
FEDERAL FORM 990
RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX
FOR THE YEAR ENDED DECEMBER 31, 2024

PUBLIC DISCLOSURE COPY

Return of Organization Exempt From Income Tax

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

Do not enter social security numbers on this form as it may be made public.

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

Open to Public Inspection

Department of the Treasury Internal Revenue Service

A For the 2024 calendar year, or tax year beginning and ending

B Check if applicable: C Name of organization: CENTRASTATE MEDICAL CENTER, INC. D Employer identification number: 22-1750190 E Telephone number: (732) 294-7050 G Gross receipts \$: 406,412,886. F Name and address of principal officer: THOMAS W. SCOTT, FACHE, FABC 901 WEST MAIN STREET, FREEHOLD, NJ 07728 H(a) Is this a group return for subordinates? Yes No H(b) Are all subordinates included? Yes No I Tax-exempt status: X 501(c)(3) 501(c) () (insert no.) 4947(a)(1) or 527 J Website: WWW.CENTRASTATE.COM K Form of organization: X Corporation Trust Association Other L Year of formation: 1964 M State of legal domicile: NJ

Part I Summary

Table with 3 columns: Description, Prior Year, Current Year. Rows include: 1 Briefly describe the organization's mission... 2 Check this box if the organization discontinued its operations... 3 Number of voting members... 4 Number of independent voting members... 5 Total number of individuals employed... 6 Total number of volunteers... 7a Total unrelated business revenue... 7b Net unrelated business taxable income... 8 Contributions and grants... 9 Program service revenue... 10 Investment income... 11 Other revenue... 12 Total revenue... 13 Grants and similar amounts paid... 14 Benefits paid to or for members... 15 Salaries, other compensation... 16a Professional fundraising fees... 16b Total fundraising expenses... 17 Other expenses... 18 Total expenses... 19 Revenue less expenses... 20 Total assets... 21 Total liabilities... 22 Net assets or fund balances.

Part II Signature Block

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

Sign Here: Signature of officer, Date, Type or print name and title

Paid Preparer Use Only: Print/Type preparer's name: SCOTT J MARIANI, Preparer's signature, Date, Check self-employed, PTIN: P00642486, Firm's name: WITHUMSMITH+BROWN, PC, Firm's EIN: 22-2027092, Firm's address: 200 JEFFERSON PARK SUITE 400 WHIPPANY, NJ 07981, Phone no.: 973-898-9494

May the IRS discuss this return with the preparer shown above? See instructions. X Yes No

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission:

CENTRASTATE MEDICAL CENTER'S MISSION IS TO ENHANCE THE HEALTH AND WELL-BEING OF OUR COMMUNITIES THROUGH THE COMPASSIONATE DELIVERY OF QUALITY HEALTHCARE. PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No
If "Yes," describe these new services on Schedule O.

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

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

4a (Code:) (Expenses \$ 364,463,408. including grants of \$ NONE) (Revenue \$ 388,674,107.)
SEE SCHEDULE O

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

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

4d Other program services (Describe on Schedule O.)
(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 364,463,408.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors? See instructions.	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>		X
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments-other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>		X
c Did the organization report an amount for investments-program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>	X	
d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?	X	
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I. See instructions</i>		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		X

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question number, Question text, Yes, No. Rows 22-38 covering various organizational requirements.

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 []

Table with 3 columns: Question number, Question text, Yes, No. Rows 1a-1c regarding Form 1096, W-2G forms, and backup withholding rules.

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return 2a 2,521		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i>	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)? . .		X
b	If "Yes," enter the name of the foreign country _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? 13a Note: See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i>		
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? 15 If "Yes," see the instructions and file Form 4720, Schedule N.	X	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O. 16		X
17	Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? 17 If "Yes," complete Form 6069.		

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NJ,
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records.

JSA 732-294-7050

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) THOMAS W. SCOTT, FACHE, FABC TRUSTEE-PRESIDENT/CEO	55.00 NONE	X		X				1,317,453.	NONE	66,618.
(2) JAMES J. MATERA, M.D. SVP/MEDICAL DIRECTOR	55.00 NONE				X			647,840.	NONE	41,227.
(3) AMIT S. KHAROD, M.D. TRUSTEE	50.00 NONE	X						37,000.	513,896.	65,409.
(4) JOHN A. DELLOCONO SVP/CFO (TERM 7/24)	55.00 NONE			X				502,040.	NONE	48,497.
(5) KAREN B. FREEMAN, MSA VP QUALITY & PATIENT SAFETY	50.00 NONE				X			404,966.	NONE	40,235.
(6) CATHLEEN G. JANZEKOVICH VP, PATIENT SERVICES	50.00 NONE				X			406,581.	NONE	32,642.
(7) MOUSTAFA H. SHAFEY, M.D. MEDICAL DIR. - MENTAL HLTH	50.00 NONE					X		387,312.	NONE	40,341.
(8) DEBORAH ROMMEL-CONNORS, MBA VP REVENUE CYCLE	50.00 NONE				X			359,016.	NONE	53,025.
(9) JOHN BRANDEISKY, DPM VP MED DIR QUALITY INFORMATICS	50.00 NONE					X		368,804.	NONE	42,581.
(10) HOWARD A. STEIN, M.D. PHYSICIAN	50.00 NONE					X		348,042.	NONE	31,433.
(11) DANIELLE VANWERT VP CLINICAL SERVICES	50.00 NONE				X			321,402.	NONE	55,052.
(12) NANCY BARONE CSHCF VP OF DEVELOPMENT	50.00 NONE					X		330,265.	NONE	45,731.
(13) LAURA L. SCHILARE, MBA, CPA VP FINANCE	50.00 NONE			X				297,003.	NONE	44,264.
(14) KIMBERLY H. SIMERS AVP INTEGRATIVE HEALTH	50.00 NONE				X			283,925.	NONE	39,353.

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

Table with 7 main columns: (A) Name and title, (B) Average hours per week, (C) Position, (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, (F) Estimated amount of other compensation. Includes rows for KENNETH ENG, VINCENT L. D'ELIA, JOHN P. DETULLIO, DAVID A. DE SIMONE, ASHISH AWASTHI, RAMANASRI KUDIPUDI, NADIA K. BATCHELOR, MAUREEN M. LAWRENCE, BARBARA J. MCMORROW, JOHN M. CANTALUPO, BRIAN GRAGNOLATI, and sub-totals.

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 519

Table with 3 columns: Question number, Yes, No. Contains questions 3, 4, and 5 regarding compensation reporting.

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.

Table with 3 columns: (A) Name and business address, (B) Description of services, (C) Compensation. Includes empty rows for contractor data.

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) JOSEPH IANTOSCA ----- TRUSTEE	1.00 ----- NONE	X						NONE	NONE	NONE
(27) DANIEL JACKSON ----- TRUSTEE	1.00 ----- NONE	X						NONE	NONE	NONE
(28) GERARD K. NORKUS ----- TRUSTEE	1.00 ----- NONE	X						NONE	NONE	NONE
(29) MAUREEN A. SCHNEIDER, PHD MBA ----- TRUSTEE	55.00 ----- NONE	X						NONE	NONE	NONE
(30) WILLIAM A. SCHORIES ----- TRUSTEE	1.00 ----- NONE	X						NONE	NONE	NONE
(31) STEVEN SHERIS, MD, FACC, FACP ----- TRUSTEE	55.00 ----- NONE	X						NONE	NONE	NONE
(32) BRETT TAFT ----- TRUSTEE	1.00 ----- NONE	X						NONE	NONE	NONE

1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

Section B. Independent Contractors

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

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

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

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Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants, and Other Similar Amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c					
	d	Related organizations	1d	5,070,809.				
	e	Government grants (contributions) . .	1e	1,744,865.				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	862,053.				
	g	Noncash contributions included in lines 1a-1f	1g	\$				
	h	Total. Add lines 1a-1f			7,677,727.			
	Program Service Revenue				Business Code			
2a		NET PATIENT SERVICE REVENUE		621990	381,350,973.	381,350,973.		
b		OTHER HEALTHCARE RELATED REVENUE		621990	7,028,473.	7,028,473.		
c								
d								
e								
f		All other program service revenue						
g	Total. Add lines 2a-2f			388,379,446.				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)			5,062,601.		5,062,601.	
	4	Income from investment of tax-exempt bond proceeds . . .			NONE			
	5	Royalties			NONE			
	6a	Gross rents	6a	(i) Real	(ii) Personal			
						3,326,099.		
	b	Less: rental expenses	6b					
	c	Rental income or (loss)	6c	3,326,099.	NONE			
	d	Net rental income or (loss)			3,326,099.		294,661.	
	7a	Gross amount from sales of assets other than inventory	7a	(i) Securities	(ii) Other			
						168,667.		
	b	Less: cost or other basis and sales expenses . .	7b	5,048,628.				
	c	Gain or (loss)	7c	-4,879,961.				
	d	Net gain or (loss)			-4,879,961.		-4,879,961.	
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a		NONE				
				NONE				
				NONE				
b	Less: direct expenses	8b						
c	Net income or (loss) from fundraising events			NONE				
9a	Gross income from gaming activities. See Part IV, line 19	9a		NONE				
				NONE				
				NONE				
b	Less: direct expenses	9b						
c	Net income or (loss) from gaming activities			NONE				
10a	Gross sales of inventory, less returns and allowances	10a		NONE				
				NONE				
				NONE				
b	Less: cost of goods sold	10b						
c	Net income or (loss) from sales of inventory			NONE				
Miscellaneous Revenue				Business Code				
	11a	CAFETERIA INCOME		621990	1,798,346.		1,798,346.	
	b							
	c							
	d	All other revenue						
e	Total. Add lines 11a-11d			1,798,346.				
12	Total revenue. See instructions				401,364,258.	388,379,446.	294,661.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	NONE			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	NONE			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	NONE			
4 Benefits paid to or for members	NONE			
5 Compensation of current officers, directors, trustees, and key employees	5,023,626.	4,521,263.	502,363.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	NONE			
7 Other salaries and wages	148,909,182.	134,018,264.	14,890,918.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,627,220.	5,064,498.	562,722.	
9 Other employee benefits	19,804,581.	17,824,123.	1,980,458.	
10 Payroll taxes	11,352,182.	10,216,964.	1,135,218.	
11 Fees for services (nonemployees):				
a Management	471,976.	424,778.	47,198.	
b Legal	283,053.	254,748.	28,305.	
c Accounting	NONE			
d Lobbying	20,204.	18,184.	2,020.	
e Professional fundraising services. See Part IV, line 17	NONE			
f Investment management fees	192,338.	173,104.	19,234.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.)	38,701,100.	34,830,990.	3,870,110.	NONE
12 Advertising and promotion	2,403,238.	2,162,914.	240,324.	
13 Office expenses	12,887,882.	11,599,094.	1,288,788.	
14 Information technology	2,557,539.	2,301,785.	255,754.	
15 Royalties	NONE			
16 Occupancy	5,995,308.	5,395,777.	599,531.	
17 Travel	159,323.	143,391.	15,932.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	NONE			
19 Conferences, conventions, and meetings	NONE			
20 Interest	3,751,423.	3,376,281.	375,142.	
21 Payments to affiliates	NONE			
22 Depreciation, depletion, and amortization	18,253,848.	16,428,463.	1,825,385.	
23 Insurance	1,908,771.	1,717,894.	190,877.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	92,613,167.	83,351,850.	9,261,317.	
b SUPPORT SERVICES	6,880,034.	6,192,031.	688,003.	
c REPAIRS & MAINTENANCE	4,602,620.	4,142,358.	460,262.	
d PURCHASED SERVICES	3,242,751.	2,918,476.	324,275.	
e All other expenses	19,317,975.	17,386,178.	1,931,797.	
25 Total functional expenses. Add lines 1 through 24e	404,959,341.	364,463,408.	40,495,933.	NONE
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)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	8,511,481.	1	11,926,041.
	2 Savings and temporary cash investments	11,754,015.	2	35,232,834.
	3 Pledges and grants receivable, net	NONE	3	NONE
	4 Accounts receivable, net	34,963,642.	4	35,366,240.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	5	NONE
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	NONE	6	NONE
	7 Notes and loans receivable, net	NONE	7	NONE
	8 Inventories for sale or use	2,635,234.	8	2,591,243.
	9 Prepaid expenses and deferred charges . . SEE SCHEDULE O	2,336,909.	9	2,301,788.
	10 a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 280,662,524.		
	b Less: accumulated depreciation	10b 49,723,119.		
		216,311,807.	10c	230,939,405.
	11 Investments - publicly traded securities	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11	NONE	12	NONE
	13 Investments - program-related. See Part IV, line 11	120,014,864.	13	126,513,925.
	14 Intangible assets	NONE	14	NONE
15 Other assets. See Part IV, line 11	45,995,560.	15	42,569,393.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	442,523,512.	16	487,440,869.	
Liabilities	17 Accounts payable and accrued expenses	53,030,558.	17	45,993,216.
	18 Grants payable	NONE	18	NONE
	19 Deferred revenue	NONE	19	NONE
	20 Tax-exempt bond liabilities	NONE	20	NONE
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	6,336,850.	23	10,150,976.
	24 Unsecured notes and loans payable to unrelated third parties	NONE	24	NONE
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	130,186,342.	25	148,442,877.
	26 Total liabilities. Add lines 17 through 25	189,553,750.	26	204,587,069.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33. <input checked="" type="checkbox"/>			
	27 Net assets without donor restrictions	232,051,000.	27	262,704,280.
	28 Net assets with donor restrictions	20,918,762.	28	20,149,520.
	Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33. <input type="checkbox"/>			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	252,969,762.	32	282,853,800.
33 Total liabilities and net assets/fund balances	442,523,512.	33	487,440,869.	

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	401,364,258.
2	Total expenses (must equal Part IX, column (A), line 25)	2	404,959,341.
3	Revenue less expenses. Subtract line 2 from line 1	3	-3,595,083.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	252,969,762.
5	Net unrealized gains (losses) on investments	5	5,847,427.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	27,631,694.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	282,853,800.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits

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

**SCHEDULE A
(Form 990)**

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Name of the organization CENTRASTATE MEDICAL CENTER, INC.	Employer identification number 22-1750190
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Part I Reason for Public Charity Status. (All organizations must complete this part.) See instructions.

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990).)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
- 10 An organization that normally receives (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 11 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

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

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

Schedule A (Form 990) 2024

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

Section A. Public Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2020, (b) 2021, (c) 2022, (d) 2023, (e) 2024, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2020, (b) 2021, (c) 2022, (d) 2023, (e) 2024, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2024 (line 6, column (f), divided by line 11, column (f)); 15 Public support percentage from 2023 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2024. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization; b 33 1/3% support test - 2023. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization; 17a 10%-facts-and-circumstances test - 2024. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization; b 10%-facts-and-circumstances test - 2023. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization; 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions.

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

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(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) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(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 on line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

15 Public support percentage for 2024 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2023 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2024 (line 10c, column (f), divided by line 13, column (f)),	17	%
18 Investment income percentage from 2023 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2024. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization . . .

b 33 1/3% support tests - 2023. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization . .

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a	<input type="checkbox"/>	The organization satisfied the Activities Test. Complete line 2 below.	
b	<input type="checkbox"/>	The organization is the parent of each of its supported organizations. Complete line 3 below.	
c	<input type="checkbox"/>	The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).	
2	Activities Test. Answer lines 2a and 2b below.		
a		Yes	No
	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
b		Yes	No
	Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
3	Parent of Supported Organizations. Answer lines 3a and 3b below.		
a		Yes	No
	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>If "Yes" or "No," provide details in Part VI.</i>		
b		Yes	No
	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	8
9	Distributable amount for 2024 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2024	(iii) Distributable Amount for 2024
1	Distributable amount for 2024 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2024 (reasonable cause required - explain in Part VI). See instructions.			
3	Excess distributions carryover, if any, to 2024			
a	From 2019			
b	From 2020			
c	From 2021			
d	From 2022			
e	From 2023			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2024 distributable amount			
i	Carryover from 2019 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2024 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2024 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2024, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6	Remaining underdistributions for 2024. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7	Excess distributions carryover to 2025. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2020			
b	Excess from 2021			
c	Excess from 2022			
d	Excess from 2023			
e	Excess from 2024			

**SCHEDULE C
(Form 990)**

Political Campaign and Lobbying Activities

OMB No. 1545-0047

For Organizations Exempt From Income Tax Under Section 501(c) and Section 527

2024

Department of the Treasury
Internal Revenue Service

Complete if the organization is described below. Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

Open to Public Inspection

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

- Section 501(c)(3) organizations: Complete Parts I-A and I-B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and I-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 CENTRASTATE MEDICAL CENTER, INC.	Employer identification number (EIN) 22-1750190
--	--

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

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

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

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

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities. \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b \$ _____
- 4 Did the filing organization file Form 1120-POL for this year? Yes No
- 5 Enter the names, addresses, and EINs 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) 2024

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)			
b Total lobbying expenditures to influence a legislative body (direct lobbying)			
c Total lobbying expenditures (add lines 1a and 1b)			
d Other exempt purpose expenditures			
e Total exempt purpose expenditures (add lines 1c and 1d)			
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.			
IF the amount on line 1e, column (a) or (b), is:	THEN 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) 2021	(b) 2022	(c) 2023	(d) 2024	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total. Add lines 1c through 1i...; 2a Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?; b If "Yes," enter the amount of any tax incurred under section 4912...; c If "Yes," enter the amount of any tax incurred by organization managers...; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?...

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Blank lines for providing supplemental information as required by the instructions.

Part IV Supplemental Information (continued)

SCHEDULE C, PART II-B; LINE II

DURING 2024, THE ORGANIZATION PAID AN OUTSIDE LOBBYING FIRM WHICH ENGAGED IN LOBBYING EFFORTS ON BEHALF OF THE ORGANIZATION ADDRESSING FEDERAL AND STATE HEALTHCARE MATTERS. THIS ALLOCATION AMOUNTED TO \$15,600 DURING THE YEAR ENDED DECEMBER 31, 2024.

IN ADDITION, THE ORGANIZATION IS A MEMBER OF THE NEW JERSEY HOSPITAL ASSOCIATION AND THE NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION WHICH ENGAGE IN LOBBYING EFFORTS ON BEHALF OF THEIR MEMBER HOSPITALS. A PORTION OF THE DUES PAID TO THESE ORGANIZATIONS HAS BEEN ALLOCATED TO LOBBYING ACTIVITIES PERFORMED ON BEHALF OF THE ORGANIZATION. THIS ALLOCATION AMOUNTED TO \$4,604 DURING THE YEAR ENDED DECEMBER 31, 2024.

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.

Department of the Treasury Internal Revenue Service

Attach to Form 990.

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

Open to Public Inspection

Table with 2 columns: Name of the organization (CENTRASTATE MEDICAL CENTER, INC.), Employer identification number (22-1750190)

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts

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

Table with 3 columns: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Includes questions 1-6 regarding donor advised funds.

Part II Conservation Easements

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

Table with 3 columns: Line number, Description, Held at the End of the Tax Year. Includes questions 1-9 regarding 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.

Table with 3 columns: Line number, Description, Amount. Includes questions 1a, 1b, 2, a, b regarding art and historical treasures.

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

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?

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

Table with 2 columns: Description, Amount. Rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

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

Part V Endowment Funds

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

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a-1g (Beginning of year balance, Contributions, Net investment earnings, gains, and losses, Grants or scholarships, Other expenditures for facilities and programs, Administrative expenses, End of year balance).

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 %
c Term endowment %

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?

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

Table with 2 columns: Yes, No. Rows: 3a(i), 3a(ii), 3b.

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.

Table with 5 columns: Description of property, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total.

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)		
Total. (Column (b) must equal Form 990, Part X, line 12, col. (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	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) PROGRAM RELATED INVESTMENTS	106,055,959.	FMV
(2) ASSETS HELD BY RELATED ORG.	20,149,520.	FMV
(3) INVESTMENT IN SURGICARE	308,446.	FMV
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, line 13, col. (B)) . . .	126,513,925.	

Part IX Other Assets

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES - CURRENT	19,535,079.
(2) DUE FROM AFFILIATES - NC	5,050,278.
(3) OTHER RECEIVABLES	8,265,044.
(4) SECURITY DEPOSITS	1,042,088.
(5) RESTRICTED CASH - ASSET	1,130,176.
(6) OPERATING LEASE ASSETS	7,546,728.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 15, col. (B)).	42,569,393.

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	21,352,426.
(3) EST. 3RD PARTY PAYOR SETTLEMENTS	10,975,108.
(4) RESTRICTED FUNDS - LIABILITY	1,130,176.
(5) WORKERS COMP INSURANCE - RESERVE	5,197,443.
(6) AHS OBLIGATED GROUP LIABILITIES	109,787,724.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 25, col. (B)).	148,442,877.

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include description, sub-column (2a-2d, 4a-4b), and total column (1, 2e, 3, 4c, 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.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include description, sub-column (2a-2d, 4a-4b), and total column (1, 2e, 3, 4c, 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.

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information (continued)

SCHEDULE D, PART X; LINE 2

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM, INC.; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF CENTRASTATE HEALTHCARE SYSTEM, INC AND RELATED ENTITIES FOR THE YEARS ENDED DECEMBER 31, 2024 AND DECEMBER 31, 2023; RESPECTIVELY. THE FOLLOWING FOOTNOTE IS INCLUDED IN THE SYSTEM'S 2024 AUDITED CONSOLIDATED FINANCIAL STATEMENTS THAT REPORTS THE ORGANIZATION'S LIABILITY FOR UNCERTAIN TAX POSITIONS UNDER FIN 48 (ASC 740):

THE SYSTEM ACCOUNTS FOR DEFERRED TAX ASSETS AND LIABILITIES BASED ON THE DIFFERENCES BETWEEN THE FINANCIAL REPORTING AND TAX BASIS OF ASSETS AND LIABILITIES USING ENACTED TAX RATES AND LAWS THAT WILL BE IN EFFECT WHEN DIFFERENCES ARE EXPECTED TO REVERSE.

AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023, THE SYSTEM HAS MADE REASONABLE ESTIMATES OF THE PROVISION FOR THE INCOME TAXES AND DEFERRED TAX BALANCES BASED ON ACCOUNTING GUIDANCE INCLUDED IN ACCOUNTING STANDARDS CODIFICATION 740, INCOME TAXES. THE SYSTEM WILL CONTINUE TO REFINE ITS CALCULATIONS IN FUTURE PERIODS AS ADDITIONAL REGULATIONS AND GUIDANCE ARE ISSUED BY THE INTERNAL REVENUE SERVICE (IRS).

**SCHEDULE F
(Form 990)**

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

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

Attach to Form 990.

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

OMB No. 1545-0047

**Open to Public
Inspection**

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Employer identification number

22-1750190

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 the region	(d) Activities conducted in the region (by type) (such as, 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 the region	(f) Total expenditures for and investments in the region
(1) CENTRAL AMERICA/CARIBBEAN	1	1	PROGRAM SERVICES	FINANCIAL VEHICLE	1,646,189.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Subtotal	1	1.			1,646,189.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)	1.	1.			1,646,189.

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

Schedule F (Form 990) (Rev. 12-2024)

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 noncash assistance	(h) Description of noncash 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 a tax exempt 501(c)(3) organization by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter _____

3 Enter total number of other organizations or entities _____

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" 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 noncash assistance	(g) Description of noncash 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 U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see the Instructions for Form 926)* Yes No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see the Instructions for Forms 3520 and 3520-A; don't file with Form 990)* Yes No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect to Certain Foreign Corporations (see the 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 the Instructions for Form 8621)* Yes No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see the 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 the Instructions for Form 5713; don't file with Form 990)* Yes No

Part V Supplemental Information

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

SCHEDULE F, PART I

DURING 2024, THIS ORGANIZATION REMITTED \$1,646,189 TO AHS INSURANCE COMPANY, LTD., A FINANCIAL VEHICLE, ON BEHALF OF AND FOR THE BENEFIT OF THIS ORGANIZATION.

A FORM 5471 IS ATTACHED TO THE FORM 990 OF ATLANTIC HEALTH SYSTEM, INC. (FEID: 22-3380375); A RELATED INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION, AS THIS ENTITY IS THE OWNER OF AHS INSURANCE COMPANY, LTD., NOT CENTRASTATE MEDICAL CENTER, INC.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2024

Open to Public Inspection

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.
Attach to Form 990.

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

Department of the Treasury
Internal Revenue Service

Name of the organization CENTRASTATE MEDICAL CENTER, INC.	Employer identification number 22-1750190
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Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy (FAP) during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
1b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the FAP to its various hospital facilities during the tax year: <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use federal poverty guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____%	<input checked="" type="checkbox"/>	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> %	<input checked="" type="checkbox"/>	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's FAP that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its FAP during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<input checked="" type="checkbox"/>	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		<input checked="" type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

7 Financial Assistance and Certain Other Community Benefits at Cost						
	(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
Financial Assistance and Means-Tested Government Programs						
a Financial assistance at cost (from Worksheet 1)			7,599,770.	362,974.	7,236,796.	1.79
b Medicaid (from Worksheet 3, column a).			39,298,355.	38,174,906.	1,123,449.	0.28
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial assistance and means-tested government programs . .			46,898,125.	38,537,880.	8,360,245.	2.07
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	22	736857.	1,147,487.	193,462.	954,025.	0.24
f Health professions education (from Worksheet 5)	4	144.	1,534,367.	62,400.	1,471,967.	0.36
g Subsidized health services (from Worksheet 6)	1		12,093,514.	NONE	12,093,514.	2.99
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2	86.	220,584.	23,000.	197,584.	0.05
j Total. Other benefits	29	737087.	14,995,952.	278,862.	14,717,090.	3.64
k Total. Add lines 7d and 7j	29	737087.	61,894,077.	38,816,742.	23,077,335.	5.71

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule H (Form 990) 2024

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	90,639,525.
6 Enter Medicare allowable costs of care relating to payments on line 5	124,324,885.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	-33,685,360.
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

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

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

1 CENTRASTATE MEDICAL CENTER
 901 WEST MAIN STREET
 FREEHOLD NJ 07728
 WWW.CENTRASTATE.COM

Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
X	X		X			X	X		

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: CENTRASTATE MEDICAL CENTER

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

		Yes	No
Community Health Needs Assessment (CHNA)			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3	During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>2022</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
6b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		X
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.CENTRASTATE.COM</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>2022</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a	If "Yes," list url: <u>WWW.CENTRASTATE.COM</u>		
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)?		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group: CENTRASTATE MEDICAL CENTER

		Yes	No
Did the hospital facility have in place during the tax year a written FAP that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> FPG, with FPG family income limit for eligibility for free care of and FPG family income limit <u>200.0000</u> % for eligibility for discounted care of <u>500.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? 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):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.CENTRASTATE.COM</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.CENTRASTATE.COM</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.CENTRASTATE.COM</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group: CENTRASTATE MEDICAL CENTER

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group: CENTRASTATE MEDICAL CENTER

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

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, QUESTION 5

IN ITS MOST RECENTLY CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") THIS ORGANIZATION TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY ITS HOSPITAL FACILITIES.

CENTRASTATE MEDICAL CENTER IS A FOUNDING MEMBER OF THE HEALTH IMPROVEMENT COALITION OF MONMOUTH COUNTY (HICMC) AND HAS A SEAT ON THE ORGANIZATION'S SEVEN-MEMBER STEERING COMMITTEE, ALONG WITH REPRESENTATIVES OF COUNTY AND LOCAL HEALTH DEPARTMENTS AND OTHER MONMOUTH COUNTY HOSPITALS. ORGANIZED IN 2005, HICMC, WITH THE COOPERATION OF THE GOVERNMENTAL PUBLIC HEALTH PARTNERSHIP OF MONMOUTH COUNTY, AREA AGENCIES, ORGANIZATIONS, HEALTHCARE PROVIDERS INCLUDING ALL FIVE HOSPITALS IN MONMOUTH COUNTY, AND INDIVIDUALS, HAS COLLABORATED TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) EVERY FIVE YEARS (2007-2011, 2012-2016 AND 2017-2019). THE CURRENT MONMOUTH COUNTY PLAN WAS COMPLETED IN 2022 AND IS FOR THE YEARS 2016-2020 AND INCLUDES THE COMMUNITIES OF WESTERN MONMOUTH COUNTY.

CENTRASTATE IS ALSO A PARTICIPATING MEMBER OF THE OCEAN MONMOUTH HEALTH ALLIANCE, THE PREVENTION COALITION OF MONMOUTH COUNTY, THE FREEHOLD AREA MUNICIPAL ALLIANCE AND NEIGHBORHOOD CONNECTIONS TO HEALTH.

FOR THE PURPOSES OF THIS CHNA, CENTRASTATE MEDICAL CENTER, INC. ALSO REVIEWED THE CHNA'S AND CHIP'S OF ADJACENT COUNTIES, SPECIFICALLY OCEAN, MERCER AND MIDDLESEX, AND CONDUCTED SURVEYS THROUGHOUT THE COMMUNITIES SERVED BY CENTRASTATE MEDICAL CENTER, INC. BOTH ELECTRONICALLY AND VIA HARD-COPY AND DETERMINED THE RESULTS WERE CONSISTENT WITH THE MONMOUTH COUNTY ASSESSMENTS AND PLANS UPON WHICH CENTRASTATE MEDICAL CENTER, INC. BASED IT'S CHNA.

A BASE "SECONDARY DATA PROFILE" AND AN "URBAN PROFILE" WERE PREPARED FOR MONMOUTH COUNTY BY HOLLERAN CONSULTING OF PHILADELPHIA THAT INCLUDED DEMOGRAPHIC AND HOUSEHOLD INFORMATION, MORTALITY RATES, COMMUNICABLE DISEASE RATES AND CANCER INCIDENCE AND MORTALITY RATES. THE PROFILES WERE UPDATED PERIODICALLY. COPIES OF BOTH STUDIES ARE AVAILABLE IN THE CENTRASTATE MEDICAL CENTER, INC. COMMUNITY RELATIONS OFFICE. THE COALITION EXAMINED SCIENTIFIC SURVEY DATA FROM NEARLY 600 HOUSEHOLDS, AS WELL AS FOCUS GROUP FEEDBACK. CENTRASTATE MEDICAL CENTER, INC. FURTHER REVIEWED THE HEALTHY NEW JERSEY 2020 OBJECTIVES, BASELINES, AND TARGETS. BECAUSE MANY OF THE STATISTICS REFLECT AVAILABLE COUNTY-WIDE OR STATE-WIDE DATA, CENTRASTATE MEDICAL CENTER, INC. CONDUCTED AN ADDITIONAL SURVEY AS WELL AS SEVERAL INTERVIEWS AND MEETINGS DESIGNED TO FURTHER IDENTIFY THE HEALTH NEEDS PARTICULAR TO WESTERN MONMOUTH COUNTY. THE RESULTS WERE RANKED ACCORDING TO SEVERITY AFTER CONSULTATIONS WERE CONDUCTED BETWEEN CENTRASTATE MEDICAL CENTER, INC. CHNA LEADERSHIP AND THE PUBLIC HEALTH OFFICERS SERVING MONMOUTH COUNTY AS WELL AS EACH OF THE

Part V Facility Information (continued)

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

COMMUNITIES IN WESTERN MONMOUTH COUNTY TO IDENTIFY THE SIGNIFICANT HEALTH NEEDS OF THE CENTRASTATE MEDICAL CENTER, INC. COMMUNITIES.

SCHEDULE H, PART V, SECTION B, QUESTIONS 6A & 6B

CENTRASTATE MEDICAL CENTER IS A FOUNDING MEMBER OF THE HEALTH IMPROVEMENT COALITION OF MONMOUTH COUNTY (HICMC) AND HAS A SEAT ON THE ORGANIZATION'S SEVEN-MEMBER STEERING COMMITTEE, ALONG WITH REPRESENTATIVES OF COUNTY AND LOCAL HEALTH DEPARTMENTS AND OTHER MONMOUTH COUNTY HOSPITALS. ORGANIZED IN 2005, HICMC, WITH THE COOPERATION OF THE GOVERNMENTAL PUBLIC HEALTH PARTNERSHIP OF MONMOUTH COUNTY, AREA AGENCIES, ORGANIZATIONS, HEALTHCARE PROVIDERS INCLUDING ALL FIVE HOSPITALS IN MONMOUTH COUNTY, AND INDIVIDUALS, HAS COLLABORATED TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) EVERY FIVE YEARS (2007-2011, 2012-2016 AND 2017-2019). THE CURRENT MONMOUTH COUNTY PLAN WAS COMPLETED IN 2022 AND IS FOR THE YEARS 2016-2020 AND INCLUDES THE COMMUNITIES OF WESTERN MONMOUTH COUNTY.

CENTRASTATE IS ALSO A PARTICIPATING MEMBER OF THE OCEAN MONMOUTH HEALTH ALLIANCE, THE PREVENTION COALITION OF MONMOUTH COUNTY, THE FREEHOLD AREA MUNICIPAL ALLIANCE AND NEIGHBORHOOD CONNECTIONS TO HEALTH.

SCHEDULE H, PART V, SECTION B, QUESTIONS 7A & 7D

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM, INC.; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). DUE TO CHARACTER LIMITATIONS, THE WEBSITE LISTED IN SCHEDULE H, PART V, SECTION B, QUESTION 7A, IS THE HOME PAGE FOR THE SYSTEM. THE CHNA CAN BE ACCESSED AT THE FOLLOWING PAGE INCLUDED IN THE SYSTEM'S WEBSITE:

[HTTPS://WWW.CENTRASTATE.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/](https://www.centrastate.com/community-health-needs-assessment/)

SCHEDULE H, PART V, SECTION B, QUESTION 10A

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM, INC.; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). DUE TO CHARACTER LIMITATIONS, THE WEBSITE LISTED IN SCHEDULE H, PART V, SECTION B, QUESTION 10A, IS THE HOME PAGE FOR THE SYSTEM. THE IMPLEMENTATION STRATEGY CAN BE ACCESSED AT THE FOLLOWING PAGE INCLUDED IN THE SYSTEM'S WEBSITE:

[HTTPS://WWW.CENTRASTATE.COM/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/](https://www.centrastate.com/community-health-needs-assessment/)

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, QUESTION 11

CENTRASTATE HEALTHCARE SYSTEM, A PARTNER OF ATLANTIC HEALTH SYSTEM, IS A FULLY ACCREDITED, NOT-FOR-PROFIT, COMMUNITY-BASED HEALTH SYSTEM THAT PROVIDES COMPREHENSIVE HEALTH SERVICES IN THE CENTRAL NEW JERSEY REGION. CENTRASTATE HEALTHCARE SYSTEM CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") IN 2022 AND REVIEWED THE HEALTH PRIORITIES IDENTIFIED THROUGH THAT ASSESSMENT. THE ASSESSMENT INCORPORATED DATA FROM MULTIPLE SOURCES, INCLUDING PRIMARY RESEARCH THROUGH PHONE AND ONLINE SURVEYS WITH COMMUNITY LEADERS AND THE PUBLIC AT LARGE, AS WELL AS SECONDARY RESEARCH THROUGH VITAL STATISTICS AND OTHER EXISTING HEALTH RELATED DATA.

THE COMMUNITY DEFINED FOR THIS ASSESSMENT IS MONMOUTH COUNTY, IN GENERAL, AND WESTERN MONMOUTH COUNTY IN PARTICULAR.

TAKING INTO ACCOUNT THE TOP-IDENTIFIED NEEDS - AS WELL AS HOSPITAL RESOURCES AND OVERALL ALIGNMENT WITH THE HOSPITAL'S MISSION, GOALS AND STRATEGIC PRIORITIES - IT WAS DETERMINED AT THIS TIME THAT CENTRASTATE WOULD FOCUS ON DEVELOPING AND/OR SUPPORTING STRATEGIES AND INITIATIVES TO IMPROVE HEALTH IN THE AREAS OF:

- CANCER
- HEART DISEASE
- BEHAVIORAL HEALTH
- NUTRITION, PHYSICAL ACTIVITY & WEIGHT (DIABETES)

THIS IMPLEMENTATION PLAN REPRESENTS A COLLABORATION OF THE CHNA TEAM ACROSS THE HEALTH SYSTEM, AND WITH ITS COMMUNITY PARTNERS, AND WILL BE USED TO INFORM DECISIONS AND GUIDE EFFORTS TO IMPROVE COMMUNITY HEALTH AND WELLNESS. WHEREVER POSSIBLE CENTRASTATE WILL WORK WITH OTHER AGENCIES TO INFLUENCE THE SOCIAL DETERMINANTS OF HEALTH ("SDOH"), WHICH MAY IMPACT ACCESS TO HEALTHCARE, ADHERENCE TO HEALTH REGIMENS AND HEALTH OUTCOMES. FOLLOWING A DATA DRIVEN APPROACH AND A SERIES OF DELIBERATIVE MEETINGS, THE FOLLOWING GOALS, OBJECTIVES AND STRATEGIES WERE DEVELOPED.

CANCER

BRIEF DESCRIPTION OF NEED: THE INCIDENCE AND PREVALENCE OF CANCER IN THE CENTRASTATE SERVICE AREA SLIGHTLY EXCEEDS NEW JERSEY AND U.S. BENCHMARKS WITH THE MOST COMMON CANCERS CITED LOCALLY BEING BREAST, PROSTATE AND SKIN CANCER.

GOAL: ADDRESS BARRIERS TO CANCER CARE THROUGH DIRECT SERVICES AND PROGRAM DEVELOPMENT THAT FOCUS ON CLINICAL AREAS OF HIGHER UTILIZATION AND VARIOUS HEALTH DISPARITIES THAT MAY EXIST WITHIN THE COMMUNITY SERVED. PROMOTE HEALTH AND WELLNESS AMONG THE PATIENT'S CONTINUUM OF 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, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

DIAGNOSIS, TREATMENT, AND SURVIVORSHIP.

OBJECTIVES:

- PROVIDE TAILORED INFORMATION AND EDUCATIONAL PROGRAMS ON TOPICS RELATED TO EARLY DETECTION AND CANCER RISK REDUCTION FOR THE GENERAL, OLDER-ADULT, AND HIGH-RISK POPULATIONS.
- REDUCE RISK OF CANCER THROUGH HEALTHY LIFESTYLES INCLUDING NUTRITION AND PHYSICAL ACTIVITY.
- SMOKING CESSATION.
- IMPORTANCE OF EARLY DETECTION THROUGH SCREENINGS FOR BREAST, LUNG, COLORECTAL, PROSTATE, AND SKIN CANCERS.
- CLINICIANS ASSESS AND APPROPRIATELY REFER EACH PATIENT TO INTERNAL RESOURCES (SOCIAL WORKERS, NURSE NAVIGATORS, AND DIETICIANS) BASED ON THEIR FINANCIAL, PRACTICAL, AND PSYCHOSOCIAL NEEDS.
- INTERNAL RESOURCES WILL COLLABORATE WITH COMMUNITY HEALTH CLINICS TO CREATE STREAMLINED REFERRAL PATHWAYS FOR PATIENTS WITH FINANCIAL BARRIERS.
- PROVIDE RESOURCES AND MATERIALS TO HELP PATIENTS NAVIGATE FINANCIAL RESOURCES (MEDICAID ELIGIBILITY AND CHARITY CARE), COMMUNITY FOOD INSECURITY, NUTRITIONAL EDUCATION, RESOURCES, PHARMACEUTICAL ASSISTANCE, AND OTHER BARRIERS TO CARE.
- THE SOCIAL WORKERS, NURSE NAVIGATORS, AND/OR ONCOLOGY NURSING PROFESSIONALS CONDUCT A DISTRESS SCREENING ON PATIENTS AND REFER THEM TO APPLICABLE RESOURCES.
- REFERRALS ARE PROVIDED TO OUR BEHAVIORAL HEALTH SERVICES OR OTHER COMMUNITY RESOURCES FOR COUNSELING AND PSYCHIATRIC SERVICES.
- IDENTIFY PATIENTS WHO HAVE HEALTH INSURANCE BARRIERS AND REFER THEM TO THE PREAUTHORIZATION TEAM, CSMC PATIENT FINANCIAL SERVICES (PFS), AND/OR NJCEED PROGRAM.
- SOCIAL WORKERS MEET WITH AND COUNSEL EACH PATIENT IN NEED, DIRECTING AND REFERRING TO THE APPROPRIATE RESOURCES.

STRATEGIES:

- PROVIDE MULTILINGUAL EDUCATIONAL MATERIALS AND SCREENING REMINDERS TO PROMOTE PARTICIPATION IN PREVENTIVE AND SCREENING SERVICES.
- INCREASE CLINICIAN AND COMMUNITY AWARENESS ON ADVANCED CARE PLANNING AND PALLIATIVE CARE SERVICES.
- ESTABLISH PARTNERSHIPS WITH FOUNDATIONS AND GRANT PROGRAMS TO SUBSIDIZE DIAGNOSTIC AND TREATMENT COSTS FOR UNINSURED OR UNDERINSURED INDIVIDUALS.
 - INCLUDE FINANCIAL WELLNESS EDUCATION IN SURVIVORSHIP PROGRAMS TO SUPPORT LONGTERM RECOVERY AND REDUCE POST-TREATMENT ECONOMIC STRESS.
 - CSMC CONTINUES TO IDENTIFY RESOURCES AND OPPORTUNITIES THROUGH COMMUNITY PARTNERSHIPS TO PROVIDE ACCESS TO MENTAL HEALTH SERVICE(S).
 - INCLUDE MENTAL HEALTH NAVIGATION IN SURVIVORSHIP PLANNING.
 - CANCER NAVIGATORS, NURSING STAFF, REGISTERED DIETITIANS, AND SOCIAL WORKERS CONTINUALLY REASSESS A PATIENT'S BARRIERS TO CARE AT EACH

Part V Facility Information (continued)

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

ENCOUNTER.

- EDUCATE CLINICAL STAFF TO IDENTIFY AND REFER UNINSURED AND UNDERINSURED PATIENTS TO THE APPROPRIATE CARE TEAM.
- NOTIFY RESEARCH NURSES OF APPROPRIATE PATIENTS FOR STUDY, COSTCOM EAQ222CD, TO ASSIST WITH ONGOING TREATMENT/CARE PLAN.
- PROVIDE RESOURCES AND MATERIALS TO HELP PATIENTS NAVIGATE FINANCIAL RESOURCES.

HEART DISEASE

BRIEF DESCRIPTION OF NEED: HEART DISEASE IS THE LEADING CAUSE OF DEATH IN THE UNITED STATES. THE PREVALENCE OF HEART DISEASE AND HIGH BLOOD CHOLESTEROL IN THE CENTRASTATE SERVICE AREA SIGNIFICANTLY EXCEEDED NEW JERSEY AND U.S. BENCHMARKS.

GOAL: OFFER SUPPORTIVE SERVICES DESIGNED TO REDUCE CARDIOVASCULAR RISK FACTORS WHICH PUT A PERSON AT INCREASED RISK FOR CARDIOVASCULAR DISEASE.

OBJECTIVES:

- OFFER PROGRAMS AND SERVICES THAT HELP MODIFY BEHAVIORS SUCH AS CIGARETTE SMOKING, PHYSICAL INACTIVITY AND OVERWEIGHT/OBESITY.
- OFFER PROGRAMS/SCREENINGS THAT STRESS THE IMPORTANCE OF ADHERING TO TREATMENT FOR HIGH BLOOD PRESSURE AND CHOLESTEROL, BOTH CRITICAL FOR PREVENTING AND CONTROLLING CARDIOVASCULAR DISEASE.
- PROVIDE EDUCATION ON CHRONIC CONDITIONS INCLUDING RELATED TO HEART DISEASE SUCH AS HEART FAILURE, HYPERTENSION AND DIABETES.
- TRAIN PEOPLE TO IDENTIFY THE SIGNS AND SYMPTOMS OF A HEART ATTACK AND HOW TO PROVIDE EARLY HEART ATTACK CARE (EHAC).

STRATEGIES:

- ASSIST PATIENTS AND COMMUNITY MEMBERS IN OBTAINING AND UNDERSTANDING INFORMATION ABOUT HEART HEALTH:
 - MYCHART ELECTRONIC HEALTH RECORD PROMOTION AND UTILIZATION.
 - WORK WITH PCPS AND RN HEALTH COACHES TO LOWER PATIENTS' CARDIOVASCULAR RISK SCORES.
 - EARLY HEART ATTACK CARE TRAINING, HANDS ONLY CPR, AND BLS TRAINING.
- PROVIDE AND PROMOTE SCREENINGS ONSITE AND IN COMMUNITY SETTINGS FOR CARDIOVASCULAR DISEASE:
 - LIPID PROFILE, BLOOD PRESSURE, BLOOD SUGAR AND/OR A1C.
- PARTNER WITH COMMUNITY ORGANIZATIONS TO SUPPORT INITIATIVES RELATED TO NUTRITION EDUCATION AND ACCESS TO HEALTHY FOOD:
 - NEIGHBORHOOD CONNECTIONS TO HEALTH, FREEHOLD FAMILY HEALTH CENTER,

Part V Facility Information (continued)

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

FULFILL FOOD BANK.

- PROVIDE AND PROMOTE PHYSICAL ACTIVITY:
- LIVE LIFE WELL PROGRAMS.
- FITNESS CENTER DISEASE SPECIFIC PROGRAMS INCLUDING CARDIAC REHAB STEP DOWN PROGRAM.
- OFFER DIABETES PREVENTION PROGRAM TO REDUCE RISK FACTORS.

BEHAVIORAL HEALTH

BRIEF DESCRIPTION OF NEED: ABOUT HALF OF ALL PEOPLE IN THE UNITED STATES WILL BE DIAGNOSED WITH A MENTAL DISORDER AT SOME POINT IN THEIR LIFETIME AND MENTAL HEALTH AND PHYSICAL HEALTH ARE CLOSELY CONNECTED. A SIGNIFICANT NUMBER OF CENTRASTATE SERVICE AREA RESPONDENTS EXPERIENCE "FAIR" TO "POOR" MENTAL HEALTH AND HAVE BEEN DIAGNOSED WITH A DEPRESSIVE DISORDER. KEY INFORMANTS RANKED MENTAL HEALTH AS A TOP CONCERN.

IN TERMS OF SUBSTANCE USE DISORDERS, COMMUNITY MEMBERS REPORTED BINGE DRINKING (5 IF MALE)/4 (IF FEMALE) OR MORE DRINKS ON AN OCCASION, WHICH IS SIGNIFICANTLY HIGHER THAN THE NEW JERSEY AND U.S. BENCHMARKS. MOST PREVALENT IN THE 18 TO 39 AGE GROUP. NEARING 50 PERCENT OF COMMUNITY MEMBERS PERCEIVED SUBSTANCE ABUSE AS A MAJOR PROBLEM IN THE COMMUNITY. KEY INFORMANTS ALSO RANKED SUBSTANCE ABUSE AS A TOP CONCERN.

GOAL: OFFER A RANGE OF EDUCATION, PREVENTION AND TREATMENT OPTIONS FOR BEHAVIORAL HEALTH ISSUES AND SUBSTANCE USE DISORDERS.

OBJECTIVES:

- PROVIDE SUICIDE SCREENINGS TO EMERGENCY DEPARTMENT PATIENTS AND REFER TO TREATMENT AS NEEDED.
- EXPAND PRIMARY CARE PRACTITIONERS IN THE SERVICE AREA WHO CAN IDENTIFY AT-RISK INDIVIDUALS.
- GENERATE OUTPATIENT REFERRALS TO COMMUNITY PARTNERS AND ENCOURAGE TREATMENT WITHIN 30 DAYS OF HOSPITAL/ED DISCHARGE.
- PROMOTE AWARENESS OF CENTRASTATE'S CRISIS LINE AND BEHAVIORAL HEALTH RESOURCES.

STRATEGIES:

- PROMOTE AWARENESS OF CENTRASTATE'S CRISIS LINE AND BEHAVIORAL HEALTH RESOURCES.
- INCREASE COMMUNITY AWARENESS AND UNDERSTANDING ABOUT MENTAL HEALTH ISSUES THROUGH COMMUNITY EDUCATION EVENTS.
- COLLABORATE WITH SCHOOLS TO IMPROVE LIFE SKILLS AND DECISION-MAKING

Part V Facility Information (continued)

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

REGARDING DRUGS AND ALCOHOL.

- PROVIDE SELF-ASSESSMENTS TO IDENTIFY POTENTIAL BINGE-DRINKING PATTERNS.
- OFFER SUPPORT FOR SMOKING/VAPING CESSATION.
- PARTNER WITH COLLABORATING AGENCIES TO IDENTIFY AND ASSIST ED AND INPATIENTS, INCLUDING MATERNAL/CHILD PATIENTS, WITH SUBSTANCE USE DISORDERS FOR OUTPATIENT TREATMENT.
- REFER PATIENTS TO 12-STEP AND OTHER PEER-PROGRAMS AS NEEDED.

NUTRITION, PHYSICAL ACTIVITY AND WEIGHT (DIABETES)

BRIEF DESCRIPTION OF NEED: MANY PEOPLE DON'T EAT A HEALTHY DIET ARE AT AN INCREASED RISK FOR OBESITY, HEART DISEASE, STROKE, TYPE 2 DIABETES, AND OTHER HEALTH PROBLEMS. THE POPULATION OF MONMOUTH COUNTY HAS LOWER FOOD ACCESS, A HIGHER PREVALENCE OF TOTAL OVERWEIGHT (OVERWEIGHT AND OBESE), AND A HIGH PREVALENCE OF FAST-FOOD RESTAURANTS AS COMPARED TO THE NEW JERSEY AND U.S. BENCHMARKS. KEY INFORMANTS RANKED AS A TOP CONCERN.

GOAL: REFER COMMUNITY RESIDENTS WITH DIABETES OR SIGNIFICANT RISK FACTORS TO EXISTING DIABETES MANAGEMENT AND PREVENTION PROGRAMS, AND TO CLINICAL SERVICES, AS NEEDED. CENTRASTATE WILL SEEK TO IMPROVE AWARENESS OF DIABETES RISK FACTORS, WITH AN EMPHASIS ON RESIDENTS OF UNDERSERVED AREAS. IMPROVE ACCESS TO AND AWARENESS OF SERVICES IN THE CENTRASTATE SERVICE AREA.

OBJECTIVE:

- SCREEN 300+ PEOPLE FOR PRE-DIABETES - SPECIFICALLY TARGETING THOSE COMMUNITY MEMBERS AT INCREASED RISK FOR SEVERE COMPLICATIONS OF DIABETES.
- REFER PERSONS WITH DIABETES TO THE CDC-RECOGNIZED DIABETES PREVENTION PROGRAM AT CENTRASTATE OR ELSEWHERE FOR MANAGEMENT AND MONITORING OF NUTRITION AND PHYSICAL ACTIVITY.
- REFER PERSONS WITH DIABETES-TO-DIABETES SELF-MANAGEMENT EDUCATION (DSME) WITH A CERTIFIED DIABETES EDUCATOR.
- PROVIDE A1C SCREENINGS TO EMPLOYEES AND REFER THEM TO APPROPRIATE RESOURCES DEPENDING ON THE FINDINGS.
- CONTINUE TO GROW THE CLINICAL TEAM TO MEET THE DEMANDS OF THE COMMUNITY SEEKING CARE.
- NURSING TRACKS AND MONITORS DATA ON A QUARTERLY BASIS ON SEVERE HYPERGLYCEMIA AND SEVERE HYPOGLYCEMIA.

STRATEGIES:

- INCREASE AWARENESS ANNUAL MEDICARE EDUCATION BENEFIT FOR 2 HOURS OF DSME EDUCATION.
- COLLABORATE WITH EMPLOYERS TO OFFER A RANGE OF PREVENTIVE HEALTH PROGRAMS.

Part V Facility Information (continued)

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

- INCREASE ACCESS TO HEALTHY FOOD OPTIONS:
- FOOD BANK MOBILE FOOD PANTRY.
- PARTICIPATE IN FARMERS' MARKETS AND VOUCHER PROGRAMS.

- OFFER WEIGHT MANAGEMENT PROGRAMS TO THE COMMUNITY.
- OFFER EXERCISE AND FITNESS CLASSES.
- OFFER HEAD, NECK, AND THYROID SCREENINGS TO THE COMMUNITY.

- SUBMIT AN INPATIENT CONSULT TO CERTIFIED DIABETES EDUCATOR FOR:
- NEWLY DIAGNOSED PATIENTS AND FOR CONTINUED SUPPORT AND EDUCATION IF NON-ADHERENCE FOUND.
- AS NEEDED, FOR PROBLEM SOLVING (UNEXPLAINED HYPO OR HYPERGLYCEMIA, DECLINE IN CONTROL, CHANGES IN PHYSICAL OR EMOTIONAL HEALTH, CHANGE IN LIVING SITUATIONS, COGNITIVE OR PHYSICAL AND SELF-CARE ABILITY).
- CDE REVIEW OF REPORT FOR INPATIENTS WITH A1C>8 AND, IF APPROPRIATE, RECOMMEND A CONSULT.
- PCP/ HOSPITALIST RECOMMENDATION/BEST PRACTICE ADVISORY FOR OUTPATIENT DSME REFERRAL IF A1C>8.
- ISSUE GLUCOMETER AND TEST STRIPS TO PATIENTS IN NEED.

- SCREEN PATIENTS 18+ FOR SOCIAL DETERMINANTS OF HEALTH. REFER PATIENTS TO COMMUNITY-BASED RESOURCES VIA UNITE US AS NEEDED. HAND OFF TO POPULATION HEALTH SOCIAL WORKER TO HELP PATIENT NAVIGATE COMMUNITY-BASED RESOURCES POST DISCHARGE. POPULATION HEALTH SOCIAL WORKER TO HELP PATIENT NAVIGATE COMMUNITY-BASED RESOURCES POST DISCHARGE. RESOURCES POST DISCHARGE.

SCHEDULE H, PART V, SECTION B, QUESTION 16

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM, INC.; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). DUE TO CHARACTER LIMITATIONS, THE WEBSITE LISTED IN SCHEDULE H, PART V, SECTION B, QUESTION 16, IS THE HOME PAGE FOR THE SYSTEM. THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION AND PLAIN LANGUAGE SUMMARY ARE MADE WIDELY AVAILABLE ON THE ORGANIZATION'S WEBSITE. THESE DOCUMENTS CAN BE ACCESSED AT THE FOLLOWING PAGE INCLUDED IN THE SYSTEM'S WEBSITE:

[HTTPS://WWW.CENTRASTATE.COM/BILLING/](https://www.centrastate.com/billing/)

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	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

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). FEDERAL POVERTY GUIDELINES ARE INCLUDED IN THE CRITERIA FOR DETERMINING ELIGIBILITY FOR CHARITY AND DISCOUNTED CARE.

CENTRASTATE MEDICAL CENTER, INC. FOLLOWS THE NJ ADMINISTRATIVE CODE 8:31B AND CONSIDERS INDIVIDUAL ASSETS OVER \$7,500 AND FAMILY ASSETS OVER \$15,000 IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE. IN ADDITION, THERE IS A "SPEND DOWN" PROVISION ALLOWING FINANCIAL ASSISTANCE IF THE AMOUNT DUE FROM THE PATIENT IS GREATER THAN THE ASSETS OVER THE STATED THRESHOLDS.

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 6A

NOT APPLICABLE.

SCHEDULE H, PART I; QUESTION 7

WORKSHEETS 2 AND 3 WERE USED TO CALCULATE THE COST TO CHARGE RATIO FOR FINANCIAL ASSISTANCE AND UNREIMBURSED MEDICAID. ALL OTHER COSTS WERE EITHER OBTAINED FROM THE HOSPITAL'S COST ACCOUNTING, COST REPORTING OR GENERAL LEDGER SYSTEMS.

SCHEDULE H, PART I, QUESTION 7B

CENTRASTATE MEDICAL CENTER PARTNERED WITH MONMOUTH COUNTY AND THE STATE OF NEW JERSEY THROUGH A PROVIDER ASSESSMENT MECHANISM TO MAKE THE STATE OF NEW JERSEY MEDICAID PROGRAM HEALTHIER FOR ALL. THE PROGRAM INCREASES FINANCIAL RESOURCES PROVIDED TO CERTAIN HOSPITALS USING THE STATE OF NEW

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.

BETTER SERVE THE NEEDS IN THE COMMUNITY. THE ADDITIONAL FUNDS RECEIVED FROM THE PROGRAM DURING 2024 TOTALED APPROXIMATELY \$13M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; DIRECT OFFSETTING MEDICAID REVENUE. THE ASSOCIATED COUNTY OPTION EXPENSES ASSOCIATED WITH THE PROGRAM DURING 2024 TOTALED APPROXIMATELY \$7M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; MEDICAID TOTAL COMMUNITY BENEFIT EXPENSE. IN ADDITION, CENTRASTATE MEDICAL CENTER RECEIVED MEDICAID ADD-ON PAYMENTS AND QUALITY IMPROVEMENT PROGRAM - NEW JERSEY ("QIP-NJ") FUNDING TO SUPPORT CONTINUED POPULATION HEALTH IMPROVEMENT ACROSS NEW JERSEY. THE ADDITIONAL FUNDS RECEIVED FROM MEDICAID ADD-ON PAYMENTS AND QIP-NJ PROGRAM DURING 2024 TOTALED APPROXIMATELY \$473K AND \$1.4M; RESPECTIVELY, AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; DIRECT OFFSETTING MEDICAID REVENUE. IF CENTRASTATE MEDICAL CENTER DID NOT RECEIVE THESE ADDITIONAL FUNDS, THE NET COMMUNITY BENEFIT EXPENSE REPORTED ON SCHEDULE H, PART I; LINE 7K WOULD BE \$31,063,482 AND THE NET COMMUNITY BENEFIT PERCENTAGE REPORTED ON SCHEDULE H, PART I; LINE K WOULD BE 7.68%.

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 II

COMMUNITY BUILDING ACTIVITIES UNDERTAKEN BY CENTRASTATE MEDICAL CENTER, INC. IMPROVE THE MEDICAL AND SOCIOECONOMIC WELL-BEING OF OUR COMMUNITIES. THIS IS ACCOMPLISHED THROUGH SERVICE ON STATE AND REGIONAL ADVOCACY COMMITTEES AND BOARDS, VOLUNTEERISM WITH LOCAL COMMUNITY-BASED NON-PROFIT ADVOCACY GROUPS AND PARTICIPATION IN CONFERENCES AND OTHER EDUCATIONAL ACTIVITIES TO PROMOTE UNDERSTANDING OF THE ROOT CAUSES OF HEALTH CONCERNS. CENTRASTATE MEDICAL CENTER, INC. PROVIDES EDUCATIONAL MATERIALS, CONDUCTS COMMUNITY HEALTH FAIRS AND HOLDS HEALTH EDUCATION SEMINARS AND OUTREACH SESSIONS FOR ITS PATIENTS, COMMUNITY AND PROVIDERS. PHYSICIANS, NURSES AND OTHER HEALTHCARE PROFESSIONALS DEDICATE THEIR KNOWLEDGE AND TIME TO ENSURE THE COMMUNITY IS WELL EDUCATED ON TOPICS PROMOTING HEALTHY LIVING.

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 III, SECTION A; QUESTION 4

THE FOOTNOTE BELOW EXPLAINS THE ORGANIZATIONS METHODOLOGY WITH RESPECT TO
NET PATIENT SERVICE REVENUE.

CHANGES IN THE SYSTEM'S ESTIMATES OF IMPLICIT PRICE CONCESSIONS,
DISCOUNTS, CONTRACTUAL ADJUSTMENTS OR OTHER CHANGES TO EXPECTED PAYMENTS
FOR PERFORMANCE OBLIGATIONS SATISFIED IN PRIOR YEARS WERE NOT
SIGNIFICANT. PORTFOLIO COLLECTION ESTIMATES ARE UPDATED BASED ON
COLLECTION TRENDS. SUBSEQUENT CHANGES THAT ARE DETERMINED TO BE THE
RESULT OF AN ADVERSE CHANGE IN THE PATIENT'S ABILITY TO PAY (DETERMINED
ON A PORTFOLIO BASIS WHEN APPLICABLE) ARE RECORDED AS BAD DEBT EXPENSE.
BAD DEBT EXPENSE FOR THE YEARS ENDED DECEMBER 31, 2024 AND 2023 WAS NOT
SIGNIFICANT.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, SECTION B; QUESTION 8

MEDICARE COSTS WERE DERIVED FROM THE 2024 MEDICARE COST REPORT.

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

THE ORGANIZATION 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 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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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 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.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CHARITY CARE STANDARD

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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 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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

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

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

Part VI Supplemental Information

Provide the following information.

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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 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.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

- 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 "DUAL ELIGIBLES."

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

Part VI Supplemental Information

Provide the following information.

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

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 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

Part VI Supplemental Information

Provide the following information.

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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 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

Part VI Supplemental Information

Provide the following information.

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

DURING FINANCIAL COUNSELING, THE PATIENT IS SCREENED FOR ELIGIBILITY IN PUBLIC ASSISTANCE PROGRAMS, INCLUDING MEDICARE, MEDICAID, THE CATASTROPHIC ILLNESS FUND FOR CHILDREN, AND THE VIOLENT CRIME COMPENSATION BOARD. THE PATIENT IS ASSISTED WITH THE ENROLLMENT PROCESS FOR ANY PROGRAMS FOR WHICH THE PATIENT HAS PROBABLE ELIGIBILITY. BILLS MAY BE REDUCED FROM 20% TO 100% BASED UPON FINANCIAL ASSISTANCE CRITERIA. THE PATIENT RESPONSIBILITY PORTION OF 20%, 40%, 60% OR 80% IS BASED UPON RATES ESTABLISHED IN P.L. 1971 C. 136. SPEND DOWN ASSETS, THROUGH PARTIAL PAYMENT OF THE HOSPITAL BILL IS ALLOWED TO ENABLE THE PATIENT TO QUALIFY FOR FINANCIAL ASSISTANCE. THE AMOUNT FOR WHICH THE PATIENT IS RESPONSIBLE

Part VI Supplemental Information

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

AFTER PARTIAL FINANCIAL ASSISTANCE SHALL BE LIMITED TO 30% OF INCOME, PER NJAC 8:31B. UNINSURED PATIENTS WITH INCOME BETWEEN 301%-500% OF FEDERAL POVERTY LEVELS WILL BE PROVIDED A SIGNIFICANT DISCOUNT, IN ACCORDANCE WITH P.L. 1971 C. 136.

PATIENTS ARE BILLED ROUTINELY FOR UNPAID BALANCES AND SHALL BE NOTIFIED OF ANY IMPENDING COLLECTION OR LEGAL ACTION. PATIENTS ARE PROVIDED WITH CONTACT INFORMATION TO DISCUSS ANY QUESTIONS OR PROBLEMS. PATIENT BILLS INDICATE THE AVAILABILITY OF PAYMENT SCHEDULES. UPON PATIENT REQUEST, THE FOLLOWING PAYMENT SCHEDULE FOR BALANCES OF \$100 OR MORE MAY BE AGREED UPON: BALANCE OF \$100 - \$450 - MONTHLY PAYMENT = 1/4 OF THE BALANCE, \$451 - \$3,000 = 1/12 OF THE BALANCE, OVER \$3,000 = MINIMUM OF \$250 PER MONTH OR 1% OF GROSS INCOME/MONTH, WHICHEVER IS MORE. IF THE PATIENT AND MEDICAL CENTER REPRESENTATIVE MUTUALLY AGREE TO A PAYMENT SCHEDULE AND PAYMENTS ARE RECEIVED AS AGREED, FURTHER COLLECTION ACTION WILL NOT BE TAKEN. EXCEPTIONS TO THE ABOVE SCHEDULE MAY BE MADE BY PATIENT FINANCIAL SERVICES MANAGEMENT UPON THE REQUEST OF THE PATIENT, AND DOCUMENTATION BY THE PATIENT OF INABILITY TO PAY ACCORDING TO THE ESTABLISHED SCHEDULE.

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.

IF, AT THE END OF THE FINANCIAL SCREENING ATTEMPTS AND BILLING CYCLE, THE PATIENT HAS NOT BEEN APPROVED FOR FINANCIAL ASSISTANCE AND/OR IS NOT ON A PAYMENT PLAN, OR AFTER THERE HAS BEEN A DEFAULT IN PAYMENT, THE ACCOUNT WILL BE ASSIGNED TO A COLLECTION AGENCY AND/OR ATTORNEY FOR COLLECTIONS. PAYMENT PLAN, OR AFTER THERE HAS BEEN A DEFAULT IN PAYMENT, THE ACCOUNT WILL BE ASSIGNED TO A COLLECTION AGENCY AND/OR ATTORNEY FOR COLLECTIONS.

SCHEDULE H, PART VI; QUESTION 2

IN ADDITION TO THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS OUTLINED IN SCHEDULE H, SECTION B, QUESTIONS 1-12 AND SECTION C, THIS ORGANIZATION CONDUCTS A REVIEW OF KEY FACTOR INFORMATION ANNUALLY WHICH INCLUDES: A REVIEW OF HEALTHCARE UTILIZATION OF ITS SERVICE AREA POPULATION BY SERVICES (UROLOGY, CARDIOLOGY, OBSTETRICS, ETC.) FOR DETERMINING INCREASED OR DECREASED HEALTH NEEDS; HEALTHCARE SERVICES ESTIMATES AND FORECASTS (BOTH INPATIENT AND OUTPATIENT); ASSESSMENTS OF LOCAL DEMOGRAPHIC AND SOCIOECONOMIC INFORMATION; AND A REVIEW OF HEALTH

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

STATUS/NEEDS ASSESSMENTS AND STUDIES CONDUCTED BY EXTERNAL PARTIES. THE ORGANIZATION CONDUCTS AN EXTENSIVE SERVICE AREA PHYSICIAN NEEDS STUDY (BY PRIMARY AND SPECIALTY) EVERY THREE TO FIVE YEARS. SPECIFIC SPECIALTY NEEDS ARE CONDUCTED FOR IDENTIFIED GAPS IN SERVICE. THESE REVIEWS INFORM MEDICAL STAFF DEVELOPMENT AT THE MEDICAL CENTER TO ASSURE RESPONSIVENESS TO IDENTIFIED COMMUNITY NEEDS.

THE ORGANIZATION COLLABORATES WITH COMMUNITY PARTNERS TO PLAN AND CONDUCT HEALTH NEEDS ASSESSMENTS TO ASSESS AND ADDRESS HEALTH NEEDS OF THE COMMUNITY IT SERVES. THE WIDE-BASED COLLABORATIVE PARTNERSHIP RETAINS AN OUTSIDE CONSULTING FIRM TO ASSESS COMMUNITY DATA AND PERCEPTION. COMMUNITY DATA IS COLLECTED FROM COUNTY HEALTH PROFILES, HEALTH STATISTICS, DEMOGRAPHICS, SOCIOECONOMIC DATA, PHONE SURVEYS, PAPER SURVEYS AND FOCUS GROUPS. FROM THOSE ASSESSMENTS, COMMUNITY HEALTH IMPROVEMENT PLANS ARE PUBLISHED IDENTIFYING THE SPECIFIC HEALTH PRIORITIES. THROUGH A PLANNED AND ORGANIZED EFFORT, THE GROUP WORKS COLLECTIVELY TO ADDRESS THE PRIORITIES BY TAPPING THE RESOURCES OF THE COMMUNITY AND COLLABORATING ON INITIATIVES. CENTRASTATE HEALTHCARE

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SYSTEM, INC. ACTIVELY CONTRIBUTES TO THIS PROCESS AND ENGAGES IN THE IDENTIFIED PRIORITIES THAT MATCH ITS MISSION, EXPERTISE, RESOURCES, AND CAPACITY.

IN ADDITION TO THESE ORGANIZED NEEDS ASSESSMENT EFFORTS, VARIOUS CENTRASTATE HEALTHCARE SYSTEM, INC. LEADERSHIP ATTEND COMMUNITY MEETINGS WITH LOCAL PROVIDERS, LOCAL HEALTH DEPARTMENTS, LOCAL POLITICIANS, ORGANIZATIONS, AND COMMUNITY LEADERS TO DISCUSS THE HEALTH NEEDS OF THE POPULATION.

SCHEDULE H, PART VI; QUESTION 3

IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 501(R)(4) THE ORGANIZATION INFORMS AND EDUCATES PATIENTS AND PERSONS WHO MAY BE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY FOR FINANCIAL ASSISTANCE BY WIDELY PUBLICIZING VARIOUS DOCUMENTS.

THESE DOCUMENTS ARE WIDELY PUBLICIZED IN THE FOLLOWING WAYS:

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

(1) THE FINANCIAL ASSISTANCE POLICY ("FAP"), FINANCIAL ASSISTANCE APPLICATION ("APPLICATION") AND PLAIN LANGUAGE SUMMARY ("PLS") ARE ALL AVAILABLE ON-LINE AT THE FOLLOWING WEBSITE:

[HTTPS://WWW.CENTRASTATE.COM/BILLING/](https://www.centrastate.com/billing/)

(2) PAPER COPIES OF THE FAP, APPLICATION AND THE PLS ARE AVAILABLE UPON REQUEST WITHOUT CHARGE BY MAIL AND ARE AVAILABLE IN AT VARIOUS AREAS THROUGHOUT THE HOSPITAL FACILITY WHICH INCLUDE THE HOSPITAL ADMISSIONS DEPARTMENT AND THE OUTPATIENT AND EMERGENCY ROOM REGISTRATION AREAS.

(3) THE FAP, APPLICATION AND PLS ARE AVAILABLE IN ENGLISH AND IN THE PRIMARY LANGUAGE OF POPULATIONS WITH LIMITED PROFICIENCY IN ENGLISH ("LEP") THAT CONSTITUTE THE LESSER OF 1,000 INDIVIDUALS OR 5% OF THE COMMUNITY SERVED BY THE ORGANIZATION'S PRIMARY SERVICE AREA.

(4) ALL PATIENTS ARE OFFERED A COPY OF THE PLS AS PART OF THE INTAKE PROCESS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ADDITIONALLY, SIGNS OR DISPLAYS ARE CONSPICUOUSLY POSTED IN PUBLIC MEDICAL CENTER LOCATIONS INCLUDING ALL ADMISSIONS/REGISTRATION AREAS AND THE EMERGENCY DEPARTMENT, THAT NOTIFY AND INFORM PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE.

ALL BILLING STATEMENTS INCLUDE CONSPICUOUS WRITTEN NOTICE WHICH INFORMS PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE.

CENTRASTATE MEDICAL CENTER, INC. ALSO INFORMS AND NOTIFIES MEMBERS OF THE COMMUNITY SERVED ABOUT THE FAP.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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SCHEDULE H, PART VI; QUESTION 4

THE COMMUNITY IN WHICH CENTRASTATE MEDICAL CENTER, INC. SERVES IS CONCENTRATED IN MONMOUTH AND OCEAN COUNTIES. THE AVERAGE HOUSEHOLD INCOME IN THE SERVICE AREA IS \$122,727. THE MEDIAN HOUSEHOLD AGE IS 43. THE TOTAL POPULATION IN THE SERVICE AREA FOR 2020 IS 620,821 WITH 124,895 HOUSEHOLDS. THE RACIAL MIX OF THE SERVICE AREA POPULATION INCLUDES 79% WHITE, 6% ASIAN, 4% BLACK, 8% HISPANIC AND 3% MULTI-RACIAL/OTHER. GENDER MIX IS REPRESENTED BY 52% FEMALE AND 48% MALE.

SCHEDULE H, PART VI; QUESTION 5

CENTRASTATE CONTRIBUTES TO THE COMMUNITY THROUGH SUBSTANTIAL EMPLOYEE INVOLVEMENT WITH OTHER CHARITABLE AND PUBLIC ORGANIZATIONS SUCH AS GIRL SCOUTS OF THE JERSEY SHORE, WORK FORCE INVESTMENT BUREAU OF MONMOUTH COUNTY, VETERANS COMMUNITY ASSOCIATION, FINGERPRINT AMERICA, SUNRISE OPTIMIST CLUB, MONMOUTH-OCEAN DEVELOPMENT COUNCIL, MUSCULAR DYSTROPHY ASSOCIATION, FREEHOLD TOWNSHIP, MONMOUTH COUNTY CHILD ADVOCACY CENTER,

Part VI Supplemental Information

Provide the following information.

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE NATIONAL ORGANIZATION OF WOMEN BUSINESS OWNERS, RUTGERS UNIVERSITY,
CANCER INSTITUTE OF NEW JERSEY AND THE COLLEGE ADVISORY BOARDS OF
MONMOUTH COUNTY COMMUNITY COLLEGE AND BROOKDALE COMMUNITY COLLEGE.
EFFORTS INCLUDE INCREASING SERVICES TO CANCER SURVIVORS, COORDINATING
EFFORTS FOR FUND RAISING AND ORGANIZING STUDENT TRAINING PROGRAMS.

CENTRASTATE ALSO PROVIDES ADDITIONAL COMMUNITY BENEFIT THROUGH ITS 351
VOLUNTEERS WHO CONTRIBUTED OVER 34,320 HOURS OF SERVICE TO THEIR
COMMUNITY THROUGH OPPORTUNITIES IN EVERY HOSPITAL DEPARTMENT. VOLUNTEERS
SIGNIFICANTLY ENHANCE PATIENT AND FAMILY SUPPORT IN THE FOLLOWING SERVICE
CATEGORIES: INFORMATION DESKS, MAIL OR MESSENGER, CALL BELL, SPIRITUAL
CARE, ANIMAL ASSISTED THERAPY, SURGERY WAITING AREA, PATIENT TRANSPORT,
FOOD SERVICES, ASSISTED LIVING ACTIVITIES, GIFT SHOP, STERILE PROCESSING,
WAREHOUSE.

Part VI Supplemental Information

Provide the following information.

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI; QUESTION 6

OUTLINED BELOW IS A SUMMARY OF THE ENTITIES WHICH COMPRISE THE
CENTRASTATE HEALTHCARE SYSTEM, INC.:

NOT-FOR-PROFIT CENTRASTATE HEALTHCARE SYSTEM, INC. ENTITIES

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CENTRASTATE HOLDING COMPANY, INC.

CENTRASTATE HOLDING COMPANY, INC. ("CSHC") 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). THE ORGANIZATION OWNS A 49% MEMBERSHIP INTEREST IN CENTRASTATE HEALTHCARE SYSTEM, INC.; THE TAX-EXEMPT PARENT OF THE CENTRASTATE HEALTHCARE SYSTEM, INC. THE ORGANIZATION WAS CREATED AS PART OF THE CO-MEMBER AFFILIATION AGREEMENT UNDER WHICH ATLANTIC HEALTH

Part VI Supplemental Information

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

SYSTEM HOLDS A 51% MEMBERSHIP INTEREST IN CENTRASTATE HEALTHCARE SYSTEM, INC. PLEASE REFER TO THE ATLANTIC HEALTH SYSTEM, INC. (EIN: 22-3380375) FORM 990 AND ATLANTIC HEALTH SYSTEM, INC. GROUP RETURN (EIN: 65-1301877) FORM 990 FOR A LISTING AND DESCRIPTION OF ATLANTIC HEALTH SYSTEM, INC. RELATED ENTITIES.

CENTRASTATE HEALTHCARE SYSTEM, INC.

CENTRASTATE HEALTHCARE SYSTEM, INC. ("CSHS") IS THE TAX-EXEMPT PARENT OF THE CENTRASTATE HEALTHCARE SYSTEM, INC. ("SYSTEM"). THIS INTEGRATED HEALTHCARE DELIVERY SYSTEM CONSISTS OF A GROUP OF AFFILIATED HEALTHCARE ORGANIZATIONS. THE SOLE MEMBER OR STOCKHOLDER OF EACH ENTITY IS CSHS. THE SYSTEM IS AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS THROUGHOUT THE STATE OF NEW JERSEY AND IS 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).

Part VI Supplemental Information

Provide the following information.

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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CENTRASTATE MEDICAL CENTER, INC.

CENTRASTATE MEDICAL CENTER, INC. ("CSMC") IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY, IS A 276-BED ACUTE CARE FACILITY. CSMC IS RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS AN INTERNAL REVENUE CODE §501(C)(3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, CSMC 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, CSMC OPERATES CONSISTENTLY WITH THE CRITERIA OUTLINED IN IRS REVENUE RULING 69-545.

CENTER FOR AGING, INC.

CENTER FOR AGING, INC. ("APPLEWOOD") 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

Part VI Supplemental Information

Provide the following information.

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CODE §509(A)(2). ON JULY 2, 2024, AFTER APPROVAL FROM THE NEW JERSEY DEPARTMENT OF COMMUNITY AFFAIRS, CENTRASTATE HEALTHCARE SYSTEM, INC. COMPLETED THE SALE OF CERTAIN ASSETS, LIABILITIES, AND OPERATIONS OF CENTER FOR AGING, INC.

APPLEWOOD CONSISTED OF 281 INDEPENDENT APARTMENTS, 20 COTTAGES, 40 RESIDENTIAL HEALTH CARE UNITS, AND A 60-BED SKILLED NURSING FACILITY. THE ORGANIZATION PROVIDED FOR THE CARE OF THE ELDERLY. APPLEWOOD ALSO WENT OUT TO THE COMMUNITY THROUGH SENIOR'S FIRST, WHICH WAS A COMPLIMENTARY COMMUNITY OUTREACH AND HEALTHCARE EDUCATION PROGRAM FOR THOSE 60 YEARS AND OLDER IN A 25-MILE RADIUS OF FREEHOLD, NJ. THE CENTER'S PROGRAMS INCLUDED HEALTH FAIRS, BLOOD PRESSURE SCREENINGS, AND HEALTH EDUCATION AND RESENTATIONS ON PREVENTION AND TREATMENT. IN ADDITION, THERE WAS ALSO A SUPPORT GROUP FOR PARKINSON'S DISEASE AS WELL AS COMMUNITY SERVICE REFERRALS.

CENTRASTATE ASSISTED LIVING, INC.

Part VI Supplemental Information

Provide the following information.

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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CENTRASTATE ASSISTED LIVING, INC. ("MONMOUTH CROSSING") 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). MONMOUTH CROSSING OWNS AND OPERATES AN ASSISTED LIVING FACILITY FOR THE ELDERLY CONSISTING OF 76 UNITS WITH 16 UNITS FOR MEMORY CARE. THE FACILITY PROVIDES RESIDENTS WITH SPECIAL NEEDS AND MEMORY-RELATED DISEASES: RECEIVE COMPREHENSIVE, ATTENTIVE SERVICES IN A SAFE ENVIRONMENT WHERE SPECIALIZED ACTIVITIES AND PROGRAMMING ARE PROVIDED. MONMOUTH CROSSING OFFERS SERVICES TO RESIDENTS OF LOW AND MODERATE MEANS AND THOSE ON MEDICAID AS WELL.

HEALTHCARE AFFILIATES, INC.

HEALTHCARE AFFILIATES, INC. ("THE MANOR") IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL

Part VI Supplemental Information

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

REVENUE CODE §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO
INTERNAL REVENUE CODE §509(A)(2). THE MANOR PROVIDES SKILLED NURSING
SERVICES FOR 123 ELDERLY RESIDENTIAL UNITS INCLUDING SUBACUTE,
REHABILITATION AND I.V. THERAPY. THE FACILITY FOCUS IS ON HELPING
RESIDENTS ACHIEVE THEIR MAXIMUM POTENTIAL FOR INDEPENDENCE, PERSONAL
COMFORT AND QUALITY OF LIFE. THE MANOR IS MEDICARE/MEDICAID CERTIFIED,
LICENSED BY THE STATE OF NEW JERSEY, AND ACCREDITED BY THE JOINT
COMMISSION. THE FACILITY PROVIDES CHARITY CARE FOR THE INDIGENT WHERE
APPROPRIATE.

CENTRASTATE HEALTHCARE FOUNDATION, INC.

CENTRASTATE HEALTHCARE 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). THROUGH FUNDRAISING ACTIVITIES, THE ORGANIZATION
SUPPORTS THE CHARITABLE PURPOSES, PROGRAMS AND SERVICES OF CSMC; A

Part VI Supplemental Information

Provide the following information.

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

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 OR ABILITY TO PAY.

OTHER CENTRASTATE HEALTHCARE SYSTEM, INC. ENTITIES

=====

CENTRASTATE CARDIOLOGY ASSOCIATES, P.C.

CENTRASTATE CARDIOLOGY ASSOCIATES, P.C. IS AN ENTITY WHOSE NOMINEE SOLE SHAREHOLDER IS A LICENSED MD HOLDING SHARES FOR THE BENEFIT OF CSMC. THE ORGANIZATION IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY. THIS ENTITY PROVIDES MEDICAL SERVICES IN SUPPORT OF AND IN FURTHERANCE OF THE CHARITABLE TAX-EXEMPT PURPOSES OF CSMC.

CENTRASTATE HEALTHCARE SERVICES, 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.

CENTRASTATE HEALTHCARE SERVICES, INC. IS AN ENTITY WHOSE SOLE SHAREHOLDER IS CSHS. THE ORGANIZATION IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY AND PROVIDES HEALTHCARE SERVICES.

CENTRASTATE MEDICAL ASSOCIATES, P.C.

CENTRASTATE MEDICAL ASSOCIATES, P.C. IS AN ENTITY WHOSE NOMINEE SOLE SHAREHOLDER IS A LICENSED MD HOLDING SHARES FOR THE BENEFIT OF CSMC. THE ORGANIZATION IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY. THIS ENTITY PROVIDES MEDICAL SERVICES IN SUPPORT OF AND IN FURTHERANCE OF THE CHARITABLE TAX-EXEMPT PURPOSES OF CSMC.

CENTRASTATE SPECIALISTS, P.C.

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.

CENTRASTATE SPECIALISTS, P.C. IS AN ENTITY WHOSE NOMINEE SOLE SHAREHOLDER IS A LICENSED MD HOLDING SHARES FOR THE BENEFIT OF CSMC. THE ORGANIZATION IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY. THIS ENTITY PROVIDES MEDICAL SERVICES IN SUPPORT OF AND IN FURTHERANCE OF THE CHARITABLE TAX-EXEMPT PURPOSES OF CSMC. CENTRASTATE SPECIALISTS, P.C. IS AN ENTITY WHOSE NOMINEE SOLE SHAREHOLDER IS A LICENSED MD HOLDING SHARES FOR THE BENEFIT OF CSMC. THE ORGANIZATION IS LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY. THIS ENTITY PROVIDES MEDICAL SERVICES IN SUPPORT OF AND IN FURTHERANCE OF THE CHARITABLE TAX-EXEMPT PURPOSES OF CSMC. TAX-EXEMPT PURPOSES OF CSMC.

SCHEDULE H, PART VI; QUESTION 7

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

**SCHEDULE J
(Form 990)**

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

Attach to Form 990.

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

OMB No. 1545-0047

**Open to Public
Inspection**

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Employer identification number

22-1750190

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input checked="" type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in or receive payment from a supplemental nonqualified retirement plan?
- c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

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

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

Schedule J (Form 990) (Rev. 12-2024)

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
THOMAS W. SCOTT, FACHE 1 TRUSTEE-PRESIDENT/CEO	(i)	778,204.	334,647.	204,602.	30,500.	36,118.	1,384,071.	79,304.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JAMES J. MATERA, M.D. 2 SVP/MEDICAL DIRECTOR	(i)	508,719.	131,597.	7,524.	23,000.	18,227.	689,067.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
AMIT S. KHAROD, M.D. 3 TRUSTEE	(i)	NONE	NONE	37,000.	NONE	NONE	37,000.	NONE
	(ii)	512,925.	NONE	971.	37,024.	28,385.	579,305.	NONE
JOHN A. DELLOCONO 4 SVP/CFO (TERM 7/24)	(i)	358,289.	138,256.	5,495.	23,000.	25,497.	550,537.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KAREN B. FREEMAN, MSA 5 VP QUALITY & PATIENT SAFETY	(i)	307,527.	63,375.	34,064.	30,500.	9,735.	445,201.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
CATHLEEN G. JANZEKOVIC 6 VP, PATIENT SERVICES	(i)	339,117.	63,900.	3,564.	30,500.	2,142.	439,223.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
MOUSTAFA H. SHAFEY, M. 7 MEDICAL DIR. - MENTAL HLTH	(i)	346,352.	39,106.	1,854.	30,500.	9,841.	427,653.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DEBORAH ROMMEL-CONNORS 8 VP REVENUE CYCLE	(i)	267,927.	57,025.	34,064.	30,500.	22,525.	412,041.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JOHN BRANDEISKY, DPM 9 VP MED DIR QUALITY INFORMATICS	(i)	303,573.	58,500.	6,731.	23,000.	19,581.	411,385.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
HOWARD A. STEIN, M.D. 10 PHYSICIAN	(i)	314,505.	30,545.	2,992.	23,000.	8,433.	379,475.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DANIELLE VANWERT 11 VP CLINICAL SERVICES	(i)	254,957.	52,221.	14,224.	23,000.	32,052.	376,454.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
NANCY BARONE 12 CSHCF VP OF DEVELOPMENT	(i)	272,019.	51,547.	6,699.	30,500.	15,231.	375,996.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
LAURA L. SCHILARE, MBA 13 VP FINANCE	(i)	247,611.	47,156.	2,236.	23,000.	21,264.	341,267.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KIMBERLY H. SIMERS 14 AVP INTEGRATIVE HEALTH	(i)	248,369.	34,022.	1,534.	30,500.	8,853.	323,278.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KENNETH ENG, D.O. 15 TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	252,390.	NONE	2,772.	14,940.	511.	270,613.	NONE
VINCENT L. D'ELIA 16 VP MK PUB/GOV REL.(TERM 7/24)	(i)	179,487.	50,195.	2,852.	17,516.	11,297.	261,347.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE

Schedule J (Form 990) (Rev. 12-2024)

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JOHN P. DETULLIO, M.D. TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	207,067.	NONE	5.	25,356.	NONE	232,428.	NONE
2 DAVID A. DE SIMONE, ES FORMER KEY EMPLOYEE	(i)	NONE	NONE	130,000.	NONE	NONE	130,000.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
3	(i)							
	(ii)							
4	(i)							
	(ii)							
5	(i)							
	(ii)							
6	(i)							
	(ii)							
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE J, PART I; QUESTIONS 1A AND 1B

THE ORGANIZATION PROVIDED TRAVEL FOR COMPANIONS OF OFFICERS AND TRUSTEES FOR THE ANNUAL BOARD RETREAT AND CERTAIN EDUCATIONAL SEMINARS.

THE ORGANIZATION PAID SOCIAL CLUB DUES FOR THOMAS W. SCOTT FACHE, FABC, PRESIDENT/CEO OF THE ORGANIZATION, WHICH ARE PART OF HIS EMPLOYMENT AGREEMENT CONTRACT. UTILIZATION OF THIS MEMBERSHIP WAS PRIMARILY FOR THE BENEFIT OF CENTRASTATE MEDICAL CENTER, INC.

SCHEDULE J, PART I; QUESTION 4A

THE FOLLOWING INDIVIDUAL RECEIVED SEVERANCE DURING CALENDAR YEAR 2024 WHICH WAS INCLUDED IN HIS 2024 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: DAVID A. DE SIMONE, ESQ., \$130,000.

Part III Supplemental Information

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

SCHEDULE J, PART I; QUESTION 4B

THE AMOUNT REFLECTED IN COLUMN B(III) FOR THE FOLLOWING INDIVIDUAL INCLUDES PARTICIPATION IN A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN ("SERP") AS THE AMOUNT WAS NO LONGER SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. THE AMOUNT OUTLINED HEREIN WAS INCLUDED IN HIS 2024 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: THOMAS W. SCOTT, FACHE, FABC, \$199,788.

SCHEDULE J, PART I; QUESTION 7

CERTAIN INDIVIDUALS INCLUDED IN SCHEDULE J, PART II RECEIVED A BONUS DURING CALENDAR YEAR 2024 WHICH AMOUNTS WERE INCLUDED IN COLUMN B(II) HEREIN AND IN EACH INDIVIDUAL'S 2024 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES. PLEASE REFER TO THIS SECTION OF THE FORM 990, SCHEDULE J FOR THIS INFORMATION BY PERSON BY AMOUNT.

Part III Supplemental Information

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

SCHEDULE J, PART II; COLUMN F

THE AMOUNTS REPORTED IN SCHEDULE J, PART II, COLUMN (F) INCLUDE AMOUNTS REPORTED ON PRIOR YEARS' FORMS 990 IN SCHEDULE J, PART II, IN COLUMN (C) AS NON-TAXABLE UNVESTED DEFERRED COMPENSATION WITH A SUBSTANTIAL RISK OF COMPLETE FORFEITURE COMPONENT THAT IS NOW BEING REPORTED AGAIN ON THIS YEAR'S FORM 990. ACCORDINGLY, IN PRIOR YEARS THE INDIVIDUALS NEVER ACTUALLY RECEIVED ANY OF THESE UNVESTED AT-RISK BENEFIT AMOUNTS.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

22-1750190

CORE FORM, PART III, STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

CENTRASTATE MEDICAL CENTER ("CSMC") IS A 284-BED GENERAL ACUTE CARE HOSPITAL LOCATED IN FREEHOLD, MONMOUTH COUNTY, NEW JERSEY. CSMC IS RECOGNIZED BY THE INTERNAL REVENUE SERVICE ("IRS") AS AN INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, CSMC 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, CSMC OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

22-1750190

COMMUNITY; AND

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

THE OPERATIONS OF CSMC, AS SHOWN THROUGH THE FACTORS OUTLINED ABOVE AND OTHER INFORMATION CONTAINED HEREIN, CLEARLY DEMONSTRATE THE HOSPITAL PROVIDES SUBSTANTIAL COMMUNITY BENEFIT AND THAT THE USE AND CONTROL OF CSMC 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 INCIDENTALY.

CSMC'S SOLE CORPORATE MEMBER IS CENTRASTATE HEALTHCARE SYSTEM, INC. ("CSHS"). CSHS IS ALSO THE TAX-EXEMPT NEW JERSEY NON-PROFIT PARENT CORPORATION OF CENTRASTATE HEALTHCARE SYSTEM; AN INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). THE SOLE MEMBER OF EACH ENTITY IS EITHER CSHS OR ANOTHER CENTRASTATE HEALTHCARE SYSTEM AFFILIATE CONTROLLED OR OWNED BY CSHS. CENTRASTATE HEALTHCARE SYSTEM IS A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM CONSISTING OF A GROUP OF AFFILIATE HEALTHCARE ORGANIZATIONS.

CENTRASTATE HEALTHCARE SYSTEM IS A WORLD-CLASS PATIENT-FOCUSED ORGANIZATION COMPRISED OF A RENOWNED TEAM OF HEALTHCARE PROFESSIONALS

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

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

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

▶ Attach to Form 990 or 990-EZ.

2024

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

Employer identification number

CENTRASTATE MEDICAL CENTER, INC.

22-1750190

WORKING TOGETHER TO TRANSFORM THE LIVES OF THOSE IN THE COMMUNITY.

MISSION

=====

TO ENHANCE THE HEALTH AND WELL-BEING OF THE COMMUNITIES THROUGH THE
COMPASSIONATE DELIVERY OF QUALITY HEALTHCARE.

VISION

=====

AN ORGANIZATION OF CARING PROFESSIONALS TRUSTED AS THE COMMUNITY'S HEALTH
CARE SYSTEM OF CHOICE FOR CLINICAL EXCELLENCE.

RECOGNITION/QUALITY AWARDS

=====

MAGNET NURSING EXCELLENCE

CENTRASTATE IS IN AN ELITE GROUP OF 1 PERCENT OF HOSPITALS NATIONWIDE TO
EARN MAGNET RECOGNITION FROM THE AMERICAN NURSES CREDENTIALING CENTER
(ANCC) FIVE TIMES, ATTESTING TO ITS EXCELLENCE IN NURSING CARE.

MAGNET-DESIGNATED HOSPITALS ARE REGARDED AS THE PINNACLE OF NURSING
PRACTICE, LEADERSHIP AND INNOVATION.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
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HIGH-QUALITY STROKE CARE

CENTRASTATE RECEIVED THE AMERICAN HEART ASSOCIATION'S 2024 GET WITH THE GUIDELINES - STROKE GOLD PLUS WITH TARGET: STROKE HONOR ROLL ELITE AND TARGET: TYPE 2 DIABETES HONOR ROLL, RECOGNIZING THE COMMITMENT TO ENSURING STROKE PATIENTS RECEIVE THE MOST APPROPRIATE TREATMENT ACCORDING TO NATIONALLY RECOGNIZED, RESEARCH-BASED GUIDELINES. THE TARGET: STROKE HONOR ROLL ELITE LEVEL HIGHLIGHTS EFFORTS TO EXPEDITE THE TIME BETWEEN A PATIENT'S ARRIVAL AT THE HOSPITAL AND TREATMENT WITH CLOT-BUSTING MEDICATION. TARGET: TYPE 2 DIABETES HONOR ROLL: HIGHLIGHTS EFFORTS TO ENSURE PATIENTS WITH TYPE 2 DIABETES, WHO MIGHT BE AT HIGHER RISK FOR COMPLICATIONS, RECEIVE THE MOST UP-TO-DATE, EVIDENCE-BASED CARE WHEN HOSPITALIZED DUE TO STROKE.

HEART CARE EXPERTISE

CENTRASTATE WAS AWARDED CARDIAC CATH LAB ACCREDITATION WITH PCI BY THE AMERICAN COLLEGE OF CARDIOLOGY (ACC) FOR ITS DEMONSTRATED EXPERTISE AND COMMITMENT IN TREATING PATIENTS WHO COME TO A CARDIAC CATHETERIZATION LAB FOR CARE, INCLUDING DIAGNOSTIC CATHETERIZATIONS AND PERCUTANEOUS CORONARY INTERVENTION (PCI) PROCEDURES.

CENTRASTATE ALSO EARNED THE AMERICAN HEART ASSOCIATION'S 2024 GET WITH THE GUIDELINES - HEART FAILURE GOLD PLUS AWARD WITH TARGET: HEART FAILURE HONOR ROLL AND TARGET: TYPES 2 DIABETES HONOR ROLL FOR QUALITY OUTCOMES

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AND CONSISTENT ADHERENCE TO THE LATEST EVIDENCE-BASED TREATMENT
GUIDELINES.

PIONEER IN NEW JERSEY NURSE RESIDENCY EDUCATION

IN 2024, CENTRASTATE BECAME THE FIRST IN NEW JERSEY TO ATTAIN COMMISSION
ON COLLEGIATE NURSING EDUCATION ACCREDITATION FOR THE ENTRY-TO-PRACTICE
NURSE RESIDENCY PROGRAM.

EXCELLENCE IN CRITICAL CARE

CENTRASTATE MEDICAL CENTER'S CRITICAL CARE AND STEP-DOWN UNITS HAVE
EARNED THE NATIONAL SILVER-LEVEL BEACON AWARD FOR EXCELLENCE FROM THE
AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES (AACN), AN ORGANIZATION THAT
SHAPES PROGRESSIVE CRITICAL CARE NURSING PRACTICE.

DESIGNATED A SURGICAL QUALITY PARTNER

AMERICAN COLLEGE OF SURGEONS AWARDED CENTRASTATE THE NOVEL DISTINCTION OF
SURGICAL QUALITY PARTNER (SQP). BEING A SURGICAL QUALITY PARTNER MEANS
THAT AN INSTITUTION IS DEDICATED TO SURGICAL QUALITY AND IS COMMITTED TO
MAINTAINING THE HIGHEST STANDARDS IN SURGICAL CARE.

RANKED HIGH-PERFORMING IN THE TREATMENT OF ADULT MEDICAL CONDITIONS BY
U.S. NEWS & WORLD REPORT

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CENTRASTATE MEDICAL CENTER WAS RECOGNIZED BY U.S. NEWS & WORLD REPORT IN ITS 2024-2025 BEST HOSPITALS RANKINGS FOR ITS PERFORMANCE IN TREATING PROCEDURES AND MEDICAL CONDITIONS, RANKING HIGH PERFORMING IN THREE AREAS: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), PNEUMONIA, AND STROKE.

AMERICA'S BEST VASCULAR SURGEONS

THREE PHYSICIANS ON MEDICAL STAFF AT CENTRASTATE HAVE BEEN NAMED AMONG AMERICA'S BEST VASCULAR SURGEONS 2024 LIST BY NEWSWEEK AND STATISTA IN THEIR FIRST ANNUAL RANKING OF THE COUNTRY'S LEADING 200 VASCULAR SURGEONS.

HIGH-QUALITY MULTIPLE SCLEROSIS CARE

THE LINDA E. CARDINALE MULTIPLE SCLEROSIS CENTER AT CENTRASTATE WAS RECOGNIZED AS A CENTER FOR COMPREHENSIVE MS CARE THROUGH THE NATIONAL MULTIPLE SCLEROSIS SOCIETY'S PARTNERS IN MS CARE PROGRAM.

ORGAN AND TISSUE DONATION AWARENESS

IN RECOGNITION OF EFFORTS TO RAISE ORGAN AND TISSUE DONATION AWARENESS, CENTRASTATE WAS HONORED WITH THE 2024 DONATION CAMPAIGN PLATINUM AWARD FROM THE U.S. HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), AN AGENCY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE PLATINUM

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AWARD IS THE HIGHEST ACCOLADE GRANTED BY HRSA TO HOSPITALS THAT PROMOTE
ORGAN AND TISSUE DONATION.

CREATING AN OUTSTANDING EMPLOYEE EXPERIENCE

FOR THE FOURTH CONSECUTIVE YEAR, CENTRASTATE EARNED GREAT PLACE TO WORK
CERTIFICATION FROM GREAT PLACE TO WORK, A GLOBAL AUTHORITY ON WORKPLACE
CULTURE, EMPLOYEE EXPERIENCE AND PROVEN LEADERSHIP BEHAVIORS.

EMPLOYEE FEEDBACK AND INDEPENDENT ANALYSIS DETERMINED THE SCORES FOR THIS
RESEARCH-BACKED CERTIFICATION.

COMMITMENT TO ADVANCING EMPLOYEE HEALTH AND WELLNESS

CENTRASTATE HEALTHCARE SYSTEM WAS AWARDED THE GOLD WELL WORKPLACE AWARD
BY THE WELLNESS COUNCIL OF AMERICA (WELCOA), A PRESTIGIOUS RECOGNITION
DESIGNATES CENTRASTATE AS ONE OF AMERICA'S HEALTHIEST COMPANIES.

A HIGHER LEVEL MOST WIRED ORGANIZATION

CENTRASTATE EARNED 2024 COLLEGE OF HEALTHCARE INFORMATION MANAGEMENT
EXECUTIVES (CHIME) DIGITAL HEALTH MOST WIRED RECOGNITION AS A CERTIFIED
LEVEL 9 ACUTE CARE ORGANIZATION. CENTRASTATE HAS ACHIEVED MOST WIRED
DESIGNATION FOR 14 OF THE LAST 15 YEARS, ADVANCING THIS YEAR FROM A PRIOR
LEVEL 8 ACHIEVEMENT.

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SUPPLY CHAINS OF DISTINCTION AWARD

RECOGNIZED BY HEALTHCARE SUPPLY CHAIN LEADER GLOBAL HEALTHCARE EXCHANGE
(GHX) AS A RECIPIENT OF THE INAUGURAL 2023 SUPPLY CHAINS OF DISTINCTION
AWARD, HONORING HOSPITALS AND HEALTH SYSTEMS THAT EXCELLED IN DRIVING
BEST-IN-CLASS SUPPLY CHAIN OPERATIONS.

THE MANOR HEALTH & REHABILITATION

- RANKED HIGH PERFORMING FOR SHORT-TERM REHAB IN US NEWS & WORLD REPORT
BEST NURSING HOMES RANKINGS FOR FIVE YEARS IN A ROW.

MONMOUTH CROSSING

- ATTAINED DEMENTIA CAPABLE WORKFORCE LEADER RECOGNITION BY DEMENTIA CARE
SPECIALISTS AT CRISIS PREVENTION INSTITUTE (CPI).

ACCREDITATIONS AND RECOGNITIONS

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- THE JOINT COMMISSION

HEART FAILURE CERTIFICATION

PALLIATIVE CARE CERTIFICATION

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STROKE CERTIFICATION

TOTAL JOINT CERTIFICATION (HIP AND KNEE)

WOUND CARE CERTIFICATION

- AMERICAN ACADEMY OF SLEEP MEDICINE

SLEEP CENTER ACCREDITATION

- AMERICAN ASSOCIATION FOR CARDIOVASCULAR AND PULMONARY REHABILITATION

CARDIAC AND PULMONARY REHABILITATION CERTIFICATION

- AMERICAN COLLEGE OF CARDIOLOGY

CHEST PAIN CENTER ACCREDITATION

CARDIAC CATH LAB ACCREDITATION WITH PCI

CORE FORM, PART III, STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

- AMERICAN COLLEGE OF RADIOLOGY

RADIATION ONCOLOGY ACCREDITATION

DIAGNOSTIC IMAGING CENTER OF EXCELLENCE

CT ACCREDITATION

LOW-DOSE CT LUNG CANCER SCREENING CENTER OF EXCELLENCE

LUNG CANCER SCREENING CENTER DESIGNATION

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ULTRASOUND ACCREDITATION

NUCLEAR MEDICINE ACCREDITATION

COMPREHENSIVE BREAST IMAGING CENTER

MAMMOGRAPHY ACCREDITATION

STEREOTACTIC BREAST BIOPSY ACCREDITATION

- AMERICAN COLLEGE OF SURGEONS

COMMISSION ON CANCER - NATIONAL ACCREDITATION, ONCOLOGY SERVICE LINE,

CENTRASTATE HEALTHCARE SYSTEM

NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS - THE STAR AND BARRY

TOBIAS WOMEN'S HEALTH CENTER

- AMERICAN DIABETES ASSOCIATION

CERTIFICATION FOR MEETING NATIONAL STANDARDS FOR DIABETES SELF-MANAGEMENT

EDUCATION

AMERICAN HEART ASSOCIATION

HEART FAILURE GOLD PLUS AWARD WITH TARGET: HEART FAILURE HONOR ROLL AND

TARGET: TYPES 2 DIABETES HONOR ROLL

STROKE GOLD PLUS WITH TARGET: STROKE HONOR ROLL ELITE AND TARGET: TYPE 2

DIABETES HONOR ROLL

- AMERICAN NURSES CREDENTIALING CENTER

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MAGNET STATUS (FIVE-TIME DESIGNATION)

- CENTERS FOR DISEASE CONTROL AND PREVENTION

PRELIMINARY RECOGNITION FOR DIABETES PREVENTION PROGRAM (ONLINE)

- CEO ROUNDTABLE ON CANCER

CEO CANCER GOLD STANDARD

- SURGICAL REVIEW CORPORATION

BARIATRIC CENTER OF EXCELLENCE

- COMMISSION ON COLLEGIATE NURSING EDUCATION

ENTRY-TO-PRACTICE NURSE RESIDENCY PROGRAM

AFFILIATIONS

- AMERICAN PHYSICAL THERAPY ASSOCIATION CLINICAL EDUCATION CENTER

- ANDREWS UNIVERSITY

- BROOKDALE COMMUNITY COLLEGE: SCHOOLS OF NURSING AND ALLIED HEALTH,

MEDICAL TECHNOLOGY AND RESPIRATORY THERAPY

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- BOSTON UNIVERSITY
- BURLINGTON COUNTY COLLEGE
- THE COLLEGE OF NEW JERSEY
- JERSEY SHORE MEDICAL CENTER FOR OUTREACH RENAL DIALYSIS SERVICE
- KEAN UNIVERSITY
- MERCER COUNTY COMMUNITY COLLEGE
- MIDDLESEX COUNTY COLLEGE
- MONMOUTH COUNTY VOCATIONAL SCHOOL
- MONMOUTH-OCEAN HOSPITAL SHARED SERVICE ASSOCIATION
- MONMOUTH UNIVERSITY
- NATIONAL NETWORK OF LIBRARIES OF MEDICINE
- NEUMANN COLLEGE
- PENNSYLVANIA STATE UNIVERSITY
- PRINCETON THEOLOGICAL SEMINARY
- QUINNIPIAC COLLEGE
- ROWAN COLLEGE AT BURLINGTON COUNTY
- RUTGERS UNIVERSITY
- SAINT ELIZABETH COLLEGE SCHOOL OF NUTRITION AND HOME ECONOMICS
- SAINT FRANCIS MEDICAL CENTER SCHOOL OF NURSING
- PENNSYLVANIA STATE UNIVERSITY
- STOCKTON UNIVERSITY
- TEMPLE UNIVERSITY
- THOMAS EDISON STATE COLLEGE: SCHOOL OF NURSING
- ULTRASOUND DIAGNOSTIC SCHOOL OF NEWARK
- UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY - NEWARK

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- UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY
- SCHOOL OF HEALTH-RELATED PROFESSIONALS IN CAMDEN AND LEAN
- UNION COUNTY COLLEGE
- UNIVERSITY OF CONNECTICUT
- UNIVERSITY OF DELAWARE
- UNIVERSITY OF SCRANTON

MEMBER OF

- AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
- AMERICAN HOSPITAL ASSOCIATION
- AMERICAN SOCIETY OF CLINICAL PATHOLOGY
- NATIONAL DISASTER MEDICAL SYSTEM
- NATIONAL LYMPHEDEMA NETWORK
- NEW JERSEY ASSOCIATION OF MENTAL HEALTH AGENCIES
- NEW JERSEY ASSOCIATION OF NONPROFIT HOMES FOR THE AGING
- NEW JERSEY HOSPITAL ASSOCIATION
- NEW JERSEY SOCIETY OF HEALTH SYSTEM PHARMACISTS
- SCHIZOPHRENIA FOUNDATION OF NEW JERSEY
- UNDERSEA & HYPERBARIC MEDICAL SOCIETY

LABORATORY CERTIFIED BY

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- AMERICAN COLLEGE OF CLINICAL PATHOLOGISTS

NURSING

- CENTRASTATE MEDICAL CENTER WAS AWARDED MAGNET STATUS IN 2005 &
RE-DESIGNATED IN 2020 BY THE AMERICAN NURSES

- CREDENTIALING CENTER (ANCC) OF THE AMERICAN NURSES ASSOCIATION.

- CSMC IS AN APPROVED PROVIDER OF CONTINUING EDUCATION BY THE NEW JERSEY
STATE NURSES ASSOCIATION, PROVIDER NUMBER: P102-9/2001-2003. NJNSA IS
ACCREDITED BY THE ANCC COMMISSION ON ACCREDITATION OF THE AMERICAN
NURSES' ASSOCIATION.

LICENSED BY

- NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

APPROVED BY

- AMERICAN DENTAL ASSOCIATION FOR CONTINUING MEDICAL EDUCATION

- AMERICAN MEDICAL ASSOCIATION FOR CONTINUING MEDICAL EDUCATION

SPECIALIZED SERVICES

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CSMC OFFERS A FULL RANGE OF CLINICAL AND DIAGNOSTIC SERVICES TO MEET THE
DIVERSE HEALTHCARE NEEDS OF THE GROWING COMMUNITIES WE SERVE.

CARDIAC SERVICES

SERVICES AND PROGRAMS INCLUDE: THE THOMAS J. BLANCHET CARDIAC DIAGNOSTIC
CENTER, CARDIAC CATHETERIZATION LAB, CARDIAC REHABILITATION CENTER AND
THE GLORIA SAKER WOMEN'S HEART PROGRAM.

STATESIR CANCER CENTER

CSMC'S MULTIDISCIPLINARY, INTEGRATED APPROACH TO CANCER TREATMENT ENSURES
THAT OUR PATIENTS RECEIVE COMPASSIONATE CARE AND SUPPORT-MEDICAL,
EDUCATIONAL, EMOTIONAL AND SPIRITUAL. CSMC IS ACCREDITED BY THE AMERICAN
COLLEGE OF SURGEONS COMMISSION ON CANCER (COC) AS WELL AS THE NATIONAL
ACCREDITATION PROGRAM FOR BREAST CENTERS (NAPBC), THE AMERICAN COLLEGE OF
RADIOLOGY (ACR) FOR RADIATION ONCOLOGY, DIAGNOSTIC RADIOLOGY AND
MAMMOGRAPHY. CENTRASTATE HAS BEEN DESIGNATED AS A BREAST IMAGING CENTER
OF EXCELLENCE (BICOE) AND A DIAGNOSTIC IMAGING CENTER OF EXCELLENCE
(DICOE). SERVICES INCLUDE:

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- CANCER NAVIGATOR PROGRAM
- CANCER REHABILITATION
- CLINICAL TRIALS
- COLORECTAL CANCER PROGRAM (ROBOTIC SURGERY)
- COMPREHENSIVE BREAST CARE PROGRAM
- COMPREHENSIVE LUNG PROGRAM
- INFUSION THERAPY SERVICES
- LYMPHEDEMA CENTER
- MEDICAL ONCOLOGY - CHEMOTHERAPY AND IMMUNOTHERAPY SERVICES
- PALLIATIVE/HOSPICE SERVICES
- PROSTATE CANCER PROGRAM (ROBOTIC SURGERY)
- RADIATION ONCOLOGY (INCLUDING IMRT, IGRT, RADIOSURGERY, HDR, CONE BEAM THERAPY)
- GENETIC TESTING AND COUNSELING
- SURGICAL ONCOLOGY PROGRAM

CRITICAL CARE UNIT

OUR UNIT OFFERS ENHANCED INFECTION CONTROL FEATURES SUCH AS ELECTRONIC
PRIVACY PANELS AND A DEDICATED AIR FILTRATION SYSTEM THAT HELPS TO
CONTAIN INFECTIOUS CONDITIONS.

EMERGENCY SERVICES DEPARTMENT

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OUR GOAL IS FOR YOU TO SEE A NURSE WITHIN 15 MINUTES AND A CLINICIAN
WITHIN 30 MINUTES. THE ED ALSO OFFERS 24/7 PEDIATRIC EMERGENCY COVERAGE
AND IS DESIGNATED AS AN ADVANCED PRIMARY STROKE CENTER BY THE JOINT
COMMISSION AND THE NEW JERSEY DEPARTMENT OF HEALTH.

STATESIR FAMILY ACUTE CARE FOR ELDERLY UNIT

THIS UNIT HELPS SENIOR PATIENTS RECOVER FROM ILLNESS OR INJURY BY
PROVIDING QUALITY, SAFE, AND SEAMLESS CARE. THE ACE UNIT IS COMPRISED OF
DEDICATED AND TRAINED HEALTH CARE PROFESSIONALS WHO PROVIDE SUPPORT AND
INFORMATION TO PATIENTS AND FAMILY TO RETURN HOME, AVOID COMPLICATIONS,
AND POSSIBLY PREVENT FUTURE HOSPITALIZATIONS. OUR GOAL IS TO HELP
PATIENTS STAY STRONG, MOBILE, AND INDEPENDENT WHILE PROVIDING THE BEST
POSSIBLE CARE.

LABORATORY

THE LABORATORY IS ACCREDITED BY THE AMERICAN COLLEGE OF CLINICAL
PATHOLOGISTS AND THE AMERICAN ASSOCIATION OF BLOOD BANKS. IT IS
CONVENIENTLY LOCATED NEAR OUTPATIENT REGISTRY AND OFFERS STATE-OF-THE-ART
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MATERNITY

CSMC'S MATERNITY UNIT ALLOWS MOTHERS TO EXPERIENCE LABOR, DELIVERY, AND RECOVERY IN A WARM, PRIVATE, HOME-LIKE ROOM EQUIPPED FOR NORMAL AND COMPLICATED DELIVERIES. AFTER DELIVERY, WHEN MOTHERS AND THEIR NEWBORNS ARE READY, THEY ARE MOVED TO A PRIVATE SUITE IN THE FIRST IMPRESSIONS MATERNITY PAVILION, DEDICATED TO POSTPARTUM CARE. CSMC ALSO HAS A SPECIAL CARE NURSERY WHICH PROVIDES PREMATURE BABIES WITH TREATMENT AND CARE BY A TEAM OF TRAINED PROFESSIONALS. ALL SPECIAL NEEDS ARE MET 24 HOURS A DAY UNDER THE SUPERVISION OF A NEONATOLOGIST. THE FACILITY IS DESIGNATED BY THE STATE AS A COMMUNITY PERINATAL CENTER INTERMEDIATE AND HAS RECEIVED THE IBCLC CARE AWARD FROM THE INTERNATIONAL BOARD OF LACTATION CONSULTANT EXAMINERS (IBLCE) AND THE INTERNATIONAL LACTATION CONSULTANT ASSOCIATION (ILCA) FOR HIRING INTERNATIONAL BOARD-CERTIFIED LACTATION CONSULTANTS (IBCLCS).

PEDIATRICS

CSMC'S PEDIATRIC DEPARTMENT EMPHASIZES FAMILY-CENTERED CARE, WITH 24-HOUR VISITATION FOR PARENTS. THE PATIENT ROOMS INCLUDE BEDS FOR PARENTS OR GUARDIANS WHO WISH TO STAY OVERNIGHT AND PLAY AREAS FOR CHILDREN.

PSYCHIATRIC SERVICES

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OFFERS AN INPATIENT UNIT THAT PROVIDES CARE FOR THOSE NEEDING ACUTE
PSYCHIATRIC/MENTAL HEALTHCARE, 24-HOUR PSYCHIATRIC EMERGENCY ASSESSMENTS
THROUGH THE EMERGENCY ROOM, AND A 24-HOUR CRISIS HOTLINE.

ELECTROCONVULSIVE THERAPY (ECT SERVICES ARE ALSO AVAILABLE ON AN
OUTPATIENT OR INPATIENT BASIS.

ORTHOPEDICS

PROGRAMS AND SERVICES INCLUDE: THE TOTAL JOINT CENTER OF NEW JERSEY FOR
KNEE/HIP REPAIR AND REPLACEMENT; SHOULDER REPAIR AND REPLACEMENT; HAND
AND FOOT SURGERY; THE SPINE INSTITUTE OF CENTRAL JERSEY AND NON-SURGICAL
THERAPIES FOR OTHER ORTHOPEDIC PROBLEMS. THE TOTAL JOINT CENTER OF NEW
JERSEY IS ACCREDITED BY THE JOINT COMMISSION.

CORE FORM, PART III, STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

OUTPATIENT NUTRITION CENTER

OFFERS INDIVIDUAL NUTRITION COUNSELING WITH A REGISTERED DIETITIAN FOR
CHILDREN AND ADULTS. INCLUDES COUNSELING SESSIONS FOR WEIGHT MANAGEMENT,
CARDIAC, RENAL, HEPATIC, GASTROINTESTINAL PROBLEMS, AND OTHERS.

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RADIOLOGY

CAPABILITIES INCLUDE X-RAY, ULTRASOUND, COMPUTED TOMOGRAPHY (CT) SCAN AND
NUCLEAR MEDICINE. PRINCETON RADIOLOGY ASSOCIATES ALSO HOUSES A POSITRON
EMISSION TOMOGRAPHY (PET)/CT SCANNER FOR DIAGNOSING CANCER AND OTHER
DISEASES OR CONDITIONS, AND AN OPEN BORE MRI.

OCEANFIRST REHABILITATION CENTER

OUR FULLY EQUIPPED CENTER OFFERS PHYSICAL, OCCUPATIONAL AND SPEECH
THERAPY. INPATIENT AND OUTPATIENT SERVICES ARE OFFERED DAILY. SPECIALIZED
SERVICES INCLUDE: LINDA E. CARDINALE MS CENTER, CENTRAL JERSEY WOUND
TREATMENT CENTER WITH LYMPHEDEMA PROGRAM, CONTINENCE PROGRAM, SWALLOWING
DISORDER THERAPY, SPORTS MEDICINE AND AQUATIC THERAPY, INCLUDING A
HYDROWORX POOL.

PROGRESSIVE CARE UNIT

THIS UNIT TREATS HEART FAILURE PATIENTS, AS WELL AS TRANSITIONS PATIENTS
FROM THE CRITICAL CARE UNIT. FOLLOWING A HOSPITAL DISCHARGE, A REGISTERED
NURSE HEALTH COACH IS AVAILABLE TO WORK WITH PATIENTS TO HELP THEM BECOME
MORE KNOWLEDGEABLE AND INDEPENDENT IN MANAGING DIET, MEDICATIONS AND

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LIFESTYLE CHANGES. PATIENTS ALSO LEARN HOW TO MOST EFFECTIVELY WORK WITH
THEIR PRIMARY CARE PROVIDER FOR CONTINUED SUPPORT. ADDITIONAL SUPPORT
INCLUDES A FREE NURSE ADVICE. PATIENTS CAN CALL THE NURSE ADVICE LINE AND
SPEAK TO OUR CARDIAC COORDINATOR FOR ANSWERS AND HELP WITH ANY NEEDS THE
HEART FAILURE PATIENT MAY HAVE.

SHORT STAY UNIT

A SHORT STAY UNIT IS AVAILABLE FOR PATIENTS WHO DO NOT REQUIRE AN
OVERNIGHT STAY. OUR SAME DAY SURGERY CENTER PERFORMS A VARIETY OF
SURGICAL AND ENDOSCOPY PROCEDURES ON A MEDICAL OUTPATIENT BASIS.

SURGICAL SERVICES

CSMC'S SURGICAL SERVICES ARE DELIVERED IN STATE-OF-THE-ART FACILITIES BY
HIGHLY TRAINED PHYSICIANS AND NURSES. PATIENTS RECEIVE COMPREHENSIVE
SURGICAL SUPPORT FOR DIAGNOSTIC, THERAPEUTIC AND PALLIATIVE INTERVENTION
IN THE FOLLOWING AREAS: GENERAL SURGERY, BARIATRIC SURGERY, BREAST,
COLORECTAL, ENDOVASCULAR SURGERY, GASTROINTESTINAL SURGERY, NEUROSURGERY,
OBSTETRICS/GYNECOLOGY, OPHTHALMOLOGY, EAR, NOSE AND THROAT, ORTHOPEDICS
(INCLUDING KNEE AND HIP REPLACEMENTS AT THE TOTAL JOINT CENTER OF NEW
JERSEY AT CSMC), PLASTIC, PODIATRIC, AND THORACIC SURGERY.

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THE STAR AND BARRY TOBIAS WOMEN'S HEALTH CENTER

OFFERS SCREENINGS, DIGITAL MAMMOGRAMS, COMPUTER-AIDED DETECTION (CAD),
ULTRASOUND MAMMOTONE BIOPSY, STEREOTACTIC NEEDLE BIOPSY, HEALTH
EDUCATION, BONE DENSITOMETRY, AND INDIVIDUALIZED HEALTH COUNSELING ON A
NUMBER OF TOPICS FOR WOMEN. THE CENTER IS CERTIFIED BY THE AMERICAN
COLLEGE OF RADIOLOGY; HAS BEEN NAMED A BREAST IMAGING CENTER OF
EXCELLENCE FOR PROVIDING HIGH-QUALITY MAMMOGRAMS AND OTHER SERVICES; AND
HAS BEEN NAMED A PINK RIBBON FACILITY BY HOLOGIC FOR PROVIDING EXCELLENCE
IN BREAST HEALTH.

SPECIALIZED CENTERS AND OTHER SERVICES

CSMC OFFERS SPECIALIZED DIAGNOSTIC AND TREATMENT SERVICES AT ITS CENTER
FOR SLEEP DISORDERS AND COMPREHENSIVE LUNG PROGRAM. OTHER SPECIALTY
SERVICES INCLUDE RESPIRATORY THERAPY FOR PULMONARY DIAGNOSTIC PROCEDURES
AND REHABILITATION, AND ONCOLOGY SERVICES, INCLUDING CHEMOTHERAPY,
SUPPORT GROUPS AND HEMODIALYSIS, PODIATRIC SERVICES, PAIN MANAGEMENT, AND
PALLIATIVE CARE.

FREEHOLD FAMILY HEALTH CENTER

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THE FREEHOLD FAMILY HEALTH CENTER IS A UNIQUE COLLABORATIVE INITIATIVE WITH THE VISITING NURSE ASSOCIATION (VNA) HEALTH GROUP, VNACJ COMMUNITY HEALTH CENTER, INC. (CHS AND RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL THROUGH THE FAMILY MEDICINE RESIDENCY PROGRAM AT CSMC. THE FACILITY IS ACCESSIBLE TO ALL MEMBERS OF THE COMMUNITY, INCLUDING UNDERSERVED POPULATIONS. BILINGUAL STAFF ARE AVAILABLE TO ASSIST WITH ALL SERVICES. SERVICES INCLUDE:

- COMPREHENSIVE PRIMARY AND SPECIALTY CARE, INCLUDING GERIATRICS, PRENATAL AND BEHAVIORAL HEALTH SERVICES;
- COMMUNITY HEALTH PROGRAMS SUCH AS WIC;
- PROGRAMMING BY THE COUNTY COUNCILS FOR YOUNG CHILDREN; AND
- CANCER EDUCATION AND EARLY DETECTION PROGRAMS.

COMMUNITY-BASED PROGRAMS
=====

GOOD STEWARDSHIP THROUGH SOLAR

CSMC RECENTLY CELEBRATED THE COMPLETION OF A SOLAR CARPORT INSTALLATION IN PARKING AREAS AROUND THE MEDICAL CENTER AND AMBULATORY CAMPUS, THIS INSTALLMENT, IN COMBINATION WITH THE SOLAR FARM AT THE BACK OF THE PROPERTY, WILL ALLOW CSC TO GENERATE APPROXIMATELY 61 PERCENT OF ITS ELECTRIC CONSUMPTION AND ACHIEVE SAVINGS OF APPROXIMATELY A HALF MILLION

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DOLLARS IN ENERGY COSTS EACH YEAR, REDUCING ITS CARBON FOOTPRINT AND THE
IMPACT ON FREEHOLD TOWNSHIP'S ELECTRICAL GRID. THE CARPORTS AND SOLAR
FARM WERE INSTALLED BY KDC SOLAR, A BEDMINSTER-BASED DEVELOPER, OWNER,
AND OPERATOR OF SOLAR POWER FACILITIES. CSMC IS THE ONLY HOSPITAL IN THE
STATE WITH A SOLAR INSTALLATION OF THIS SIZE. IT NOW PRODUCES THE LARGEST
PERCENTAGE OF SOLAR POWER OF ANY HOSPITAL IN NEW JERSEY.

THE COMBINED PROJECTS WILL OFFSET GREENHOUSE GASES EQUIVALENT TO:

- 1,026,153 GALLONS OF GAS USED.
- 22,296,869 MILES OF VEHICLE TRAFFIC.
- 1.162 BILLION SMARTPHONES CHARGED.
- 9,969,586 POUNDS OF COAL BURNED.
- 1,590 HOMES SUPPLIED WITH ELECTRICITY FOR ONE YEAR.

COMMUNITY HEALTH OUTREACH

=====

- PEOPLE THROUGHOUT THE COMMUNITY USED CENTRASTATE'S LIVE LIFE WELL
SERVICES MORE THAN 55,000 TIMES TO ENHANCE THEIR HEALTH AND MANAGE OR
PREVENT CHRONIC CONDITIONS THROUGH A VARIETY OF WELLNESS OFFERINGS.

- MORE THAN 9,000 PEOPLE ATTENDED HEALTH AND WELLNESS FAIRS, SESSIONS,
AND SCREENINGS THROUGHOUT THE YEAR.

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-APPROXIMATELY 8,273 PEOPLE RECEIVED COVID VACCINES.

- MORE THAN 275 PEOPLE ATTENDED CANCER HEALTH LECTURES AND SCREENINGS,
INCLUDING THOSE FOR PROSTATE, COLORECTAL, ORAL, SKIN, BREAST, AND THYROID
CANCERS.

- CSMC PROVIDED APPROXIMATELY 2,000 DIABETES EDUCATION ENCOUNTERS TO HELP
PEOPLE MANAGE OR REDUCE THEIR RISK OF DIABETES.

- MORE THAN 300 PEOPLE BENEFITED FROM THE PEER SUPPORT OF SEVERAL CSMC
SUPPORT GROUPS.

- MORE THAN 2,000 PEOPLE RECEIVED LIFE-SAVING CPR TRAINING, INCLUDING
BASIC LIFE SUPPORT, ADVANCED LIFE SUPPORT, AND PEDIATRIC ADVANCED LIFE
SUPPORT.

CORE FORM, PART V; QUESTION 15

THOMAS W. SCOTT, FACHE, FABC IS INVOLVED IN THE LEADERSHIP AND MANAGEMENT
OF THIS ORGANIZATION ON A FULL-TIME BASIS. MR. SCOTT IS EMPLOYED BY AND
RECEIVES A FEDERAL FORM W-2 FROM THIS ORGANIZATION. ACCORDINGLY, HIS
COMMON LAW EMPLOYER/EMPLOYEE RELATIONSHIP IS WITH CENTRASTATE MEDICAL
CENTER, INC. (EIN: 22-1750190). CENTRASTATE MEDICAL CENTER, INC. FILED A
2024 FORM 4720 WHICH INCLUDED A REMITTANCE OF EXCISE TAX RELATED TO MR.
SCOTT'S COMPENSATION IN EXCESS OF \$1M.

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

CENTRASTATE HEALTHCARE SYSTEM, INC. ("CSHS") IS THE SOLE MEMBER OF THIS ORGANIZATION. CSHS HAS THE RIGHT TO ELECT THE MEMBERS OF THIS ORGANIZATION'S BOARD OF TRUSTEES AND HAS CERTAIN RESERVED POWERS AS DEFINED IN THIS ORGANIZATION'S BYLAWS. ATLANTIC HEALTH SYSTEM, INC. AND CENTRASTATE HOLDING COMPANY, INC. HOLD MEMBERSHIP INTERESTS IN CSHS OF 51% AND 49%, RESPECTIVELY.

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

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM, INC. ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. CENTRASTATE HEALTHCARE SYSTEM, INC. IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. THE ORGANIZATION'S FEDERAL FORM 990 WAS PROVIDED TO EACH VOTING MEMBER OF THE ORGANIZATION'S GOVERNING BODY (ITS BOARD OF TRUSTEES) PRIOR TO THE FILING OF THE FEDERAL FORM 990 WITH THE INTERNAL REVENUE SERVICE ("IRS") AND AFTER PRESENTATION AND REVIEW BY CENTRASTATE HEALTHCARE SYSTEM, INC.'S AUDIT COMMITTEE.

AS PART OF THE TAX RETURN PREPARATION PROCESS THE ORGANIZATION HIRED A PROFESSIONAL CERTIFIED PUBLIC ACCOUNTING ("CPA") FIRM WITH EXPERIENCE AND EXPERTISE IN BOTH HEALTHCARE AND NOT-FOR-PROFIT TAX RETURN PREPARATION TO PREPARE THE FEDERAL FORM 990. THE CPA FIRM'S TAX PROFESSIONALS WORKED CLOSELY WITH THE ORGANIZATION'S FINANCE PERSONNEL AND INTERNAL WORKING

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GROUP OF THE ORGANIZATION TO OBTAIN THE INFORMATION NEEDED IN ORDER TO
PREPARE A COMPLETE AND ACCURATE TAX RETURN.

THE CPA FIRM PREPARED A DRAFT FEDERAL FORM 990 AND FURNISHED IT TO THE
ORGANIZATION'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP FOR THEIR
REVIEW. THE ORGANIZATION'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 THE
ORGANIZATION'S FINANCE PERSONNEL AND INTERNAL WORKING GROUP FOR FINAL
REVIEW AND APPROVAL. FOLLOWING THIS REVIEW, THE FINAL FORM 990 WAS
PRESENTED TO THE MEMBERS OF CENTRASTATE HEALTHCARE SYSTEM'S AUDIT
COMMITTEE FOR REVIEW AND THEREAFTER PROVIDED TO EACH VOTING MEMBER OF
THIS ORGANIZATION'S GOVERNING BODY PRIOR TO FILING WITH THE IRS.

CORE FORM, PART VI, SECTION B; QUESTION 12

ALL OFFICERS, TRUSTEES AND KEY EMPLOYEES ARE REQUIRED ANNUALLY, TO REVIEW
THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND COMPLETE A CONFLICT OF
INTEREST QUESTIONNAIRE, WHICH IS SUBMITTED TO CORPORATE COUNSEL.

CORPORATE COUNSEL REVIEWS EACH COMPLETED QUESTIONNAIRE AND PREPARES A
REPORT, WHICH IS SHARED WITH THE BOARD OF TRUSTEES GOVERNANCE COMMITTEE
AND, ULTIMATELY, THE BOARD OF TRUSTEES. THE POLICY IS ENFORCED, AS
NEEDED, DEPENDING ON THE CIRCUMSTANCES - FOR EXAMPLE, THROUGH RECUSAL
FROM VOTING, DIVESTITURE OF CONFLICTING PROPERTY INTERESTS OR, IN CERTAIN

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PAST CASES, RESIGNATION FROM THE BOARD OF TRUSTEES.

CORE FORM, PART VI, SECTION B; QUESTION 15

THE ORGANIZATION'S BOARD OF TRUSTEES HAS AN EXECUTIVE COMPENSATION SUB-COMMITTEE ("COMMITTEE"). THE COMMITTEE HAS ADOPTED A WRITTEN EXECUTIVE COMPENSATION PHILOSOPHY WHICH IT FOLLOWS WHEN IT REVIEWS THE COMPENSATION AND BENEFITS OF THE ORGANIZATION'S SENIOR MANAGEMENT, INCLUDING THE PRESIDENT/CHIEF EXECUTIVE OFFICER. THE COMMITTEE REVIEWS THE "TOTAL COMPENSATION" OF THE INDIVIDUALS WHICH IS INTENDED TO INCLUDE BOTH CURRENT AND DEFERRED COMPENSATION AND ALL EMPLOYEE BENEFITS, BOTH QUALIFIED AND NON-QUALIFIED. THE COMMITTEE'S REVIEW IS DONE ON AT LEAST AN ANNUAL BASIS AND ENSURES THAT THE "TOTAL COMPENSATION" OF SENIOR MANAGEMENT OF THE ORGANIZATION IS REASONABLE. IN 2024, THE EXECUTIVE COMPENSATION SUB-COMMITTEE REPORTED TO THE FULL BOARD FOR RATIFICATION.

THE ACTIONS TAKEN BY THE COMMITTEE ENABLE THE ORGANIZATION TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS FOR PURPOSES OF INTERNAL REVENUE CODE SECTION 4958 WITH RESPECT TO THE TOTAL COMPENSATION OF CERTAIN MEMBERS OF THE SENIOR MANAGEMENT TEAM, INCLUDING THE PRESIDENT/CHIEF EXECUTIVE OFFICER. THE THREE FACTORS WHICH MUST BE SATISFIED IN ORDER TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS ARE THE FOLLOWING:

1. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY AN "AUTHORIZED BODY" OF THE APPLICABLE TAX-EXEMPT ORGANIZATION WHICH IS COMPOSED

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ENTIRELY OF INDIVIDUALS WHO DO NOT HAVE A "CONFLICT OF INTEREST" WITH
RESPECT TO THE COMPENSATION ARRANGEMENT;

2. THE AUTHORIZED BODY OBTAINED AND RELIED UPON "APPROPRIATE DATA AS TO
COMPARABILITY" PRIOR TO MAKING ITS DETERMINATION; AND

3. THE AUTHORIZED BODY "ADEQUATELY DOCUMENTED THE BASIS FOR ITS
DETERMINATION" CONCURRENTLY WITH MAKING THAT DETERMINATION.

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

THE COMMITTEE RELIED UPON APPROPRIATE COMPARABLE DATA; SPECIFICALLY, THE
COMMITTEE OBTAINED A WRITTEN COMPENSATION STUDY FROM AN INDEPENDENT FIRM
WHICH SPECIALIZES IN THE REVIEWING OF HOSPITAL AND HEALTHCARE SYSTEM
EXECUTIVE COMPENSATION AND BENEFITS THROUGHOUT THE UNITED STATES. THIS
STUDY USED COMPARABLE GEOGRAPHIC AND DEMOGRAPHIC MARKET DATA INCLUDING
BUT NOT LIMITED TO SIMILARLY SIZED HEALTHCARE SYSTEMS AND HOSPITALS, # OF
LICENSED BEDS AND NET PATIENT SERVICE REVENUE. IN ADDITION, THE COMMITTEE
REVIEWS AND APPROVES EXECUTIVE COMPENSATION ADJUSTMENTS BASED ON MARKET
SURVEYS DEVELOPED BY INDEPENDENT CONSULTANTS, INDUSTRY AVERAGE
COMPARISON, YEARS OF SERVICE AND OTHER EXEMPT ORGANIZATIONS IN THE
GEOGRAPHIC AREA. AFTER A REVIEW OF THE INDIVIDUAL'S PERFORMANCE FOR THE
YEAR AND RELYING ON COMPARABLE INFORMATION AND OTHER OBJECTIVE DATA, THE
EXECUTIVE COMMITTEE WILL RECOMMEND AN ADJUSTMENT TO THE INDIVIDUAL'S

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COMPENSATION. ANY DETERMINATIONS ARE DOCUMENTED CONTEMPORANEOUSLY IN THE EXECUTIVE COMMITTEE MINUTES.

THE COMMITTEE ADEQUATELY DOCUMENTED ITS BASIS FOR ITS DETERMINATION THROUGH THE TIMELY PREPARATION OF WRITTEN MINUTES OF THE COMPENSATION COMMITTEE MEETINGS DURING WHICH THE EXECUTIVE COMPENSATION AND BENEFITS WAS REVIEWED AND SUBSEQUENTLY APPROVED.

THE ACTIONS OUTLINED ABOVE WITH RESPECT TO THE COMMITTEE AND THE ESTABLISHMENT OF THE REBUTTABLE PRESUMPTION OF REASONABLENESS APPLIES TO CERTAIN SENIOR MANAGEMENT PERSONNEL, INCLUDING, BUT NOT LIMITED TO, THE PRESIDENT/CHIEF EXECUTIVE OFFICER. THE COMPENSATION AND BENEFITS OF CERTAIN OTHER INDIVIDUALS CONTAINED IN THIS FORM 990 ARE REVIEWED ANNUALLY BY THE CENTRASTATE HEALTHCARE SYSTEM, INC.'S PRESIDENT/CHIEF EXECUTIVE OFFICER WITH ASSISTANCE FROM THE ORGANIZATION'S HUMAN RESOURCES DEPARTMENT IN CONJUNCTION WITH THE INDIVIDUAL'S JOB PERFORMANCE DURING THE YEAR AND IS BASED UPON OTHER OBJECTIVE FACTORS DESIGNED TO ENSURE THAT REASONABLE AND FAIR MARKET VALUE COMPENSATION IS PAID BY THE ORGANIZATION. OTHER OBJECTIVE FACTORS INCLUDE MARKET SURVEY DATA FOR COMPARABLE POSITIONS, INDIVIDUAL GOALS AND OBJECTIVES, PERSONNEL REVIEWS, EVALUATIONS, SELF-EVALUATIONS AND PERFORMANCE FEEDBACK MEETINGS.

CORE FORM, PART VI, SECTION C; QUESTION 18

PURSUANT TO STATE OF NEW JERSEY P.L. 2019, CHAPTER 513, (WHICH WAS

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EFFECTIVE ON JULY 21, 2020), AND AMENDED P.L. 2008, CHAPTER 58 (C.26:
2H-5.1B), THIS ORGANIZATION HAS POSTED ON ITS INTERNET WEBSITE A COPY OF
THIS INTERNAL REVENUE SERVICE (IRS) FORM 990 AND ALL SCHEDULES AND
SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED TO THE IRS IN
CONJUNCTION WITH THE FORM 990 WITH THE EXCEPTION OF THOSE SCHEDULES NOT
OPEN FOR PUBLIC INSPECTION. SAID FORM 990 WAS POSTED BY THE ORGANIZATION
AFTER FILING ITS FORM 990 WITH THE IRS.

CORE FORM, PART VI, SECTION C; QUESTION 19

THE ORGANIZATION'S FILED CERTIFICATE OF INCORPORATION AND ANY AMENDMENTS
CAN BE OBTAINED AND REVIEWED THROUGH THE STATE OF NEW JERSEY DEPARTMENT
OF THE TREASURY.

CORE FORM, PART VII AND SCHEDULE J

CORE FORM, PART VII AND SCHEDULE J REFLECT CERTAIN BOARD MEMBERS AND
OFFICERS RECEIVING COMPENSATION AND BENEFITS FROM THIS ORGANIZATION.
PLEASE NOTE THIS REMUNERATION WAS FOR SERVICES RENDERED AS FULL-TIME
EMPLOYEES OF THIS ORGANIZATION AND NOT FOR SERVICES RENDERED AS A VOTING
MEMBER OR OFFICER OF THIS ORGANIZATION'S BOARD OF TRUSTEES.

CORE FORM, PART VII AND SCHEDULE J

BRIAN GRAGNOLATI, STEVEN SHERIS, M.D., FACC, FACP AND MAUREEN A.

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SCHNEIDER, PH.D., MBA, RN ARE TRUSTEES OF THIS ORGANIZATION'S GOVERNING BODY; AN UNCOMPENSATED POSITION. THESE INDIVIDUALS RECEIVE A FEDERAL FORM W-2 FROM A RELATED ORGANIZATION WITHIN ATLANTIC HEALTH SYSTEM.

ACCORDINGLY, THEIR RESPECTIVE REPORTABLE COMPENSATION, RETIREMENT/OTHER DEFERRED COMPENSATION AND NON-TAXABLE BENEFITS ARE REPORTED WITHIN CORE FORM, PART VII AND SCHEDULE J OF THE ATLANTIC HEALTH SYSTEM, INC. GROUP RETURN (EIN: 65-1301877) FEDERAL FORM 990. PLEASE REFER TO THE ATLANTIC HEALTH SYSTEM, INC. GROUP RETURN FEDERAL FORM 990 FOR THIS INFORMATION.

CORE FORM, PART VII, SECTION A, COLUMN B

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

22-1750190

EMPLOYEES, REFLECT TOTAL HOURS WORKED PER WEEK ON BEHALF OF CENTRASTATE
HEALTHCARE SYSTEM, INC.; NOT SOLELY THIS ORGANIZATION.

CORE FORM, PART XI; LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCE INCLUDE

- NET ASSET TRANSFER FROM ATLANTIC HEALTH SYSTEM, INC.; A RELATED
INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION -
\$9,376,685;
- CHANGE IN BENEFICIAL INTEREST IN CENTRASTATE HEALTHCARE FOUNDATION,
INC.; A RELATED INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT
ORGANIZATION - (\$769,812);
- NET ASSET TRANSFER FROM CENTER FOR AGING, INC.; A RELATED INTERNAL
REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION - \$23,479,821; AND
- NET ASSET TRANSFER TO A RELATED ORGANIZATION - (\$4,455,000).

CORE FORM, PART XII; QUESTION 2

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM,
INC. ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM.
CENTRASTATE HEALTHCARE SYSTEM, INC. IS THE TAX-EXEMPT PARENT ENTITY OF
THE SYSTEM. AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL
STATEMENTS OF CENTRASTATE HEALTHCARE SYSTEM, INC. AND ALL ENTITIES WITHIN
THE SYSTEM FOR THE YEARS ENDED DECEMBER 31, 2024 AND DECEMBER 31, 2023;
RESPECTIVELY. THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS CONTAIN

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

22-1750190

CONSOLIDATING SCHEDULES ON AN ENTITY BY ENTITY BASIS. THE INDEPENDENT CPA
FIRM ISSUED AN UNMODIFIED OPINION WITH RESPECT TO THE AUDITED
CONSOLIDATED FINANCIAL STATEMENTS.

CORE FORM, PART XII; QUESTION 3

THE ORGANIZATION IS AN AFFILIATE WITHIN CENTRASTATE HEALTHCARE SYSTEM,
INC. ("SYSTEM"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY 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.

Name of the organization

Employer identification number

CENTRASTATE MEDICAL CENTER, INC.

22-1750190

FORM 990, PART III - PROGRAM SERVICE
=====

LINE 4A, PROGRAM SERVICE

EXPENSES INCURRED IN PROVIDING INPATIENT, OUTPATIENT, EMERGENCY AND 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 AND IN FURTHERANCE OF CHARITABLE TAX-EXEMPT PURPOSES. PLEASE REFER TO THE COMMUNITY BENEFIT STATEMENT IN SCHEDULE O.

Name of the organization

Employer identification number

CENTRASTATE MEDICAL CENTER, INC.

22-1750190

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HEALTH CAROUSEL, LLC P.O. BOX 714216 CINCINNATI, OH 45271-4216	STAFFING	11,483,432.
THE BARHAM GROUP, LLC 4239 HWY 33 TINTON FALLS, NJ 07753	CONSTRUCTION	2,890,737.
CREST CONSTRUCTION GROUP, LLC 401 NORTH MAIN STREET BARNEGAT, NJ 08005	CONSTRUCTION	927,765.
BKT ARCHITECTS 120 COTTON STREET PHILADELPHIA, PA 19127	ARCHITECTURE	890,549.
MANAGEMENT HEALTH SYSTEMS, INC. 1580 SAWGRASS CORPORATE PKWY SUNRISE, FL 33323	STAFFING	833,670.

Name of the organization

Employer identification number

CENTRASTATE MEDICAL CENTER, INC.

22-1750190

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

=====

DESCRIPTION	BEGINNING BOOK VALUE	ENDING BOOK VALUE
-----	-----	-----
PREPAID EXPENSE	2,336,909.	2,301,788.
TOTALS	----- 2,336,909. =====	----- 2,301,788. =====

**SCHEDULE R
(Form 990)**

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

Attach to Form 990.

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

OMB No. 1545-0047

**Open to Public
Inspection**

Name of the organization

CENTRASTATE MEDICAL CENTER, INC.

Employer identification number

22-1750190

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) CENTER FOR AGING, INC. 22-2575377 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	501(C)(3)	10	CSHS		X
(2) CENTRASTATE ASSISTED LIVING, INC. 22-3520730 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	501(C)(3)	10	CSHS		X
(3) HEALTHCARE AFFILIATES, INC. 52-1594300 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	501(C)(3)	10	CSHS		X
(4) CENTRASTATE HEALTHCARE SYSTEM, INC. 22-2482803 901 WEST MAIN STREET FREEHOLD, NJ 07728	MANAGEMENT	NJ	501(C)(3)	12A	AHS		X
(5) CENTRASTATE HEALTHCARE FOUNDATION, INC. 27-2383065 901 WEST MAIN STREET FREEHOLD, NJ 07728	FUNDRAISING	NJ	501(C)(3)	7	CSHS		X
(6) CENTRASTATE HOLDING COMPANY, INC. 85-1112301 901 WEST MAIN STREET FREEHOLD, NJ 07728	MANAGEMENT	NJ	501(C)(3)	12B	N/A		X
(7) ATLANTIC HEALTH SYSTEM, INC. 22-3380375 475 SOUTH STREET MORRISTOWN, NJ 07960	MANAGEMENT	NJ	501(C)(3)	12A	N/A		X

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

Schedule R (Form 990) (Rev. 12-2024)

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CENTRASTATE HEALTHCARE SERVICES, INC. 22-2512830 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	N/A	C CORP.					X
(2) CENTRASTATE MEDICAL ASSOCIATES, P.C. 22-3402359 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	N/A	C CORP.					X
(3) CENTRASTATE SPECIALISTS, P.C. 82-3704077 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	N/A	C CORP.					X
(4) CENTRASTATE CARDIOLOGY, P.C. 87-2845417 901 WEST MAIN STREET FREEHOLD, NJ 07728	HEALTH SVCS.	NJ	N/A	C CORP.					X
(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.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity.	X	
b Gift, grant, or capital contribution to related organization(s)		X
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)	X	
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)	X	
k Lease of facilities, equipment, or other assets from related organization(s)	X	
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)		X
p Reimbursement paid to related organization(s) for expenses.	X	
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)		X
s Other transfer of cash or property from related organization(s)	X	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a - s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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

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

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

Part VII Supplemental Information

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

SCHEDULE R

ATLANTIC HEALTH SYSTEM, INC. AND CENTRASTATE HOLDING COMPANY, INC. HOLD MEMBERSHIP INTERESTS IN CENTRASTATE HEALTHCARE SYSTEM, INC. OF 51% AND 49%, RESPECTIVELY. PLEASE REFER TO ATLANTIC HEALTH SYSTEM, INC. (EIN: 22-3380375) FORM 990, SCHEDULE R FOR THE REPORTING OF RELATED ORGANIZATIONS.

SCHEDULE R, PART V

THIS ORGANIZATION IS A MEMBER OF CENTRASTATE HEALTHCARE SYSTEM, INC.; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. FUNDS ARE ROUTINELY TRANSFERRED BETWEEN AFFILIATES AND BUSINESS ACTIVITIES ARE COMMON ON BEHALF OF THE SYSTEM'S AFFILIATES, INCLUDING THIS ORGANIZATION. THESE TRANSACTIONS MAY BE RECORDED ON THE REVENUE/EXPENSE AND BALANCE SHEET STATEMENTS OF THIS ORGANIZATION AND OTHER AFFILIATES. THESE ENTITIES WORK TOGETHER TO DELIVER HIGH QUALITY COST EFFECTIVE HEALTHCARE AND WELLNESS SERVICES TO THEIR COMMUNITIES REGARDLESS OF ABILITY TO PAY AND IN FURTHERANCE OF CHARITABLE TAX-EXEMPT PURPOSES.

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE
=====

OTHER INCOME

RENTAL INCOME

3,326,099.

3,326,099.

=====

RENT AND ROYALTY SUMMARY

=====

PROPERTY -----	TOTAL INCOME -----	DEPLETION/ DEPRECIATION -----	OTHER EXPENSES -----	ALLOWABLE NET INCOME -----
RENTAL INCOME	3,326,099.			3,326,099.
	-----	-----	-----	-----
TOTALS	3,326,099.			3,326,099.
	=====	=====	=====	=====

**SCHEDULE D
(Form 1041)**

Department of the Treasury
Internal Revenue Service

Capital Gains and Losses

Attach to Form 1041, Form 5227, or Form 990-T.
Use Form 8949 to list your transactions for lines 1b, 2, 3, 8b, 9, and 10.
Go to www.irs.gov/Form1041 for instructions and the latest information.

OMB No. 1545-0092

2024

Name of estate or trust: **CENTRASTATE MEDICAL CENTER, INC.** Employer identification number: **22-1750190**

Did you dispose of any investment(s) in a qualified opportunity fund during the tax year? Yes No
If "Yes," attach Form 8949 and see its instructions for additional requirements for reporting your gain or loss.

Note: Form 5227 filers need to complete **only** Parts I and II.

Part I Short-Term Capital Gains and Losses - Generally Assets Held 1 Year or Less (see instructions)

See instructions for how to figure the amounts to enter on the lines below. This form may be easier to complete if you round off cents to whole dollars.	(d) Proceeds (sales price)	(e) Cost (or other basis)	(g) Adjustments to gain or loss from Form(s) 8949, Part I, line 2, column (g)	(h) Gain or (loss) Subtract column (e) from column (d) and combine the result with column (g)
1a Totals for all short-term transactions reported on Form 1099-B for which basis was reported to the IRS and for which you have no adjustments (see instructions). However, if you choose to report all these transactions on Form 8949, leave this line blank and go to line 1b.				
1b Totals for all transactions reported on Form(s) 8949 with Box A checked.	NONE	5,048,628.		-5,048,628.
2 Totals for all transactions reported on Form(s) 8949 with Box B checked.				
3 Totals for all transactions reported on Form(s) 8949 with Box C checked.				
4 Short-term capital gain or (loss) from Forms 4684, 6252, 6781, and 8824				4
5 Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts				5
6 Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2023 Capital Loss Carryover Worksheet				6 ()
7 Net short-term capital gain or (loss). Combine lines 1a through 6 in column (h). Enter here and on Part III, line 17, column (3).				7 -5,048,628.

Part II Long-Term Capital Gains and Losses - Generally Assets Held More Than 1 Year (see instructions)

See instructions for how to figure the amounts to enter on the lines below. This form may be easier to complete if you round off cents to whole dollars.	(d) Proceeds (sales price)	(e) Cost (or other basis)	(g) Adjustments to gain or loss from Form(s) 8949, Part II, line 2, column (g)	(h) Gain or (loss) Subtract column (e) from column (d) and combine the result with column (g)
8a Totals for all long-term transactions reported on Form 1099-B for which basis was reported to the IRS and for which you have no adjustments (see instructions). However, if you choose to report all these transactions on Form 8949, leave this line blank and go to line 8b.				
8b Totals for all transactions reported on Form(s) 8949 with Box D checked.	168,667.	NONE		168,667.
9 Totals for all transactions reported on Form(s) 8949 with Box E checked.				
10 Totals for all transactions reported on Form(s) 8949 with Box F checked.				
11 Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824				11
12 Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts.				12
13 Capital gain distributions.				13
14 Gain from Form 4797, Part I.				14
15 Long-term capital loss carryover. Enter the amount, if any, from line 14 of the 2023 Capital Loss Carryover Worksheet				15 ()
16 Net long-term capital gain or (loss). Combine lines 8a through 15 in column (h). Enter here and on Part III, line 18a, column (3).				16 168,667.

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

Schedule D (Form 1041) 2024

Part III Summary of Parts I and II		(1) Beneficiaries' (see instr.)	(2) Estate's or trust's	(3) Total
Caution: Read the instructions before completing this part.				
17	Net short-term gain or (loss)	17		-5,048,628.
18	Net long-term gain or (loss):			
a	Total for year	18a		168,667.
b	Unrecaptured section 1250 gain (see line 18 of the worksheet)	18b		
c	28% rate gain	18c		
19	Total net gain or (loss). Combine lines 17 and 18a.	19		-4,879,961.

Note: If line 19, column (3), is a net gain, enter the gain on Form 1041, line 4 (or Schedule A (Form 990-T), Part I, line 4a). If lines 18a and 19, column (2), are net gains, go to Part V, and **don't** complete Part IV. If line 19, column (3), is a net loss, complete Part IV and the **Capital Loss Carryover Worksheet**, as necessary.

Part IV Capital Loss Limitation		
20	Enter here and enter as a (loss) on Form 1041, line 4 (or Schedule A (Form 990-T), Part I, line 4c, if a trust), the smaller of:	
a	The loss on line 19, column (3); or b \$3,000	20 (3,000.)

Note: If the loss on line 19, column (3), is more than \$3,000, or if Form 1041, page 1, line 23 (or Form 990-T, Part I, line 11), is a loss, complete the **Capital Loss Carryover Worksheet** in the instructions to figure your capital loss carryover.

Part V Tax Computation Using Maximum Capital Gains Rates

Form 1041 filers. Complete this part **only** if both lines 18a and 19 in column (2) are gains, or an amount is entered in Part I or Part II and there is an entry on Form 1041, line 2b(2), and Form 1041, line 23, is more than zero.

Caution: Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if:

- Either line 18b, column (2), or line 18c, column (2), is more than zero;
- Both Form 1041, line 2b(1), and Form 4952, line 4g, are more than zero; or
- There are amounts on lines 4e and 4g of Form 4952.

Form 990-T trusts. Complete this part **only** if both lines 18a and 19 are gains, or qualified dividends are included in income in Part I of Form 990-T, and Form 990-T, Part I, line 11, is more than zero. Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if either line 18b, column (2), or line 18c, column (2), is more than zero.

21	Enter taxable income from Form 1041, line 23 (or Form 990-T, Part I, line 11)	21		
22	Enter the smaller of line 18a or 19 in column (2) but not less than zero.	22		
23	Enter the estate's or trust's qualified dividends from Form 1041, line 2b(2) (or enter the qualified dividends included in income in Part I of Form 990-T)	23		
24	Add lines 22 and 23	24		
25	If the estate or trust is filing Form 4952, enter the amount from line 4g; otherwise, enter -0-	25		
26	Subtract line 25 from line 24. If zero or less, enter -0-	26		
27	Subtract line 26 from line 21. If zero or less, enter -0-	27		
28	Enter the smaller of the amount on line 21 or \$3,150	28		
29	Enter the smaller of the amount on line 27 or line 28	29		
30	Subtract line 29 from line 28. If zero or less, enter -0-. This amount is taxed at 0%	30		
31	Enter the smaller of line 21 or line 26	31		
32	Subtract line 30 from line 26	32		
33	Enter the smaller of line 21 or \$15,450	33		
34	Add lines 27 and 30	34		
35	Subtract line 34 from line 33. If zero or less, enter -0-	35		
36	Enter the smaller of line 32 or line 35	36		
37	Multiply line 36 by 15% (0.15)	37		
38	Enter the amount from line 31	38		
39	Add lines 30 and 36	39		
40	Subtract line 39 from line 38. If zero or less, enter -0-	40		
41	Multiply line 40 by 20% (0.20)	41		
42	Figure the tax on the amount on line 27. Use the 2024 Tax Rate Schedule for Estates and Trusts. See the Schedule G instructions in the Instructions for Form 1041	42		
43	Add lines 37, 41, and 42	43		
44	Figure the tax on the amount on line 21. Use the 2024 Tax Rate Schedule for Estates and Trusts. See the Schedule G instructions in the Instructions for Form 1041	44		
45	Tax on all taxable income. Enter the smaller of line 43 or line 44 here and on Form 1041, Schedule G, Part I, line 1a (or Form 990-T, Part II, line 2)	45		

Department of the Treasury
 Internal Revenue Service

Go to www.irs.gov/Form8949 for instructions and the latest information.

Name(s) shown on return CENTRASTATE MEDICAL CENTER, INC.	Social security number or taxpayer identification number 22-1750190
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Before you check Box A, B, or C below, see whether you received any Form(s) 1099-B or substitute statement(s) from your broker. A substitute statement will have the same information as Form 1099-B. Either will show whether your basis (usually your cost) was reported to the IRS by your broker and may even tell you which box to check.

Part I Short-Term. Transactions involving capital assets you held 1 year or less are generally short-term (see instructions). For long-term transactions, see page 2.

Note: You may aggregate all short-term transactions reported on Form(s) 1099-B showing basis was reported to the IRS and for which no adjustments or codes are required. Enter the totals directly on Schedule D, line 1a; you aren't required to report these transactions on Form 8949 (see instructions).

You must check Box A, B, or C below. Check only one box. If more than one box applies for your short-term transactions, complete a separate Form 8949, page 1, for each applicable box. If you have more short-term transactions than will fit on this page for one or more of the boxes, complete as many forms with the same box checked as you need.

- (A)** Short-term transactions reported on Form(s) 1099-B showing basis was reported to the IRS (see **Note** above)
- (B)** Short-term transactions reported on Form(s) 1099-B showing basis **wasn't** reported to the IRS
- (C)** Short-term transactions not reported to you on Form 1099-B

1	(a) Description of property (Example: 100 sh. XYZ Co.)	(b) Date acquired (Mo., day, yr.)	(c) Date sold or disposed of (Mo., day, yr.)	(d) Proceeds (sales price) (see instructions)	(e) Cost or other basis See the Note below and see <i>Column (e)</i> in the separate instructions.	Adjustment, if any, to gain or loss If you enter an amount in column (g), enter a code in column (f). See the separate instructions.		(h) Gain or (loss) Subtract column (e) from column (d) and combine the result with column (g).
						(f) Code(s) from instructions	(g) Amount of adjustment	
	VARIOUS SECURITIES	VARIOUS	VARIOUS	NONE	5,048,628.00			-5,048,628.00
2 Totals.	Add the amounts in columns (d), (e), (g), and (h) (subtract negative amounts). Enter each total here and include on your Schedule D, line 1b (if Box A above is checked), line 2 (if Box B above is checked), or line 3 (if Box C above is checked)			NONE	5,048,628.			-5,048,628.

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

Name(s) shown on return. Name and SSN or taxpayer identification no. not required if shown on other side

Social security number or taxpayer identification number

CENTRASTATE MEDICAL CENTER, INC.

22-1750190

Before you check Box D, E, or F below, see whether you received any Form(s) 1099-B or substitute statement(s) from your broker. A substitute statement will have the same information as Form 1099-B. Either will show whether your basis (usually your cost) was reported to the IRS by your broker and may even tell you which box to check.

Part II Long-Term. Transactions involving capital assets you held more than 1 year are generally long-term (see instructions). For short-term transactions, see page 1.

Note: You may aggregate all long-term transactions reported on Form(s) 1099-B showing basis was reported to the IRS and for which no adjustments or codes are required. Enter the totals directly on Schedule D, line 8a; you aren't required to report these transactions on Form 8949 (see instructions).

You must check Box D, E, or F below. Check only one box. If more than one box applies for your long-term transactions, complete a separate Form 8949, page 2, for each applicable box. If you have more long-term transactions than will fit on this page for one or more of the boxes, complete as many forms with the same box checked as you need.

- (D)** Long-term transactions reported on Form(s) 1099-B showing basis was reported to the IRS (see **Note** above)
- (E)** Long-term transactions reported on Form(s) 1099-B showing basis **wasn't** reported to the IRS
- (F)** Long-term transactions not reported to you on Form 1099-B

1	(a) Description of property (Example: 100 sh. XYZ Co.)	(b) Date acquired (Mo., day, yr.)	(c) Date sold or disposed of (Mo., day, yr.)	(d) Proceeds (sales price) (see instructions)	(e) Cost or other basis See the Note below and see <i>Column (e)</i> in the separate instructions.	Adjustment, if any, to gain or loss If you enter an amount in column (g), enter a code in column (f). See the separate instructions.		(h) Gain or (loss) Subtract column (e) from column (d) and combine the result with column (g).
						(f) Code(s) from instructions	(g) Amount of adjustment	
	VARIOUS INVESTMENTS	VARIOUS	VARIOUS	168,667.00	NONE			168,667.00
2 Totals.	Add the amounts in columns (d), (e), (g), and (h) (subtract negative amounts). Enter each total here and include on your Schedule D, line 8b (if Box D above is checked), line 9 (if Box E above is checked), or line 10 (if Box F above is checked) . . .			168,667.	NONE			168,667.

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