation contribution - Historic structures . . . . .				
14 Qualified conservation contribution - Other . . . . .				
15 Real estate - Residential . . . . .				
16 Real estate - Commercial . . . . .				
17 Real estate - Other . . . . .				
18 Collectibles. . . . .				
19 Food inventory. . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens. . . . .				
24 Archeological artifacts. . . . .				
25 Other ►( <u>ATCH 1</u> )		20.	58,163.	
26 Other ►( _____ )				
27 Other ►( _____ )				
28 Other ►( _____ )				
29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement . . . . .			29	

		Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? . . . . .	30a	X
b	If "Yes," describe the arrangement in Part II		
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions? . . . . .	31	X
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? . . . . .	32a	X
b	If "Yes," describe in Part II		
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II		

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

Schedule M (Form 990) (2015)

JSA

5E1298 1 000

4608KZ U600

SHORT-PERIOD

PAGE 92

**Part II Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

## SCHEDULE M, PART I; QUESTION 32A

THE ORGANIZATION HIRES INDEPENDENT THIRD-PARTIES TO SELL NON-CASH CONTRIBUTIONS IT RECEIVES; IF THE ORGANIZATION DECIDES NOT TO RETAIN THE ITEM(S). THE ORGANIZATION PAYS FAIR MARKET VALUE RATES AND COMMISSIONS IN THESE INSTANCES.

**Part II Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

ATTACHMENT 1

SCHEDULE M, PART I - OTHER NONCASH CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>(A) CHECK</u>	<u>(B) NUMBER OF CONTRIBUTIONS</u>	<u>(C) REVENUES REPORTED</u>	<u>(D) METHOD OF DETERMINING</u>
RECEPTION AND DINNER	X	12.	46,160.	FMV
GOLF FOURESOME	X	1.	4,000.	FMV
VARIOUS ITEMS	X	7.	8,003.	FMV
<b>TOTALS</b>		<b>20.</b>	<b>58,163.</b>	

## 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

2015

Open to Public  
Inspection

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

### CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

ATLANTICARE HEALTH SYSTEM, INC.

FEID: 22-3265213

ATLANTICARE HEALTH SYSTEM, INC. ("SYSTEM") IS A TAX-EXEMPT ORGANIZATION LOCATED IN ATLANTIC CITY, NEW JERSEY. IT IS AN AFFILIATE MEMBER OF THE GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES, HAVING JOINED THE ENTERPRISE IN OCTOBER OF 2015. THE SYSTEM IS THE SOLE CORPORATE MEMBER OF VARIOUS HEALTHCARE RELATED ORGANIZATIONS, THE MAJORITY OF WHICH ARE TAX-EXEMPT ENTITIES (COLLECTIVELY "ATLANTICARE"). THE SYSTEM PROVIDES LEADERSHIP, MANAGERIAL AND SUPPORT SERVICES TO A NUMBER OF AFFILIATED HEALTHCARE RELATED ORGANIZATIONS. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED THE SYSTEM AS BEING A TAX-EXEMPT ORGANIZATION UNDER INTERNAL REVENUE CODE ("IRC") CODE S501(C)(3).

SYSTEM AND AFFILIATES ("ATLANTICARE") IS PART OF AN INTEGRATED HEALTHCARE DELIVERY SYSTEM DEDICATED TO TRANSFORMING HEALTHCARE AT THE REGIONAL LEVEL BY PROVIDING HIGH QUALITY HEALTH AND WELLNESS SERVICES. ATLANTICARE INCLUDES THE SYSTEM, ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC" AND FORMERLY THE ATLANTIC CITY MEDICAL CENTER), ATLANTICARE BEHAVIORAL HEALTH ("ABH"), ATLANTICARE FOUNDATION ("FOUNDATION"), ATLANTICARE HEALTH SERVICES ("SERVICES"), ATLANTICARE HEALTH SOLUTIONS ("HEALTH SOLUTIONS") AND ATLANTICARE HEALTH ENGAGEMENT ("ENGAGEMENT"). ADDITIONALLY, OTHER

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer Identification number

90-0779828

ATLANTICARE DIVISIONS PARTICIPATE IN OTHER HEALTHCARE RELATED ACTIVITIES  
IN COLLABORATION WITH OTHER MEMBERS OF THE COMMUNITY.

THE REGION'S LARGEST HEALTHCARE ORGANIZATION AND LARGEST NON-CASINO  
EMPLOYER, ATLANTICARE'S NEARLY 5,000 EMPLOYEES SERVE THE COMMUNITY IN  
MORE THAN 80 LOCATIONS. ATLANTICARE AND ITS AFFILIATED ORGANIZATIONS ARE  
GOVERNED BY MORE THAN 50 VOLUNTEER COMMUNITY LEADERS WHO DEDICATE  
CONSIDERABLE TIME AND ENERGY TOWARD THE ULTIMATE ACHIEVEMENT OF  
ATLANTICARE'S MISSION, VISION AND VALUES:

## MISSION STATEMENT

=====

WE MAKE A DIFFERENCE IN HEALTH AND HEALING, ONE PERSON AT A TIME, THROUGH  
TRUSTING RELATIONSHIPS.

## VISION

=====

ATLANTICARE BUILDS HEALTHY COMMUNITIES.

## VALUES

=====

ATLANTICARE STRESSES THE FOLLOWING VALUES:

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

## INTEGRITY

ACTIONS AND DECISIONS CONSISTENTLY REFLECT THE HIGHEST ETHICAL STANDARDS.

ATLANTICARE OPERATES ON THE BASIS OF OPENNESS, TO NURTURE AN ENVIRONMENT OF HONESTY AND TRUST.

## RESPECT

EACH INDIVIDUAL IS TREATED WITH DIGNITY AND COMPASSION. CREATIVITY IS ENCOURAGED. EACH INDIVIDUAL IS EQUALLY IMPORTANT IN A UNIQUE WAY.

## SAFETY

SAFETY OF PATIENTS AND STAFF IS OUR TOP PRIORITY. ATLANTICARE CONTINUES TO APPLY NEW LEARNING IN QUALITY IMPROVEMENT AND SAFETY MANAGEMENT TO ALL ASPECTS OF OUR CARE ENVIRONMENT.

## SERVICE

CUSTOMER COMMITMENTS ARE BUILT UPON THE PHILOSOPHY THAT QUALITY, SERVICE,

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

AND KINDNESS WILL ENSURE LOYALTY. SERVICE IS DEFINED AND MEASURED BY OUR CUSTOMERS. ATLANTICARE'S GOAL IS TO EXCEED THEIR EXPECTATIONS.

TEAMWORK

-----

TO ACHIEVE THE GREATEST SUCCESS, COLLABORATION AND OPEN COMMUNICATION ARE ESSENTIAL.

CHARITABLE PURPOSE

=====

ATLANTICARE'S PRIMARY SERVICE OFFERING OF HEALTHCARE DELIVERY, INTEGRATED WITH THE COMPLEMENTARY AND STRATEGIC SERVICE OFFERINGS OF HEALTH INFORMATION AND HEALTH ENGAGEMENT, FOCUSES ON DELIVERING QUALITY AND VALUE AT EVERY STAGE OF HEALTH: HEALTHY, AT-RISK OR WITH ACUTE OR CHRONIC ILLNESS. WE ARE DEEPLY COMMITTED TO PROVIDING HEALTHCARE SERVICES TO ALL INDIVIDUALS WHO RESIDE IN OUR PRIMARY AND REGIONAL SERVICE AREAS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, LIFESTYLE, FINANCIAL STATUS OR ABILITY TO PAY.

ARMC IS ONE OF TWO "SAFETY NET" HOSPITALS IN SOUTHERN NEW JERSEY PROVIDING APPROXIMATELY \$26 MILLION IN CHARITY CARE, AT COST, WHICH REPRESENTS APPROXIMATELY 90% OF THE CHARITY CARE PROVIDED IN ATLANTIC

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

COUNTY. WITHIN THE REGION ATLANTICARE PROVIDES MORE CHARITY CARE THAN THE 7 CLOSEST HOSPITALS COMBINED. TO FURTHER ENSURE THAT OUR COMMUNITY'S HEALTHCARE NEEDS ARE MEET, ATLANTICARE ALSO PROVIDES FREE CARE TO PATIENTS THAT DO NOT MEET THE STATE ELIGIBILITY REQUIREMENTS FOR CHARITY CARE DESIGNATION OR WHO ARE NOT COMPLIANT IN PURSUING ELIGIBILITY STATUS.

WHILE THE ABOVE STATISTICS ALONE DIFFERENTIATE ATLANTICARE'S COMMITMENT TO THE COMMUNITY IT SERVES, IT RECOGNIZES THAT HEALTH AND THE ASSURANCE OF GOOD HEALTH IS TRULY CULTIVATED BEYOND THE WALLS OF ITS CLINICAL SETTINGS. AS SUCH, ATLANTICARE HAS ESTABLISHED ITSELF WITHIN ITS SERVICE AREA AS A COLLABORATOR AND PARTNER TO AGENCIES AND SERVICES THAT IMPROVE THE QUALITY OF LIFE FOR OUR AREA RESIDENTS. ATLANTICARE SPONSORS MANY CHARITABLE AGENCIES AND THEIR PROGRAMS, WHICH PROVIDE SUBSTANTIAL BENEFIT AND CLOSE EVIDENT SERVICE GAPS. THESE PROGRAMS INCLUDE SERVICES FOR OLDER ADULTS, COMMUNITY OUTREACH PROGRAMS FOR AT-RISK POPULATIONS, SUPPORT INITIATIVES FOR THE CONTINUED HEALING OF PATIENTS AND THEIR CAREGIVERS POST DISCHARGE, IN ADDITION TO HEALTH PROMOTION AND DISEASE PREVENTION CAMPAIGNS TO IMPROVE OVERALL HEALTH AND WELL-BEING. EXAMPLES INCLUDE ATLANTICARE'S SUPPORT OF THE UNITED WAY OF GREATER PHILADELPHIA AND SOUTHERN NEW JERSEY, WHICH THROUGH THE GENEROSITY OF ATLANTICARE EMPLOYEES RAISED OVER \$145,000 AND ITS EMPLOYEE-LED FUNDRAISING EFFORTS TO SUPPORT THE AMERICAN HEART ASSOCIATION IN THE AMOUNT OF \$40,000. ADDITIONAL COMMUNITY AGENCIES WHICH ATLANTICARE AND ITS EMPLOYEES HAVE SUPPORTED INCLUDE BUT ARE NOT LIMITED TO THE BIG BROTHERS & BIG

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

SISTERS, JEWISH FAMILY SERVICES, RUTH NEWMAN SHAPIRO HEART & CANCER  
 MEMORIAL FUND, SHIRLEY MAE BREAST CANCER ASSISTANCE FUND, GILDA'S CLUB OF  
 SOUTH JERSEY, MARCH OF DIMES, AND JUVENILE DIABETES RESEARCH FUND.

ATLANTICARE HOSTS AND SUPPORTS VARIOUS PROFESSIONAL AND HIGHER  
 EDUCATIONAL PROGRAMS AND STRONGLY BELIEVES IN INVESTING IN THE  
 INDIVIDUALS WHO ONE DAY WILL BECOME HEALTHCARE PROFESSIONALS. EMPLOYEES  
 PARTICIPATE IN JOB SHADOW DAYS AND CONDUCT CAREER PRESENTATIONS AND  
 SKILLS FAIRS AT LOCAL SCHOOLS. IN ADDITION, ATLANTICARE OFFERS  
 SCHOLARSHIPS AND OTHER FORMS OF SUPPORT TO LOCAL STUDENTS WHO WISH TO  
 PURSUE NURSING AND ALLIED HEALTH DEGREES AND SPONSORS TECHNICAL HONOR  
 SOCIETIES. ATLANTICARE ALSO CREATED THE ATLANTICARE SCHOLARS PROGRAM,  
 WHICH ASSISTED PEOPLE IN DEVELOPING NEW SKILLS BY EXTENDING SCHOLARSHIPS  
 TO DISPLACED CASINO WORKERS WHO LOST THEIR JOB AS A RESULT OF CASINO  
 CLOSURES IN ATLANTIC CITY. THIS PROGRAM WAS LAUNCHED IN MAY 2015. TO  
 DATE, ATLANTICARE HAS RECEIVED OVER 100 APPLICANTS, 28 OF WHICH RECEIVED  
 SCHOLARSHIPS TO THE LOCAL COMMUNITY COLLEGE. A NUMBER OF THESE 28 HAVE  
 COMPLETED CLASS AND HAVE ALREADY BEEN HIRED WHILE MANY MORE ARE STILL  
 CONTINUING WITH THEIR EDUCATION.

VARIOUS COMMUNITY EVENTS AND ACTIVITIES ARE OFFERED BY ATLANTICARE. THESE  
 COMMUNITY EVENTS ARE PROMOTED IN A VARIETY OF WAYS INCLUDING VIA SOCIAL  
 MEDIA, THE ATLANTICARE WEBSITE, WORD OF MOUTH, AND DISTRIBUTED AT  
 COMMUNITY EVENTS. EXAMPLES OF EVENTS INCLUDE:

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

- CANCER SURVIVOR'S DAY
- DIABETES, BREAST CANCER, AND STROKE SUPPORT GROUPS
- WEIGHT LOSS SURGERY SEMINARS & SUPPORT GROUPS
- HEART HEROES MEETINGS
- FIRST AID AND CPR COURSES
- HEALTHY BABY CLASSES SUCH AS PRENATAL AND BREASTFEEDING CLASSES
- HEALTHY COOKING DEMONSTRATIONS
- SENIOR UNIVERSITY, AN EDUCATIONAL PROGRAM FOR OLDER ADULTS
- SAFE DRIVING PROGRAM FOR YOUTH

RECENTLY, ATLANTICARE ADDED A NEW COMMUNITY EDUCATION PROGRAM ENTITLED, MATTER OF BALANCE, WHICH IS AN EVIDENCED BASED 8-WEEK STRUCTURED GROUP EDUCATION THAT EMPHASIZES PRACTICAL STRATEGIES TO REDUCE FEAR OF FALLING AND INCREASE ACTIVITY LEVELS IN OLDER ADULTS. THE CLASS IS CONDUCTED BY WELLNESS STAFF MEMBERS WHO HAVE RECEIVED A MATTER OF BALANCE COACH CERTIFICATION. SINCE THE INCEPTION OF THE PROGRAM APPROXIMATELY 100 OLDER ADULTS HAVE BENEFITTED FROM THIS PROGRAM. IN ADDITION TO EDUCATIONAL EVENTS, ATLANTICARE BRINGS HEALTH AND WELLNESS SERVICES TO THE COMMUNITY THROUGH RISK BASED SCREENINGS. SPECIALLY TRAINED NURSES AND HEALTH CARE PROFESSIONALS PROVIDE SCREENINGS IN AN EFFORT TO DETECT HEALTH CONDITIONS EARLY WHEN THEY ARE EASIER TO TREAT, PROMOTE HEALTHY LIFESTYLE BEHAVIORS, AND TO REFER INDIVIDUALS TO NEEDED PROGRAMS AND SUPPORT SERVICES.

ATLANTICARE CONDUCTS OVER 200 WELLNESS SCREENINGS ANNUALLY (FOR EXAMPLE, BLOOD PRESSURE, BODY MASS INDEX, CHOLESTEROL) IN THE COMMUNITY, IN ADDITION TO EDUCATIONAL LECTURES, HEALTH FAIRS, COOKING DEMONSTRATION AND

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

OTHER HEALTH EVENTS CONDUCTED AT A VARIETY OF VENUES, INCLUDING SENIOR CENTERS, FAITH BASED ORGANIZATIONS, MUNICIPALITIES, AND OTHER COMMUNITY SETTINGS WHERE INDIVIDUALS GATHER. IN THE FIRST 6 MONTHS OF 2016, ATLANTICARE STAFF ATTENDED OVER 50 COMMUNITY EVENTS AND CONDUCTED 264 WELLNESS SCREENINGS.

FURTHERMORE, ATLANTICARE EMBRACES ITS STRATEGIC COMMITMENT TO DIVERSITY AND INCLUSION. WE HAVE POSITIONED DIVERSITY AS A STRATEGIC BUSINESS PRIORITY THAT ALIGNS WITH OUR OVERALL VISION, MISSION AND VALUES. AT THE HEART OF OUR DIVERSITY AND INCLUSION EFFORTS, ARE OUR DEDICATED AND ENGAGED EMPLOYEE RESOURCE GROUPS (ERGS). THESE GROUPS OF PHYSICIANS AND STAFF HELP US WITH CULTURAL AND COMMUNITY AWARENESS ACTIVITIES, EDUCATION, AND COMMUNITY OUTREACH, THUS IMPACTING EMPLOYEE ENGAGEMENT, CUSTOMER EXPERIENCES, AND COMMUNITY CONNECTIVITY. THE GROUPS ARE FORMED AROUND COMMON INTERESTS BUT ARE OPEN TO ALL EMPLOYEES. THE GROUPS CONTINUE TO EXPERIENCE MEMBERSHIP GROWTH FROM 33 MEMBERS IN 2010, TO 218 ACTIVE MEMBERS IN 2016. CURRENT GROUPS INCLUDE: AFRICAN-AMERICAN (LEGACY), ASIAN-PACIFIC (APEG), DISABILITIES (CAARE), INTERFAITH (PATHS), LATINO (ALMA), LGBTQ (PRIDE), MILITARY (HONORS), AND WOMEN (LEADS).

EXAMPLES OF SOME ERG ACTIVITIES INCLUDE:

- ANNUAL "STRENGTH IN DIVERSITY" EVENT WHICH IS OPEN TO STUDENTS, EMPLOYEES AND COMMUNITY MEMBERS;
- NUTRITION EDUCATION PROGRAM TO OVER 400 STUDENTS IN THE COMMUNITY TO COMMEMORATE NATIONAL NUTRITION MONTH

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

THROUGH FUNDRAISING ACTIVITIES, OUR ERGS ARE ABLE TO PROVIDE FINANCIAL AND IN-KIND SUPPORT TO COMMUNITY PROGRAMS AND ORGANIZATIONS. IN 2016, OUR ERGS DONATED \$6,700 IN FINANCIAL SUPPORT TO VARIOUS COMMUNITY ORGANIZATIONS. ADDITIONALLY, THEY SUPPORTED VARIOUS COMMUNITY ORGANIZATIONS THROUGH PARTICIPATION IN WALKS, HEALTH AND CAREER FAIRS, AS WELL AS OTHER IN-KIND DONATIONS.

LASTLY, ATLANTICARE OPERATES THREE SIGNATURE COMMUNITY PROGRAMS WHOSE SOLE FOCUS IS TO IMPROVE THE HEALTH AND WELL-BEING OF OUR COMMUNITY. THESE INNOVATIVE PROGRAMS ARE HEALTHY SCHOOLS, HEALTHY CHILDREN; GROWING GREEN; AND HEALING ARTS.

HEALTHY SCHOOLS, HEALTHY CHILDREN PARTNERS WITH OVER 100 SCHOOLS IN A VARIETY OF DIFFERENT MODALITIES TO TEACH CHILDREN, PARENTS, AND STAFF ABOUT THE IMPORTANCE OF HEALTHY EATING AND PHYSICAL ACTIVITY. SIGNATURE COMPONENTS OF THIS PROGRAM ARE THE SCHOOL NURSE LECTURE SERIES AND PROFESSIONAL DEVELOPMENT WORKSHOPS THAT PROVIDE EDUCATION AND RESOURCES TO SCHOOL PERSONNEL.

THE ATLANTICARE GROWING GREEN PROGRAM ADDRESSES THE ROOT CAUSES OF CHRONIC DISEASE BY INCREASING CONSUMPTION OF HEALTHY FOODS THROUGH THE CREATION OF ACCESS POINTS FOR FRESH, LOCAL PRODUCE. THIS PROGRAM HAS FUNDED THE CONSTRUCTION OF 42 SCHOOL GARDENS AND 19 COMMUNITY GARDENS IN SOUTHEASTERN NEW JERSEY. SOUTHEASTERN NEW JERSEY.

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

## CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

THESE TWO AFOREMENTIONED PROGRAMS HAVE COLLECTIVELY IMPACTED APPROXIMATELY 8,350 LIVES.

HEALING ARTS IS A UNIQUE INITIATIVE DESIGNED TO SHOWCASE ORIGINAL ARTWORK. BY INTEGRATING THE ARTS WITHIN AND NEAR OUR FACILITIES, WE VISIBLY DEMONSTRATE OUR INTENT TO CREATE A HEALING PRESENCE IN OUR COMMUNITY.

THESE PROGRAMS ALLOW US TO SERVE DISTINCT AUDIENCES: CHILDREN AND THEIR CARETAKERS, THOSE WITH LIMITED ACCESS TO HEALTHY FOODS, AND THOSE SEEKING RESPITE AND HEALING, RESPECTIVELY.

STAFFING COSTS TO SUPPORT SCREENING OUTREACH AND THE AFOREMENTIONED SIGNATURE PROGRAMS FROM JANUARY TO JUNE 2016 TOTLED APPROXIMATELY \$156,005.41.

ATLANTICARE IS PROUD TO HAVE RECEIVED THE FOLLOWING AWARDS AND RECOGNITIONS

---

-U.S. NEWS & WORLD REPORT RECOGNIZES ATLANTICARE REGIONAL MEDICAL CENTER AS ONE OF THE BEST HOSPITALS IN 16 SPECIALTIES FOR 2015-16

-AMERICAN HEART ASSOCIATION RECOGNIZES ATLANTICARE AS A PLATINUM-LEVEL

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer Identification number

90-0779828

## FIT-FRIENDLY WORKSITE - 2015 AND 2016

-NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION RECOGNIZES ATLANTICARE WITH ITS OUTSTANDING EMPLOYER AWARD - 2014

-NAMED IN HEALTHGRADES AS ONE OF AMERICA'S BEST 100 HOSPITALS FOR CARDIAC CARE (2014-2017), JOINT REPLACEMENT (2015), AND ORTHOPEDIC SURGERY (2015).

- ARMC JOINT COMMISSION'S NAMED A TOP PERFORMER ON KEY QUALITY MEASURES - 2013.

- ARMC MAINLAND ICU RECEIVED THE SILVER BEACON AWARD FOR CRITICAL CARE NURSING EXCELLENCE - 2013.

- ARMC EARNED REACCREDITATION BY THE AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY (ASMBS) AS A BARIATRIC SURGERY CENTER OF EXCELLENCE (BSCOE) - 2013.

- ATLANTICARE PRIDE EMPLOYEE RESOURCE GROUP ACHIEVED "LEADER IN LGBT HEALTHCARE EQUALITY" STATUS IN THE HEALTHCARE EQUALITY INDEX (HEI) FOR THE SECOND CONSECUTIVE YEAR - 2012-2017.

- ATLANTICARE HOMECARE NAMED ONE OF THE "TOP 100" HOME CARE AGENCIES IN THE NATION BY HOMECARE ELITE - 2013-2016.

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

-ATLANTICARE'S CENTER FOR CHILDBIRTH EARNED BABY FRIENDLY DESIGNATION FOR HIGHEST QUALITY CARE OF INFANTS.

-APEX QUALITY AWARD - SURGERY CENTER CAPE MAY COURT HOUSE.

IN ADDITION, ATLANTICARE PROVIDES A SIGNIFICANT POSITIVE ECONOMIC CONTRIBUTION TO THE COMMUNITY. ATLANTICARE DIRECTLY IMPACTS THE COMMUNITY IN A POSITIVE MANNER BY VIRTUE OF EMPLOYING MORE THAN 5,000 AREA RESIDENTS. ATLANTICARE SUPPORTS THE LOCAL BUSINESS COMMUNITY BY PURCHASING GOODS AND SERVICES FROM MANY LOCAL AREA BUSINESSES AS WELL AS PARTICIPATING IN COMMUNITY BASED ORGANIZATIONS AS VOLUNTEERS OR BOARD MEMBERS.

ATLANTICARE REGIONAL MEDICAL CENTER

FEID: 21-0634549

#### BACKGROUND

=====

ARMC IS A 593-BED, NOT-FOR-PROFIT HOSPITAL THAT WAS FOUNDED IN 1898 AS A TEN-BED FACILITY IN A CONVERTED HOME ON OHIO AVENUE IN ATLANTIC CITY. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED ARMC AS BEING A TAX-EXEMPT ORGANIZATION UNDER IRC CODE §501(C)(3). ARMC OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ARMC PROVIDES URGENT AND EMERGENT HEALTHCARE SERVICES TO ALL INDIVIDUALS AND ALSO PROVIDES ELECTIVE PROCEDURES TO INDIVIDUALS WHO RESIDE IN OUR PRIMARY SERVICE AREA IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, COLOR, CREED, SEX, NATIONAL ORIGINS, HANDICAP, AGE, LIFESTYLE, FINANCIAL STATUS OR ABILITY TO PAY.

ARMC OPERATES THREE ACTIVE EMERGENCY ROOMS FOR ALL PERSONS; WHICH ARE OPEN 24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;

ARMC MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;

CONTROL OF ARMC RESTS WITH ITS BOARD OF TRUSTEES; WHICH IS COMPRISED OF INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY; AND

SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE; PROGRAMS AND ACTIVITIES.

THE OPERATIONS OF ARMC, AS SHOWN THROUGH THE FACTORS OUTLINED ABOVE AND OTHER INFORMATION CONTAINED HEREIN, CLEARLY DEMONSTRATE THAT THE USE AND CONTROL OF ARMC IS FOR THE BENEFIT OF THE PUBLIC AND THAT NO PART OF THE INCOME OR NET EARNINGS OF THE ORGANIZATION INURES TO THE BENEFIT OF ANY PRIVATE INDIVIDUAL NOR IS ANY PRIVATE INTEREST BEING SERVED OTHER THAN

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

INCIDENTALLY.

ARMC'S CITY CAMPUS IS LOCATED IN ATLANTIC CITY WHERE THE HOSPITAL WAS FOUNDED, AND IS A BUSY METROPOLITAN HOSPITAL SERVING A GROWING RESIDENT POPULATION AND MORE THAN 35 MILLION TOURISTS EACH YEAR. ARMC'S MAINLAND CAMPUS, WHICH OPENED IN 1975, IS LOCATED IN GALLOWAY, NEW JERSEY, ONE OF THE STATE'S FASTEST GROWING RESIDENTIAL AND COMMERCIAL AREAS. ARMC ALSO HAS A SATELLITE EMERGENCY DEPARTMENT IN HAMMONTON, NJ. ARMC OFFERS A NUMBER OF OUTPATIENT SERVICES SPREAD OUT OVER 70 LOCATIONS. ONE OF THESE LOCATIONS, THE ATLANTICARE HEALTHPLEX, WHICH IS LOCATED IN ATLANTIC CITY, OFFERS SERVICES REGARDLESS OF THE ABILITY TO PAY. ARMC IS A TEACHING HOSPITAL, TRAINING RESIDENTS IN A NUMBER OF SPECIALTIES. ARMC IS HOME TO MANY CENTERS OF EXCELLENCE AND SPECIALIZED SERVICES, SEVERAL OF WHICH ARE EXCLUSIVE TO THE REGION.

- LEVEL II REGIONAL TRAUMA CENTER
- NEONATAL INTENSIVE CARE UNIT (NICU)
- ACCREDITED CHEST PAIN CENTER
- ACCREDITED STROKE CENTER
- HEART INSTITUTE - THE REGION'S ONLY FULL SERVICE CARDIAC SURGERY PROGRAM
- THE JOINT INSTITUTE
- STANLEY M. GROSSMAN PEDIATRIC CENTER
- THE CANCER CARE INSTITUTE
- CENTER FOR SURGICAL WEIGHT LOSS AND WELLNESS

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

- ROGER B. HANSEN CENTER FOR CHILDBIRTH
- PSYCHIATRIC UNIT AND CRISIS INTERVENTION PROGRAM
- SPECIAL CARE CENTER
- TEAM DIABETES
- WOUND CARE CENTERS

ARMC IS PROUD OF ITS AFFILIATIONS WITH RENOWNED HEALTHCARE ORGANIZATIONS  
 INCLUDING BUT NOT LIMITED TO ROTHMAN INSTITUTE; THOMAS JEFFERSON  
 UNIVERSITY HOSPITAL; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; AND FOX  
 CHASE CANCER CENTER.

## MISSION, VISION AND VALUES

=====

## MISSION STATEMENT

=====

TO CARE FOR THE SICK, INJURED AND POOR IN AN ENVIRONMENT WHERE PATIENTS,  
 THEIR FAMILIES AND PHYSICIANS ARE EXTENDED A SUPERIOR LEVEL OF PERSONAL  
 SERVICE; WHERE QUALITY IMPROVES IN MEASURABLE TERMS; IN AN ENVIRONMENT  
 WHICH RESPECTS THE DIGNITY OF THE PATIENT, FAMILY AND ALL ON THE  
 HEALTHCARE TEAM.

## VISION

=====

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ATLANTICARE REGIONAL MEDICAL CENTER WILL BE THE PREMIER HEALTHCARE PROVIDER IN NEW JERSEY. WE WILL ACHIEVE AND SUSTAIN EXCELLENCE IN QUALITY OF CARE AND PERSONAL SERVICE THROUGH TOTAL CONFORMANCE TO CUSTOMER'S EXPECTATIONS WHILE PROVIDING AN OUTSTANDING WORK ENVIRONMENT.

CHARITABLE PURPOSE

=====

ARMC PROVIDES URGENT AND EMERGENT HEALTHCARE SERVICES TO ALL INDIVIDUALS AND ALSO PROVIDES ELECTIVE PROCEDURES TO INDIVIDUALS WHO RESIDE IN OUR PRIMARY SERVICE AREA IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, COLOR, CREED, SEX, NATIONAL ORIGINS, HANDICAP, AGE, LIFESTYLE, FINANCIAL STATUS OR ABILITY TO PAY. MOREOVER, ARMC PROVIDES HEALTHCARE SERVICES TO PATIENTS WHO MEET CERTAIN CRITERIA DEFINED BY THE NEW JERSEY DEPARTMENT OF HEALTH AND HUMAN SERVICES WITHOUT CHARGE OR AT AMOUNTS LESS THAN ESTABLISHED RATES. THE COST OF PROVIDING THESE SERVICES AND SUPPLIES TO PATIENTS WHO MEET THE STATE-MANDATED CHARITY CARE ELIGIBILITY REQUIREMENTS APPROXIMATED \$13 MILLION AND \$26 MILLION FOR THE YEAR JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND CALENDAR YEAR 2015, RESPECTIVELY. THE SIGNIFICANT REDUCTION IN THE COST OF PROVIDING CHARITY CARE IS THE RESULT OF THE MEDICAL CENTER'S EFFORTS IN ASSISTING PATIENTS TO ENROLL IN THE STATE MEDICAID PROGRAM. THE ESTIMATED UNREIMBURSED COST OF PROVIDING CARE TO MEDICAID PATIENTS WAS \$19 MILLION AND \$37 MILLION FOR THE YEAR JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

CALENDAR YEAR 2015, RESPECTIVELY. BECAUSE THE MEDICAL CENTER DOES NOT PURSUE COLLECTIONS OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. THE MEDICAL CENTER ALSO PROVIDES FREE CARE TO PATIENTS WHO DO NOT MEET THE STATE ELIGIBILITY REQUIREMENTS OR ARE NOT COMPLIANT IN PURSUING ELIGIBILITY STATUS. SUCH AMOUNTS ARE INCLUDED IN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS AS PART OF THE PROVISION FOR UNCOLLECTIBLES, NET OF ANY RECOVERIES REALIZED THROUGH COLLECTION EFFORTS.

ARMC HAS ALSO INSTITUTED A SELF-PAY DISCOUNT POLICY THAT LIMITS CHARGES FOR MEDICAL SERVICES TO AN AMOUNT NOT TO EXCEED THE LESSER OF THE CALCULATED AMOUNTS GENERALLY BILLED UNDER IRC S501(R)(5) OR 115% OF THE APPLICABLE MEDICARE REIMBURSEMENT RATE FOR ALL QUALIFIED UNINSURED PATIENTS WHO ARE NOT ELIGIBLE FOR EXISTING STATE, FEDERAL AND LOCAL PROGRAMS.

ADDITIONALLY, THE COMPANY SPONSORS OTHER CHARITABLE PROGRAMS, WHICH PROVIDE SUBSTANTIAL BENEFIT TO THE BROADER COMMUNITY. SUCH PROGRAMS INCLUDE SERVICES TO THE NEEDY AND ELDERLY POPULATION THAT REQUIRE SPECIALS SUPPORT, VARIOUS CLINICAL OUTREACH PROGRAMS AS WELL AS HEALTH PROMOTION AND EDUCATION FOR THE GENERAL COMMUNITY WELFARE.

ARMC'S COLLECTION POLICIES INCLUDE DISCOUNTS FOR THOSE PATIENTS WHO ARE UNINSURED BUT DO NOT QUALIFY FOR THE STATE CHARITY CARE PROGRAM.

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ARMC IS ONE OF TWO DESIGNATED SAFETY NET HOSPITALS IN SOUTHERN NEW JERSEY  
PROVIDING APPROXIMATELY 90% OF THE CHARITY CARE IN ATLANTIC COUNTY AND  
MORE CHARITY CARE THAN THE 7 CLOSEST HOSPITALS COMBINED.

## CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

## AWARDS AND RECOGNITIONS

=====

- U.S. NEWS & WORLD REPORT RECOGNIZES ATLANTICARE REGIONAL MEDICAL CENTER  
AS ONE OF THE BEST HOSPITALS IN 16 SPECIALTIES FOR 2015-16

- NAMED IN HEALTHGRADES AS ONE OF AMERICA'S BEST 100 HOSPITALS FOR  
CARDIAC CARE (2015-2015), JOINT REPLACEMENT (2015), AND ORTHOPEDIC  
SURGERY (2015).

- ARMC JOINT COMMISSION'S NAMED A TOP PERFORMER ON KEY QUALITY MEASURES -  
2013.

- U.S. NEWS & WORLD REPORT NAMED ARMC "THE BEST HOSPITAL IN THE REGION" -  
RECOGNIZING 10 SPECIALTIES - 2012/2013.

- ARMC MAINLAND ICU RECEIVED THE SILVER BEACON AWARD FOR CRITICAL CARE  
NURSING EXCELLENCE - 2013.

- ARMC EARNED REACCREDITATION BY THE AMERICAN SOCIETY FOR METABOLIC AND

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

BARIATRIC SURGERY (ASMBS) AS A BARIATRIC SURGERY CENTER OF EXCELLENCE

(BSCOE) - 2013. (BSCOE) - 2013.

ATLANTICARE BEHAVIORAL HEALTH (ABH)

FEID: 21-0721208

ABH IS SOUTHEASTERN NEW JERSEY'S LARGEST PROVIDER OF BEHAVIORAL HEALTH AND SUBSTANCE ABUSE/ADDICTION RECOVERY SERVICES. WITH 22 LOCATIONS THROUGHOUT THE REGION, ABH OFFERS A BROAD RANGE OF SERVICES TO HELP INDIVIDUALS AND THEIR FAMILIES WITH SERIOUS MENTAL ILLNESSES, ANXIETIES RELATED TO SCHOOL OR JOB STRESS, AND MARRIAGE COUNSELING SERVICES. ABH ALSO PROVIDES EMPLOYEE ASSISTANCE PROGRAMS FOR AREA EMPLOYERS, WHICH INCLUDE EMPLOYEE COUNSELING SERVICES, BEHAVIORAL HEALTH AND WELLNESS PROGRAMS AND CRITICAL INCIDENT DEBRIEFING SERVICES. ABH MANAGES A 34-BED PSYCHIATRIC INPATIENT PROGRAM LOCATED AT THE MAINLAND CAMPUS AND A PSYCHIATRIC CRISIS INTERVENTION PROGRAM AT THE CITY CAMPUS OF ARMC. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED ABH AS A TAX-EXEMPT ORGANIZATION UNDER IRC CODE §501 (C) (3).

THE MAJORITY OF ABH'S PATIENTS ARE UNDERINSURED (MEDICAID/MEDICARE) OR UNINSURED. BEHAVIORAL HEALTH PROVIDES SERVICES TO CLIENTS WITHOUT INSURANCE COVERAGE AND CHARGES RATES BASED ON A SLIDING SCALE FEE BASED ON INCOME AND FAMILY SIZE. THE COST OF PROVIDING THESE SERVICES AND SUPPLIES TO PATIENTS THAT MEET THE ESTABLISHED CRITERIA APPROXIMATED \$753,752 AND \$1,646,424 FOR THE YEAR JANUARY 1, 2016 THROUGH JUNE 30,

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

2016 AND CALENDAR YEAR 2015 RESPECTIVELY.

ABH PROVIDES MANY OF THEIR SERVICES UNDER GRANTS FROM STATE AND FEDERAL AGENCIES. SUCH PROGRAMS INCLUDE:

## DEPARTMENT OF HUMAN SERVICES

-----

- ADULT OUTPATIENT PROGRAM
- INTENSIVE OUTPATIENT TREATMENT
- ADULT PARTIAL CARE
- ADULT EARLY INTERVENTION PROGRAM
- RESIDENTIAL INTENSIVE SUPPORT TEAM
- SUPPORTED HOUSING
- SUPPORTED EMPLOYMENT
- SUBSTANCE ABUSE INTENSIVE OUTPATIENT TREATMENT FOR MEDICALLY INDIGENT ADULTS
- PROGRAM ASSERTIVE COMMUNITY TREATMENT

## DEPARTMENT OF CHILDREN AND FAMILIES

-----

- SCHOOL BASED YOUTH SERVICES PROGRAM - OAKCREST TEEN CENTER
- SCHOOL BASED YOUTH SERVICES PROGRAM - AC TEEN
- SCHOOL BASED YOUTH SERVICES PROGRAM - BUENA TEEN AND BUENA REGIONAL

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

## MIDDLE SCHOOL

- HAMMONTON FAMILY SUCCESS CENTER - DEPARTMENT OF CHILDREN AND FAMILIES
- FAMILY FRIENDLY CENTER - HAMMONTON ELEMENTARY SCHOOL
- OUTREACH TO AT-RISK YOUTH - ATLANTIC CITY HIGH SCHOOL- EAST CAMPUS
- ADOLESCENT PREGNANCY PREVENTION INITIATIVE- OAKCREST HIGH SCHOOL
- JUVENILE DELINQUENCY PREVENTION - ATLANTIC CITY HIGH SCHOOL
- DEPARTMENT OF HUMAN SERVICES
- CHILDREN AND ADOLESCENT OUTPATIENT TREATMENT
- MOBILE OUTREACH
- SUBSTANCE ABUSE TREATMENT SERVICES TO WOMEN

## U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

- PRIMARY AND HEALTH AND HUMAN SERVICES

## ATLANTICARE FOUNDATION

FEID: 22-2148992

THE FOUNDATION EXISTS TO IMPROVE THE HEALTH AND WELLBEING OF OUR COMMUNITY THROUGH A COMPREHENSIVE DEVELOPMENT PROGRAM TO SUPPORT SAFE, EQUITABLE, QUALITY HEALTHCARE; AND TO PROMOTE HEALTHY BEHAVIORS. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED THE FOUNDATION AS BEING A TAX-EXEMPT ORGANIZATION UNDER IRC CODE §501(C) (3). THE FOUNDATION IS COMMITTED TO SUPPORTING ATLANTICARE'S EXPANSION AND CLINICAL INVESTMENTS BY SECURING THE FINANCIAL RESOURCES NECESSARY TO ENSURE HIGH QUALITY

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

EVIDENCED BASED MEDICINE FOR CURRENT AND FUTURE GENERATIONS.

ATLANTICARE HEALTH SERVICES

FEID: 22-3265214

SERVICES IS PRIMARILY AN AMBULATORY CARE NETWORK THAT REACHES BEYOND THE HOSPITAL TO ADDRESS THE HEALTH AND WELLNESS NEEDS FOR THE REGIONS RESIDENTS THROUGHOUT ALL STAGES OF LIFE. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED SERVICES AS BEING A TAX-EXEMPT ORGANIZATION UNDER THE IRC CODE §501(C) (3). SERVICES PROGRAMS INCLUDE:

- ATLANTICARE SURGERY CENTER LLC, A FULL SERVICE, FREESTANDING AMBULATORY SURGERY CENTERS.
- ATLANTICARE LIFE CENTER, OFFERING A FULL SPECTRUM OF HEALTH AND WELLNESS, PHYSICAL AND REHABILITATIVE CONDITIONING.
- ATLANTICARE CLINICAL LABS, PROVIDING LAB SERVICES AT FIFTEEN CONVENIENT LOCATIONS.
- ATLANTICARE HOME CARE NURSES AND OTHER HEALTHCARE PROFESSIONALS MAKE HOME VISITS TO ASSIST PATIENTS WITH THEIR MEDICAL NEEDS.
- ATLANTICARE HOSPICE WORKS WITH PATIENTS AND THEIR FAMILIES TO ENHANCE THE END STAGES OF LIFE IN THE COMFORTABLE SURROUNDINGS OF THE PATIENT'S

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

HOME.

- ATLANTICARE HEALTH PARK, A REGIONAL HEALTHCARE AMBULATORY CARE CAMPUS OFFERING A VARIETY OF SERVICES.

- ATLANTICARE OCCUPATIONAL MEDICINE PROVIDES OCCUPATIONAL MEDICINE FOR BUSINESSES AND MUNICIPALITIES, INCLUDING THE TREATMENT OF WORK RELATED INJURIES.

- MISSION HEALTHCARE, A PROGRAM OFFERING PRIMARY CARE TO THE HOMELESS POPULATION OPERATING AS A FEDERALLY QUALIFIED HEALTH CENTER

- ATLANTICARE LIFELINE PROVIDES EMERGENCY MEDICAL ALERT CAPABILITY TO INDIVIDUALS WHO REQUIRE CONVENIENT NOTIFICATION CAPABILITIES.

ATLANTICARE PHYSICIAN GROUP, P.A.

FEID: 02-0701782

THE PHYSICIAN GROUP PROVIDES SERVICES IN AND OUTSIDE OF THE HOSPITAL ATMOSPHERE TO SPECIALIZE IN PREVENTIVE CARE AND IN DIAGNOSING AND TREATING VARIOUS ILLNESSES. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED SERVICES AS BEING A TAX-EXEMPT ORGANIZATION UNDER THE IRC §501(C) (3).

- ATLANTICARE PRIMARY/URGENT CARE CENTERS (LOCATED IN ATLANTIC, CAPE MAY, BURLINGTON, AND OCEAN COUNTIES) OFFERING PRIMARY CARE AND URGENT CARE AS

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

AN ALTERNATIVE TO MORE EXPENSIVE EMERGENCY ROOM TREATMENT.

- PAVILION OB/GYN A FULL SERVICE OBSTETRICS AND GYNECOLOGY PRACTICE.

ATLANTICARE INFORMATION TECHNOLOGY ("AIT")

ATLANTICARE INFORMATION TECHNOLOGY (A DIVISION OF ATLANTICARE HEALTH SYSTEM, INC.) SUPPORTS ALL OTHER ATLANTICARE AFFILIATES TO ACHIEVE MAXIMUM RESULTS THROUGH THE USE OF INFORMATION TECHNOLOGY. AIT'S INNOVATIVE NETWORKING TECHNOLOGY ENHANCES THE SPEED AND EFFICIENCY OF PATIENT'S DIAGNOSIS AND TREATMENT WHILE MAINTAINING PATIENT CONFIDENTIALITY AND SAFETY. AIT HAS BEEN RECOGNIZED FOR ITS INNOVATION IN HEALTHCARE THROUGH THE FOLLOWING AWARDS:

- TOP 100 INTEGRATED HEALTHCARE SYSTEMS BY HOSPITALS AND HEALTH NETWORK MAGAZINE.
- TOP (7) NETWORKED HEALTHCARE SYSTEMS IN THE UNITED STATES FOR INFORMATION TECHNOLOGY BY HEALTHCARE INFORMATICS MAGAZINE.

ATLANTICARE HEALTH ENGAGEMENT, INC.

FEID: 61-1608389

AT THE END OF 2009 ATLANTICARE HEALTH ENGAGEMENT, INC. WAS ESTABLISHED TO SUPPORT THE DEVELOPMENT OF HEALTH MANAGEMENT CAPABILITIES AND STRUCTURES,

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

AND HEALTH STATUS IMPROVEMENT INITIATIVES FOR THE BENEFIT OF THE BROADER COMMUNITY. THE ATLANTICARE REGIONAL MEDICAL CENTER CONTRIBUTED FOR THE YEAR ENDED DECEMBER 31, 2012 AND 2013 \$2,000,000 AND \$5,000,000 RESPECTIVELY, AND AN ADDITIONAL \$10,000,000 IN 2014. IN 2015, THE MEDICAL CENTER CONTRIBUTED \$15,000,000 TO SUPPORT THE MISSION OF HEALTH ENGAGEMENT.

## CORE FORM, PART III; LINE 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 OR ABILITY TO PAY. PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O.

## CORE FORM, PART I; SUMMARY

THE TOTAL VOTING AND INDEPENDENT VOTING MEMBERS DISCLOSED ON PAGE 1 OF THIS FORM 990 IS FOR ATLANTICARE REGIONAL MEDICAL CENTER; THE LARGEST SUBORDINATE ORGANIZATION INCLUDED IN THE GROUP EXEMPTION RULING AND IN THIS CONSOLIDATED GROUP FORM 990. OUTLINED BELOW IS THE VOTING AND INDEPENDENT VOTING DISCLOSURE INFORMATION FOR ALL OTHER ORGANIZATIONS INCLUDED IN THE GROUP EXEMPTION:

- ATLANTICARE BEHAVIORAL HEALTH, INC.; 16 VOTING, 11 INDEPENDENT;

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

- ATLANTICARE REGIONAL HEALTH SERVICES A NEW JERSEY NONPROFIT CORPORATION; 16 VOTING, 11 INDEPENDENT;
- ATLANTICARE FOUNDATION; 19 VOTING, 13 INDEPENDENT;
- ATLANTICARE HEALTH ENGAGEMENT; 3 VOTING, 0 INDEPENDENT;
- ATLANTICARE HEALTH SERVICES, INC.; 16 VOTING, 11 INDEPENDENT; AND
- INFOSHARE, INC. FILED A CERTIFICATE OF DISSOLUTION WITH THE STATE OF NEW JERSEY ON MARCH 18, 2016 AND IS NO LONGER IN EXISTENCE.

CORE FORM, PART I, LINES 3 & 4 & PART VI, SECTION A; Q'S 1A & 1B

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED FORM 990 ARE AFFILIATES WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). AS REFLECTED ON CORE FORM, PART I, LINES 3 AND 4 AND ALSO IN PART VI, LINES 1A AND 1B, THERE ARE A TOTAL OF SIXTEEN VOTING MEMBERS ON THE BOARD OF TRUSTEES OF ATLANTICARE REGIONAL MEDICAL CENTER; THE LARGEST SUBORDINATE ORGANIZATION INCLUDED IN THE GROUP EXEMPTION RULING AND IN THIS CONSOLIDATED FORM 990. OF THESE SIXTEEN VOTING MEMBERS, FIVE ARE NON-INDEPENDENT DUE TO THE FACT THAT THEY ARE EITHER EMPLOYED BY AN ORGANIZATION INCLUDED IN THIS CONSOLIDATED FORM 990 OR BY AN AFFILIATE WITHIN THE SYSTEM AND RECEIVE COMPENSATION IN THEIR RESPECTIVE ROLES OR ARE NON-INDEPENDENT DUE TO A BUSINESS TRANSACTION BETWEEN THEIR 35% CONTROLLED ENTITY AND AN AFFILIATE

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

WITHIN THE SYSTEM. IN ACCORDANCE WITH CURRENT INTERNAL REVENUE SERVICE FORM 990 INSTRUCTIONS, NO COMPENSATION OR EMPLOYEE BENEFIT AMOUNTS ARE REPORTED HEREIN AS THIS RETURN IS A SHORT-PERIOD RETURN, BUT NOT A FINAL RETURN. THE ORGANIZATION CHANGED ITS YEAR-END FROM DECEMBER 31 TO JUNE 30. THIS RETURN IS FOR THE SIX-MONTH PERIOD JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND, ACCORDINGLY, THERE IS NO REPORTABLE COMPENSATION FROM FEDERAL FORMS W-2 OR 1099 SINCE NO CALENDAR YEAR ENDS WITHIN THE ORGANIZATION'S REPORTING PERIOD.

CORE FORM, PART I, LINE 5 & PART V, QUESTION 2A

IN ACCORDANCE WITH CURRENT INTERNAL REVENUE SERVICE FORM 990 INSTRUCTIONS, THE ORGANIZATION ENTERED -0- FOR THE NUMBER OF EMPLOYEES REPORTED ON FORM W-3, TRANSMITTAL OF WAGE AND TAX STATEMENTS, AS THIS RETURN IS A SHORT-PERIOD RETURN, BUT NOT A FINAL RETURN. THE ORGANIZATION CHANGED ITS YEAR-END FROM DECEMBER 31 TO JUNE 30. THIS RETURN IS FOR THE SIX-MONTH PERIOD JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND, ACCORDINGLY, THERE IS NO CALENDAR YEAR WHICH ENDED WITHIN THE ORGANIZATION'S REPORTING PERIOD.

CORE FORM, PART V, QUESTION 1A

IN ACCORDANCE WITH CURRENT INTERNAL REVENUE SERVICE FORM 990 INSTRUCTIONS, THE ORGANIZATION ENTERED -0- FOR THE NUMBER REPORTED IN BOX 3 OF FORM 1096, AS THIS RETURN IS A SHORT-PERIOD RETURN, BUT NOT A FINAL RETURN. THE ORGANIZATION CHANGED ITS YEAR-END FROM DECEMBER 31 TO JUNE

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

30. THIS RETURN IS FOR THE SIX-MONTH PERIOD JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND, ACCORDINGLY, THERE IS NO CALENDAR YEAR WHICH ENDED WITHIN THE ORGANIZATION'S REPORTING PERIOD.

CORE FORM, PART VI, SECTION A; QUESTIONS 6 & 7

ATLANTICARE HEALTH SYSTEM, INC. ("SYSTEM") IS THE SOLE MEMBER OF ALL ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 WITH THE EXCEPTION OF ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC"), ATLANTICARE HEALTH SERVICES, INC. ("SERVICES") AND ATLANTICARE BEHAVIORAL HEALTH, INC. ("ABH"). ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NON-PROFIT CORPORATION HAS THE RIGHT TO ELECT THE MEMBERS OF THE ARMC, SERVICES, AND ABH BOARDS OF TRUSTEES AND HAS CERTAIN RESERVED POWERS AS DEFINED IN ARMC, SERVICES AND ABH BYLAWS.

GEISINGER HEALTH SYSTEM FOUNDATION ("GHSF") IS THE SOLE MEMBER OF THE SYSTEM. GHSF HAS THE ULTIMATE AUTHORITY AND RIGHT TO ELECT THE MEMBERS OF EACH SUBORDINATE ORGANIZATION'S BOARD OF TRUSTEES AND HAS CERTAIN RESERVED POWERS AS DEFINED IN EACH SUBORDINATE ORGANIZATION'S BYLAWS.

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

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN THE GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM") WHICH INCLUDES ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM"). THIS FEDERAL FORM

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

990 WAS PROVIDED TO AH SYSTEM'S GOVERNING BODY; ITS FULL BOARD OF TRUSTEES, FOR REVIEW PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE ("IRS"). THE ORGANIZATION HAS DELEGATED THE FORM 990 PREPARATION, REVIEW AND FILING PROCESS TO AH SYSTEM'S GOVERNING BODY; ITS BOARD OF TRUSTEES.

AS PART OF THE TAX RETURN PREPARATION PROCESS THE SYSTEM 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 SYSTEM'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP 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 AH SYSTEM'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP FOR THEIR REVIEW. AH SYSTEM'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP REVIEWED THE DRAFT FEDERAL FORM 990 AND DISCUSSED QUESTIONS AND COMMENTS WITH THE CPA FIRM. REVISIONS WERE MADE TO THE DRAFT FEDERAL FORM 990 WHERE NECESSARY AND A FINAL DRAFT WAS FURNISHED BY THE CPA FIRM TO AH SYSTEM'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP FOR FINAL REVIEW AND APPROVAL PRIOR TO PROVIDING THE FEDERAL FORM 990 TO EACH MEMBER OF AH SYSTEM'S GOVERNING BODY AND FILING WITH THE IRS. A FORM 990 PRESENTATION WAS ALSO GIVEN BY THE CPA FIRM TO AH SYSTEM'S BOARD OF TRUSTEES PRIOR TO FILING.

CORE FORM, PART VI, SECTION B; QUESTION 12

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM") WHICH INCLUDES ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM"). AH SYSTEM HAS ADOPTED A CONFLICT OF INTEREST POLICY WHICH IS APPLICABLE TO ALL OF ITS SUBSIDIARY ORGANIZATIONS. THE ORGANIZATIONS REGULARLY MONITOR AND ENFORCE COMPLIANCE WITH THIS CONFLICT OF INTEREST POLICY. ANNUALLY ALL MEMBERS OF THE BOARD OF TRUSTEES, OFFICERS AND SENIOR MANAGEMENT PERSONNEL OF ALL AFFILIATES ARE REQUIRED TO REVIEW THE EXISTING CONFLICT OF INTEREST POLICY AND COMPLETE A QUESTIONNAIRE. THE COMPLETED QUESTIONNAIRES ARE RETURNED TO THE ORGANIZATION AND AH SYSTEM'S GENERAL COUNSEL FOR REVIEW. THEREAFTER, THE GENERAL COUNSEL PREPARES A SUMMARY OF THE COMPLETED QUESTIONNAIRES WHICH CONTAINS INFORMATION DISCLOSED ON AN INDIVIDUAL BY INDIVIDUAL BASIS AND PRESENTS THIS SUMMARY TO AH SYSTEM'S GOVERNANCE COMMITTEE FOR ITS REVIEW AND DISCUSSION.

## CORE FORM, PART VI, SECTION B; QUESTION 15

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM") WHICH INCLUDES ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM"). THE EXECUTIVE COMPENSATION COMMITTEE ("COMMITTEE") OF THE BOARD OF TRUSTEES ("BOARD") OF AH SYSTEM REVIEWS AND APPROVES THE COMPENSATION PROVIDED TO THE EXECUTIVE STAFF. THE COMPENSATION DECISIONS OF THE COMMITTEE ARE SET WITHIN THE FRAMEWORK OF A FORMAL COMPENSATION PHILOSOPHY THAT IS APPROVED

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

BY THE BOARD. THE COMPENSATION PHILOSOPHY APPROVES THE USE OF A NATIONAL PEER GROUP OF NOT-FOR-PROFIT HEALTHCARE ORGANIZATIONS THAT ARE SIMILAR TO AH SYSTEM IN SIZE AND ORGANIZATIONAL CHARACTERISTICS. THE KEY ELEMENTS OF THE COMPENSATION PHILOSOPHY ARE:

TOTAL COMPENSATION POSITIONED AROUND THE 75TH PERCENTILE, COMPOSED OF THE FOLLOWING ELEMENTS OF PAY:

- BASE SALARIES POSITIONED BETWEEN THE MEDIAN AND THE 75TH PERCENTILE;
- INCENTIVE OPPORTUNITIES COMPARABLE TO THOSE OF THE PEER GROUP AND DESIGNED TO POSITION TOTAL CASH COMPENSATION AT THE 75TH PERCENTILE FOR EXPECTED PERFORMANCE (INCLUDES BOTH ANNUAL AND LONG-TERM INCENTIVES);
- EXECUTIVE BENEFITS POSITIONED AT THE 75TH PERCENTILE; AND
- CONSERVATIVE PERQUISITES AND SEVERANCE.

THE COMMITTEE APPROVES THE PAY OF ALL EXECUTIVES. IT SETS THE COMPENSATION FOR THE PRESIDENT AND CHIEF EXECUTIVE OFFICER ("PRESIDENT"). THE PRESIDENT RECOMMENDS SALARY ADJUSTMENTS AND INCENTIVE AWARD PAYMENTS TO THE COMMITTEE. THE COMMITTEE CAN APPROVE, MODIFY OR REJECT THE PRESIDENT'S RECOMMENDATIONS AS APPROPRIATE.

EACH YEAR, PRIOR TO MAKING CHANGES TO THE COMPENSATION OF ANY EXECUTIVE, THE COMMITTEE ENGAGES AN INDEPENDENT, OUTSIDE CONSULTANT TO REVIEW EACH ELEMENT OF EXECUTIVE COMPENSATION, INCLUDING SALARIES, INCENTIVES, BENEFITS, PERQUISITES, AND TOTAL COMPENSATION. THE INTENT OF THE REVIEW

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

IS TO PROVIDE THE COMMITTEE WITH INFORMATION IT NEEDS TO ENSURE THAT COMPENSATION PROVIDED TO THE SYSTEM'S EXECUTIVES IS REASONABLE, APPROPRIATE, AND CONSISTENT WITH THE BOARD-APPROVED COMPENSATION PHILOSOPHY. THE CONSULTANT COMPILES APPROPRIATE COMPARABILITY DATA ON TOTAL COMPENSATION FROM A PEER GROUP OR ORGANIZATIONS COMPARABLE TO AH SYSTEM.

THE COMMITTEE'S PROCESS FOR REVIEWING EXECUTIVE COMPENSATION ESTABLISHES A "REBUTTABLE PRESUMPTION OF REASONABLENESS," AS DESCRIBED IN IRC SECTION 4958:

- COMPENSATION FOR ALL EXECUTIVES IS APPROVED IN ADVANCE BY A COMMITTEE MADE UP ENTIRELY OF INDEPENDENT DIRECTORS WITH NO CONFLICT OF INTEREST WITH REGARD TO THE COMPENSATION DECISIONS.
- THE COMMITTEE OBTAINS AND RELIES ON APPROPRIATE COMPARABILITY DATA ON TOTAL COMPENSATION IN MAKING THESE DECISIONS. ("APPROPRIATE" MEANS DATA ON PAY FOR LIKE JOBS IN LIKE ORGANIZATIONS AND LIKE CIRCUMSTANCES).
- THE COMMITTEE DOCUMENTS ITS PROCESS AND THE TERMS OF ITS DECISIONS IN TIMELY MINUTES.

CORE FORM, PART VI, SECTION C; QUESTION 19

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. CERTAIN ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FROM 990 HAVE ISSUED TAX-EXEMPT BONDS TO FINANCE VARIOUS CAPITAL IMPROVEMENT PROJECTS, RENOVATIONS AND EQUIPMENT. IN CONJUNCTION WITH THE ISSUANCE OF THESE TAX-EXEMPT BONDS, THE ISSUING ORGANIZATION'S FINANCIAL STATEMENTS WERE INCLUDED WITH THE TAX-EXEMPT BOND PROSPECTUS WHICH WAS MADE AVAILABLE TO THE GENERAL PUBLIC FOR REVIEW. IN ADDITION, EACH ORGANIZATION'S FILED CERTIFICATE OF INCORPORATION AND ANY AMENDMENTS CAN BE OBTAINED AND REVIEWED THROUGH THE STATE OF NEW JERSEY DEPARTMENT OF THE TREASURY.

## CORE FORM, PART VII

CORE FORM, PART VII INCLUDES, AS OF JUNE 30, 2016, THE MEMBERS OF THE BOARD OF TRUSTEES, OFFICERS, AND KEY EMPLOYEES OF EACH OF THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. OUTLINED BELOW IS A SUMMARY BY ORGANIZATION:

THE BOARD OF TRUSTEES FOR EACH OF THE FOLLOWING SUBORDINATES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990, AS OF JUNE 30, 2016, IS IDENTICAL. THESE SUBORDINATES ARE:

- ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION;
- ATLANTICARE REGIONAL MEDICAL CENTER;
- ATLANTICARE HEALTH SERVICES, INC.; AND
- ATLANTICARE BEHAVIORAL HEALTH, INC.

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

THE BOARD OF TRUSTEE LIST REFLECTED IN PART VII FOR THESE SUBORDINATES

INCLUDES KENNETH R. STEINBERG THROUGH FRANCIS WREN, M.D.

ATLANTICARE FOUNDATION INCLUDES BENJAMIN ZELTNER, ESQ. THROUGH DAVID P. TILTON. PLEASE NOTE THAT LORI S. HERNDON IS ALSO A MEMBER OF THIS ORGANIZATION'S BOARD OF TRUSTEES BUT IS ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990 AS A BOARD MEMBER OF ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION, ATLANTICARE REGIONAL MEDICAL CENTER, ATLANTICARE HEALTH SERVICES, INC. AND ATLANTICARE BEHAVIORAL HEALTH, INC.

ATLANTICARE HEALTH ENGAGEMENT, INC. INCLUDES DOMINIC S. MOFFA THROUGH WALTER A. GREINER. PLEASE NOTE THAT DAVID P. TILTON IS ALSO A MEMBER OF THIS ORGANIZATION'S BOARD OF TRUSTEES BUT IS ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990 AS A BOARD MEMBER OF ATLANTICARE FOUNDATION.

INFOSHARE, INC. FILED A CERTIFICATE OF DISSOLUTION WITH THE STATE OF NEW JERSEY ON MARCH 18, 2016 AND IS NO LONGER IN EXISTENCE.

THE OFFICERS OF ALL ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 WHICH FOLLOW THE LIST OF ATLANTICARE BOARD OF TRUSTEES ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990 ARE OUTLINED IN THE FOLLOWING ORDER:

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION ("ARHS") INCLUDES DONNA MICHAEL-ZIEREIS, ESQ AND JAMES P. NOLAN, JR, CPA. PLEASE NOTE THAT LORI S. HERNDON (ATLANTICARE REGIONAL MEDICAL CENTER PRESIDENT/CHIEF EXECUTIVE OFFICER), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL CENTER EXECUTIVE VICE PRESIDENT) AND WALTER A. GREINER (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER) ARE ALSO OFFICERS OF ARHS BUT ARE ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE REGIONAL MEDICAL CENTER INCLUDES MARGARET A. BELFIELD THROUGH BARBARA YOUNG. PLEASE NOTE THAT LORI S. HERNDON (ATLANTICARE REGIONAL MEDICAL CENTER PRESIDENT/CHIEF EXECUTIVE OFFICER), DAVID P. TILTON (ATLANTICARE HEALTH SYSTEM, INC. PRESIDENT/CHIEF EXECUTIVE OFFICER), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL CENTER EXECUTIVE VICE PRESIDENT), WALTER A. GREINER (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER), JAMES P. NOLAN, JR., CPA (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER TERMED 2/1/2016) AND DONNA MICHAEL-ZIEREIS, ESQ. (ATLANTICARE REGIONAL HEALTH SERVICES VP AND GENERAL COUNSEL) ARE ALSO OFFICERS OF ATLANTICARE REGIONAL MEDICAL CENTER BUT ARE ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE HEALTH SERVICES, INC. INCLUDES JATIN MOTIWAL. PLEASE NOTE THAT LORI S. HERNDON (ATLANTICARE REGIONAL MEDICAL CENTER PRESIDENT/CHIEF

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

EXECUTIVE OFFICER), DAVID P. TILTON (ATLANTICARE HEALTH SYSTEM, INC. PRESIDENT/CHIEF EXECUTIVE OFFICER), MARGARET A. BELFIELD (ATLANTICARE REGIONAL MEDICAL CENTER CHIEF OPERATING OFFICER), WALTER A. GREINER (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER) JAMES P. NOLAN, JR., CPA (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER TERMED 2/1/2016), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL CENTER EXECUTIVE VICE PRESIDENT), RICHARD D. LOVERING (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP HUMAN RESOURCES AND ORGANIZATIONAL DEVELOPMENT), DONNA MICHAEL-ZIEREIS, ESQ. (ATLANTICARE REGIONAL HEALTH SERVICES VP AND GENERAL COUNSEL), AND BARBARA YOUNG (ATLANTICARE REGIONAL MEDICAL CENTER CORPORATE DIRECTOR - SUPPLY CHAIN) ARE THE OFFICERS OF ATLANTICARE HEALTH SERVICES, INC. BUT ARE ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE BEHAVIORAL HEALTH, INC. INCLUDES JULIA DREW THROUGH LOYAL M. OWNES. PLEASE NOTE THAT LORI S. HERNDON (ATLANTICARE REGIONAL MEDICAL CENTER PRESIDENT/CHIEF EXECUTIVE OFFICER), JOSEPH J. MCCARTHY, CPA (ATLANTICARE REGIONAL MEDICAL CENTER VP FINANCIAL OPERATIONS), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL CENTER EXECUTIVE VP), RICHARD D. LOVERING (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP HUMAN RESOURCES AND ORGANIZATIONAL DEVELOPMENT), DONNA MICHAEL-ZIEREIS, ESQ. (ATLANTICARE REGIONAL HEALTH SERVICES VP AND GENERAL COUNSEL) AND BARBARA YOUNG (ATLANTICARE REGIONAL MEDICAL CENTER CORPORATE DIRECTOR - SUPPLY CHAIN) ARE ALSO OFFICERS OF ATLANTICARE BEHAVIORAL HEALTH, INC. BUT ARE ONLY

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE FOUNDATION INCLUDES SAMANTHA A. KILEY. PLEASE NOTE THAT DAVID P. TILTON (ATLANTICARE HEALTH SYSTEM, INC. PRESIDENT/CHIEF EXECUTIVE OFFICER), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL EXECUTIVE VICE PRESIDENT) AND JOSEPH J. MCCARTHY, CPA (ATLANTICARE REGIONAL MEDICAL CENTER VP FINANCIAL OPERATIONS) ARE ALSO OFFICERS OF ATLANTICARE FOUNDATION BUT ARE ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE HEALTH ENGAGEMENT, INC. INCLUDES STEVEN M. BLUMBERG. PLEASE NOTE THAT DAVID P. TILTON (ATLANTICARE HEALTH SYSTEM, INC. PRESIDENT/CHIEF EXECUTIVE OFFICER), DOMINIC S. MOFFA (ATLANTICARE REGIONAL MEDICAL CENTER EXECUTIVE VICE PRESIDENT), WALTER A. GREINER (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER), JAMES P. NOLAN, JR., CPA (ATLANTICARE REGIONAL MEDICAL CENTER SENIOR VP OF FINANCE AND CHIEF FINANCIAL OFFICER TERMED 2/1/2016) AND DONNA MICHAEL-ZIEREIS, ESQ. (ATLANTICARE REGIONAL HEALTH SERVICES VP AND GENERAL COUNSEL) ARE ALSO OFFICERS OF ATLANTICARE HEALTH ENGAGEMENT, INC. BUT ARE ONLY DISCLOSED ONCE ON CORE FORM, PART VII OF THIS CONSOLIDATED GROUP FORM 990.

CORE FORM, PART VII, SECTION A AND SCHEDULE J

IN ACCORDANCE WITH CURRENT INTERNAL REVENUE SERVICE FORM 990

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

INSTRUCTIONS, NO COMPENSATION OR EMPLOYEE BENEFIT AMOUNTS ARE REPORTED HEREIN AS THIS RETURN IS A SHORT-PERIOD RETURN, BUT NOT A FINAL RETURN. THE ORGANIZATION CHANGED ITS YEAR-END FROM DECEMBER 31 TO JUNE 30. THIS RETURN IS FOR THE SIX-MONTH PERIOD JANUARY 1, 2016 THROUGH JUNE 30, 2016 AND, ACCORDINGLY, THERE IS NO REPORTABLE COMPENSATION FROM FEDERAL FORMS W-2 OR 1099 IN WHICH A CALENDAR YEAR FALLS WITHIN THIS REPORTING PERIOD. FOR CALENDAR YEAR 2015 COMPENSATION AND BENEFITS INFORMATION, PLEASE REFER TO THE DECEMBER 31, 2015 FEDERAL FORM 990 FOR THIS ORGANIZATION. THE ORGANIZATION ENTERED -0- FOR THE TOTAL NUMBER OF INDIVIDUALS (INCLUDING BUT NOT LIMITED TO THOSE LISTED ABOVE) WHO RECEIVED MORE THAN \$100,000 OF REPORTABLE COMPENSATION FROM THE ORGANIZATION SINCE THERE IS NO REPORTABLE COMPENSATION FROM FEDERAL FORMS W-2 OR 1099 SINCE NO CALENDAR YEAR ENDS WITHIN THE ORGANIZATION'S REPORTING PERIOD.

CORE FORM, PART VII, SECTION A, COLUMN B

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN THE GEISINGER HEALTH SYSTEM FOUNDATION 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 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

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

A MEMBER OF THE BOARD OF TRUSTEES OF OTHER RELATED ORGANIZATIONS WITHIN THE SYSTEM, THEIR RESPECTIVE HOURS PER WEEK PER ORGANIZATION ARE APPROXIMATELY THE SAME AS REFLECTED ON CORE FORM, PART VII OF THIS FORM 990. 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 OFFICERS AND KEY EMPLOYEES, REFLECT TOTAL HOURS WORKED PER WEEK ON BEHALF OF THE SYSTEM; NOT SOLELY THIS ORGANIZATION. PLEASE NOTE THAT THERE IS NO COMPENSATION DISCLOSED ON THIS FEDERAL FORM 990 FOR THE PERIOD OF JANUARY 1 THROUGH JUNE 30, 2016.

CORE FORM, PART VII, SECTION B

IN ACCORDANCE WITH CURRENT INTERNAL REVENUE SERVICE FORM 990 INSTRUCTIONS, NO FIVE HIGHEST COMPENSATED INDEPENDENT CONTRACTORS ARE REPORTED HEREIN AS THIS RETURN IS A SHORT-PERIOD RETURN, BUT NOT A FINAL RETURN. THE ORGANIZATION CHANGED ITS YEAR-END FROM DECEMBER 31 TO JUNE 30. THE ORGANIZATION ENTERED -0- FOR THE TOTAL NUMBER OF INDEPENDENT CONTRACTORS (INCLUDING BUT NOT LIMITED TO THOSE LISTED ABOVE) WHO RECEIVED MORE THAN \$100,000 OF REPORTABLE COMPENSATION FROM THE ORGANIZATION SINCE NO CALENDAR YEAR ENDS WITHIN THE ORGANIZATION'S REPORTING PERIOD.

CORE FORM, PART X; LINE 20

GEISINGER HEALTH SYSTEM FOUNDATION ("GHSF") IS CURRENTLY THE SOLE OBLIGOR UNDER A SERIES OF BOND ISSUES WITH A TOTAL OUTSTANDING BALANCE OF

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

\$1,447,263,694, INCLUSIVE OF UNAMORTIZED ORIGINAL ISSUE DISCOUNT AS OF JUNE 30, 2016. BECAUSE THE BOND PROCEEDS ARE DISBURSED TO GHSF SUBSIDIARIES, THE BOND LIABILITIES ARE REFLECTED ON THE BALANCE SHEETS OF THE FOLLOWING SUBSIDIARY ORGANIZATIONS:

- GEISINGER MEDICAL CENTER, EIN: 24-0795959
- GEISINGER WYOMING VALLEY MEDICAL CENTER, EIN: 23-1996150
- GEISINGER CLINIC, EIN: 23-6291113
- MARWORTH, EIN: 23-2171417
- GEISINGER SYSTEM SERVICES, EIN: 23-2164794
- COMMUNITY MEDICAL CENTER, EIN: 24-0862246
- MOUNTAIN VIEW NURSING HOME, INC., EIN: 23-2568288
- GEISINGER-BLOOMSBURG HOSPITAL, EIN: 23-2193572
- GEISINGER-BLOOMSBURG HEALTH CARE CENTER, EIN: 23-2242854
- GEISINGER-LEWISTOWN HOSPITAL, EIN: 23-1352187
- HOLY SPIRIT HOSPITAL, EIN: 23-1512747
- ATLANTICARE REGIONAL MEDICAL CENTER, EIN 21-0634549

SCHEDULE K WAS PREPARED ON A CONSOLIDATED BASIS AND IS INCLUDED IN THE FORM 990 FILING OF GEISINGER HEALTH SYSTEM FOUNDATION, EIN: 23-1995911.

CORE FORM, PART XI; QUESTION 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCE INCLUDE:

- NET ASSETS RELEASED FROM RESTRICTIONS AND GRANTS RECEIVED FOR THE

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer Identification number

90-0779828

PURCHASE OF PROPERTY, PLANT AND EQUIPMENT - \$233,392;

- OTHER DECREASES IN FUND BALANCE - (\$2,007,698);
- TRANSFERS TO INTERNAL REVENUE CODE SECTION 501(C) (3) TAX-EXEMPT AFFILIATES - (\$1,980,000);
- COLAR MARKET TO MARKET ADJUSTMENT - \$61,824;
- CHANGE IN PENSION AND POSTRETIREMENT LIABILITIES - (\$41,693,085);
- NET ASSETS RELEASED FROM TEMPORARY RESTRICTION - (\$3,668,050);
- NET CHANGE IN TEMPORARILY RESTRICTED NET ASSETS - (\$81,032); AND
- NET CHANGE IN PERMANENTLY RESTRICTED NET ASSETS - \$47,684.

## CORE FORM, PART XII; QUESTION 2

THE ORGANIZATION IS AN AFFILIATE WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). THE SYSTEM'S PARENT ENTITY IS GEISINGER HEALTH SYSTEM FOUNDATION. AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF THE SYSTEM FOR THE FISCAL YEAR ENDED JUNE 30, 2016 AND ISSUED A CONSOLIDATED FINANCIAL STATEMENT WITH CONSOLIDATING SCHEDULES BY ENTITY. AN UNQUALIFIED OPINION WAS ISSUED BY THE INDEPENDENT CPA FIRM. GEISINGER HEALTH SYSTEM FOUNDATION'S AUDIT AND COMPLIANCE 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

THIS ORGANIZATION IS AN AFFILIATE WITHIN GEISINGER HEALTH SYSTEM

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). THE SYSTEM ENGAGED AN INDEPENDENT ACCOUNTING FIRM TO PREPARE AND ISSUE A SYSTEM WIDE CONSOLIDATED AUDIT UNDER THE SINGLE AUDIT ACT AND OMB CIRCULAR A-133 AUDIT. THIS ORGANIZATION WAS INCLUDED IN THE SYSTEM WIDE A-133 AUDIT.

## SCHEDULE B

THE GIFTS, GRANTS AND CONTRIBUTIONS REFLECTED ON SCHEDULE B ARE AMOUNTS RECEIVED BY ALL ENTITIES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE REGIONAL MEDICAL CENTER ARE REFLECTED IN NUMBERS 1 THROUGH 3.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE BEHAVIORAL HEALTH, INC. ARE REFLECTED IN NUMBERS 4 THROUGH 12.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE FOUNDATION ARE REFLECTED IN NUMBERS 13 THROUGH 16 AND 20 THROUGH 22.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE HEALTH SERVICES, INC. ARE REFLECTED IN NUMBERS 17 THROUGH 19 AND 21.

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

THE ORGANIZATIONS ARE COMMITTED TO IMPROVING THE HEALTH AND WELL-BEING OF THE RESIDENTS OF NEW JERSEY BY PROVIDING QUALITY, PATIENT-CENTERED HEALTHCARE SERVICES. THE ENTITIES WORK TOGETHER TO

Name of the organization <b>ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES</b>	Employer identification number <b>90-0779828</b>
--	---

ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

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

ATTACHMENT 2FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INVESTMENT IN ATLANTICARE SURGERY CTR	2,283,914.			2,283,914.
INVESTMENT GAIN, NET		1,295,279.		1,295,279.
INTEREST AND DIVIDEND INCOME		11,664,760.		11,664,760.
<b>TOTALS</b>	<b><u>15,243,953.</u></b>			<b><u>15,243,953.</u></b>

ATTACHMENT 3FORM 990, PART VIII - INCOME FROM INVESTMENT OF TE BOND PROCEEDS

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
BOND INTEREST INCOME	27.			27.
<b>TOTALS</b>	<b><u>27</u></b>			<b><u>27</u></b>

ATTACHMENT 4FORM 990, PART VIII - EXCLUDED CONTRIBUTIONS

DESCRIPTION	AMOUNT
GALA	306,410.

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer Identification number

90-0779828

ATTACHMENT 4 (CONT'D)

FORM 990, PART VIII - EXCLUDED CONTRIBUTIONSDESCRIPTION AMOUNTTOTAL 306,410.FORM 990, PART VIII - FUNDRAISING EVENTS

ATTACHMENT 5

<u>DESCRIPTION</u>	<u>GROSS INCOME</u>	<u>DIRECT EXPENSES</u>
GALA	307,536.	307,536.
TOTALS	<u>307,536.</u>	<u>307,536.</u>

ATTACHMENT 6

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

<u>DESCRIPTION</u>	<u>BEGINNING BOOK VALUE</u>	<u>ENDING BOOK VALUE</u>
PREPAID	7,274,446.	8,773,350.
TOTALS	<u>7,274,446.</u>	<u>8,773,350.</u>

ATTACHMENT 7

FORM 990, PART X - DEFERRED REVENUE

<u>DESCRIPTION</u>	<u>BEGINNING BOOK VALUE</u>	<u>ENDING BOOK VALUE</u>
DEFERRED REVENUE	2,249,323.	2,203,196.
TOTALS	<u>2,249,323.</u>	<u>2,203,196.</u>

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ATTACHMENT 8FORM 990, PART X - SECURED MORTGAGES AND NOTES PAYABLE

LENDER: DEPARTMENT OF MENTAL HEALTH SERVICES  
 DATE OF NOTE: 02/13/1992  
 MATURITY DATE: 03/13/2017  
 SECURITY PROVIDED: 6010 BLACK HORSE PIKE, EGG HARBOR TWP., NJ

BEGINNING BALANCE DUE .....	55,178.
ENDING BALANCE DUE .....	<u>55,178.</u>

LENDER: DEPARTMENT OF MENTAL HEALTH SERVICES  
 DATE OF NOTE: 03/18/2003  
 MATURITY DATE: 12/01/2023  
 REPAYMENT TERMS: REDUCED ANNUALLY BY A FACTOR OF 1/X  
 SECURITY PROVIDED: 13 NORTH HARTFORD AVE, ATLANTIC CITY, NJ

BEGINNING BALANCE DUE .....	55,385.
ENDING BALANCE DUE .....	<u>55,385.</u>

LENDER: SERIES 2003  
 INTEREST RATE: 2.0000 %  
 DATE OF NOTE: 10/01/2003  
 MATURITY DATE: 10/01/2033  
 REPAYMENT TERMS: MONTHLY

BEGINNING BALANCE DUE .....	13,482,967.
ENDING BALANCE DUE .....	<u>13,484,869.</u>

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

ATTACHMENT 8 (CONT'D)

LENDER: CONTINUUM HEALTH ALLIANCE, LLC  
 ORIGINAL AMOUNT: 1,391,309.  
 INTEREST RATE: 3.0000 %  
 DATE OF NOTE: 12/01/2011  
 MATURITY DATE: 12/01/2016  
 REPAYMENT TERMS: MONTHLY INSTALLMENTS OF \$25,000 PLUS INTEREST  
 PURPOSE OF LOAN: MANAGEMENT SERVICE AGREEMENT

BEGINNING BALANCE DUE .....	295,181.
ENDING BALANCE DUE .....	<u>148,696.</u>

LENDER: SUN BANK  
 ORIGINAL AMOUNT: 2,273,071.  
 INTEREST RATE: 5.4000 %  
 DATE OF NOTE: 11/04/2011  
 MATURITY DATE: 12/01/2021  
 REPAYMENT TERMS: MONTHLY INSTALLMENTS OF \$14,000 PLUS INTEREST  
 PURPOSE OF LOAN: PURCHASE SHOREVIEW BUILDING SOMERS POINT

BEGINNING BALANCE DUE .....	2,394,933.
ENDING BALANCE DUE .....	<u>2,344,411.</u>

LENDER: TD BANK  
 ORIGINAL AMOUNT: 4,980,000.  
 INTEREST RATE: 4.4000 %  
 DATE OF NOTE: 04/01/2012  
 MATURITY DATE: 04/01/2022  
 REPAYMENT TERMS: MONTHLY INSTALLMENTS OF \$24,000 AND INTEREST  
 PURPOSE OF LOAN: PURCHASE HEALTH PARK BUILDING B & C

BEGINNING BALANCE DUE .....	4,784,960.
ENDING BALANCE DUE .....	<u>4,659,117.</u>

Name of the organization <b>ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES</b>	Employer identification number <b>90-0779828</b>
--	---

ATTACHMENT 8 (CONT'D)

LENDER: TD BANK  
 ORIGINAL AMOUNT: 3,825,000.  
 INTEREST RATE: 4.3200 %  
 DATE OF NOTE: 06/01/2012  
 MATURITY DATE: 06/01/2032  
 REPAYMENT TERMS: MONTHLY INSTALLMENTS OF \$31,000 PLUS INTEREST  
 PURPOSE OF LOAN: PURCHASED OF AIRPORT COMMERCE

BEGINNING BALANCE DUE .....	3,734,094.
ENDING BALANCE DUE .....	<u>3,652,532.</u>
 TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE	<u>24,802,698.</u>
 TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE	<u>24,400,188.</u>

**SCHEDULE R**  
**(Form 990)****Related Organizations and Unrelated Partnerships**

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

Department of the Treasury  
Internal Revenue Service

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

OMB No. 1545-0047  
**2015**Open to Public  
Inspection

► Attach to Form 990.

► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

Employer identification number  
90-0779828**Part I Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
Yes	No					
(1) ATLANTICARE HEALTH SYSTEM, INC 2300 ENGLISH CREEK AVE.	22-3265213 SUPPORT	ARMC NJ	501 (C) (3)	509 (A) (3)	GHSF	X
(2) ATLANTICARE PHYSICIAN GROUP, P.A. 2500 ENGLISH CREEK AVE., BLDG	02-0701782 EGG HARBOR TOWNSHIP, NJ 08	HEALTHCARE NJ	501 (C) (3)	509 (A) (3)	ARMC	X
(3) GEISINGER MEDICAL CENTER 100 NORTH ACADEMY AVE MC 49-70	24-0795959 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	HOSPITAL	GHSF	X
(4) GEISINGER HEALTH SYSTEM FOUNDATION 100 NORTH ACADEMY AVE MC 49-70	23-1995911 DANVILLE, PA 17822	PHILANTHROPIC PA	501 (C) (3)	509 (A) (1)	N/A	X
(5) GEISINGER CLINIC 100 NORTH ACADEMY AVE MC 49-70	23-6291113 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	509 (A) (3)	GHSF	X
(6) GEISINGER WYOMING VALLEY MEDICAL CTR 100 NORTH ACADEMY AVE MC 49-70	23-1996150 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	HOSPITAL	GHSF	X
(7) MARWORTH 100 NORTH ACADEMY AVE MC 49-70	23-2171417 DANVILLE, PA 17822	D&A REHAB PA	501 (C) (3)	HOSPITAL	GHSF	X

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

JSA

**SCHEDULE R**  
(Form 990)Department of the Treasury  
Internal Revenue Service  
Name of the organization**Related Organizations and Unrelated Partnerships**

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

► Attach to Form 990.

► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).OMB No. 1545-0047  
**2015**Open to Public  
Inspection

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Name of the organization

90-0779828

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	Yes	No
(1) GETSINGER HEALTH PLAN 23-2311553 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH INS.	PA	501 (C) (4)	N/A		GHSF	X	
(2) GETSINGER SYSTEM SERVICES 23-2164794 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	SUPPORT SVCS.	PA	501(C) (3)	509 (A) (3)		GHSF	X	
(3) GETSINGER COMMUNITY HEALTH SERVICES 23-2967235 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS.	PA	501 (C) (3)	509 (A) (2)		GSS	X	
(4) GETSINGER INSURANCE CORPORATION REG 14-1909894 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	SELF INS.	VT	501(C) (3)	509 (A) (3)		GRSF	X	
(5) COMMUNITY MEDICAL CENTER 24-0862246 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS.	PA	501 (C) (3)	HOSPITAL		GHSF	X	
(6) MOUNTAIN VIEW NURSING HOME INC 23-2568288 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	LONG TERM	PA	501 (C) (3)	509 (A) (2)		GHSF	X	
(7) COMMUNITY MEDICAL CTR HEALTHCARE SYS 23-2279376 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	SUPPORT SVCS.	PA	501 (C) (3)	509 (A) (3)		GHSF	X	

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

JSA

5E1307 1 0000 4608KZ U600

**Schedule R (Form 990) 2015**

**SCHEDULE R**  
(Form 990)**Related Organizations and Unrelated Partnerships**

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

► Attach to Form 990.

Department of the Treasury  
Internal Revenue Service  
Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

OMB No 1545-0047  
**2015**Open to Public  
Inspection► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section (if section 501(c)(3))	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
Yes	No					
(1) GEISINGER-BLOOMSBURG HOSPITAL 23-2193572 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	HOSPITAL	GHSF	X	
(2) GEISINGER-BLOOMSBURG HEALTHCARE CTR 23-2242854 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	SKILLED NU. PA	501 (C) (3)	509 (A) (2)	GHSF	X	
(3) LEWISTOWN HEALTHCARE FOUNDATION 23-2344363 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	PHILANTHROPIC PA	501 (C) (3)	509 (A) (3)	GHSF	X	
(4) GEISINGER-LEWISTOWN HOSPITAL 23-1352187 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	HOSPITAL	GHSF	X	
(5) LEWISTOWN AMBULATORY CARE CORP 23-2344362 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	R. E. HOLDING PA	501 (C) (3)	509 (A) (3)	GHSF	X	
(6) FAM HLTH ASSOC OF GEISINGER-LEWISTOWN 25-1651582 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	PHYSICIAN PA	501 (C) (3)	509 (A) (3)	GHSF	X	
(7) REYSTONE HEALTH INFO EXCHANGE INC 46-4359893 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	RHIO PA	501 (C) (3)	509 (A) (3)	GHSF	X	

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

JSA

9E1307 1 000 4 608KZ U600

Schedule R (Form 990) 2015

**SCHEDULE R  
(Form 990)**Department of the Treasury  
Internal Revenue Service  
Name of the organization**Related Organizations and Unrelated Partnerships**

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

► Attach to Form 990.

► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).OMB No 1545-0047  
**2015**Open to Public  
Inspection

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number  
90-0779828**Part I Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section (if section 501(c)(3))	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	HEALTH CARE CORP OF NORTHEAST PA 23-2337286 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	SUPPORT SVCS. PA	501 (C) (3)	509 (A) (3)	CMC	X		
(2)	SUN HOME HEALTH SERVICES, INC. 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	509 (A) (2)	GCHS	X		
(3)	HOLY SPIRIT HEALTH SYSTEM 25-1865142 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	PHILANTHROPIC PA	501 (C) (3)	509 (A) (3)	GHSF	X		
(4)	HOLY SPIRIT HOSPITAL 23-1512747 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	HOSPITAL	HSHS	X		
(5)	HOLY SPIRIT CORPORATION 23-2214540 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HOLDING CO. PA	501 (C) (2)		HSHS	X		
(6)	SPIRIT PHYSICIAN SERVICES, INC. 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	509 (A) (2)	HSHS	X		
(7)	WEST SHORE ADVANCED LIFE SUPPORT 23-2463002 100 NORTH ACADEMY AVE MC 49-70 DANVILLE, PA 17822	HEALTH SVCS. PA	501 (C) (3)	509 (A) (1)	HSHS	X		

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

JSA

5E1307 1 000 4 608KZ U600

**Schedule R (Form 990) 2015**

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate share?	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1) S JERSEY ONCO, PROP 94-3463625 2500 ENGLISH GREEK AVENUE EGG	HEALTHCARE SVCS	NJ	N/A							
(2) ATL SURGERY CTR LLC 22-3491867 2500 ENGLISH GREEK AVE EGG HAR	HEALTHCARE SVCS	NJ	N/A							
(3) COOP HLTH SVS OF SJ 22-3619231 1301 ATLANTIC AVENUE ATLANTIC	WHOLESALE PURCH	NJ	N/A							
(4) KEYSTONE ACCOUNTABLE CARE ORG 100 NORTH ACADEMY AVENUE MC 49	ACO	PA	N/A							
(5) LIFESOURCE GEISINGER BLOOD CTR 100 NORTH ACADEMY AVENUE MC 49	ORG. DEL. SY.	NJ	N/A							
(6) MERIDIAN GEISINGER HLTH NETWR 100 NORTH ACADEMY AVENUE MC 49	GHS LLC 72-1398803	NJ	N/A							
(7) HEALTHSOUTH GHS LLC 72-1398803 100 NORTH ACADEMY AVENUE MC 49	PHY. THERAPY	PA	N/A							

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate share?	(i) Percentage ownership	(j) Section 512(b)(13) controlled entity?
(1) ENGLISH CREEK ASSURANCE LTD 44 CHURCH STREET HAMILTON, BERMUDA BD HM 12	98-0656394 FINANCIAL VEHICLE	BD	N/A	FOREIGN CORP.					
(2) ATLANTICARE HEALTH SOLUTIONS, INC 2500 ENGLISH CREEK AVE, BLDG 500 EGG HARBOR TOWNSHIP, NJ	38-3856295 ACCO/HEALTH	NJ	N/A	C CORP.					
(3) ATLANTICARE ASSURANCE ALLIANCE, INC. 2500 ENGLISH CREEK AVE, BLDG 500 EGG HARBOR TOWNSHIP, NJ	46-37370123 HEALTHCARE SVCS.	NJ	N/A	C CORP.					
(4) GEISINGER MEDICAL MANAGEMENT CORP 100 NORTH ACADEMY AVENUE MC 49-70 DANVILLE, PA 17822	23-2017663 HOTEL/REST	PA	N/A	C CORP.					
(5) GEISINGER INDEMNITY INSURANCE CO 100 NORTH ACADEMY AVENUE MC 49-70 DANVILLE, PA 17822	23-2815174 HEALTH INSURANCE	PA	N/A	C CORP.					
(6) GEISINGER QUALITY OPTIONS INC 100 NORTH ACADEMY AVENUE MC 49-70 DANVILLE, PA 17822	20-4275139 HEALTH INSURANCE	PA	N/A	C CORP.					
(7) XG HEALTH SOLUTIONS INC 100 NORTH ACADEMY AVENUE MC 49-70 DANVILLE, PA 17822	46-1657345 CONSULTING	DE	N/A	C CORP.					

Schedule R (Form 990) 2015

JSA  
5E1308 1000

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate share?	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1) EVANGELICAL-GEISINGER HEALTH L 100 NORTH ACADEMY AVENUE MC 49	HEALTHCARE	PA	N/A							
(2) LEINED II 23-2391766 100 NORTH ACADEMY AVENUE MC 49	RENTAL	PA	N/A							
(3) GEISINGER-SCA HOLDINGS LLC 46-100 NORTH ACADEMY AVENUE MC 49	MANAGEMENT	DE	N/A							
(4) CAMP HILL AMBULATORY SURG CTR 569 BROOKWOOD VILLAGE, SUITE 9	HEALTHCARE	AL	N/A							
(5) HS ORTHOPEDIC MANAGEMENT CO LLC 503 NORTH 21ST STREET CAMP HILL	MANAGEMENT	PA	N/A							
(6) CAELIAN MEDICAL LLC 20-8018724 880 CENTURY DRIVE MECHANICSBUR	HEALTHCARE	PA	N/A							
(7) GRANDVIEW SURGERY CENTER LTD 5 569 BROOKWOOD VILLAGE, SUITE 9	HEALTHCARE	AL	N/A							

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1) GEISINGER ASSURANCE COMPANY LTD 98-1016737 P.O. BOX 2196GT GRAND CAYMAN, C.I.	FINANCIAL VEHICLE	C.I.	N/A	FOREIGN CORP.				X
(2) HOLY SPIRIT VENTURES, INC 100 NORTH ACADEMY AVENUE MC 49-70 DANVILLE, PA	MEDICAL SVCS	PA	N/A	C CORP.			X	
(3)								
(4)								
(5)								
(6)								
(7)								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disposition(s) of assets?	(i) Code 4-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1) LACKAWANNA PHYS AMB SURG CTR L 569 BROOKWOOD VILLAGE, SUITE 9 HEALTHCARE	AL	N/A								
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) entity?
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

**Part V****Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.****Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?  
 a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity . . . . .  
 b Gift, grant, or capital contribution to related organization(s) . . . . .  
 c Gift, grant, or capital contribution from related organization(s) . . . . .  
 d Loans or loan guarantees to or for related organization(s) . . . . .  
 e Loans or loan guarantees by related organization(s) . . . . .  
 f Dividends from related organization(s) . . . . .  
 g Sale of assets to related organization(s) . . . . .  
 h Purchase of assets from related organization(s) . . . . .  
 i Exchange of assets with related organization(s) . . . . .  
 j Lease of facilities, equipment, or other assets to related organization(s) . . . . .  
 k Lease of facilities, equipment, or other assets from related organization(s) . . . . .  
 l Performance of services or membership or fundraising solicitations for related organization(s) . . . . .  
 m Performance of services or membership or fundraising solicitations by related organization(s) . . . . .  
 n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .  
 o Sharing of paid employees with related organization(s) . . . . .  
 p Reimbursement paid to related organization(s) for expenses . . . . .  
 q Reimbursement paid by related organization(s) for expenses . . . . .  
 r Other transfer of cash or property to related organization(s) . . . . .  
 s Other transfer of cash or property from related organization(s) . . . . .

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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

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

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

**Part VII Supplemental Information**

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

**SCHEDULE R; GROUP EXEMPTION**

OUTLINED BELOW IS A LIST OF ORGANIZATIONS INCLUDED AS SUBORDINATES IN THE ATLANTICARE HEALTH SYSTEM, INC. GROUP EXEMPTION RULING AND IN THIS CONSOLIDATED GROUP FORM 990.

ATLANTICARE REGIONAL MEDICAL CENTER (FEID: 21-0634549)

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NON PROFIT CORPORATION (FEID: 80-0834222)

ATLANTICARE BEHAVIORAL HEALTH, INC. (FEID: 21-0721208)

ATLANTICARE FOUNDATION (FEID: 22-2148992)

ATLANTICARE HEALTH ENGAGEMENT, INC. (FEID: 61-1608389)

ATLANTICARE HEALTH SERVICES, INC. (FEID: 22-3265214)

INFOSHARE, INC. (FEID: 22-3337816). INFOSHARE, INC. FILED A CERTIFICATE OF DISSOLUTION WITH THE STATE OF NEW JERSEY ON MARCH 18, 2016 AND IS NO LONGER IN EXISTENCE.

**Part VII Supplemental Information**

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

## SCHEDULE R, PART V

THIS ORGANIZATION IS AN AFFILIATE WITHIN GEISINGER HEALTH SYSTEM FOUNDATION AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). TRANSFERS AMONGST AFFILIATES, INCLUDING PAYING AND/OR ALLOCATING EXPENSES OCCUR IN THE ORDINARY COURSE OF BUSINESS. THESE RELATED PARTY TRANSACTIONS ARE RECORDED ON THE REVENUE/EXPENSE AND BALANCE SHEET STATEMENTS OF THESE RELATED ORGANIZATIONS. THESE ENTITIES WORK TOGETHER TO DELIVER HIGH QUALITY HEALTHCARE AND WELLNESS SERVICES TO THE COMMUNITIES IN WHICH THEY ARE SITUATED.