

\*\*\*\*\*

**FEDERAL FORM 990**  
**RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX**  
**FOR THE YEAR ENDED DECEMBER 31, 2023**

**PUBLIC DISCLOSURE COPY**

\*\*\*\*\*

Return of Organization Exempt From Income Tax

Department of the Treasury Internal Revenue Service

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

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

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

A For the 2023 calendar year, or tax year beginning and ending

Form header section containing organization name (SHORE MEMORIAL HOSPITAL), EIN (21-0660835), address (100 MEDICAL CENTER WAY, SOMERS POINT, NJ 08244-2387), and principal officer (RONALD W. JOHNSON).

Part I Summary

Summary table with columns for Revenue, Expenses, and Net Assets or Fund Balances. Rows include mission statement, governance metrics, and financial data for Prior Year and Current Year.

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.

Signature block section with fields for officer signature, preparer name (SCOTT J MARIANI), firm name (WITHUMSMITH+BROWN, PC), and firm address.

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:

SEE 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 \$ 76,578,666. including grants of \$ NONE ) (Revenue \$ 65,137,844. )

EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY INPATIENT MEDICAL SERVICES (EXCLUDES SURGICAL CASES AND MATERNAL CHILD HEALTH), TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. DURING 2023, THE ORGANIZATION HAD 6,322 DISCHARGES FOR A TOTAL OF 30,530 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

**4b** (Code: ) (Expenses \$ 28,778,362. including grants of \$ NONE ) (Revenue \$ 37,251,730. )

EXPENSES INCURRED IN PROVIDING MEDICAL NECESSARY SAME DAY SURGERY SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. DURING 2023, THE ORGANIZATION TREATED 3,695 SAME DAY SURGERY CASES. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

**4c** (Code: ) (Expenses \$ 8,887,950. including grants of \$ NONE ) (Revenue \$ 11,731,849. )

EXPENSES INCURRED IN PROVIDING MEDICAL NECESSARY MATERNAL AND PEDIATRIC INPATIENT SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. DURING 2023, THE ORGANIZATION HAD 2,149 DISCHARGES FOR A TOTAL OF 5,393 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT.

**4d** Other program services (Describe on Schedule O.)

(Expenses \$ 63,896,619. including grants of \$ 120,240. ) (Revenue \$ 118,284,678. )

**4e** Total program service expenses 178,141,597.

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows 1-21 with various questions about organizational activities and financial reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question, Yes, No. Rows 22-38 covering various organizational requirements and reporting obligations.

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, Yes, No. Rows 1a-1c regarding Form 1096, Forms W-2G, and backup withholding rules.

<b>Part V Statements Regarding Other IRS Filings and Tax Compliance</b> (continued)		Yes	No
<b>2a</b>	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 <span style="float:right">2a 1,436</span>		
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	X	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .		X
<b>b</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> . . . . .		
<b>4a</b>	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>b</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).		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .		X
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
<b>c</b>	If "Yes" to line 5a or 5b, did the organization file Form 8886-T? . . . . .		
<b>6a</b>	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>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	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>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	X	
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .		X
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year <span style="float:right">7d</span> . . . . .		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . .		X
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . . <span style="float:right">10a</span>		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . <span style="float:right">10b</span>		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>a</b>	Gross income from members or shareholders . . . . . <span style="float:right">11a</span>		
<b>b</b>	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) . . . . . <span style="float:right">11b</span>		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . <span style="float:right">12b</span>		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? . . . . . <b>Note:</b> See the instructions for additional information the organization must report on Schedule O.		
<b>b</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 . . . . . <span style="float:right">13b</span>		
<b>c</b>	Enter the amount of reserves on hand . . . . . <span style="float:right">13c</span>		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .		X
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i> . . . . .		
<b>15</b>	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? . . . . . If "Yes," see the instructions and file Form 4720, Schedule N.	X	
<b>16</b>	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X
<b>17</b>	<b>Section 501(c)(21) organizations.</b> 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? . . . . . 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 (20), 1b (18), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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 (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 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. [X] Own website [ ] Another's website [X] Upon request [ ] Other (explain on Schedule O)
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. DAVID R. HUGHES 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244-2387

(609) 653-3545

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See 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			
<b>(1)</b> RONALD W. JOHNSON TRUSTEE - CEO	55.00 NONE	X		X				1,427,567.	NONE	93,794.
<b>(2)</b> DAVID R. HUGHES PRESIDENT/CFO	55.00 NONE			X				1,313,397.	NONE	96,644.
<b>(3)</b> JEANNE M. ROWE, M.D. CHIEF MEDICAL OFFICER	55.00 NONE			X				664,386.	NONE	96,785.
<b>(4)</b> FREDERICK L. BANNER CHIEF INFORMATION OFFICER	55.00 NONE				X			406,631.	NONE	53,131.
<b>(5)</b> HOLLY BADALI CHIEF NURSING OFFICER	55.00 NONE				X			375,726.	NONE	63,224.
<b>(6)</b> ALAN L. BEATTY VP HUMAN RESOURCES	55.00 NONE				X			419,504.	NONE	18,602.
<b>(7)</b> ROBIN KEYACK VP AMBULATORY & SURGICAL SVCS	55.00 NONE				X			371,484.	NONE	31,260.
<b>(8)</b> DANIEL JACOBY, M.D. HOSPITALIST	55.00 NONE					X		356,500.	NONE	22,089.
<b>(9)</b> STEPHEN CAPECCI, D.O. HOSPITALIST	55.00 NONE					X		317,532.	NONE	23,295.
<b>(10)</b> ROBERT L. WOOD DIRECTOR OF FINANCE	55.00 NONE					X		244,185.	NONE	33,942.
<b>(11)</b> ROBERT ROBERTSON ADMIN DIRECTOR LOGISTICS	55.00 NONE					X		206,759.	NONE	26,409.
<b>(12)</b> MATTHEW PISKUN ADMIN DIRECTOR PHARMACY	55.00 NONE					X		207,365.	NONE	1,374.
<b>(13)</b> DAVID BEYEL CHAIR - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
<b>(14)</b> EDWARD KUEHNLE VICE CHAIR - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE



**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			
( 15 ) R. SCOTT HALLIDAY SECRETARY/ASST TREAS - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
( 16 ) RONALD B. STABLINI, CPA, MBA TREAS/ASST SECRETARY - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
( 17 ) ROBERT C. ALLEN TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 18 ) MICHAEL BRAY TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 19 ) ROBERT J. BRAY, DDS, MS TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 20 ) AUGGIE CIPOLLINI TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 21 ) PATRICIA Q. CONNOLLY TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 22 ) JOHN DABEK TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 23 ) KEN KOREYVA TRUSTEE	2.00 NONE	X						NONE	NONE	NONE
( 24 ) FRANCIS LAMB, CPA TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
( 25 ) CHRISTOPHER LUCASTI, D.O. TRUSTEE; EX-OFFICIO	1.00 NONE	X						NONE	NONE	NONE
<b>1b Sub-total</b> . . . . .								6,311,036.	NONE	560,549.
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .								NONE	NONE	NONE
<b>d Total (add lines 1b and 1c)</b> . . . . .								6,311,036.	NONE	560,549.

**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 **▶** 214

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .		
<b>4</b> 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> . . . . .		
<b>5</b> 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> . . . . .		

**Section B. Independent Contractors**

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 26 ) BARBARA RIDGE ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
( 27 ) JUDITH L. ROMAN ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
( 28 ) MUKESH ROY, M.D. ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
( 29 ) ANGELO SPARAGNA, III, M.D. ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
( 30 ) CARMINE J. TAGLIALATELLA, JWC ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
( 31 ) RICHARD L. TRAA ----- TRUSTEE	1.00 ----- NONE	X					NONE	NONE	NONE	
----- ----- ----- ----- ----- ----- ----- ----- ----- -----										
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

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

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> . . . . .		X
<b>4</b> 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	
<b>5</b> 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 ▶ 68

**Part VIII Statement of Revenue**

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants, and Other Similar Amounts</b>	<b>1a</b>	Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b>	Membership dues . . . . .	<b>1b</b>					
	<b>c</b>	Fundraising events . . . . .	<b>1c</b>	291,188.				
	<b>d</b>	Related organizations . . . . .	<b>1d</b>					
	<b>e</b>	Government grants (contributions) . .	<b>1e</b>	510,440.				
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above .	<b>1f</b>	1,558,563.				
	<b>g</b>	Noncash contributions included in lines 1a-1f . . . . .	<b>1g</b>	\$				
	<b>h</b>	<b>Total.</b> Add lines 1a-1f . . . . .			2,360,191.			
	<b>Program Service Revenue</b>				<b>Business Code</b>			
<b>2a</b>		NET PATIENT SERVICE REVENUE		622110	232,065,980.	232,065,980.		
<b>b</b>		AUXILIARY INCOME		813410	340,121.	340,121.		
<b>c</b>								
<b>d</b>								
<b>e</b>								
<b>f</b>		All other program service revenue . . . . .						
<b>g</b>	<b>Total.</b> Add lines 2a-2f . . . . .			232,406,101.				
<b>Other Revenue</b>	<b>3</b>	Investment income (including dividends, interest, and other similar amounts) . . . . .		NONE				
	<b>4</b>	Income from investment of tax-exempt bond proceeds . . .		NONE				
	<b>5</b>	Royalties . . . . .		NONE				
	<b>6a</b>	Gross rents . . . . .	<b>6a</b>	(i) Real				
				(ii) Personal				
					1,063,173.			
	<b>b</b>	Less: rental expenses	<b>6b</b>		189,294.			
	<b>c</b>	Rental income or (loss)	<b>6c</b>		873,879.	NONE		
	<b>d</b>	Net rental income or (loss) . . . . .			873,879.		873,879.	
	<b>7a</b>	Gross amount from sales of assets other than inventory	<b>7a</b>	(i) Securities				
				(ii) Other				
					5,627,262.	9,012.		
	<b>b</b>	Less: cost or other basis and sales expenses . .	<b>7b</b>					
	<b>c</b>	Gain or (loss) . . . . .	<b>7c</b>		5,627,262.	9,012.		
	<b>d</b>	Net gain or (loss) . . . . .			5,636,274.		5,636,274.	
<b>8a</b>	Gross income from fundraising events (not including \$ 291,188. of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>8a</b>			91,377.			
			<b>b</b>	Less: direct expenses . . . . .	<b>8b</b>		91,377.	
			<b>c</b>	Net income or (loss) from fundraising events . . . . .			NONE	
<b>9a</b>	Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>9a</b>			13,089.			
			<b>b</b>	Less: direct expenses . . . . .	<b>9b</b>		3,615.	
			<b>c</b>	Net income or (loss) from gaming activities . . . . .			9,474.	9,474.
<b>10a</b>	Gross sales of inventory, less returns and allowances . . . . .	<b>10a</b>			NONE			
			<b>b</b>	Less: cost of goods sold . . . . .	<b>10b</b>		NONE	
			<b>c</b>	Net income or (loss) from sales of inventory . . . . .			NONE	
<b>Miscellaneous Revenue</b>				<b>Business Code</b>				
	<b>11a</b>	CAFETERIA/VENDING		722310	766,608.		766,608.	
	<b>b</b>							
	<b>c</b>							
	<b>d</b>	All other revenue . . . . .						
<b>e</b>	<b>Total.</b> Add lines 11a-11d . . . . .			766,608.				
<b>12</b>	<b>Total revenue.</b> See instructions . . . . .				242,052,527.	232,406,101.	7,286,235.	

**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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	120,240.	120,240.		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	NONE			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 . . . . .	NONE			
<b>4</b> Benefits paid to or for members . . . . .	NONE			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	5,432,135.	4,471,455.	932,891.	27,789.
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	NONE			
<b>7</b> Other salaries and wages . . . . .	72,548,479.	59,718,186.	12,459,158.	371,135.
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	1,605,899.	1,321,894.	275,790.	8,215.
<b>9</b> Other employee benefits . . . . .	7,611,133.	6,265,094.	1,307,103.	38,936.
<b>10</b> Payroll taxes . . . . .	6,707,072.	5,520,918.	1,151,843.	34,311.
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management . . . . .	176,665.	121,135.	54,884.	646.
<b>b</b> Legal . . . . .	187,928.	130,416.	56,843.	669.
<b>c</b> Accounting . . . . .	310,000.	212,559.	96,308.	1,133.
<b>d</b> Lobbying . . . . .	59,079.	59,079.		
<b>e</b> Professional fundraising services. See Part IV, line 17 . . . . .	NONE			
<b>f</b> Investment management fees . . . . .	16,199.	11,107.	5,033.	59.
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.) . . . . .	SEE SCHE O 46,730,994.	32,700,035.	13,867,744.	163,215.
<b>12</b> Advertising and promotion . . . . .	500,014.	500,014.		
<b>13</b> Office expenses . . . . .	2,033,801.	1,395,021.	631,349.	7,431.
<b>14</b> Information technology. . . . .	124,833.	85,595.	38,782.	456.
<b>15</b> Royalties. . . . .	NONE			
<b>16</b> Occupancy . . . . .	3,178,815.	2,185,000.	982,254.	11,561.
<b>17</b> Travel . . . . .	44,636.	44,636.		
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	NONE			
<b>19</b> Conferences, conventions, and meetings . . . . .	67,432.	67,432.		
<b>20</b> Interest . . . . .	778,917.	534,084.	241,985.	2,848.
<b>21</b> Payments to affiliates. . . . .	NONE			
<b>22</b> Depreciation, depletion, and amortization . . . . .	8,192,443.	5,617,569.	2,544,922.	29,952.
<b>23</b> Insurance . . . . .	2,511,448.	1,722,488.	779,782.	9,178.
<b>24</b> 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.)				
<b>a</b> MEDICAL SUPPLIES	43,377,931.	43,377,931.		
<b>b</b> PHYSICIAN SERVICES	3,763,562.	3,763,562.		
<b>c</b> REPAIRS & MAINTENANCE	6,643,596.	6,643,596.		
<b>d</b> COLLECTION EXPENSES	1,344,116.	1,344,116.		
<b>e</b> All other expenses _____	323,876.	208,435.	114,098.	1,343.
<b>25</b> Total functional expenses. Add lines 1 through 24e	214,391,243.	178,141,597.	35,540,769.	708,877.
<b>26</b> 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
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing . . . . .	5,023,469.	<b>1</b>	2,246,387.
	<b>2</b> Savings and temporary cash investments. . . . .	2,095,911.	<b>2</b>	1,787,252.
	<b>3</b> Pledges and grants receivable, net . . . . .	76,646.	<b>3</b>	59,097.
	<b>4</b> Accounts receivable, net . . . . .	24,830,999.	<b>4</b>	24,325,840.
	<b>5</b> 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	<b>5</b>	NONE
	<b>6</b> 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	<b>6</b>	NONE
	<b>7</b> Notes and loans receivable, net . . . . .	NONE	<b>7</b>	NONE
	<b>8</b> Inventories for sale or use . . . . .	4,598,613.	<b>8</b>	6,446,923.
	<b>9</b> Prepaid expenses and deferred charges . . . . .	4,445,396.	<b>9</b>	3,109,293.
	<b>10 a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D . . . . .	<b>10a</b> 397,692,452.		
	<b>b</b> Less: accumulated depreciation. . . . .	<b>10b</b> 287,949,620.		
		108,698,691.	<b>10c</b>	109,742,832.
	<b>11</b> Investments - publicly traded securities. . . . .	NONE	<b>11</b>	NONE
	<b>12</b> Investments - other securities. See Part IV, line 11. . . . .	NONE	<b>12</b>	NONE
	<b>13</b> Investments - program-related. See Part IV, line 11. . . . .	156,028,270.	<b>13</b>	146,791,284.
	<b>14</b> Intangible assets . . . . .	NONE	<b>14</b>	NONE
<b>15</b> Other assets. See Part IV, line 11 . . . . .	29,122,107.	<b>15</b>	36,277,395.	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .	334,920,102.	<b>16</b>	330,786,303.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses. . . . .	34,678,742.	<b>17</b>	33,859,158.
	<b>18</b> Grants payable . . . . .	NONE	<b>18</b>	NONE
	<b>19</b> Deferred revenue . . . . .	1,872,578.	<b>19</b>	1,428,797.
	<b>20</b> Tax-exempt bond liabilities . . . . .	31,425,952.	<b>20</b>	NONE
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .	NONE	<b>21</b>	NONE
	<b>22</b> 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	<b>22</b>	NONE
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	NONE	<b>23</b>	NONE
	<b>24</b> Unsecured notes and loans payable to unrelated third parties. . . . .	NONE	<b>24</b>	NONE
	<b>25</b> 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 . . . . .	34,553,539.	<b>25</b>	21,880,903.
	<b>26 Total liabilities.</b> Add lines 17 through 25. . . . .	102,530,811.	<b>26</b>	57,168,858.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33.</b> <input checked="" type="checkbox"/>			
	<b>27</b> Net assets without donor restrictions. . . . .	229,201,704.	<b>27</b>	270,265,679.
	<b>28</b> Net assets with donor restrictions. . . . .	3,187,587.	<b>28</b>	3,351,766.
	<b>Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33.</b> <input type="checkbox"/>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds . . . . .		<b>31</b>	
	<b>32</b> Total net assets or fund balances . . . . .	232,389,291.	<b>32</b>	273,617,445.
<b>33</b> Total liabilities and net assets/fund balances. . . . .	334,920,102.	<b>33</b>	330,786,303.	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	242,052,527.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	214,391,243.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	27,661,284.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	232,389,291.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	6,590,273.
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O)	<b>9</b>	6,976,597.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	273,617,445.

**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
<b>2a</b>		X
<b>2b</b>	X	
<b>2c</b>	X	
<b>3a</b>	X	
<b>3b</b>	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](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Name of the organization

SHORE MEMORIAL HOSPITAL

Employer identification number

21-0660835

**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)						
<b>Total</b>						

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

Schedule A (Form 990) 2023

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: (a) 2019, (b) 2020, (c) 2021, (d) 2022, (e) 2023, (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: (a) 2019, (b) 2020, (c) 2021, (d) 2022, (e) 2023, (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 2023 (line 6, column (f), divided by line 11, column (f)); 15 Public support percentage from 2022 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2023. 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 - 2022. 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 - 2023. 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 - 2022. 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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> 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 . . . . .						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
<b>6 Total.</b> Add lines 1 through 5. . . . .						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons . . . . .						
<b>b</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 . . . . .						
<b>c</b> Add lines 7a and 7b. . . . .						
<b>8 Public support.</b> (Subtract line 7c from line 6.) . . . . .						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>9</b> Amounts from line 6. . . . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources . . . . .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 . . . . .						
<b>c</b> Add lines 10a and 10b . . . . .						
<b>11</b> Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on. . . . .						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>13 Total support.</b> (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**

<b>15</b> Public support percentage for 2023 (line 8, column (f), divided by line 13, column (f)) . . . . .	<b>15</b>	%
<b>16</b> Public support percentage from 2022 Schedule A, Part III, line 15 . . . . .	<b>16</b>	%

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

<b>17</b> Investment income percentage for <b>2023</b> (line 10c, column (f), divided by line 13, column (f)), . . . . .	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2022</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	%

**19a 33 1/3% support tests - 2023.** 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 - 2022.** 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>		
3b	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>		
3c	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>		
4b	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>		
4c	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>		
5b	<b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
5c	<b>Substitutions only.</b> 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>		
9b	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>		
9c	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>		
10b	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
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> 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>b</b> A family member of a person described on line 11a above?		
<b>c</b> 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
<b>1</b> 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>		
<b>2</b> 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
<b>1</b> 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
<b>1</b> 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?		
<b>2</b> 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>		
<b>3</b> 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**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).			
<b>2</b> Activities Test. Answer lines 2a and 2b below.		Yes	No
<b>a</b> 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>b</b> 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>			
<b>3</b> Parent of Supported Organizations. Answer lines 3a and 3b below.			
<b>a</b> 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>b</b> 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.

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3.	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt-use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d.	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035.	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, column A)	<b>1</b>	
<b>2</b>	Enter 0.85 of line 1.	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3.	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Schedule A (Form 990) 2023

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

<b>Section D - Distributions</b>		<b>Current Year</b>
<b>1</b>	Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>
<b>2</b>	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>
<b>3</b>	Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>
<b>4</b>	Amounts paid to acquire exempt-use assets	<b>4</b>
<b>5</b>	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )	<b>5</b>
<b>6</b>	Other distributions ( <i>describe in Part VI</i> ). See instructions.	<b>6</b>
<b>7</b>	<b>Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>
<b>8</b>	Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions.	<b>8</b>
<b>9</b>	Distributable amount for 2023 from Section C, line 6	<b>9</b>
<b>10</b>	Line 8 amount divided by line 9 amount	<b>10</b>

<b>Section E - Distribution Allocations</b> (see instructions)		<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2023</b>	<b>(iii) Distributable Amount for 2023</b>
<b>1</b>	Distributable amount for 2023 from Section C, line 6			
<b>2</b>	Underdistributions, if any, for years prior to 2023 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b>	Excess distributions carryover, if any, to 2023			
<b>a</b>	From 2018 . . . . .			
<b>b</b>	From 2019 . . . . .			
<b>c</b>	From 2020 . . . . .			
<b>d</b>	From 2021 . . . . .			
<b>e</b>	From 2022 . . . . .			
<b>f</b>	<b>Total</b> of lines 3a through 3e			
<b>g</b>	Applied to underdistributions of prior years			
<b>h</b>	Applied to 2023 distributable amount			
<b>i</b>	Carryover from 2018 not applied (see instructions)			
<b>j</b>	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b>	Distributions for 2023 from Section D, line 7: \$			
<b>a</b>	Applied to underdistributions of prior years			
<b>b</b>	Applied to 2023 distributable amount			
<b>c</b>	Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b>	Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b>	Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7</b>	<b>Excess distributions carryover to 2024.</b> Add lines 3j and 4c.			
<b>8</b>	Breakdown of line 7:			
<b>a</b>	Excess from 2019 . . . .			
<b>b</b>	Excess from 2020 . . . .			
<b>c</b>	Excess from 2021 . . . .			
<b>d</b>	Excess from 2022 . . . .			
<b>e</b>	Excess from 2023 . . . .			

**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**

**2023**

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

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

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

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

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

Name of organization SHORE MEMORIAL HOSPITAL	Employer identification number 21-0660835
---	--

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

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

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

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

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

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

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

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

Schedule C (Form 990) 2023

**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.

<b>Limits on Lobbying Expenditures</b> <b>(The term "expenditures" means amounts paid or incurred.)</b>	<b>(a) Filing organization's totals</b>	<b>(b) Affiliated group totals</b>												
<b>1a</b> Total lobbying expenditures to influence public opinion (grassroots lobbying) . . . . .														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) . . . . .														
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) . . . . .														
<b>d</b> Other exempt purpose expenditures . . . . .														
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) . . . . .														
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 70%; text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>not over \$500,000,</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>over \$500,000 but not over \$1,000,000,</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>over \$1,000,000 but not over \$1,500,000,</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>over \$1,500,000 but not over \$17,000,000,</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>over \$17,000,000,</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	not over \$500,000,	20% of the amount on line 1e.	over \$500,000 but not over \$1,000,000,	\$100,000 plus 15% of the excess over \$500,000.	over \$1,000,000 but not over \$1,500,000,	\$175,000 plus 10% of the excess over \$1,000,000.	over \$1,500,000 but not over \$17,000,000,	\$225,000 plus 5% of the excess over \$1,500,000.	over \$17,000,000,	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
not over \$500,000,	20% of the amount on line 1e.													
over \$500,000 but not over \$1,000,000,	\$100,000 plus 15% of the excess over \$500,000.													
over \$1,000,000 but not over \$1,500,000,	\$175,000 plus 10% of the excess over \$1,000,000.													
over \$1,500,000 but not over \$17,000,000,	\$225,000 plus 5% of the excess over \$1,500,000.													
over \$17,000,000,	\$1,000,000.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) . . . . .														
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- . . . . .														
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- . . . . .														
<b>j</b> 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.)

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column (e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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...; 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 under section 4912; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?

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

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 supplemental information.



**Part IV** Supplemental Information (continued)

SCHEDULE C, PART II-B; QUESTION 1I

SHORE MEDICAL CENTER ("MEDICAL CENTER") ENGAGES IN LOBBYING EFFORTS ON A FEDERAL AND STATE LEVEL. DURING 2023, THE MEDICAL CENTER PAID AN INDEPENDENT LOBBYING FIRM A TOTAL OF \$55,000 FOR LOBBYING CONSULTING SERVICES.

IN ADDITION, THE MEDICAL CENTER IS A MEMBER OF THE NEW JERSEY HOSPITAL ASSOCIATION WHICH ENGAGES IN LOBBYING EFFORTS ON BEHALF OF ITS MEMBER HOSPITALS. A PORTION OF THE ORGANIZATION'S ANNUAL DUES PAID TO THIS ORGANIZATION IS ALLOCATED TOWARDS ITS LOBBYING EFFORTS. THIS ALLOCATION AMOUNTED TO \$4,079 DURING 2023.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2023

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

Attach to Form 990.

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

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

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 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Part II Conservation Easements

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

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2d above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

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

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

Schedule D (Form 990) 2023

**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? . . . . .  **Yes**  **No**

**Part IV Escrow and Custodial Arrangements**

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? . . . . .  **Yes**  **No**
- b** If "Yes," explain the arrangement in Part XIII and complete the following table.
- |  | Amount    |
|--|-----------|
| <b>c</b> Beginning balance . . . . .             | <b>1c</b> |
| <b>d</b> Additions during the year . . . . .     | <b>1d</b> |
| <b>e</b> Distributions during the year . . . . . | <b>1e</b> |
| <b>f</b> Ending balance . . . . .                | <b>1f</b> |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?  **Yes**  **No**
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII. . . . .

**Part V Endowment Funds**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	888,989.	1,071,577.	1,076,572.	942,234.	819,362.
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses . . . . .	124,945.	-182,588.	-4,995.	134,338.	122,872.
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	1,013,934.	888,989.	1,071,577.	1,076,572.	942,234.

- 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 100.0000 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- |   | Yes           | No |
|---|---------------|----|
| <b>(i)</b> Unrelated organizations? . . . . .   | <b>3a(i)</b>  | X  |
| <b>(ii)</b> Related organizations? . . . . .  | <b>3a(ii)</b> | X  |
| <b>b</b> If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? . . . . . | <b>3b</b>     |    |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		5,378,070.		5,378,070.
<b>b</b> Buildings . . . . .		143,530,779.	68,652,395.	74,878,384.
<b>c</b> Leasehold improvements . . . . .				
<b>d</b> Equipment . . . . .		247,443,218.	217,996,360.	29,446,858.
<b>e</b> Other . . . . .		1,340,385.	1,300,865.	39,520.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B)) . . . . .				109,742,832.

**Part VII Investments - Other Securities**

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely held equity interests . . . . .		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (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) CASH & CASH EQUIVALENTS	83,454,588.	FMV
(2) CERTIFICATES OF DEPOSIT	18,495,613.	FMV
(3) EQUITY MUTUAL FUNDS	52,772,697.	FMV
(4) FIXED INCOME MUTUAL FUNDS	107,760.	FMV
(5) U.S. EQUITY SECURITIES	731,505.	FMV
(6) INSURANCE CONTRACTS	184,081.	FMV
(7) BEN INT IN PERPETUAL TRUST	1,972,251.	FMV
(8) INVESTMENT IN AFFILIATES	-10,927,211.	FMV
(9)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 13, col. (B)) . . .	146,791,284.	

**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	19,587,890.
(2) DEPOSITS	242,916.
(3) OTHER RECEIVABLES	11,602,729.
(4) OTHER ASSETS	4,843,860.
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 15, col. (B)). . . . .	36,277,395.

**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 THIRD PARTIES	2,230,138.
(3) ACCRUED RETIREMENT BENEFITS	15,479,984.
(4) RESERVE FOR INSURANCE CLAIMS	2,472,798.
(5) OTHER LIABILITIES	1,697,983.
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 25, col. (B)). . . . .	21,880,903.

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 line numbers and a final column for totals. Rows include: 1 Total revenue, gains, and other support per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part VIII, line 12, but not on line 1; 5 Total revenue. Add lines 3 and 4c.

**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 line numbers and a final column for totals. Rows include: 1 Total expenses and losses per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part IX, line 25; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part IX, line 25, but not on line 1; 5 Total expenses. Add lines 3 and 4c.

**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 V; QUESTION 4

THE MEDICAL CENTER HAS ADOPTED INVESTMENT POLICIES FOR ITS ENDOWMENT ASSETS THAT ARE CONSISTENT WITH THE POLICIES AND OBJECTIVES OF THEIR OVERALL INVESTMENTS; TO FURTHER THE ORGANIZATION'S CHARITABLE PURPOSES, PROGRAMS AND SERVICES. THE ASSETS ARE INVESTED IN A MANNER THAT IS INTENDED TO PRODUCE A POSITIVE RATE OF RETURN WHILE ASSUMING A LOW LEVEL OF RISK. FROM TIME TO TIME, THE FAIR VALUE OF ASSETS ASSOCIATED WITH THE DONOR-RESTRICTED ENDOWMENT FUNDS MAY FALL BELOW THE LEVEL THAT THE DONOR REQUIRES THE MEDICAL CENTER TO MAINTAIN IN PERPETUAL DURATION.

## SCHEDULE D, PART X

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTING FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF THE SYSTEM FOR THE YEARS ENDED DECEMBER 31, 2023 AND DECEMBER 31, 2022; RESPECTIVELY. THE FOOTNOTE BELOW IS FROM THE SYSTEM'S 2023 AUDITED CONSOLIDATED FINANCIAL STATEMENTS AND REPORTS THE ORGANIZATION'S LIABILITY FOR UNCERTAIN TAX POSITIONS UNDER FIN 48 (ASC 740):

THE SYSTEM FOLLOWS THE ACCOUNTING GUIDANCE FOR UNCERTAINTIES IN INCOME TAX POSITIONS, WHICH REQUIRES THAT A TAX POSITION BE RECOGNIZED OR DERECOGNIZED BASED ON A "MORE LIKELY THAN NOT" THRESHOLD. THIS APPLIES TO

**Part XIII** Supplemental Information *(continued)*

---

POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. THE SYSTEM DOES NOT BELIEVE ITS CONSOLIDATED FINANCIAL STATEMENTS INCLUDE ANY MATERIAL UNCERTAIN TAX POSITIONS.

**SCHEDULE G  
(Form 990)**

**Supplemental Information Regarding Fundraising or Gaming Activities**

OMB No. 1545-0047

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

**2023**

Department of the Treasury  
Internal Revenue Service

Attach to Form 990 or Form 990-EZ.

**Open to Public  
Inspection**

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

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

- 1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- |   |  |
|---|--|
| a <input type="checkbox"/> Mail solicitations               | e <input type="checkbox"/> Solicitation of non-government grants |
| b <input type="checkbox"/> Internet and email solicitations | f <input type="checkbox"/> Solicitation of government grants     |
| c <input type="checkbox"/> Phone solicitations              | g <input type="checkbox"/> Special fundraising events            |
| d <input type="checkbox"/> In-person solicitations          |  |
- 2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees, or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services?  Yes  No
- b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		GALA (event type)	(event type)	NONE (total number)	(add col. (a) through col. (c))
Revenue	<b>1</b> Gross receipts . . . . .	382,565.			382,565.
	<b>2</b> Less: Contributions . . . . .	291,188.			291,188.
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	91,377.			91,377.
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .				
	<b>6</b> Rent/facility costs . . . . .				
	<b>7</b> Food and beverages . . . . .	68,789.			68,789.
	<b>8</b> Entertainment . . . . .	7,000.			7,000.
	<b>9</b> Other direct expenses . . . . .	15,588.			15,588.
	<b>10</b> Direct expense summary. Add lines 4 through 9 in column (d) . . . . .				91,377.
<b>11</b> Net income summary. Subtract line 10 from line 3, column (d) . . . . .					

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

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

**9** Enter the state(s) in which the organization conducts gaming activities: \_\_\_\_\_

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

**b** If "No," explain: \_\_\_\_\_

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

**b** If "Yes," explain: \_\_\_\_\_

- 11 Does the organization conduct gaming activities with nonmembers?  Yes  No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13 Indicate the percentage of gaming activity conducted in:
 

a The organization's facility	<b>13a</b>	%
b An outside facility	<b>13b</b>	%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ \_\_\_\_\_

Address ▶ \_\_\_\_\_

- 15 a Does the organization have a contract with a third party from whom the organization receives gaming revenue?  Yes  No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_.
- c If "Yes," enter name and address of the third party:

Name ▶ \_\_\_\_\_

Address ▶ \_\_\_\_\_

16 Gaming manager information:

Name ▶ \_\_\_\_\_

Gaming manager compensation ▶ \$ \_\_\_\_\_

Description of services provided ▶ \_\_\_\_\_

Director/officer       Employee       Independent contractor

17 Mandatory distributions:

- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?  Yes  No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ \_\_\_\_\_

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

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2023**

**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](http://www.irs.gov/Form990) for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

Name of the organization <b>SHORE MEMORIAL HOSPITAL</b>	Employer identification number <b>21-0660835</b>
--	---

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy? . . . . .	<input checked="" type="checkbox"/>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year: <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		
<b>3</b> 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.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <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"/>	
<b>c</b> 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.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .	<input checked="" type="checkbox"/>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	<input checked="" type="checkbox"/>	
<b>c</b> 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"/>
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .		<input checked="" type="checkbox"/>
<b>b</b> If "Yes," did the organization make it available to the public? . . . . .		

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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			1,776,711.	261,815.	1,514,896.	0.71
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			43,897,117.	43,572,912.	324,205.	0.15
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total.</b> Financial Assistance and Means-Tested Government Programs . . . . .			45,673,828.	43,834,727.	1,839,101.	0.86
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			33,165.		33,165.	0.02
<b>f</b> Health professions education (from Worksheet 5) . . . . .			905,633.		905,633.	0.42
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			13,645,437.		13,645,437.	6.36
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			108,150.		108,150.	0.05
<b>j Total.</b> Other Benefits . . . . .			14,692,385.		14,692,385.	6.85
<b>k Total.</b> Add lines 7d and 7j . . . . .			60,366,213.	43,834,727.	16,531,486.	7.71

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

Schedule H (Form 990) 2023

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

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

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) . . . . .	5	51,974,440.
6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	6	64,605,890.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	7	-12,631,450.
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? . . . . .	9a	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	9b	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):

	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
<b>1</b> SHORE MEMORIAL HOSPITAL 100 MEDICAL CENTER WAY SOMERS POINT NJ 08244-2387 WWW.SHOREMEDICALCENTER.ORG	X	X					X			1
<b>2</b>										
<b>3</b>										
<b>4</b>										
<b>5</b>										
<b>6</b>										
<b>7</b>										
<b>8</b>										
<b>9</b>										
<b>10</b>										

**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: SHORE MEMORIAL HOSPITAL

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

		Yes	No
<b>Community Health Needs Assessment</b>			
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 two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . .	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
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 checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
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? . . . . .	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.SHOREMEDICALCENTER.ORG</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 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.SHOREMEDICALCENTER.ORG</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	X	
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: SHORE MEMORIAL HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	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:	<b>X</b>	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>500.0000</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance status		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>X</b>	
<b>15</b>	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):	<b>X</b>	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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):	<b>X</b>	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.SHOREMEDICALCENTER.ORG</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.SHOREMEDICALCENTER.ORG</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.SHOREMEDICALCENTER.ORG</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" 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		
<b>j</b>	<input 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: SHORE MEMORIAL HOSPITAL

		Yes	No
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	X	
<b>18</b>	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:		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>f</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b>	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
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b>	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):		
<b>a</b>	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
<b>b</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)		
<b>c</b>	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
<b>d</b>	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>f</b>	<input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

		Yes	No
<b>22</b>	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:		
	<b>a</b> <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>b</b> <input checked="" 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		
	<b>c</b> <input 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		
	<b>d</b> <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b>	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.		<b>X</b>
<b>24</b>	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.		<b>X</b>

**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 3I

THE IMPACT OF ANY ACTIONS TAKEN TO ADDRESS THE SIGNIFICANT HEALTH NEEDS IDENTIFIED IN SMC'S PRIOR CHNA WAS INADVERTENTLY OMITTED FROM THE 2022 CHNA. HOWEVER, THE ORGANIZATION HAS COMPILED THIS INFORMATION, WHICH IS CURRENTLY MADE WIDELY AVAILABLE ON ITS WEBSITE AS WELL AS INCLUDED BELOW:

AS A RESULT OF THE FINDING OF SHORE MEDICAL CENTER'S 2019 CHNA, THE ORGANIZATION DEVELOPED AND ADOPTED AN IMPLEMENTATION PLAN TO ADDRESS THE FOLLOWING HEALTH RISK FACTORS AND DISEASES IDENTIFIED AS HAVING THE GREATEST LEVEL OF PRIORITIZATION FOR THE COMMUNITY WE SERVE, THROUGH 2022.

THOSE AREAS ARE:

- OBESITY;
- HEART DISEASE;
- CANCER;
- DIABETES; AND
- OPIOIDS.

BELOW PLEASE FIND A DESCRIPTION OF THE ACTIONS TAKEN TO ADDRESS THE SIGNIFICANT HEALTH NEEDS IDENTIFIED IN THE ORGANIZATION'S CHNA. ADDITIONALLY, DESCRIBED BELOW IS THE IMPACT OF ALL OF THOSE ACTIONS TAKEN.

OBESITY

-----

SHORE PHYSICIANS GROUP WELCOMED DR. MARIA CERNA TO ITS PRIMARY CARE TEAM IN MAY OF 2022. DR. CERNA SEES PATIENTS OUT OF NORTHFIELD AND IS FLUENT IN BOTH ENGLISH AND SPANISH. ONE OF DR. CERNA'S FOCUS IS OBESITY. PRIOR TO JOINING THE TEAM DR. CERNA PARTICIPATED IN NUMEROUS COMMUNITY SERVICE PROGRAMS BOTH IN HONDURAS AND THE UNITED STATES, INCLUDING A PROJECT IN THE BRONX TO HELP REDUCE THE OBESITY RATE IN CHILDREN.

SHORE PARTNERED WITH GOJI, A LOCAL EATERY TO PROMOTE HEALTHY EATING HABITS TO EMPLOYEES OF THE HOSPITAL, PATIENTS, AND COMMUNITY MEMBERS.

TIFFANY RIOS, A CERTIFIED DIABETES EDUCATOR AND REGISTERED DIETITIAN WAS INTERVIEWED TWICE ON LOCAL TALK RADIO, WOND, ON BEHALF OF SHORE TO DISCUSS OBESITY, HEALTHY WEIGHT LOSS, AND ADVOCATE FOR THE PLATE METHOD.

HEART DISEASE

-----

SCREENING & EDUCATION: SHORE PARTICIPATED IN SEVERAL MAJOR HEALTH SCREENING EVENTS DURING THE TIME FRAME, INCLUDING THE ANNUAL BAYFEST

**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.

HEALTH FAIR, AMERICAN HEART WALK, OCEAN CITY SUMMER HEALTH FAIR, SOMERS POINT GOOD OL' DAYS FESTIVAL WHICH EACH RESULTED IN DIRECT EDUCATION AND BLOOD PRESSURE TESTING FOR HUNDREDS OF MEMBERS

SHORE MEDICAL CENTER'S CARDIOVASCULAR SERVICES FEATURE A TEAM OF HIGHLY TRAINED AND EXPERIENCED DOCTORS, NURSES AND SUPPORT STAFF THAT PROVIDES COMPREHENSIVE CARDIOVASCULAR HEALTH SERVICES WITH A SPECIAL EMPHASIS ON ADVANCED DIAGNOSIS, EDUCATION AND PREVENTION. WITH ITS PARTNERSHIP WITH PENN CARDIOLOGY, SHORE HAS BROUGHT UNIVERSITY-SETTING CARDIAC AND VASCULAR SERVICES TO THE COMMUNITY HOSPITAL ENVIRONMENT. PENN CARDIOLOGY-SOMERS POINT OFFICES ARE LOCATED ACROSS AN ENCLOSED WALK-BRIDGE THAT CONNECTS THE HOSPITAL TO THE HOSPITAL PARKING GARAGE. THE CLINICAL TEAM AT SHORE MEDICAL CENTER CARDIOVASCULAR SERVICES USES SOPHISTICATED TECHNOLOGY FOR DIAGNOSIS AND TREATMENT OF DISORDERS OF THE HEART AND CIRCULATORY SYSTEM. THROUGH ITS CLINICAL AFFILIATION WITH THE NATIONALLY RENOWNED PENN HEART & VASCULAR NETWORK PROGRAM AT THE PENN PRESBYTERIAN MEDICAL CENTER, SHORE HAS CONTINUED ACCESS TO THE NEWEST ADVANCES, TECHNIQUES AND CLINICAL RESEARCH IN THE FIGHT AGAINST HEART DISEASE.

CANCER

-----

SHORE MEDICAL CENTER HAS A DEDICATED CANCER CENTER. THE CANCER CENTER WORKS ON A VARIETY OF PROJECTS THAT FOCUS ON COMMUNITY OUTREACH. THIS IS DONE THROUGH OUR CANCER EDUCATION AND EARLY DETECTION (CEED) PROGRAM, REGIONAL COALITION (CAPE ATLANTIC COALITION FOR HEALTH), AND COMMISSION ON CANCER PROGRAMS. A RANGE OF SPEAKERS IS OFFERED ON SHORE MEDICAL CENTER'S SPEAKERS BUREAU.

DURING 2023, PARTICIPATION IN 51 EVENTS OCCURRED REACHING OVER 4,278 PEOPLE ON VARIOUS CANCER AND HEALTH/WELLNESS TOPICS. EXAMPLES OF COMMUNITY EFFORTS TO IMPACT THESE HEALTH RISKS INCLUDE:

- CEED PROGRAM: THE CEED PROGRAM PROVIDES FREE SCREENINGS FOR BREAST, CERVICAL, COLORECTAL, AND/OR PROSTATE CANCER. THIS IS AVAILABLE FOR UNINSURED AND UNDERINSURED LOW-INCOME PATIENTS. THESE EFFORTS RESULTED IN 729 SCREENINGS DURING 2023.

- SIX FREE CANCER SCREENINGS EVENTS OCCURRED IN 2023. THE SCREENINGS INCLUDED ONE BREAST, TWO LUNG, AND THREE PROSTATE RESULTING IN 83 PARTICIPANTS.

- A CANCER SUPPORT SIX WEEK WORKSHOP SERIES (CANCER THRIVING AND SURVIVING) WAS MADE AVAILABLE ONLINE TO ASSIST CANCER PATIENTS, CANCER SURVIVORS, AND CANCER PATIENT CAREGIVERS WITH SUPPORT AND EDUCATION REGARDING A VARIETY OF TOPICS SUCH AS FATIGUE MANAGEMENT, NUTRITION, EXERCISE, BETTER SLEEP, EMOTIONAL COMPONENTS, AND MORE. ONE WORKSHOP

**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.

SERIES WAS COMPLETED IN 2023.

- A MEDITATION RETREAT WAS COMPLETED TO ASSIST PEOPLE WITH LEARNING HOW TO MEDITATE - SPECIFICALLY IN REGARDS TO CANCER AND CHRONIC DISEASE. 21 PEOPLE ATTENDED.

- SUMMER PROJECT WITH BEACH TAGGERS. 370 POUCHES WERE HANDED OUT TO ATLANTIC AND CAPE MAY COUNTY BEACH TAGGERS FOCUSING ON SUN SAFETY FOR HIGH-RISK JOBS. EDUCATIONAL INFORMATION WITH A SURVEY, SUNSCREEN AND SUN STICKS WERE IN THE POUCHES.

DIABETES

-----

THE HOSPITAL WORKS WITH SHORE PHYSICIANS GROUP TO OFFER A GRANT-FUNDED DIABETES PREVENTION PROGRAM. THE PROGRAM WAS CREATED PRIOR TO THE PANDEMIC AND CONTINUED TO HAVE GREAT SUCCESS IN 2022. IN 2022 THE PROGRAM HAD 22 PATIENTS.

SPG'S TIFFANY RIOS IS A CERTIFIED DIABETES EDUCATOR AND REGISTERED DIETICIAN WHO HAS SPOKEN AT MANY EVENTS TO PROVIDE DIABETES EDUCATION TO COMMUNITY MEMBERS. MS. RIOS SPOKE AT SHORE'S COMMUNITY BREAKFAST DIABETES 101: MANAGEMENT AND PREVENTION EVENT ALONGSIDE TAYLOR DONOVAN, RN, MSN, DIABETES CARE SPECIALIST AND DR. MATTHEW CORCORAN, ENDOCRINOLOGIST IN NOVEMBER 2022. THIS EVENT WAS ATTENDED BY OVER 100 PEOPLE.

OPIOIDS

-----

SHORE MEDICAL CENTER IMPLEMENTED AND PARTOOK IN THE FOLLOWING INITIATIVES AND PROGRAMS TO ADDRESS THE ABUSE OF OPIOIDS IN ATLANTIC COUNTY:

INPATIENT AND EMERGENCY DEPARTMENT POWERPLANS. THESE UPDATED PLANS INCLUDE EVIDENCE-BASED MULTIMODAL PAIN MANAGEMENT STRATEGIES.

IV PUSH DIPHENHYDRAMINE (BENADRYL) RESTRICTION: (1) IMPLEMENTED TO DETER DRUG-SEEKING BEHAVIOR DUE TO THE EUPHORIC EFFECTS OF ADMINISTERING DIPHENHYDRAMINE QUICKLY; AND (2) ADMINISTRATION OF IV DIPHENHYDRAMINE IS STILL PERMITTED AS AN IV PIGGYBACK OF MORE THAN 30-60 MINUTES FOR PATIENTS WHO REQUIRE THIS MEDICATION FOR THE ITCHING OFTEN EXPERIENCED AFTER RECEIVING HIGH DOSES OF IV OPIOIDS

NALOXONE DISCHARGE KITS: SHORE IS PROVIDING NALOXONE DISCHARGE KITS TO PATIENTS WHO PRESENT TO SHORE MEDICAL CENTER AFTER AN OPIOID OVERDOSE OR WHO DISPLAY SIGNS/SYMPTOMS OF OPIOID AND/OR IV DRUG ABUSE. A NALOXONE DISCHARGE KIT CONTAINS: 1 DOSE OF NASAL NALOXONE, INFORMATION ON HOW TO USE NASAL NALOXONE FOR PATIENTS AND CAREGIVERS, A JTAC ALCOHOL AND DRUG TREATMENT RESOURCE GUIDE, AND NEW JERSEY SYRINGE ACCESS PROGRAM

**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.

## INFORMATION

SHORE IS ALSO PILOTING A PHARMACY PAIN CONSULT SERVICE AS A PHARMACY RESIDENT RESEARCH PROJECT. PROVIDERS CAN CONTACT A PHARMACIST TO PERFORM A COMPREHENSIVE CHART REVIEW AND PROVIDE PATIENT-SPECIFIC PAIN MANAGEMENT RECOMMENDATIONS.

SHORE PARTICIPATED IN THE ATLANTIC COUNTY OPIOID COMMITTEE. THIS COMMITTEE WAS ESTABLISHED TO HELP IDENTIFY THE BEST USE OF FUNDS ALLOCATED TO ATLANTIC COUNTY FROM DAMAGES AWARDED IN THE NATIONAL OPIOID SETTLEMENT. THE COMMITTEE WAS CHARGED TO REVIEW CURRENT SERVICES AND PRIORITIZE HOW WE COULD BEST ADDRESS GAPS IN CARE.

MEMBERS OF THE PHARMACY STAFF HAVE COMPLETED ADDITIONAL PAIN MANAGEMENT CERTIFICATE TRAINING. PROVIDERS CAN CONTACT A PHARMACIST TO PERFORM A COMPREHENSIVE CHART REVIEW AND PROVIDE PATIENT-SPECIFIC PAIN MANAGEMENT RECOMMENDATIONS.

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

THE ORGANIZATION'S CHNA TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVICED BY THE HOSPITAL FACILITY.

SHORE MEDICAL CENTER COMPLETED AN ONLINE COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY IN AN EFFORT TO GAIN INPUT FROM THE COMMUNITY ON HEALTH ISSUES OF CONCERN. THE SURVEY QUESTIONS WERE DEVELOPED IN A TEAM APPROACH BY BRAINSTORMING QUESTIONS AND EXAMINING SEVERAL SAMPLE SURVEYS. THE SURVEY WAS DISPERSED THROUGH SHORE MEDICAL CENTER EMAIL BLASTS (21,000 TOTAL EMAILS SENT) AND A LINK/DESCRIPTION OF THE SURVEY WAS HIGHLIGHTED ON THE HOME PAGE THE SHORE MEDICAL CENTER WEBSITE (HOME PAGE RECEIVES A MINIMUM OF 70,000 HITS A MONTH). THE SURVEY WAS UP ON THE ORGANIZATION'S WEBSITE FOR FOUR MONTHS.

APPROXIMATELY 100 PEOPLE COMPLETED THE SURVEY. PEOPLE WHO RESPONDED TO THE SURVEY WERE PREDOMINANTLY WOMEN, WHITE, AND/OR OVER 65. THE INFORMATION GATHERED COMPLEMENTED INFORMATION RECEIVED FROM OUR PATIENT POPULATION AT THE HOSPITAL TO HELP DETERMINE CONCERNS THAT SHORE NEEDED TO ADDRESS IN THE COMMUNITY.

SHORE MEDICAL CENTER'S 2022 CHNA PROCESS INCLUDED REVAMPING ALL THE STATISTICS, ADDING NEW TOPICS SUCH AS COVID-19, AND CONDENSING CONTENT FOR CONSISTENCY. ALL STATISTICAL INFORMATION WAS GATHERED FROM QUALITY DATA SOURCES, WHICH INCLUDED THE FOLLOWING:

- AMERICAN DIABETES ASSOCIATION

**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.

- CENTERS FOR DISEASE CONTROL AND PREVENTION
- COUNTY HEALTH RANKINGS, UNIVERSITY OF WISCONSIN
- MAYO CLINIC
- NATIONAL CANCER INSTITUTE
- NATIONAL INSTITUTE OF DRUG ABUSE
- NATIONAL INSTITUTE OF HEALTH
- NEW JERSEY STATE HEALTH ASSESSMENT DATA
- NEW JERSEY CANCER REGISTRY
- NEW JERSEY DEPARTMENT OF HEALTH
- THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
- UNITED STATES CENSUS BUREAU

SHORE'S CHNA INTERNAL COMMITTEE INCLUDED THE FOLLOWING INDIVIDUALS/GROUPS IN ORDER TO ENSURE THAT THE HOSPITAL'S OUTREACH EFFORTS TRULY REFLECT THE CHANGING HEALTH NEEDS OF THE COMMUNITY THAT IT SERVES.

- ALAN BEATTY, MBA, VICE PRESIDENT OF HUMAN RESOURCES
- FREDERICK CANTZ, CHIEF COMPLIANCE OFFICER
- BRIAN CAHILL, DIRECTOR OF MARKETING
- ANGELA A. BAILEY, MSW, LSW, MANAGER OF CANCER COMMUNITY OUTREACH
- JASIAH SANCHEZ, OUTREACH COORDINATOR
- ALEXA PETILLO, HUMAN RESOURCE ASSISTANT
- ERICA BARRON, COMMUNITY HEALTH WORKER
- ALYSSA RICKETTS, SOCIAL WORK INTERN
- NICK PELLEGRINO, MARKETING INTERN

SCHEDULE H, PART V, SECTION B, QUESTION 7A

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; 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 ORGANIZATION'S CHNA CAN BE ACCESSED AT THE FOLLOWING PAGE INCLUDED IN THE SYSTEM'S WEBSITE:  
[HTTPS://SHOREMEDICALCENTER.ORG/WELLYES/COMMUNITY\\_NEEDS\\_ASSESSMENT](https://shoremehicalcenter.org/wellyes/community_needs_assessment)

SCHEDULE H, PART V, SECTION B, QUESTION 10

**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.

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). DUE TO CHARACTER LIMITATIONS, THE WEBSITE LISTED IN SCHEDULE H, PART V, SECTION B, QUESTION 10, IS THE HOME PAGE FOR THE SYSTEM. THE ORGANIZATION'S IMPLEMENTATION STRATEGY CAN BE ACCESSED AT THE FOLLOWING PAGE INCLUDED IN THE SYSTEM'S WEBSITE:  
[HTTPS://SHOREMEDICALCENTER.ORG/WELLYES/COMMUNITY\\_NEEDS\\_ASSESSMENT](HTTPS://SHOREMEDICALCENTER.ORG/WELLYES/COMMUNITY_NEEDS_ASSESSMENT)

SCHEDULE H, PART V, SECTION B, QUESTION 11

THE ORGANIZATION'S IMPLEMENTATION STRATEGY WAS ADOPTED AND POSTED ON THE HOSPITAL'S WEBSITE ON DECEMBER 5, 2022. THIS IMPLEMENTATION STRATEGY IDENTIFIES THE MEANS BY WHICH SHORE MEDICAL CENTER PLANS TO ADDRESS COMMUNITY HEALTH NEEDS DURING 2023 THROUGH 2025. BEYOND THE SERVICES AND PROGRAMS DETAILED IN ITS IMPLEMENTATION STRATEGY, SHORE HAS AND CONTINUES TO PROVIDE A FULL-RANGE OF SERVICES AND PROGRAMS TO OUR COMMUNITY. SHORE MEDICAL CENTER'S COMMITMENT TO ITS COMMUNITY, PATIENTS AND THEIR FAMILY MEMBERS RUNS PARALLEL TO ITS NOT-FOR-PROFIT MISSION.

THE FOLLOWING HEALTH ISSUES WERE IDENTIFIED AS PRIORITY HEALTH NEEDS: OBESITY, TOBACCO, CANCER, MENTAL HEALTH, OPIOIDS, COVID-19, AND PRIMARY CARE SHORTFALLS.

PROJECTS WERE DEVELOPED TO SPECIFICALLY ADDRESS EACH OF THE IDENTIFIED HEALTH NEEDS OVER THE COURSE OF THE IMPLEMENTATION PERIOD. THIS STRATEGY INCLUDES PROVIDING PRIORITY ATTENTION AND PLANS TO ADDRESS THESE KEY HEALTH ISSUES THROUGH BETTER EDUCATION AND IMPLEMENTATION OF PROGRAMS DESIGNED TO ADDRESS THE NEEDS OF OUR COMMUNITY.

THROUGH THE IMPLEMENTATION STRATEGY PLAN, SHORE MEDICAL CENTER LOOKS TO IMPACT THE FOLLOWING:

- CHRONIC DISEASE REDUCTION
- IMPROVED ACCESS TO CARE (INCLUDING MENTAL HEALTH)
- INCREASED ACCESS TO ADDICTION TREATMENT
- IMPROVEMENT TO HEALTHY LIFESTYLES
- CONNECTION TO FINANCIAL RESOURCES

BELOW IS A SUMMARY OF HOW THE ORGANIZATION PLANS TO ADDRESS THE IDENTIFIED HEALTH NEEDS:

POOR HEALTH STATUS AND CHRONIC DISEASE CAN RESULT WHEN MEMBERS OF THE COMMUNITY ARE IMPACTED BY RISK FACTORS. SOME RISK FACTORS CAN BE PREVENTED AND CAN SERVE TO IMPROVE QUALITY OF LIFE AND REDUCE MORTALITY AND MORBIDITY. THE LEADING PREVENTABLE CAUSES OF CHRONIC DISEASE IS

**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.

OBESITY AND TOBACCO USE (SPECIFICALLY SMOKING).

STRATEGY 1: OBESITY - DEVELOP AND INTEGRATE NUTRITIONAL SERVICES INTO THE SHORE PHYSICIANS GROUP ADULT PRIMARY CARE OFFICES. PROVIDE A HIGH FOCUS ON PEDIATRICS, COORDINATING A WORKING RELATIONSHIP BETWEEN OUR ONSITE NEONATAL PARTNERS AS WELL AS UNIDINE IN BOTH AN AMBULATORY AND INPATIENT ENVIRONMENT.

STRATEGY 2: TOBACCO - EDUCATE PROVIDERS AND STAFF ABOUT THE BENEFITS OF QUITTING TOBACCO THROUGH OFFERING ASK, ADVISE, REFER TRAINING; OBTAINING EASY TO HANDOUT MATERIALS FOR PATIENTS ON SMOKING CESSATION SERVICES AVAILABLE; AND DEVELOP AN EASY REFERRAL PROCESS TO SERVICES.

CANCER IS A COMPLEX DISEASE IN WHICH PREVENTION, SCREENING AND TREATMENT IS AN ASPECT OF FOCUS. DETECTING CANCER EARLY AND OFFERING QUALITY TREATMENT LOCALLY FOR THE COMMUNITY IN ESPECIALLY HIGH INCIDENCE CANCERS IS A PRIORITY.

STRATEGY 3: INCREASE CAPACITY AND ACCESS OF QUALITY MEDICAL AND RADIATION ONCOLOGY TARGETING BOTH HIGH INCIDENCE AND MORTALITY.

STRATEGY 4: EXPAND ACCESS TO CANCER SCREENING INCLUDING UNDERSERVED POPULATIONS TO FIND CANCER EARLY WHEN MOST TREATABLE.

STRATEGY 5: EDUCATE PRIMARY CARE PROVIDERS ABOUT CANCER SCREENING, SPECIFICALLY LUNG CANCER SCREENING. DEVELOP EASY REFERRAL PROCESSES TO CONNECT PATIENTS TO CANCER SCREENING.

MENTAL HEALTH ISSUES HAVE BECOME MORE ACKNOWLEDGED DURING THE COVID-19 PANDEMIC. THE OPIOID EPIDEMIC HAS GAINED MOMENTUM BOTH LOCALLY AND NATIONALLY AND HAS BECOME A GROWING CONCERN. SHORE SUPPORTS HEALTHCARE PROVIDERS AND PATIENTS IN THE BATTLE AGAINST OPIOID ADDICTION AND REFERRALS TO MENTAL HEALTH SERVICES.

STRATEGY 6: MENTAL HEALTH - DEVELOP STRATEGIES FOR INTEGRATING MORE MENTAL HEALTH RESOURCES AND REFERRALS INTO PRIMARY CARE PROVIDER PRACTICES LEVERAGING OUR MENTAL HEALTH PARTNER LEGACY.

STRATEGY 7: OPIOIDS - LEVERAGING A FOUR YEAR, \$1 MIL/YEAR, FEDERAL GRANT RECEIVED BY OUR MENTAL HEALTH PARTNERS LEGACY, INCREASE ACCESS TO OPIOID ADDICTION SUPPORT SERVICES BY PARTNERING WITH ADDICTION/MENTAL HEALTH SERVICE AGENCIES. CONTINUE THE SUPPORT TO OUR BAYFRONT EMERGENCY PARTNERS IN THEIR OPIOID MONITORING/REDUCTION PROGRAM IN THE EMERGENCY DEPARTMENT.

THE COVID-19 PANDEMIC HAS DISRUPTED ALL ASPECTS OF LIFE. REMAINING PREPARED FOR SHIFTS OF SERVICES AND PATIENTS' NEEDS THROUGH HEIGHTENED PERIODS OF CONTAGIOUS OUTBREAKS REMAINS IMPORTANT.



**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.

STRATEGY 8: CONTINUE TO MONITOR COMMUNITY COVID-19 INFECTION RATES; MAINTAIN SAFETY PRECAUTIONS TO PREVENT SPREAD OF CONTAGIOUS DISEASE; AND MAINTAIN APPROPRIATE LEVELS OF NEGATIVE PRESSURE ROOMS AND CONVERT ROOMS AS NECESSARY.

STRATEGY 9: PARTNER WITH PRIMARY CARE AND PUBLIC HEALTH ORGANIZATIONS TO PROMOTE COVID-19 VACCINE COMPLIANCE AND ACCESS.

MANY HEALTH PROVIDERS RELY ON VIRTUAL COMMUNICATION WITH PATIENTS TO PROVIDE SERVICES. FOR EXAMPLE, PROVIDERS CLOSED THEIR OFFICES TO PREVENT THE TRANSMISSION OF THE VIRUS DURING THE COVID-19 PANDEMIC. POPULATIONS WITH POOR ACCESS TO VIRTUAL HEALTHCARE TEND TO HAVE HIGHER RATES OF CHRONIC CONDITIONS AND WORSE HEALTH OUTCOMES, SUGGESTING THAT THEY MAY BE PARTICULARLY VULNERABLE TO THE CONSEQUENCES FROM LAPSES IN CARE.

STRATEGY 10: PROVIDE INITIAL FINANCIAL RESOURCES AS SECURED BY A FEDERAL FCC GRANT TO ACQUIRE AND DEPLOY FREE INTERNET TABLETS PRELOADED WITH PATIENT PORTALS AND A WIDE RANGE OF HEALTHCARE RESOURCES.

CHRONIC DISEASE, AGAIN POPULATIONS, AND UNHEALTHY LIFESTYLE HABITS ALL CONNECT TO THE NEED OF ROUTINE HEALTHCARE. PATIENT'S FIRST POINT OF CONTACT FOR NON-URGENT HEALTH CONCERNS SHOULD BE THEIR PRIMARY CARE PHYSICIAN. A SHORTFALL IN THE NUMBER OF HEALTHCARE PROVIDERS HAS MAJOR CONSEQUENCES FOR PATIENTS.

STRATEGY 11: PROVIDE ROBUST MEDICAL SERVICES IN OUR COMMUNITY THROUGH MAINTAINING, RECRUITING AND TRAINING PHYSICIANS AS WELL AS SUPPORTING DELIVERY OF CARE THROUGH ADVANCE NURSE PRACTITIONERS. LEVERAGE TELEHEALTH FOR SERVICES WHERE APPROPRIATE. DELIVER SERVICES IN A WAY THAT PROVIDES THE MOST CONVENIENT ACCESS FOR THE GENERAL COMMUNITY WHILE ALSO OFFERING EXCEPTIONAL PATIENT EXPERIENCE.

SCHEDULE H, PART V, SECTION B, QUESTION 16

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; 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://SHOREMEDICALCENTER.ORG/PATIENTS\\_VISITORS/PATIENTS/INSURANCE/FINANCIAL\\_ASSISTANCE](https://shoremedicalcenter.org/patients_visitors/patients/insurance/financial_assistance)

**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.

**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.

SCHEDULE H, PART I, LINE 3C

IN ADDITION TO THE FEDERAL POVERTY GUIDELINES, THE ORGANIZATION USES OTHER FACTORS IN DETERMINING ELIGIBILITY CRITERIA FOR FREE AND DISCOUNTED CARE. AS OUTLINED IN PART V, SECTION B, QUESTION 13, OTHER FACTORS TO DETERMINE ELIGIBILITY INCLUDE:

- ASSET LEVEL;
- MEDICAL INDIGENCY;
- INSURANCE STATUS;
- UNDERINSURANCE STATUS; AND
- RESIDENCY.

ADDITIONAL INFORMATION WITH RESPECT TO ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE IS OUTLINED BELOW.

NEW JERSEY HOSPITAL CHARITY CARE PAYMENT ASSISTANCE PROGRAM ("CHARITY CARE")

**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.

-----

CHARITY CARE IS A NEW JERSEY PROGRAM IN WHICH FREE OR DISCOUNTED CARE IS AVAILABLE TO PATIENTS WHO RECEIVE INPATIENT AND OUTPATIENT SERVICES AT ACUTE CARE HOSPITALS THROUGHOUT THE STATE OF NEW JERSEY. HOSPITAL ASSISTANCE AND REDUCED CHARGE CARE ARE ONLY AVAILABLE FOR NECESSARY EMERGENCY OR OTHER MEDICALLY NECESSARY CARE.

PATIENTS MAY BE ELIGIBLE FOR CHARITY CARE IF THEY ARE NEW JERSEY RESIDENTS WHO:

- 1) HAVE NO HEALTH COVERAGE OR HAVE COVERAGE THAT PAYS ONLY PART OF THE HOSPITAL BILL (UNINSURED OR UNDERINSURED);
- 2) ARE INELIGIBLE FOR ANY PRIVATE OR GOVERNMENTAL SPONSORED COVERAGE (SUCH AS MEDICAID); AND
- 3) MEET THE FOLLOWING INCOME AND ASSET ELIGIBILITY CRITERIA DESCRIBED

**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.

BELOW.

INCOME CRITERIA: PATIENTS WITH FAMILY GROSS INCOME LESS THAN OR EQUAL TO 200% OF FEDERAL POVERTY GUIDELINES ("FPG") ARE ELIGIBLE FOR 100% CHARITY CARE COVERAGE. PATIENTS WITH FAMILY GROSS INCOME GREATER THAN 200% AND LESS THAN OR EQUAL TO 300% OF FPG ARE ELIGIBLE FOR DISCOUNTED CARE. FREE CARE OR PARTIALLY COVERED CHARGES WILL BE DETERMINED BY USE OF THE NEW JERSEY DEPARTMENT OF HEALTH FEE SCHEDULE.

IF PATIENTS ON THE 20% TO 80% SLIDING FEE SCALE ARE RESPONSIBLE FOR QUALIFIED OUT-OF-POCKET PAID MEDICAL EXPENSES IN EXCESS OF 30% OF THEIR GROSS ANNUAL INCOME (I.E. BILLS UNPAID BY OTHER PARTIES), THEN THE AMOUNT IN EXCESS OF 30% IS CONSIDERED HOSPITAL CARE PAYMENT ASSISTANCE.

ASSET CRITERIA: CHARITY CARE INCLUDES ASSET ELIGIBILITY THRESHOLDS WHICH STATES THAT INDIVIDUAL ASSETS CANNOT EXCEED \$7,500 AND FAMILY ASSETS CANNOT EXCEED \$15,000 AS OF THE DATE OF SERVICE.

**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.

CHARITY CARE MAY BE AVAILABLE TO NON-NEW JERSEY RESIDENTS, REQUIRING IMMEDIATE MEDICAL ATTENTION FOR AN EMERGENCY MEDICAL CONDITION.

NEW JERSEY UNINSURED DISCOUNT PUBLIC LAW 2008, C. 60 ("UNINSURED DISCOUNT")

-----

THE NEW JERSEY UNINSURED DISCOUNT (NJ LAW - BILL S-1797/A-2609) IS AVAILABLE TO UNINSURED PATIENTS WHOSE FAMILY GROSS INCOME IS LESS THAN 500% OF FPG. ELIGIBLE INDIVIDUALS MUST BE NEW JERSEY RESIDENTS. HOWEVER, SMC HAS ELECTED TO APPLY THIS DISCOUNT TO ALL UNINSURED PATIENTS IRRESPECTIVE OF INCOME LEVEL OR RESIDENCY. SMC OFFERS DISCOUNTED RATES TO ALL UNINSURED INDIVIDUALS. UNDER THIS PROGRAM, AN ELIGIBLE PATIENT WILL BE CHARGED AN AMOUNT NO GREATER THAN 115% OF THE MEDICARE FEE SCHEDULE. UNINSURED BILLING LIMITS ARE IN ACCORDANCE WITH NJ P.L.2008 C60.

**Part VI** Supplemental Information

Provide the following information.

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

SCHEDULE H, PART I, LINE 6A

NOT APPLICABLE.

SCHEDULE H, PART I, LINE 7

WORKSHEET 2 WAS USED FOR THE COST TO CHARGE RATIO.

SCHEDULE H, PART I, QUESTION 7B

SHORE MEMORIAL HOSPITAL D/B/A SHORE MEDICAL CENTER PARTNERED WITH ATLANTIC 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 JERSEY'S MEDICAID PROGRAM AND CERTAIN



**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.

FEDERAL MATCHING FUNDS IN ORDER TO BETTER SERVE THE NEEDS IN THE COMMUNITY. THE ADDITIONAL FUNDS RECEIVED FROM THE PROGRAM DURING 2023 TOTALED APPROXIMATELY \$15.6M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; DIRECT OFFSETTING MEDICAID REVENUE. THE ASSOCIATED COUNTY OPTION EXPENSES ASSOCIATED WITH THE PROGRAM DURING 2023 TOTALED APPROXIMATELY \$4.6M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; MEDICAID TOTAL COMMUNITY BENEFIT EXPENSE. IN ADDITION, SHORE MEDICAL CENTER RECEIVED QUALITY IMPROVEMENT PROGRAM - NEW JERSEY ("QIP-NJ") FUNDING TO SUPPORT CONTINUED POPULATION HEALTH IMPROVEMENT ACROSS NEW JERSEY. THE ADDITIONAL FUNDS RECEIVED FROM QIP-NJ PROGRAM DURING 2023 TOTALED APPROXIMATELY \$1.5M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; DIRECT OFFSETTING MEDICAID REVENUE. IF SHORE MEDICAL CENTER DID NOT RECEIVE THESE ADDITIONAL FUNDS, THE NET COMMUNITY BENEFIT EXPENSE REPORTED ON SCHEDULE H, PART I; LINE 7K WOULD BE \$29,058,031 AND THE NET COMMUNITY BENEFIT PERCENTAGE REPORTED ON SCHEDULE H, PART I; LINE K WOULD BE 13.55%.

**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

SHORE MEMORIAL HOSPITAL D/B/A SHORE MEDICAL CENTER ("THE MEDICAL CENTER")

IS PROUD TO MAKE A DIFFERENCE IN THE COMMUNITIES WE CALL HOME. OUR

GENEROUS MEDICAL CENTER STAFF HAVE PARTICIPATED IN NUMEROUS EVENTS THAT

SUPPORT AND EXEMPLIFY THE MEDICAL CENTER'S COMMITMENT TO OUR COMMUNITY.

OUR PRIMARY GOAL IS TO CARE FOR AND RESPECT, ALL PATIENTS, THEIR FAMILIES

AND EACH OTHER. ALONG WITH THE SUPERIOR CARE THAT WE DELIVER EVERY DAY,

WE STRIVE TO EDUCATE AND PROMOTE WELLNESS TO THE COMMUNITY THROUGH THE

MANY OUTREACH PROGRAMS WE OFFER. MORE RECENTLY, THE MEDICAL CENTER BECAME

THE FIRST HOSPITAL IN NEW JERSEY AND ONE OF LESS THAN 50 ORGANIZATIONS

WORLDWIDE TO RECEIVE PLANETREE PATIENT-CENTERED CARE DESIGNATION. THE

PLANETREE MODEL OF CARE IS A PATIENT-CENTERED, HOLISTIC APPROACH TO

HEALTHCARE, PROMOTING MENTAL, EMOTIONAL, SPIRITUAL, SOCIAL AND PHYSICAL

HEALING. WE HOPE TO EMPOWER OUR PATIENTS AND FAMILIES THROUGH THE

EXCHANGE OF INFORMATION TO ULTIMATELY ENCOURAGE AND FOSTER HEALING

PARTNERSHIPS WITH CAREGIVERS.

**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, LINES 2, 3 & 4

BAD DEBT EXPENSE WAS CALCULATED USING THE PROVIDERS' BAD DEBT EXPENSE FROM THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS, NET OF ACCOUNTS WRITTEN OFF AT CHARGES.

SHORE MEMORIAL HEALTH SYSTEM PREPARES AND ISSUES AUDITED CONSOLIDATED FINANCIAL STATEMENTS. THE ATTACHED TEXT WAS OBTAINED FROM THE FOOTNOTES TO THE AUDITED FINANCIAL STATEMENTS OF SHORE MEMORIAL HEALTH SYSTEM & AFFILIATES.

PATIENT ACCOUNTS RECEIVABLE

-----

THE SYSTEM RECOGNIZES A RECEIVABLE WHEN THERE IS AN UNCONDITIONAL RIGHT TO PAYMENT, SUBJECT ONLY TO THE PASSAGE OF TIME. PATIENT ACCOUNTS RECEIVABLE, INCLUDING BILLED ACCOUNTS AND UNBILLED ACCOUNTS, WHICH HAVE THE UNCONDITIONAL RIGHT TO PAYMENT, AND ESTIMATED AMOUNTS DUE FROM

**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.

THIRD-PARTY PAYERS FOR RETROACTIVE ADJUSTMENTS, ARE RECORDED AS RECEIVABLES SINCE THE RIGHT TO CONSIDERATION IS UNCONDITIONAL AND ONLY THE PASSAGE OF TIME IS REQUIRED BEFORE PAYMENT OF THAT CONSIDERATION IS DUE. THE ESTIMATED UNCOLLECTIBLE AMOUNTS ARE GENERALLY CONSIDERED IMPLICIT PRICE CONCESSIONS THAT ARE RECORDED AS A DIRECT REDUCTION TO PATIENT ACCOUNTS RECEIVABLE.

PATIENT SERVICE REVENUE

-----

PATIENT SERVICE REVENUE IS REPORTED AT THE AMOUNTS THAT REFLECT THE CONSIDERATION TO WHICH THE SYSTEM IS EXPECTED TO BE ENTITLED TO IN EXCHANGE FOR PROVIDING PATIENT CARE FOR BOTH THE MEDICAL CENTER AND ANY EMPLOYED PHYSICIANS. THESE AMOUNTS ARE DUE FROM PATIENTS, THIRD-PARTY PAYORS (INCLUDING MANAGED CARE ORGANIZATIONS AND GOVERNMENT PROGRAMS, I.E., MEDICARE AND MEDICAID) AND OTHERS AND THEY INCLUDE VARIABLE CONSIDERATION FOR RETROACTIVE ADJUSTMENTS DUE TO SETTLEMENT OF FUTURE AUDITS, REVIEWS, AND INVESTIGATIONS. RETROACTIVE ADJUSTMENTS ARE

**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.

CONSIDERED IN THE RECOGNITION OF REVENUE ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED, AND SUCH AMOUNTS ARE ADJUSTED IN FUTURE PERIODS AS ADJUSTMENTS BECOME KNOWN OR AS YEARS ARE NO LONGER SUBJECT TO SUCH AUDITS, REVIEWS, AND INVESTIGATIONS. GENERALLY, PATIENTS AND THIRD-PARTY PAYORS ARE BILLED SEVERAL DAYS AFTER THE SERVICES ARE PERFORMED OR SHORTLY AFTER DISCHARGE. PATIENT SERVICE REVENUE IS RECOGNIZED IN THE PERIOD IN WHICH THE PERFORMANCE OBLIGATIONS ARE SATISFIED UNDER CONTRACTS BY TRANSFERRING SERVICES TO PATIENTS.

PERFORMANCE OBLIGATIONS ARE DETERMINED BASED ON THE NATURE OF THE SERVICES PROVIDED. THE SYSTEM RECOGNIZES REVENUES FOR PERFORMANCE OBLIGATIONS SATISFIED OVER TIME BASED ON ACTUAL CHARGES INCURRED IN RELATION TO TOTAL EXPECTED CHARGES. THE SYSTEM BELIEVES THAT THIS METHOD PROVIDES AN APPROPRIATE DEPICTION OF THE TRANSFER OF SERVICES OVER THE TERM OF PERFORMANCE OBLIGATIONS BASED ON THE INPUTS NEEDED TO SATISFY THE OBLIGATIONS. GENERALLY, PERFORMANCE OBLIGATIONS ARE SATISFIED OVER TIME RELATED TO PATIENTS RECEIVING INPATIENT ACUTE CARE SERVICES. THE SYSTEM MEASURES PERFORMANCE OBLIGATIONS FROM ADMISSION TO THE POINT WHEN THERE

**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.

ARE NO FURTHER SERVICES REQUIRED FOR THE PATIENT, WHICH IS GENERALLY THE TIME OF DISCHARGE. THE SYSTEM RECOGNIZES REVENUES FOR PERFORMANCE OBLIGATIONS SATISFIED AT A POINT IN TIME, WHICH GENERALLY RELATE TO PATIENTS RECEIVING OUTPATIENT SERVICES, WHEN: (1) SERVICES ARE PROVIDED; AND (2) WHEN IT IS BELIEVED THE PATIENT DOES NOT REQUIRE ADDITIONAL SERVICES.

THE SYSTEM HAS AGREEMENTS WITH THIRD-PARTY PAYORS THAT PROVIDE FOR PAYMENTS TO THE SYSTEM AT AMOUNTS DIFFERENT FROM ESTABLISHED CHARGES. INPATIENT ACUTE CARE SERVICES FOR MEDICARE AND MEDICAID BENEFICIARIES AND OUTPATIENT SERVICES FOR MEDICARE BENEFICIARIES ARE PAID PRIMARILY AT PROSPECTIVELY DETERMINED RATES. THESE RATES VARY ACCORDING TO PATIENT CLASSIFICATION SYSTEMS THAT ARE BASED ON CLINICAL, DIAGNOSTIC, AND OTHER FACTORS.

CERTAIN OUTPATIENT SERVICES FOR MEDICAID BENEFICIARIES ARE PAID BASED ON A COST-REIMBURSEMENT METHODOLOGY, SUBJECT TO CERTAIN LIMITATIONS. THE SYSTEM IS REIMBURSED FOR COST REIMBURSABLE AND OTHER ITEMS AT A TENTATIVE

**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.

RATE, WITH FINAL SETTLEMENT DETERMINED AFTER SUBMISSION OF ANNUAL COST REPORTS BY THE SYSTEM AND AUDITS THEREOF, BY THE PROGRAMS' FISCAL INTERMEDIARY. PROVISIONS FOR ESTIMATED ADJUSTMENTS RESULTING FROM AUDIT AND FINAL SETTLEMENTS HAVE BEEN RECORDED. DIFFERENCES BETWEEN THE ESTIMATED ADJUSTMENTS AND THE AMOUNTS SETTLED ARE RECORDED IN THE YEAR OF SETTLEMENT. THE SYSTEM'S COST REPORTS HAVE NOT BEEN SETTLED BY THE FISCAL INTERMEDIARIES FOR THE YEARS ENDED DECEMBER 31, 2019 THROUGH DECEMBER 31, 2020.

IN THE OPINION OF MANAGEMENT, ADEQUATE PROVISION HAS BEEN MADE IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS FOR ANY ADJUSTMENTS THAT MAY RESULT FROM THE FINAL SETTLEMENT OF THE SYSTEM'S COST REPORTS. FOR THE YEARS ENDED DECEMBER 31, 2023 AND 2022, PATIENT SERVICE REVENUE INCLUDES REVENUE OF APPROXIMATELY \$3,308,000 AND \$8,072,000, RESPECTIVELY, RELATED TO FAVORABLE FINAL SETTLEMENTS OF PRIOR YEAR COST REPORTS AND OTHER CHANGES IN ESTIMATES.

LAWS AND REGULATIONS GOVERNING THE MEDICARE AND MEDICAID PROGRAMS ARE

**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.

EXTREMELY COMPLEX AND SUBJECT TO INTERPRETATION. AS A RESULT, THERE IS AT LEAST A REASONABLE POSSIBILITY THAT RECORDED ESTIMATES WILL CHANGE BY A MATERIAL AMOUNT IN THE NEAR TERM. THE SYSTEM BELIEVES THAT IT IS IN COMPLIANCE WITH ALL APPLICABLE LAWS AND REGULATIONS AND IS NOT AWARE OF ANY PENDING OR THREATENED INVESTIGATIONS INVOLVING ALLEGATIONS OF POTENTIAL WRONGDOING THAT WOULD HAVE A MATERIAL ADVERSE EFFECT ON THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS. WHILE NO SUCH REGULATORY INQUIRIES HAVE BEEN MADE, COMPLIANCE WITH SUCH LAWS AND REGULATIONS CAN BE SUBJECT TO FUTURE GOVERNMENT REVIEW AND INTERPRETATIONS AS WELL AS SIGNIFICANT REGULATORY ACTION INCLUDING FINES, PENALTIES, AND EXCLUSION FROM THE MEDICARE AND MEDICAID PROGRAMS.

THE SYSTEM HAS ALSO ENTERED INTO PAYMENT AGREEMENTS WITH CERTAIN COMMERCIAL INSURANCE CARRIERS AND HEALTH MAINTENANCE ORGANIZATIONS. THE BASIS FOR PAYMENT TO THE SYSTEM UNDER THESE AGREEMENTS INCLUDES PROSPECTIVELY DETERMINED RATES PER DISCHARGE, DISCOUNTS FROM ESTABLISHED CHARGES, AND PROSPECTIVELY DETERMINED DAILY RATES. THESE AGREEMENTS HAVE RETROSPECTIVE AUDIT CLAUSES ALLOWING THE PAYOR TO REVIEW AND ADJUST



**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.

CLAIMS SUBSEQUENT TO INITIAL PAYMENT.

THE SYSTEM RECOGNIZES PATIENT SERVICE REVENUE ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY PAYOR COVERAGE ON THE BASIS OF THE CONTRACTUAL RATES FOR THE SERVICES RENDERED. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR THE STATE CHARITY CARE ASSISTANCE PROGRAM, THE SYSTEM RECOGNIZES REVENUE ON THE BASIS OF DISCOUNTED RATES UNDER THE UNINSURED SELF PAY PATIENT DISCOUNT POLICY. UNDER THIS POLICY, UNINSURED PATIENTS THAT ARE INELIGIBLE FOR ANY GOVERNMENT ASSISTANCE PROGRAM ARE BILLED AT REDUCED CHARGES COMPARABLE TO THE COST OF PROVIDING CARE BASED UPON THE SYSTEM-SPECIFIC MEDICARE COST TO CHARGE RATIO. THE IMPACT OF THIS UNINSURED SELF PAY DISCOUNT POLICY ON THE CONSOLIDATED FINANCIAL STATEMENTS IS LOWER PATIENT SERVICE REVENUE, AS THE DISCOUNT IS CONSIDERED A PRICING CONSTRAINT.

DEDUCTIBLES AND COPAYMENTS UNDER THIRD-PARTY PAYMENT PROGRAMS WITHIN THE THIRD-PARTY PAYOR AMOUNTS ABOVE ARE THE PATIENTS' RESPONSIBILITY, AND THE SYSTEM CONSIDERS THESE AMOUNTS IN ITS DETERMINATION OF THE IMPLICIT PRICE

**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.

CONCESSIONS BASED ON COLLECTION EXPERIENCE.

THE SYSTEM IS ALSO ELIGIBLE TO RECEIVE ADDITIONAL MEDICAID FUNDING UNDER THE NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM. THIS PROGRAM IS ADMINISTERED THROUGH THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES-DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES FOR ATLANTIC COUNTY, NEW JERSEY. THE PROGRAM REQUIRES THAT PARTICIPATING HOSPITALS PAY QUARTERLY ASSESSED FEES BASED ON ESTIMATED MEDICAID UTILIZATION DATA WITHIN THE COUNTY, AND SUCH PAYMENTS ARE THEN POOLED WITH FEDERAL MEDICAID MATCHING FUNDS AND REDISTRIBUTED TO THE PARTICIPATING HOSPITALS AS STATE DIRECTED PAYMENTS. THE STATE DIRECTED PAYMENTS ARE SUBJECT TO AN ANNUAL SETTLEMENT BASED ON ACTUAL MEDICAID UTILIZATION DATA AND OTHER FACTORS. FOR THE YEARS ENDED DECEMBER 31, 2023 AND 2022, THE SYSTEM PAID ASSESSMENTS OF \$4,598,488 AND \$4,640,322, WHICH ARE INCLUDED IN SUPPLIES AND OTHER EXPENSES IN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS AND RECEIVED MEDICAID STATE DIRECTED PAYMENTS OF \$15,608,524 AND \$14,208,471, WHICH ARE INCLUDED IN PATIENT SERVICE REVENUE IN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS.

**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, LINE 8

MEDICARE COSTS WERE DERIVED FROM THE 2023 MEDICARE COST REPORT.

THE ORGANIZATION FEELS THAT MEDICARE UNDERPAYMENTS (SHORTFALL), BAD DEBT AND ASSOCIATED COSTS ARE COMMUNITY BENEFIT AND ARE INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I. AS OUTLINED MORE FULLY BELOW, THE ORGANIZATION BELIEVES THAT THESE SERVICES AND RELATED COSTS PROMOTE THE HEALTH OF THE COMMUNITY AS A WHOLE AND ARE RENDERED IN CONJUNCTION WITH THE ORGANIZATION'S CHARITABLE TAX-EXEMPT PURPOSES AND MISSION IN PROVIDING MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER WITHOUT REGARD TO RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY AND CONSISTENT WITH THE COMMUNITY BENEFIT STANDARD PROMULGATED BY THE IRS. THE COMMUNITY BENEFIT STANDARD IS THE CURRENT STANDARD FOR A HOSPITAL FOR RECOGNITION AS A TAX-EXEMPT AND CHARITABLE ORGANIZATION UNDER INTERNAL REVENUE CODE ("IRC") §501(C)(3).

**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.

THE ORGANIZATION IS RECOGNIZED AS A TAX-EXEMPT ENTITY AND CHARITABLE ORGANIZATION UNDER §501(C)(3) OF THE IRC. ALTHOUGH THERE IS NO DEFINITION IN THE TAX CODE FOR THE TERM "CHARITABLE" A REGULATION PROMULGATED BY THE DEPARTMENT OF THE TREASURY PROVIDES SOME GUIDANCE AND STATES THAT "THE TERM CHARITABLE IS USED IN SECTION 501(C)(3) IN ITS GENERALLY ACCEPTED LEGAL SENSE," AND PROVIDES EXAMPLES OF CHARITABLE PURPOSES, INCLUDING THE RELIEF OF THE POOR OR UNPRIVILEGED; THE PROMOTION OF SOCIAL WELFARE; AND THE ADVANCEMENT OF EDUCATION, RELIGION, AND SCIENCE. NOTE IT DOES NOT EXPLICITLY ADDRESS THE ACTIVITIES OF HOSPITALS. IN THE ABSENCE OF EXPLICIT STATUTORY OR REGULATORY REQUIREMENTS APPLYING THE TERM "CHARITABLE" TO HOSPITALS, IT HAS BEEN LEFT TO THE IRS TO DETERMINE THE CRITERIA HOSPITALS MUST MEET TO QUALIFY AS IRC §501(C)(3) CHARITABLE ORGANIZATIONS. THE ORIGINAL STANDARD WAS KNOWN AS THE CHARITY CARE STANDARD. THIS STANDARD WAS REPLACED BY THE IRS WITH THE COMMUNITY BENEFIT STANDARD WHICH IS THE CURRENT STANDARD.

CHARITY CARE 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.
- 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.

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 MUST PROVIDE, TO THE EXTENT OF ITS FINANCIAL ABILITY, FREE OR REDUCED-COST CARE TO PATIENTS WHO CANNOT PAY FOR SUCH SERVICES. 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.

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.
- 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.

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

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

**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.

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 AVAILABLE TO ALL QUALIFIED PHYSICIANS.

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

**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.

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'S POSITION. AS OUTLINED IN THE AHA'S LETTER TO THE IRS DATED AUGUST 21, 2007 WITH RESPECT TO THE FIRST PUBLISHED DRAFT OF THE NEW FORM 990 AND SCHEDULE H, THE AHA FELT THAT THE IRS SHOULD INCORPORATE THE FULL VALUE OF THE COMMUNITY BENEFIT THAT HOSPITALS PROVIDE BY COUNTING MEDICARE UNDERPAYMENTS (SHORTFALL) AS QUANTIFIABLE COMMUNITY BENEFIT FOR THE FOLLOWING REASONS:

- PROVIDING CARE FOR THE ELDERLY AND SERVING MEDICARE PATIENTS IS AN ESSENTIAL PART OF THE COMMUNITY BENEFIT STANDARD.
- MEDICARE, LIKE MEDICAID, DOES NOT PAY THE FULL COST OF CARE. MEDICARE REIMBURSES HOSPITALS APPROXIMATELY 80 CENTS FOR EVERY DOLLAR THEY SPEND TO TAKE CARE OF MEDICARE PATIENTS.
- MANY MEDICARE BENEFICIARIES, LIKE THEIR MEDICAID COUNTERPARTS, ARE POOR. MORE THAN 42 PERCENT OF MEDICARE SPENDING IS FOR BENEFICIARIES



**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.

WHOSE INCOME IS BELOW 200 PERCENT OF THE FEDERAL POVERTY LEVEL. MANY OF THOSE MEDICARE BENEFICIARIES ARE ALSO ELIGIBLE FOR MEDICAID -- SO CALLED "DUAL ELIGIBLE."

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

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:

**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.

- 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 THOSE WHO DO NOT PAY ALL, OR A PORTION OF THE ALREADY DISCOUNTED BILLED AMOUNTS UNDER OUR FINANCIAL ASSISTANCE POLICY. A 2006 CONGRESSIONAL BUDGET OFFICE ("CBO") REPORT, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, CITED TWO STUDIES INDICATING THAT "THE GREAT MAJORITY OF BAD DEBT WAS ATTRIBUTABLE TO PATIENTS WITH INCOMES BELOW 200% OF THE FEDERAL POVERTY LINE."

- THE REPORT ALSO NOTED THAT A SUBSTANTIAL PORTION OF BAD DEBT IS PENDING CHARITY CARE. UNLIKE BAD DEBT IN OTHER INDUSTRIES, HOSPITAL BAD DEBT IS COMPLICATED BY THE FACT THAT HOSPITALS FOLLOW THEIR MISSION TO THE COMMUNITY AND TREAT EVERY PATIENT THAT COMES THROUGH THEIR EMERGENCY DEPARTMENT, REGARDLESS OF ABILITY TO PAY. PATIENTS WHO HAVE OUTSTANDING BILLS ARE NOT TURNED AWAY, UNLIKE OTHER INDUSTRIES. BAD DEBT IS FURTHER COMPLICATED BY THE AUDITING INDUSTRY'S STANDARDS ON REPORTING CHARITY CARE. MANY PATIENTS CANNOT OR DO NOT PROVIDE THE NECESSARY, EXTENSIVE

**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.

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 BENEFIT" 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 HOSPITAL'S BEST EFFORTS AND DUE DILIGENCE, PATIENT BAD DEBT IS A PART OF THE HOSPITAL'S MISSION AND CHARITABLE PURPOSES. BAD DEBT REPRESENTS PART OF THE BURDEN HOSPITALS SHOULD IN SERVING ALL PATIENTS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN 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.

**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, LINE 9B

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

SHORE MEDICAL CENTER PROVIDES A FULL-RANGE OF HEALTHCARE SERVICES TO OUR COMMUNITY REGARDLESS OF THE PATIENT'S ABILITY TO PAY. WE RECOGNIZE THAT A CRITICAL PART OF PROVIDING HEALTHCARE SERVICES INCLUDES MITIGATING CONCERNS OUR PATIENTS MAY HAVE RELATED TO BILLING MATTERS. THIS BUSINESS PHILOSOPHY IS OUR COMMITMENT TO THE COMMUNITY, PATIENTS AND FAMILY MEMBERS WE SERVE. THIS COMMITMENT RUNS PARALLEL TO OUR NOT FOR PROFIT MISSION AND IS EVIDENCED BY THE FOLLOWING PROACTIVE MEASURES TAKEN BY SHORE MEDICAL CENTER TO PROVIDE FINANCIAL ASSISTANCE TO OUR PATIENTS.

SHORE MEDICAL CENTER HAS A DISCOUNT PROGRAM TO ASSIST PATIENTS WHO ARE LEAST ABLE TO PAY. THE POLICY IS DESIGNED TO PROVIDE FINANCIAL RELIEF TO OUR SELF-PAY POPULATION BY REDUCING THE HOSPITAL'S STANDARD CHARGE FOR SERVICES RENDERED. AT THE TIME OF BILLING THE PATIENT, THE CHARGES ARE

**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.

REDUCED TO AN ESTIMATED COST OF SERVICES. THE HOSPITAL ALSO ENSURES THAT ALL PATIENTS RECEIVE INFORMATION PERTAINING TO THE STATE CHARITY CARE PROGRAM FOR THE UNINSURED AND UNDER-INSURED. TO INQUIRE ABOUT SHORE'S SELF-PAY BILLING AND DISCOUNT POLICY, CHARITY CARE OR PAYMENT ARRANGEMENTS, PATIENTS MAY CONTACT THE PATIENT FINANCIAL SERVICES CREDIT AND COLLECTIONS OFFICE.

SHORE MEDICAL CENTER ALSO OFFERS FINANCIAL COUNSELING AND SCREENING FOR PATIENTS TO ENSURE THAT ANY POTENTIAL THIRD PARTY COVERAGE UNDER OTHER GOVERNMENT PROGRAMS, SUCH AS MEDICAID, CAN BE IDENTIFIED. THIS SERVICE IS PROVIDED AT NO COST TO THE PATIENT.

BILLING & COLLECTIONS

-----

THE ORGANIZATION ABIDES BY PROVISIONS ON THE COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE. THESE PROVISIONS INCLUDE THE FOLLOWING:

**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.

THE HOSPITAL APPROVES PAYMENT ARRANGEMENTS FOR OUR PATIENTS WHO CANNOT PAY THEIR BILLS IN FULL. THESE PAYMENT ARRANGEMENTS CAN BE TAILORED TO THE INDIVIDUAL NEEDS OF THE PATIENT. WE DO NOT CHARGE ADDITIONAL FEES IN THE FORM OF INTEREST FOR CARRYING THE BALANCES BEING PAID UNDER THESE ARRANGEMENTS.

THE ACCOUNTS OF PATIENTS FOR WHICH THERE IS NO IDENTIFIED THIRD PARTY INSURANCE WILL FOLLOW A PREDEFINED SELF-PAY COLLECTION CYCLE. ANY REMAINING UNPAID ACCOUNTS THAT ARE NOT IN THE PROCESS OF MAKING PAYMENT ARRANGEMENTS AFTER A DEFINED SELF-PAY COLLECTION CYCLE OF 120 DAYS WILL BE TRANSFERRED TO A THIRD PARTY AGENCY FOR COLLECTION. THE ACCOUNT WILL REMAIN WITH THIS AGENCY FOR 180 DAYS. AFTER THIS TIME PERIOD, WITHOUT ANY AGREED UPON PAYMENT ARRANGEMENTS TO SATISFY THE UNPAID BALANCE, THE ACCOUNT WILL BE TRANSFERRED TO ANOTHER THIRDS PARTY COLLECTION AGENCY. AT THIS TIME, THE UNPAID BALANCE MAY BE REPORTED TO A CREDIT AGENCY, AND AS SUCH, APPEAR ON THE ACCOUNT GUARANTOR'S CREDIT REPORT.

**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.

SHORE MEDICAL CENTER PURSUES COLLECTION OF BALANCES RIGHTFULLY OWED BY PATIENTS FOR SERVICES RENDERED AND CONTRACTS WITH THIRD PARTY COLLECTION AGENCIES FOR THE PURPOSE OF COLLECTING DELINQUENT ACCOUNT BALANCES. THE COLLECTION AGENCIES OPERATE UNDER THE FEDERAL FAIR DEBT, CREDIT AND COLLECTION GUIDELINES.

COLLECTION AGENCY ACTIVITY IS CLOSELY MONITORED BY THE HOSPITAL TO ENSURE THAT PATIENT COLLECTION EFFORTS ARE APPROPRIATE AND IN-LINE WITH OUR CUSTOMER SERVICE PHILOSOPHY.

ALL PATIENT COMPLAINTS REGARDING DISSATISFACTION WITH SERVICES RENDERED OR BILLING ISSUES ARE HANDLED PROMPTLY AND IN A COURTEOUS MANNER TO ENSURE THAT CUSTOMER SERVICE REMAINS THE FOCUS OF ANY PATIENT CONCERN. ALL COMPLAINTS ARE CONSIDERED VALID AND PATIENT FEEDBACK IS WELCOME WITH RESPECT TO DISPUTED MATTERS.

THE HOSPITAL ABSORBS A SIGNIFICANT AMOUNT OF BAD DEBT ANNUALLY (BALANCES DUE BY PATIENTS THAT ARE INTENTIONALLY NOT PAID), OR ARE INCURRED 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.
- 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.

RESULT OF MITIGATING CIRCUMSTANCES, BANKRUPTCY FILINGS AND OTHER  
COLLECTION MATTERS.

SCHEDULE H, PART VI; QUESTION 2

IN ADDITION TO THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS OUTLINED IN  
SCHEDULE H, SECTION B, AND QUESTIONS 1-12 AND SECTION C, THE ORGANIZATION  
TOOK THE FOLLOWING STEPS TO ENSURE THAT THE CHNA WAS MANAGED IN A LOGICAL  
AND EFFECTIVE MANNER INCLUDING THE FOLLOWING:

- SELECTED QUALITY DATA SOURCES FROM KEY ORGANIZATION SUCH AS U.S. CENSUS  
BUREAU, NEW JERSEY DEPARTMENT OF HEALTH, AMERICAN CANCER SOCIETY, ETC.
- DEFINED THE COMMUNITY THAT WE SERVE THROUGH ZIP CODE ANALYSIS OF THE  
HOSPITAL CATCHMENT AREA
- DEVELOPED AND ADMINISTERED A COMMUNITY SURVEY IN AN EFFORT TO GAIN THE  
COMMUNITY'S INPUT



**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.

- PRIORITIZED THE HEALTH AND HEALTH-RELATED PROBLEMS BASED ON RELEVANT STATISTICS AND COMMUNITY'S CONCERN

THE GUIDES AND EXPERT ADVICE FOR THE CONDUCTING THE ASSESSMENT INCLUDED:

- SCHEDULE H (FORM 990) BY THE US DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE

- DEVELOPED AN INTERNAL COMMITTEE FOR THE REVISION PROCESS

IN ADDITION, THE ORGANIZATION REFERENCED KEY QUANTITATIVE SOURCES OF DATA IN ORDER TO ASSESS THE HEALTH NEEDS OF ITS COMMUNITY. INCLUDED BELOW ARE THE DATA SOURCES USED BY THE ORGANIZATION:

- AMERICAN DIABETES ASSOCIATION
- CENTERS FOR DISEASE CONTROL AND PREVENTION
- COUNTY HEALTH RANKINGS, UNIVERSITY OF WISCONSIN

**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.

- MAYO CLINIC
- NATIONAL CANCER INSTITUTE
- NATIONAL INSTITUTE OF DRUG ABUSE
- NATIONAL INSTITUTE OF HEALTH
- NEW JERSEY STATE HEALTH ASSESSMENT DATA
- NEW JERSEY CANCER REGISTRY
- NEW JERSEY DEPARTMENT OF HEALTH
- THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
- UNITED STATES CENSUS BUREAU

**Part VI Supplemental Information**

Provide the following information.

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

SCHEDULE H, PART VI; QUESTION 3

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:

(1) THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY ("FAP"), FINANCIAL ASSISTANCE APPLICATION ("APPLICATION") AND PLAIN LANGUAGE SUMMARY ("PLS") ARE ALL AVAILABLE ON-LINE AT THE FOLLOWING WEBSITE:  
[HTTPS://SHOREMEDICALCENTER.ORG/PATIENTS\\_VISITORS/PATIENTS/INSURANCE/FINANCIAL\\_ASSISTANCE](https://shoremedicalcenter.org/patients_visitors/patients/insurance/financial_assistance)

(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.

**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.

(3) THE ORGANIZATION'S 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.

(4) SIGNS OR DISPLAYS ARE CONSPICUOUSLY POSTED IN PUBLIC HOSPITAL LOCATIONS THAT NOTIFY AND INFORM PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE.

(5) THE ORGANIZATION ALSO MAKES REASONABLE EFFORTS TO INFORM MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE.

SHORE MEDICAL CENTER HAS ENGAGED A THIRD PARTY TO PROVIDE EDUCATION AND ELIGIBILITY PROCESSING FOR FINANCIAL ASSISTANCE AND MEDICAID ELIGIBILITY. THIS THIRD PARTY MEETS WITH INPATIENTS, THEIR FAMILIES AND WALK IN PATIENTS TO PROVIDE ALL NECESSARY GUIDANCE FOR THE PATIENT FINANCIAL NEEDS. IN ADDITION, THEY ALSO MAKE HOUSE CALLS FOR THOSE THAT NEED

**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.

FURTHER ASSISTANCE AND HELP IN GETTING TO THE AGENCIES NECESSARY TO COMPLETE STATE APPLICATIONS. THE MEDICAL CENTER ALSO HAS AN ADDITIONAL 4 INDIVIDUALS THAT HELP PATIENTS COMPLETE THESE FORMS IN THE BUSINESS OFFICE, EMERGENCY DEPARTMENT AND THE ADMISSIONS OFFICE.

SCHEDULE H, PART VI; QUESTION 4

SHORE MEDICAL CENTER IS LOCATED IN SOMERS POINT, ATLANTIC COUNTY, NEW JERSEY, APPROXIMATELY 10 MILES SOUTH OF ATLANTIC CITY, NEW JERSEY. THE MEDICAL CENTER SERVES THE HEALTHCARE NEEDS OF BOTH THE YEAR ROUND AND SUMMER RESIDENTS OF ATLANTIC AND CAPE MAY COUNTIES AS WELL AS SEASONAL VISITORS FROM OTHER COMMUNITIES AND STATES.

THE FOLLOWING DEMOGRAPHICS WERE CITED IN THE ORGANIZATION'S MOST RECENTLY CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENT:

- POPULATION HAS BEEN FAIRLY CONSISTENT IN NEW JERSEY, ATLANTIC COUNTY AND CAPE MAY COUNTY OVER THE LAST TEN YEARS. SLIGHT INCREASES BETWEEN

**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.

2010 AND 2015 OCCURRED AND SLIGHT DECREASES BETWEEN 2015 AND 2020

OCCURRED. IN 2020, ATLANTIC COUNTY'S POPULATION WAS 264,650 AND CAPE MAY

COUNTY'S POPULATION WAS 92,701 WITH SLIGHTLY MORE THAN HALF OF THE

POPULATION BEING FEMALE.

- THE MEDIAN AGE IN 2020 WAS 47.8 FOR ATLANTIC COUNTY AND 50.3 FOR CAPE MAY COUNTY. THE POPULATION IS GROWING OLDER. A NOTABLE DIFFERENCE BETWEEN THE COUNTIES CAN BE SEEN WITH OVER ONE-QUARTER OR 26.6% OF CAPE MAY COUNTY BEING OVER 65. THE SAME CAN BE SEEN WITH UNDER 18 AS 17.5% OF CAPE MAY COUNTY IS UNDER 18 YEARS OF AGE.

- THE TWO COUNTIES LOOK DIFFERENT IN REGARDS TO RACE AND ETHNICITY. ATLANTIC COUNTY HAS A HIGHER PERCENTAGE OF BLACK/AFRICAN AMERICANS, HISPANIC/LATINO, AND ASIAN POPULATIONS, WHEREAS CAPE MAY COUNTY IS PREDOMINIATELY WHITE WITH SMALLER AMOUNTS OF MINORITY POPULATIONS. IT IS IMPORTANT TO NOTE THAT CAPE MAY COUNTY'S MINORITY POPULATION HAS GROWN OVER THE LAST TEN YEARS. THE BREAKDOWN IS AS FOLLOWS: ATLANTIC COUNTY: 54.22% WHITE; 19.57% HISPANIC/LATINO; 14.21% BLACK/AFRICAN AMERICAN; AND

**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.

7.85% ASIAN. CAPE MAY COUNTY: 84.02% WHITE; 9.37% ASIAN; 7.84%

HISPANIC/LATINO; AND 3.47% BLACK/AFRICAN AMERICAN.

- ATLANTIC COUNTY IS SLIGHTLY LOWER AND CAPE MAY COUNTY IS SLIGHTLY HIGHER IN REGARDS TO EDUCATIONAL ATTAINMENT COMPARED TO NEW JERSEY. THE PERCENTAGES ARE VERY CLOSE BETWEEN MEN AND WOMEN. EVEN THOUGH THE HIGH SCHOOL DIPLOMA OR EQUIVALENCY PERCENTAGE IS HIGH THIS STILL LEAVES APPROXIMATELY TWENTY-TWO THOUSAND ATLANTIC COUNTY RESIDENTS AND FORTY-SIX HUNDRED CAPE MAY COUNTY RESIDENTS WITH LESS THAN A HIGH SCHOOL EDUCATION. IT SEEMS THAT MANY OF THE RESIDENTS WITH LOWER EDUCATIONAL LEVELS MOVE INTO OUR COMMUNITY. IN ATLANTIC COUNTY 70% AND IN CAPE MAY COUNTY 60% OF PEOPLE WITHOUT A HIGH SCHOOL DIPLOMA/EQUIVALENCY WERE BORN OUTSIDE OF THE COUNTY IN ANOTHER STATE OR COUNTRY.

- APPROXIMATELY 72.7% OF ALL ATLANTIC COUNTY RESIDENTS AND 91.8% OF CAPE MAY COUNTY RESIDENTS SPEAK ONLY ENGLISH. THE MOST COMMON LANGUAGE OTHER THAN ENGLISH IS SPANISH. THE CONCERN IS ISOLATED HOUSEHOLDS IN WHICH ENGLISH IS LIMITED. IN ATLANTIC COUNTY 5.0% OF ALL HOUSEHOLDS ARE LIMITED

**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.

ENGLISH-SPEAKING HOUSEHOLDS WITH THE MOST NUMBER OF HOUSEHOLDS SPEAKING SPANISH AND ASIAN/PACIFIC ISLAND LANGUAGES. IN CAPE MAY COUNTY 1.0% OF ALL HOUSEHOLDS ARE LIMITED ENGLISH-SPEAKING HOUSEHOLDS WITH THE MOST NUMBER OF HOUSEHOLDS SPEAKING SPANISH, OTHER INDO-EUROPEAN LANGUAGES AND ASIAN/PACIFIC ISLAND LANGUAGES. IT IS IMPORTANT TO NOTE THAT NOT ALL PEOPLE LIVING IN OUR COMMUNITY ARE COUNTED IN SURVEYS. IT IS ESTIMATED THAT THERE WERE ABOUT TWELVE THOUSAND UNDOCUMENTED IMMIGRANTS LIVING IN ATLANTIC COUNTY IN 2017.

- FINANCIAL CONSTRAINT CAN BE A BARRIER. BOTH ATLANTIC AND CAPE MAY COUNTIES HAVE LOWER INCOME LEVELS WHEN COMPARED TO NEW JERSEY. THE 2020 AMERICAN COMMUNITY SURVEY REPORTS: ATLANTIC COUNTY'S MEDIAN INCOME IS 63,680; MEAN INCOME IS 88,111; POVERTY STATUS AT 13.5% AND 29.3% OF HOUSEHOLDS RECEIVE ASSISTANCE. CAPE MAY COUNTY'S MEDIAN INCOME IS 72,385; MEAN INCOME IS 99,103; POVERTY STATUS AT 9.9% AND 21.0% OF HOUSEHOLDS RECEIVE ASSISTANCE.

IT IS ALSO FOUND THAT BLACK/AFRICAN AMERICANS, HISPANIC/LATINO, WOMEN



**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.

WITH CHILDREN AND NO SPOUSE LIVING IN THE HOME, AS WELL AS OTHER MINORITY GROUPS ARE CONSISTENTLY EXPERIENCING LOWER INCOMES, HIGHER POVERTY STATUS AND NEED PUBLIC ASSISTANCE MORE OFTEN. CHILDREN UNDER EIGHTEEN EXPERIENCE THE GREATEST LEVEL OF POVERTY WITH ATLANTIC COUNTY AT 19.9% AND CAPE MAY COUNTY AT 14.5%.

HOUSING AFFORDABILITY CAN ALSO CAUSE DIFFICULTIES FINANCIALLY. HOME COSTS CAN TAKE A SIGNIFICANT AMOUNT FROM A FAMILY'S AVAILABLE INCOME. IN ATLANTIC COUNTY THE MEDIAN HOUSEHOLD MORTGAGE IS \$23,784 PER YEAR WITH 26.9% OF MORTGAGES FALLING BETWEEN \$1,500 AND \$1,999 PER MONTH. THE MEDIAN HOUSEHOLD RENTER COST IS \$10,596 PER YEAR WITH 49.9% FALLING BETWEEN \$600 AND \$999 PER MONTH. IN CAPE MAY COUNTY THE MEDIAN HOUSEHOLD MORTGAGE IS \$22,152 PER YEAR WITH 29.0% OF MORTGAGES FALLING BETWEEN \$1,500 AND \$1,999 PER MONTH. THE MEDIAN HOUSEHOLD RENTER COST IS \$9,624 PER YEAR WITH 50.3% FALLING BETWEEN \$600 AND \$999 PER MONTH. THE NUMBERS ILLUSTRATE HOW DIFFICULT IT CAN BE FOR LOWER INCOME POPULATIONS TO BE ABLE TO AFFORD THEIR OWN HOME. RENTERS MAY ALSO BE MORE LIKELY TO SHARE HOUSING WITH OTHER NONFAMILY MEMBERS.

**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.

- IN 2020, ATLANTIC COUNTY HAD APPROXIMATELY 11-12 THOUSAND VETERANS.

THIS IS 5.5% OF THE POPULATION WITH A MAJORITY BEING VIETNAM ERA VETERANS AT 38.5%. IN CAPE MAY COUNTY THERE WERE APPROXIMATELY 6-7 THOUSAND VETERANS WITH A MAJORITY ALSO BEING FROM THE VIETNAM ERA AT 38.0%. IT IS IMPORTANT TO NOTE THAT THERE ARE ALSO A CONSIDERABLE NUMBER OF GULF WAR VETERANS AS WELL AND KOREAN WAR VETERANS.

- AMERICANS WHO DO NOT HAVE HEALTH INSURANCE ARE LESS LIKELY TO RECEIVE ANNUAL PREVENTIVE CARE SUCH AS ROUTINE EXAMS AND SCREENINGS FOR CHRONIC DISEASE OR ACCESS TO MEDICATION. THESE INDIVIDUALS OFTEN RECEIVE DELAYED TREATMENT, HAVE POORER HEALTH OUTCOMES AND PREMATURE MORTALITY.

POPULATIONS SUCH AS RACIAL AND ETHNIC MINORITIES AND LOWER-INCOME ADULTS ARE AT GREATER RISK FOR NOT HAVING HEALTH INSURANCE. APPROXIMATELY 15,000 PEOPLE IN ATLANTIC COUNTY AND 4,500 PEOPLE IN CAPE MAY COUNTY DO NOT HAVE HEALTH INSURANCE. HIGHER PERCENTAGES OF MEN ARE WITHOUT HEALTH INSURANCE.

- OBESITY IS A COMMON, SERIOUS CHRONIC DISEASE THAT HAS BECOME 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.

SIGNIFICANT PROBLEM. IN NEW JERSEY, OVER THE LAST TEN YEARS OBESITY RATES INCREASED 40%. THIS CALCULATES TO ONE IN FOUR ADULTS OR 24.6% OF THE ADULT POPULATION BEING OBESE. IF OBESITY RATES CONTINUE TO RISE AT THIS RATE NEARLY HALF OF NEW JERSEY WILL BE OBESE BY 2030. ACCORDING TO NEW JERSEY STATE HEALTH ASSESSMENT DATA, ATLANTIC AND CAPE MAY COUNTY FALL INTO THESE SAME PERCENTAGES. THE NEW JERSEY BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (NJBRFSS) ESTIMATES THAT 30% OF ATLANTIC COUNTY AND 32% OF CAPE MAY COUNTY ADULTS 18 AND OVER WERE OBESE IN 2018. CHILDREN ARE ALSO AFFECTED. THE NEW JERSEY HOSPITAL ASSOCIATION REPORTS ONE IN FOUR NEW JERSEY CHILDREN (10-17) ARE OVERWEIGHT OR OBESE (24.7%). ELEVEN PERCENT OF HIGH SCHOOL STUDENTS ARE OBESE.

- BOTH ATLANTIC AND CAPE MAY COUNTY HAVE SOME OF THE HIGHEST SMOKING PERCENTAGES IN NEW JERSEY. EIGHTEEN PERCENT OF ADULTS 18 AND OVER SMOKE. THIS ESPECIALLY AFFECTS POPULATIONS WITH LOWER EDUCATIONAL ATTAINMENT AND LOWER INCOME LEVELS AS THESE POPULATIONS ARE MORE AT RISK FOR SMOKING.

OTHER SUBSTANCES ARE ALSO ISSUES. SEVENTEEN PERCENT OF ATLANTIC COUNTY

**Part VI Supplemental Information**

Provide the following information.

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

AND 21% OF CAPE MAY COUNTY REPORTED BINGE DRINKING OR HEAVY DRINKING IN 2018. THIRTY PERCENT OF NEW JERSEY HIGH SCHOOL STUDENTS SURVEYED IN 2019 HAD AT LEAST ONE DRINK IN THE PAST 30 DAYS BEFORE THE SURVEY AND 23.1% OF NEW JERSEY YOUTH (12-20) USED ALCOHOL IN THE PAST MONTH. OPIOIDS ARE ALSO ON AN UPHILL TREND WITH 2022 SUSPECTED TO BE ONE OF THE HIGHEST YEARS OF REPORTED CASES OF NEW JERSEY REPORTED OPIOID DEATHS. ATLANTIC AND CAPE MAY COUNTY ALSO SHOW A GENERAL RISING TREND SIMILAR TO NEW JERSEY.

ADDITIONAL HEALTH RISK FACTORS ARE DISCUSSED IN THE CHNA SUCH AS LOW BIRTH WEIGHTS, HEALTH LITERACY, MENTAL HEALTH, AND COVID-19 VACCINATION RATES.

- THE LEADING CAUSE OF DEATH IN NEW JERSEY, ATLANTIC COUNTY AND CAPE MAY COUNTY IN 2020 WAS HEART DISEASE. GENERALLY LEADING CAUSES OF DEATH HAVE BEEN CONSISTENT OVER THE YEARS HOWEVER; COVID-19 SIGNIFICANTLY AFFECTED MORTALITY RATES IN 2020. COVID-19 WAS THE SECOND LEADING CAUSE OF DEATH IN 2020 FOR NEW JERSEY AND THIRD IN ATLANTIC AND CAPE MAY COUNTY. LEADING CAUSES OF DEATH FOR BOTH COUNTIES RESPECTIVELY INCLUDED: HEART DISEASE,

**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.

CANCER, COVID-19, LOWER RESPIRATORY DISEASE, STROKE AND DIABETES.

HEART DISEASE: ACCORDING TO THE NEW JERSEY DEPARTMENT OF HEALTH, ATLANTIC AND CAPE MAY COUNTIES HAVE SOME OF THE HIGHEST MORTALITY RATES IN THE STATE. THE MORTALITY RATE FOR ATLANTIC COUNTY WAS 203.0 AND FOR CAPE MAY COUNTY WAS 197.9 PER 100,000 PEOPLE (2016-2020). MALE GENDER AND BLACK POPULATIONS HAVE HIGHER RATES.

CANCER: ATLANTIC COUNTY'S CANCER INCIDENCE RATE FOR ALL CANCERS IS 3.2% HIGHER THAN THE STATE, AT 558.5 VS. 541.3 PER 100,000. CAPE MAY COUNTY'S CANCER INCIDENCE RATE FOR ALL CANCERS IS 22.7% HIGHER THAN THE STATE, AT 664.1 VS. 541.3 PER 100,000. ATLANTIC COUNTY'S CANCER MORTALITY RATE FOR ALL CANCERS IS 9.5% HIGHER THAN THE STATE, AT 162.4 VS. 148.3. CAPE MAY COUNTY'S CANCER MORTALITY RATE FOR ALL CANCERS IS 22.5% HIGHER THAN THE STATE, AT 181.7 VS. 148.3. ALL RATES ARE 2014-2018.

COVID-19: ACCORDING TO THE NEW JERSEY DEPARTMENT OF HEALTH, BETWEEN APRIL 2020 AND JULY 2022 COVID-19 RANGED IN THE NUMBER OF CASES THROUGHOUT THE

**Part VI Supplemental Information**

Provide the following information.

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

STATE. ATLANTIC COUNTY HAD APPROXIMATELY 64,000 CASES AND CAPE MAY COUNTY HAD APPROXIMATELY 13,000 CASES. ATLANTIC COUNTY HAD APPROXIMATELY ONE THOUSAND DEATHS AND CAPE MAY COUNTY HAD APPROXIMATELY 300 DEATHS. THIS YIELDS ATLANTIC COUNTY AT A 380 AND CAPE MAY COUNTY AT A 335 DEATH RATE PER 100,000.

ADDITIONAL CHRONIC DISEASES ARE DISCUSSED IN THE CHNA SUCH AS STROKE, CHRONIC LOWER RESPIRATORY DISEASES, AND DIABETES.

SCHEDULE H, PART VI; QUESTION 5

SHORE MEDICAL CENTER IS PROUD TO MAKE A DIFFERENCE IN THE COMMUNITIES WE CALL HOME. OUR GENEROUS MEDICAL CENTER STAFF HAVE PARTICIPATED IN NUMEROUS EVENTS THAT SUPPORT AND EXEMPLIFY THE MEDICAL CENTER'S COMMITMENT TO OUR COMMUNITY. OUR PRIMARY GOAL IS TO CARE FOR AND RESPECT, ALL PATIENTS THEIR FAMILIES AND EACH OTHER. ALONG WITH THE SUPERIOR CARE THAT WE DELIVER EVERY DAY, WE STRIVE TO EDUCATE AND PROMOTE WELLNESS TO THE COMMUNITY THROUGH THE MANY OUTREACH PROGRAMS WE OFFER. IN EARLY 2024,

**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.

SHORE MEDICAL CENTER EARNED THE JOINT COMMISSION'S GOLD SEAL OF APPROVAL® FOR HEALTHCARE EQUITY CERTIFICATION BY DEMONSTRATING CONTINUOUS COMPLIANCE WITH ITS PERFORMANCE STANDARDS FOR HEALTH CARE EQUITY. SHORE MEDICAL CENTER WAS THE FIRST COMMUNITY HOSPITAL IN THE UNITED STATES, AND ONLY THE FIFTH HOSPITAL IN NEW JERSEY, TO EARN THIS PRESTIGIOUS DISTINCTION. THE GOLD SEAL IS A SYMBOL OF QUALITY THAT REFLECTS A HEALTHCARE ORGANIZATION'S COMMITMENT TO PROVIDING SAFE, QUALITY AND EQUITABLE PATIENT CARE. WE HOPE TO EMPOWER OUR PATIENTS AND FAMILIES THROUGH THE EXCHANGE OF INFORMATION TO ULTIMATELY ENCOURAGE AND FOSTER HEALING PARTNERSHIPS WITH CAREGIVERS.

SCHEDULE H, PART VI; QUESTION 6

OUTLINED BELOW IS A SUMMARY OF THE ENTITIES THAT COMPRISE SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES.

SHORE MEMORIAL HOSPITAL D/B/A SHORE MEDICAL CENTER

-----

**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.

SHORE MEDICAL CENTER IS AN ACUTE-CARE TAX-EXEMPT HOSPITAL LOCATED IN SOMERS POINT, NEW JERSEY. THE MEDICAL CENTER PROVIDES GENERAL HEALTHCARE SERVICES TO RESIDENTS WITHIN ITS GEOGRAPHIC LOCATION FOR A WIDE RANGE OF INPATIENT AND OUTPATIENT SERVICES, INCLUDING MEDICAL, SURGICAL, OBSTETRICAL, GYNECOLOGICAL, PEDIATRIC, EMERGENCY AND AMBULATORY CARE. THE HOSPITAL IS RECOGNIZED BY THE IRS AS AN INTERNAL REVENUE CODE §501(C)(3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, THE MEDICAL CENTER PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. MOREOVER, THE MEDICAL CENTER OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

1) THE MEDICAL CENTER PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY, INCLUDING CHARITY CARE, SELF-PAY, MEDICARE AND MEDICAID PATIENTS;



**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.

2) THE MEDICAL CENTER OPERATES AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN 24 HOURS A DAY, SEVEN DAYS A WEEK, 365 DAYS PER YEAR;

3) THE MEDICAL CENTER MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;

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

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

SHORE HEALTH SERVICES CORPORATION

-----

**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.

SHORE HEALTH SERVICES CORPORATION IS AN ORGANIZATION RECOGNIZED BY THE  
 INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE  
 §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE  
 CODE §509(A)(3). THE ORGANIZATION IS CURRENTLY INACTIVE.

SHORE MEMORIAL HEALTH SYSTEM  
 -----

SHORE MEMORIAL HEALTH SYSTEM IS AN ORGANIZATION RECOGNIZED BY THE  
 INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE  
 §501(C)(3). THE ORGANIZATION FUNCTIONS AS THE PARENT CORPORATION OF AND  
 SUPPORTS THE CHARITABLE PURPOSES, PROGRAMS AND SERVICES OF SHORE MEMORIAL  
 HEALTH SYSTEM AND AFFILIATES, INCLUDING SHORE MEDICAL CENTER, WHICH  
 PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS  
 REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY.

SHORE MEMORIAL HEALTH FOUNDATION, 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.

SHORE MEMORIAL HEALTH 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). THE ORGANIZATION SUPPORTS AND RAISES FUNDS ON BEHALF OF THE SHORE MEMORIAL HEALTH SYSTEM, INCLUDING SHORE MEDICAL CENTER. THE ORGANIZATION IS CURRENTLY INACTIVE.

BRIGHTON BAY, LLC  
 -----

BRIGHTON BAY, LLC IS A LIMITED LIABILITY COMPANY WHOSE SOLE CORPORATE MEMBER IS SHORE MEDICAL CENTER. BRIGHTON BAY, LLC MAINTAINS AND OPERATES CERTAIN HEALTHCARE RELATED RENTAL REAL ESTATE.

SHORE QUALITY PARTNERS, LLC  
 -----

**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.

SHORE QUALITY PARTNERS, LLC IS A LIMITED LIABILITY COMPANY WHOSE SOLE CORPORATE MEMBER IS SHORE MEDICAL CENTER. SHORE QUALITY PARTNERS, LLC OPERATES AN INTEGRATED PHYSICIAN NETWORK.

SHORE QUALITY PARTNERS ACO, LLC

-----

SHORE QUALITY PARTNERS ACO, LLC IS A LIMITED LIABILITY COMPANY WHOSE SOLE CORPORATE MEMBER IS SHORE MEDICAL CENTER. SHORE QUALITY PARTNERS ACO, LLC OPERATES AS AN ACCOUNTABLE CARE ORGANIZATION.

SHORE HEALTH ENTERPRISES, INC.

-----

SHORE HEALTH ENTERPRISES, INC. IS CORPORATION WHOSE SOLE SHAREHOLDER IS SHORE MEMORIAL HEALTH SYSTEM. THIS CORPORATION IS A MANAGEMENT SERVICE ORGANIZATION THAT PROVIDES SERVICES TO THE SYSTEM'S AFFILIATES.

**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.

SHORE MEMORIAL PHYSICIAN'S GROUP, P.C.

-----

SHORE MEMORIAL PHYSICIAN'S GROUP, P.C. IS A PHYSICIAN PRACTICE PROFESSIONAL CORPORATION CONTROLLED BY SHORE MEDICAL CENTER THROUGH A NOMINEE OWNERSHIP BY A LICENSED PROFESSIONAL DUE TO STATE OF NEW JERSEY CORPORATE PRACTICE OF MEDICINE PROHIBITION RULES AND REGULATIONS. THIS ORGANIZATION WAS INCORPORATED AS A PROFESSIONAL CORPORATION FOR THE PURPOSE OF DEVELOPING AN EMPLOYED PHYSICIAN NETWORK. THE PHYSICIANS GROUP IS DESIGNED TO ACHIEVE A MORE INTEGRATED APPROACH TO THE DELIVERY OF MEDICAL CARE FOR THE COMMUNITY SERVED BY THE MEDICAL CENTER. THIS ORGANIZATION PROVIDES HIGH QUALITY AND COST EFFECTIVE MEDICAL SERVICES FOR THE BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE TAX-EXEMPT PURPOSES OF SHORE MEDICAL CENTER.

BAYFRONT URGENT CARE PROFESSIONAL ASSOCIATION D/B/A SHORE URGENT CARE, P.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.

SHORE URGENT CARE, P.A. IS A CONTROLLED AFFILIATE OF SHORE MEMORIAL PHYSICIANS GROUP, P.C.; A PHYSICIAN PRACTICE PROFESSIONAL ASSOCIATION CONTROLLED BY SHORE MEDICAL CENTER THROUGH A NOMINEE OWNERSHIP BY A LICENSED PROFESSIONAL DUE TO STATE OF NEW JERSEY CORPORATE PRACTICE OF MEDICINE PROHIBITION RULES AND REGULATIONS. THIS ORGANIZATION PROVIDES HIGH QUALITY AND COST EFFECTIVE URGENT CARE SERVICES FOR THE BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE TAX-EXEMPT PURPOSES OF SHORE MEDICAL CENTER.

SHORE PATHOLOGY ASSOCIATES, P.C.

-----

SHORE PATHOLOGY ASSOCIATES, P.C. IS A PHYSICIAN PRACTICE PROFESSIONAL CORPORATION CONTROLLED BY SHORE MEDICAL CENTER THROUGH A NOMINEE OWNERSHIP BY A LICENSED PROFESSIONAL DUE TO STATE OF NEW JERSEY CORPORATE PRACTICE OF MEDICINE PROHIBITION RULES AND REGULATIONS. THIS ORGANIZATION PROVIDES HIGH QUALITY AND COST EFFECTIVE PATHOLOGY SERVICES FOR THE

**Part VI Supplemental Information**

Provide the following information.

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

BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE TAX-EXEMPT  
PURPOSES OF SHORE MEDICAL CENTER.

SHORE HOSPITALISTS ASSOCIATES, P.A.  
-----

SHORE HOSPITALISTS ASSOCIATES, P.A IS A PHYSICIAN PRACTICE PROFESSIONAL  
ASSOCIATION CONTROLLED BY SHORE MEDICAL CENTER THROUGH A NOMINEE  
OWNERSHIP BY A LICENSED PROFESSIONAL DUE TO STATE OF NEW JERSEY CORPORATE  
PRACTICE OF MEDICINE PROHIBITION RULES AND REGULATIONS. THIS ORGANIZATION  
PROVIDES HIGH QUALITY AND COST EFFECTIVE INPATIENT MEDICAL SERVICES FOR  
THE BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE TAX-EXEMPT  
PURPOSES OF SHORE MEDICAL CENTER.

SHORE SPECIALTY CONSULTANTS, P.A.  
-----

SHORE SPECIALTY CONSULTANTS, P.A. IS A PHYSICIAN PRACTICE PROFESSIONAL

**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.

ASSOCIATION CONTROLLED BY SHORE MEDICAL CENTER THROUGH A NOMINEE OWNERSHIP BY A LICENSED PROFESSIONAL DUE TO STATE OF NEW JERSEY CORPORATE PRACTICE OF MEDICINE PROHIBITION RULES AND REGULATIONS. THIS ORGANIZATION PROVIDES HIGH QUALITY AND COST EFFECTIVE SPECIALTY MEDICAL SERVICES FOR THE BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE TAX-EXEMPT PURPOSES OF SHORE MEDICAL CENTER.

SCHEDULE H, PART VI; QUESTION 7

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



**SCHEDULE I  
(Form 990)**

**Grants and Other Assistance to Organizations,  
Governments, and Individuals in the United States**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.  
Attach to Form 990.

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

Name of the organization

SHORE MEMORIAL HOSPITAL

Employer identification number

21-0660835

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

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) ATLANTIC MEDICAL IMAGING, LLC P.O. BOX 1564 INDIANAPOLIS, IN 46206-1564	27-0525195		44,918.				SUB-GRANTEE
(2) ATLANTIC COUNTY DIVISION OF PUBLIC HEALTH 201 SHORE ROAD NORTHFIELD, NJ 08225	21-6000049	GOV'T ORG	13,962.				PROGRAM SUPPORT
(3) NEW JERSEY HEALTHCARE SPECIALISTS, PC P.O. BOX 452197 SUNRISE, FL 33323	22-1948732		9,960.				SUB-GRANTEE
(4) ADVANCED SHORE IMAGING ASSOCIATES, LLC P.O. BOX 6750 PORTSMOUTH, NH 03802	47-1561390		12,408.				SUB-GRANTEE
(5) THE PREMIER SURGICAL NETWORK 222 NEW ROAD, SUITE 6 LINWOOD, NJ 08221	22-2052641		10,865.				SUB-GRANTEE
(6) VMD PRIMARY PROVIDERS OF NEW JERSEY LLC 2354 US HWY 9 HOWELL, NJ 77314	86-1454831		8,143.				SUB-GRANTEE
(7) QUEST DIAGNOSTICS FOUNDATION 500 PLAZA DR SECAUCUS, NJ 07094	22-3093807	501(C)(3)	6,847.				PROGRAM SUPPORT
(8)							
(9)							
(10)							
(11)							
(12)							

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

3 Enter total number of other organizations listed in the line 1 table 5

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

Schedule I (Form 990) 2023

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

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

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

SCHEDULE I, PART I, QUESTION 2

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

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public Inspection**

Employer identification number

21-0660835

**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 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 checked="" 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? **4a**  Yes  No
- b** Participate in or receive payment from a supplemental nonqualified retirement plan? **4b**  Yes  No
- c** Participate in or receive payment from an equity-based compensation arrangement? **4c**  Yes  No
- 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? **5a**  Yes  No
- b** Any related organization? **5b**  Yes  No
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization? **6a**  Yes  No
- b** Any related organization? **6b**  Yes  No
- If "Yes" on line 6a or 6b, describe in Part III.

**7** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III **7**  Yes  No

**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 **8**  Yes  No

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**  Yes  No

	Yes	No
<b>1a</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>2</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>3</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4a</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>4b</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>4c</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5a</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5b</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6a</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6b</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>7</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>8</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>9</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

Schedule J (Form 990) 2023

**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				
RONALD W. JOHNSON 1 TRUSTEE - CEO	(i)	672,829.	292,280.	462,458.	61,000.	32,794.	1,521,361.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DAVID R. HUGHES 2 PRRESIDENT/CFO	(i)	432,402.	152,826.	728,169.	62,796.	33,848.	1,410,041.	42,469.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JEANNE M. ROWE, M.D. 3 CHIEF MEDICAL OFFICER	(i)	450,991.	160,211.	53,184.	63,246.	33,539.	761,171.	40,898.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
FREDERICK L. BANNER 4 CHIEF INFORMATION OFFICER	(i)	255,682.	117,299.	33,650.	14,834.	38,297.	459,762.	12,900.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
HOLLY BADALI 5 CHIEF NURSING OFFICER	(i)	275,558.	96,232.	3,936.	36,556.	26,668.	438,950.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ALAN L. BEATTY 6 VP HUMAN RESOURCES	(i)	261,591.	99,795.	58,118.	NONE	18,602.	438,106.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBIN KEYACK 7 VP AMBULATORY & SURGICAL SVCS	(i)	263,827.	96,806.	10,851.	12,503.	18,757.	402,744.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DANIEL JACOBY, M.D. 8 HOSPITALIST	(i)	332,527.	23,573.	400.	7,236.	14,853.	378,589.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
STEPHEN CAPECCI, D.O. 9 HOSPITALIST	(i)	255,943.	61,389.	200.	5,177.	18,118.	340,827.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBERT L. WOOD 10 DIRECTOR OF FINANCE	(i)	236,589.	5,790.	1,806.	NONE	33,942.	278,127.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBERT ROBERTSON 11 ADMIN DIRECTOR LOGISTICS	(i)	199,121.	4,894.	2,744.	NONE	26,409.	233,168.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
MATTHEW PISKUN 12 ADMIN DIRECTOR PHARMACY	(i)	201,564.	4,849.	952.	NONE	1,374.	208,739.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
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; QUESTION 1

THE ORGANIZATION MAINTAINS A CLUB MEMBERSHIP FOR BUSINESS PURPOSES AND MEETINGS. THIS MEMBERSHIP ENTITLES CERTAIN SHORE MEDICAL CENTER SENIOR EXECUTIVES TO THE USE OF THE CLUB'S FACILITIES. THE AMOUNTS OUTLINED HEREIN RELATING TO THE PERSONAL USE OF THIS CORPORATE MEMBERSHIP ARE TREATED AS TAXABLE WAGES AND ARE INCLUDED ON EACH INDIVIDUAL'S RESPECTIVE 2023 FORM W-2 AS TAXABLE WAGES: RONALD W. JOHNSON, \$1,898; DAVID HUGHES, \$1,898 AND ALAN L. BEATTY, \$1,235.

SCHEDULE J, PART I; QUESTION 4B

THE AMOUNT REFLECTED IN SCHEDULE J, PART II, COLUMN B(III) FOR THE FOLLOWING INDIVIDUALS INCLUDES A CURRENT YEAR VESTING IN A SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (NON-QUALIFIED DEFERRED COMPENSATION PLAN) AS THE AMOUNTS WERE NO LONGER SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. THE AMOUNT OUTLINED HEREIN WERE INCLUDED IN EACH INDIVIDUAL'S 2023 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: RONALD W. JOHNSON,

**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.

\$417,255 AND DAVID R. HUGHES, \$624,142.

THE AMOUNT REFLECTED IN SCHEDULE J, PART II, COLUMN B(III) FOR THE FOLLOWING INDIVIDUALS INCLUDES CURRENT YEAR VESTINGS IN AN INTERNAL REVENUE CODE SECTION 457(F) PLAN (NON-QUALIFIED DEFERRED COMPENSATION PLAN) AS THE AMOUNTS WERE NO LONGER SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. THE AMOUNT OUTLINED HEREIN WERE INCLUDED EACH INDIVIDUAL'S 2023 FORM W-2 AS TAXABLE WAGES: DAVID R. HUGHES, \$91,321; JEANNE M. ROWE, M.D., \$42,417; FREDERICK L. BANNER, \$29,316 AND ALAN L. BEATTY, \$49,604.

THE DEFERRED COMPENSATION AMOUNTS REFLECTED IN SCHEDULE J, PART II, COLUMN C FOR THE FOLLOWING INDIVIDUALS INCLUDE UNVESTED BENEFITS IN AN INTERNAL REVENUE CODE SECTION 457(F) PLAN (NON-QUALIFIED DEFERRED COMPENSATION PLAN) WHICH ARE SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. ACCORDINGLY, THESE INDIVIDUALS MAY NEVER ACTUALLY RECEIVE THIS UNVESTED BENEFIT AMOUNT. THE AMOUNTS OUTLINE HEREIN WERE NOT INCLUDED IN EACH INDIVIDUAL'S 2023 FORM W-2 BOX 5, AS TAXABLE MEDICARE

**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.

WAGES: DAVID R. HUGHES, \$46,573; JEANNE M. ROWE, M.D., \$45,721; FREDERICK  
L. BANNER, \$14,834 AND HOLLY BADALI, \$28,120.

SCHEDULE J, PART I; QUESTION 7

CERTAIN INDIVIDUALS INCLUDED IN SCHEDULE J, PART II RECEIVED A BONUS  
DURING CALENDAR YEAR 2023 WHICH AMOUNTS WERE INCLUDED IN COLUMN B(II)  
HEREIN AND IN EACH INDIVIDUAL'S 2023 FORM W-2 AS TAXABLE WAGES. PLEASE  
REFER TO THIS SECTION OF THE FORM 990, SCHEDULE J FOR THIS INFORMATION BY  
PERSON BY AMOUNT.

SCHEDULE J, PART II; COLUMN F

THE AMOUNTS REPORTED IN SCHEDULE J, PART II, COLUMN (F) INCLUDE VESTED  
BENEFITS IN A DEFERRED COMPENSATION PLAN AS THESE AMOUNTS WERE NO LONGER  
SUBJECT TO A SUBSTANTIAL RISK OF FORFEITURE. THESE AMOUNTS WERE REPORTED  
AS DEFERRED COMPENSATION ON PRIOR YEARS' FORMS 990 AND ARE NOW BEING  
REPORTED AGAIN ON THIS YEAR'S FORM 990. THESE AMOUNTS HAVE BEEN TREATED

**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.

AS TAXABLE INCOME AND WERE REPORTED ON EACH INDIVIDUAL'S FORM W-2, BOX 5,

AS TAXABLE MEDICARE WAGES.



**SCHEDULE L  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Transactions With Interested Persons**

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

Attach to Form 990 or Form 990-EZ.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open To Public  
Inspection**

Name of the organization <b>SHORE MEMORIAL HOSPITAL</b>	Employer identification number <b>21-0660835</b>
--	---

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only)  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b; or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . \$ \_\_\_\_\_

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons**  
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

1	(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
				To	From			Yes	No	Yes	No	Yes	No
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
<b>Total</b> . . . . .							\$						

**Part III Grants or Assistance Benefiting Interested Persons**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

1	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SONYA BANNER	FAMILY MEMBER OF OFFICER	37,868.	EMPLOYEE		X
(2) HANNA BANNER	FAMILY MEMBER OF OFFICER	13,275.	EMPLOYEE		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

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

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

**FORM 990, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS**

BACKGROUND

=====

SHORE MEDICAL CENTER ("THE MEDICAL CENTER") IS A GENERAL MEDICAL AND SURGICAL HOSPITAL RECOGNIZED BY THE IRS AS AN INTERNAL REVENUE CODE SECTION 501(C) (3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, SHORE PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, OR ABILITY TO PAY. MOREOVER, THE MEDICAL CENTER OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

- 1) THE MEDICAL CENTER PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF ABILITY TO PAY, INCLUDING CHARITY CARE, SELF-PAY, MEDICARE AND MEDICAID PATIENTS;
- 2) THE MEDICAL CENTER OPERATES AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN 24 HOURS A DAY, SEVEN DAYS A WEEK, 365 DAYS PER YEAR;
- 3) THE MEDICAL CENTER MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS;

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

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

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

THE OPERATIONS OF THE MEDICAL CENTER, AS SHOWN THROUGH THE FACTORS  
OUTLINED ABOVE AND OTHER INFORMATION CONTAINED HEREIN, CLEARLY  
DEMONSTRATE THAT THE MEDICAL CENTER PROVIDES SUBSTANTIAL COMMUNITY  
BENEFIT AND THAT THE USE AND CONTROL OF SHORE 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 INCIDENTALLY.

MISSION STATEMENT

=====

WE CARE FOR AND RESPECT ALL PATIENTS, THEIR FAMILIES AND EACH OTHER.

ORGANIZATION OVERVIEW

=====

THE MEDICAL CENTER IS A NOT-FOR-PROFIT HEALTHCARE RESOURCE THAT HAS

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

SERVED SOUTHERN NEW JERSEY FOR MORE THAN 80 YEARS. IN THAT TIME, THE MEDICAL CENTER HAS BECOME KNOWN FOR PROVIDING A COMPASSIONATE LEVEL OF SERVICE THAT GOES HAND IN HAND WITH ITS ADVANCED TECHNOLOGY AND MODERN MEDICAL FACILITIES.

THE MEDICAL CENTER IS A 199 BED, NOT-FOR-PROFIT ACUTE CARE MEDICAL CENTER LOCATED IN SOMERS POINT, ATLANTIC COUNTY, NEW JERSEY, APPROXIMATELY 10 MILES SOUTH OF ATLANTIC CITY, NEW JERSEY. THE MEDICAL CENTER IS LICENSED AND APPROVED BY THE STATE OF NEW JERSEY TO OPERATE AS A GENERAL ACUTE CARE HOSPITAL PROVIDING BOTH INPATIENT AND OUTPATIENT SERVICES TO THE COMMUNITY.

FOUNDED IN 1928 AND CHARTERED IN 1940 AS A NOT-FOR-PROFIT CORPORATION, THE MEDICAL CENTER SERVES THE HEALTHCARE NEEDS OF BOTH THE YEAR-ROUND AND SUMMER RESIDENTS OF ATLANTIC AND CAPE MAY COUNTIES, AS WELL AS VISITORS FROM OTHER COMMUNITIES AND STATES.

THE MEDICAL CENTER HAS UNDERGONE MORE THAN FOURTEEN MAJOR CONSTRUCTION AND RENOVATION PROJECTS SINCE 1940 TO PROVIDE NECESSARY FACILITIES AND SERVICES FOR ITS EXPANDING PATIENT POPULATION. IN 2013, THE MEDICAL CENTER UNVEILED A NEW STATE-OF-THE-ART MEDICAL ONCOLOGY SUITE ON THE THIRD FLOOR OF ITS FREESTANDING CANCER CENTER. THE 3,600 SQUARE FOOT EXPANSION FEATURES EIGHT SPACIOUS INFUSION THERAPY BAYS, THREE EXAM ROOMS, A FAMILY WAITING ROOM, NUTRITION CENTER AND A FULLY EQUIPPED AND STOCKED PHARMACY WITH A FULL-TIME ONCOLOGY PHARMACIST.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

THE MEDICAL CENTER ENGAGES THE TALENTS AND TEAMWORK OF THE BEST AND  
BRIGHTEST PEOPLE IN THE INDUSTRY. OUR TEAM OF PHYSICIANS, NURSES,  
TECHNOLOGISTS, MANAGERS, FINANCIAL EXPERTS, BOARD OF TRUSTEES AND OUR  
AFFILIATES ALL WORK TOGETHER TO ENSURE THAT THE COMMUNITY HAS ACCESS TO  
THE BEST HEALTHCARE RESOURCES WHEN NEEDED.

THE MEDICAL CENTER CONTINUES TO BE ACCREDITED BY THE JOINT COMMISSION,  
THE NATION'S PREDOMINANT STANDARDS SETTING AND ACCREDITING BODY IN  
HEALTHCARE, AS A PRIMARY STROKE CENTER. SHORE ALSO IS ALSO CERTIFIED BY  
THE JOINT COMMISSION FOR ITS SPINE SURGERY AND HIP AND KNEE REPLACEMENT  
PROGRAMS IN RECOGNITION OF THE MEDICAL CENTER'S STRICT ADHERENCE TO  
QUALITY STANDARDS.

IN ADDITION, SHORE MEDICAL CENTER IS A MEMBER OF PENN MEDICINE  
TELENEUROLOGY; A MEMBER OF THE NEW JERSEY HEALTH CARE QUALITY INSTITUTE  
TO IMPROVE THE SAFETY, QUALITY AND AFFORDABILITY OF HEALTH CARE FOR  
EVERYONE; AND A MEMBER OF THE PENN MEDICINE CANCER NETWORK. SHORE MEDICAL  
CENTER'S ICU IS MANAGED BY BOARD CERTIFIED CRITICAL CARE PHYSICIANS,  
24/7/365. IN ADDITION, SHORE MEDICAL CENTER'S STATE-OF-THE-ART PEDIATRIC  
CARE CENTER OFFERS AN "OUCHLESS" PROGRAM TO REDUCE THE PAIN AND FEAR  
CHILDREN MAY EXPERIENCE IN THE HOSPITAL, AS WELL AS A SENSORY FRIENDLY  
PROGRAM FOR CHILDREN ON THE AUTISM SPECTRUM OR WITH SENSORY PROCESSING  
DISORDERS TO HELP REDUCE SENSORY STIMULI AND CREATE A MORE CALMING  
ENVIRONMENT FOR RECEIVING CARE.

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

IN 2023, 7,892 PATIENTS WERE ADMITTED TO THE MEDICAL CENTER AND 3,580  
PLACED IN OBSERVATION. THERE WERE 47,976 PATIENTS TREATED IN SHORE'S  
EMERGENCY DEPARTMENT.

COMMUNITY FOCUSED EDUCATION

=====

THE MEDICAL CENTER'S WELLNESS PROGRAM HAS BEEN AN INTEGRAL PART OF THE  
COMMUNITY, OFFERING HEALTH EDUCATION AND SCREENINGS FOR MORE THAN 20  
YEARS.

CANCER OUTREACH

-----

SHORE IS THE LEAD AGENCY FOR THE NEW JERSEY CANCER EDUCATION AND EARLY  
DETECTION (CEED) PROGRAM IN ATLANTIC COUNTY. THE PROGRAM PROVIDES CANCER  
SCREENING, DIAGNOSTIC AND NAVIGATION SERVICES FOR UNDERSERVED POPULATIONS  
AT CONVENIENT LOCATIONS WITHIN THE COMMUNITY. SHORE COORDINATED 360  
BREAST CANCER SCREENINGS, 242 CERVICAL CANCER SCREENINGS, 83 COLORECTAL  
CANCER SCREENINGS, AND 44 PROSTATE CANCER SCREENINGS. THIS RESULTED IN  
DETECTING 2 BREAST CANCERS. IN 2023, SHORE MEDICAL CENTER RECEIVED  
\$394,036 IN CEED GRANT FUNDING FOR THESE SERVICES.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

SHORE IS ALSO THE LEAD AGENCY FOR THE COMPREHENSIVE CANCER CONTROL (CCC) COALITION GRANT TO PROVIDE POLICY, ENVIRONMENTAL AND SYSTEM CHANGES IN ATLANTIC AND CAPE MAY COUNTY IN AN EFFORT TO REDUCE CANCER. IN 2023, SHORE MEDICAL CENTER RECEIVED \$116,403 FOR THESE INITIATIVES. IN 2023, 4,278 INDIVIDUALS WERE PART OF THE EDUCATION AND OUTREACH CONDUCTED THROUGH CEED AND CCC THROUGH AWARENESS EVENTS, WORKSHOPS OR LECTURES. ACTIVITIES INCLUDED TABLE EVENTS, A MEDITATION RETREAT FOR CANCER SURVIVORSHIP, A VARIETY OF WEBINARS THAT WERE RECORDED LIVE THAT CAN BE VIEWED YOUTUBE, AND MULTIPLE FOOD DISTRIBUTION EVENTS.

CANCER SCREENING EVENTS HAVE BECOME MORE PREVALENT IN OUR OUTREACH ACTIVITIES DUE TO THE ABILITY TO HAVE THEM DURING THE PANDEMIC AND THE SUCCESS OF THE EVENTS. DURING 2023, SIX CANCER SCREENINGS OCCURRED WITH 83 PARTICIPANTS ATTENDING THESE EVENTS. THESE EVENTS ARE AVAILABLE FREE TO POPULATIONS WHO ARE UNINSURED/UNDERINSURED. TWO LUNG CANCER SCREENING EVENTS, ONE BREAST MAMMOGRAM EVENT, AND THREE TRAVELING PROSTATE CANCER SCREENING EVENTS (MULTIPLE LOCATIONS IN THE COMMUNITY) OCCURRED.

IN ORDER TO ASSIST WITH HEALTH EQUITY A GRANT FROM THE FCC FOR \$769,800 WAS WRITTEN IN PARTNERSHIP WITH SOUTHERN JERSEY FAMILY MEDICAL CENTER (SJFMC), THE LOCAL FQHC. THIS GRANT ENABLED 200 TELEHEALTH DEVICES DESIGNATED FOR THE CANCER CENTER, 400 FOR THE HOSPITAL AND 683 FOR SJFMC. THE FOCUS WAS TO IMPROVE TELEHEALTH ACCESS FOR PATIENTS - SPECIFICALLY UNDERSERVED PATIENTS. SHORE MEDICAL CENTER BEGAN HANDING OUT DEVICES IN 2022 AND FINISHED HANDING OUT THE DEVICES IN 2023.



**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.

**2023**

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

CHILDBIRTH

-----

CHILDBIRTH EDUCATION, BREAST FEEDING SUPPORT AND OTHER PROGRAMS TO  
WELCOME A NEWBORN INTO THE FAMILY ARE OFFERED TO THE ENTIRE COMMUNITY  
THROUGH THE SHORE BEGINNINGS PRENATAL AND WELLNESS PROGRAM.

**FORM 990, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS**

VIRTUAL & IN-PERSON RESOURCES AND SUPPORT

-----

THE MEDICAL CENTER'S WEBSITE PROVIDES INFORMATION ON MEDICAL CENTER  
PROGRAMS, SERVICES AND PHYSICIANS. IT ALSO OFFERS EDUCATIONAL VIDEOS,  
HEALTH-FOCUSED ARTICLES AND ASSESSMENTS. THE MEDICAL CENTER'S PHYSICIAN  
FINDER SERVICE IS FREE AND AVAILABLE ON THE INTERNET. THE SERVICE MATCHES  
A PERSON'S NEEDS SUCH AS SPECIALTY, LOCATION, INSURANCE AND OFFICE HOURS  
TO A SHORE MEDICAL STAFF PHYSICIAN.

SHORE'S VETERANS AFFAIRS NAVIGATOR PROGRAM, ALZHEIMER'S ASSOCIATION  
CAREGIVER SUPPORT GROUP AND SUPPORT THROUGH THE CENTER FOR FAMILY  
CAREGIVERS CONTINUED IN 2023 ON A LIMITED BASES DUE TO COVID, PROVIDING  
SUPPORT TO PATIENTS AND FAMILIES VIRTUALLY WHEN IN-PERSON WAS NOT  
POSSIBLE.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

1. VETERANS AFFAIRS NAVIGATOR PROGRAM: GUIDES VETERANS THROUGH THE PROCESS OF SEEKING VA MEDICAL CARE AND HELPS THEM OVERCOME BARRIERS THEY MAY ENCOUNTER, DEMYSTIFYING THE PROCESS AND HELPING THEM TAKE FULL ADVANTAGE OF THEIR HEALTHCARE OPPORTUNITIES.

2. ALZHEIMER'S ASSOCIATION'S CAREGIVER SUPPORT GROUP: DESIGNED TO PROVIDE EMOTIONAL, EDUCATIONAL AND SOCIAL SUPPORT FOR CAREGIVERS THROUGH REGULARLY SCHEDULED MEETINGS. THEY HELP PARTICIPANTS DEVELOP METHODS AND SKILLS TO SOLVE PROBLEMS. THE GROUPS ENCOURAGE CAREGIVERS TO MAINTAIN THEIR OWN PERSONAL, PHYSICAL AND EMOTIONAL HEALTH, AS WELL AS OPTIMALLY CARE FOR THE PERSON WITH DEMENTIA. THE SUPPORT GROUP AT SHORE IS HELD THE SECOND TUESDAY OF EVERY MONTH.

3. CENTER FOR FAMILY CAREGIVERS SUPPORT: STAFF ARE AVAILABLE TO PROVIDE EMOTIONAL, EDUCATIONAL AND SOCIAL SUPPORT FOR FAMILY CAREGIVERS IN NEED OF ASSISTANCE AND SUPPORT AS THEY MANAGE THE OFTEN-DAUNTING ROLE OF FAMILY CAREGIVER FOR A LOVED ONE AT HOME AFTER THEY ARE DISCHARGED.

SHORE MEDICAL CENTER OFFERS A MONTHLY VIRTUAL WELLNESS PROGRAM, "CARING TOGETHER, LIVING WELL," IN PARTNERSHIP WITH ANGELIC HEALTH. THE PROGRAM PROVIDED SPEAKERS ON A WIDE RANGE OF HEALTH AND WELLNESS TOPICS INCLUDING MUSIC THERAPY, GRIEF AND LOSS, AND HOW TO WRITE YOUR MEMOIR. THESE SESSIONS BEGAN VIRTUALLY AND THEN TRANSITIONED TO IN-PERSON.

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

IN ADDITION TO THESE SUPPORT GROUPS, SHORE HAS BEEN VERY PROACTIVE IN ASSISTING PATIENTS WITH ALZHEIMER'S DISEASE AND DEMENTIA, WORKING WITH THE ALZHEIMER'S ASSOCIATION OF AMERICA ON EDUCATIONAL AND AWARENESS ISSUES. IN OCT 2023, SHORE BROUGHT DEMENTIA LIVE - A HIGH-IMPACT, DEMENTIA SIMULATION EXPERIENCE FOR STAFF EDUCATION. DEMENTIA LIVE IMMERSSES PARTICIPANTS INTO LIFE WITH DEMENTIA, RESULTING IN A DEEPER UNDERSTANDING OF WHAT IT'S LIKE TO LIVE WITH COGNITIVE IMPAIRMENT AND SENSORY CHANGES. THE EXPERIENCE WAS VALUABLE FOR THOSE WHO DO NOT CURRENTLY CARE FOR SOMEONE WITH DEMENTIA AS IT IS FOR THOSE WHO ARE AMONG 272,000 PEOPLE IN NEW JERSEY WHO DO.

UNCOMPENSATED CARE

=====

THE MEDICAL CENTER HAS LONG BEEN A REGIONAL LEADER IN MEETING ITS COMMITMENT TO THE MEDICALLY UNDERSERVED MEMBERS OF THE COMMUNITY. IN ADDITION TO ITS COMMUNITY OUTREACH PROGRAMS, THE MEDICAL CENTER PROVIDES SUBSTANTIAL AMOUNTS OF UNCOMPENSATED CARE TO THOSE LEAST ABLE TO PAY FOR THESE SERVICES. IN KEEPING WITH ITS MISSION TO CARE FOR PATIENTS, THE MEDICAL CENTER SERVES ALL WITHOUT REGARD TO ABILITY TO PAY. IN 2023, SHORE PROVIDED \$30,231,826 IN UNCOMPENSATED CARE (\$4,667,795 IN BAD DEBT; \$10,450,948 IN CHARITY CARE, AND \$15,113,083).

THE MEDICAL CENTER RECOGNIZES THE FINANCIAL DIFFICULTY IMPOSED ON THE SELF-PAY PATIENT WHO IS LEAST ABLE TO AFFORD TO PAY FOR HEALTHCARE

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

SERVICES WHEN BILLED AT THE MEDICAL CENTER'S STANDARD CHARGES. THEREFORE,  
THE MEDICAL CENTER ESTABLISHED AN INNOVATIVE POLICY TO ADDRESS THE  
DISPARITY BETWEEN HOSPITAL-BILLED CHARGES AND THE ACTUAL COST OF  
PROVIDING CARE TO THE SELF-PAY PATIENT OR UNDER-INSURED PATIENT. THE  
METHOD ADOPTED IS BASED UPON SOUND ACCOUNTING PRINCIPLES TO DETERMINE THE  
ACTUAL COST OF PROVIDING CARE TO PATIENTS USING A KNOWN STANDARD  
DEVELOPED FOR THE MEDICARE COST REPORT.

THE POLICY IS TO APPLY THE MOST CURRENT HOSPITAL SPECIFIC MEDICARE COST  
TO CHARGE RATIO TO THE SELF-PAY PATIENT'S TOTAL CHARGE BALANCE AND ADJUST  
THE BILL TO COST. THIS ADJUSTMENT IS LIMITED ONLY TO THOSE PATIENTS NOT  
COVERED BY INSURANCE. THIS RATIO IS SUBJECT TO CHANGE AS DETERMINED BY  
THE MEDICARE FISCAL INTERMEDIARY.

PATIENTS UNABLE TO PAY THE COST ADJUSTED BILL IN FULL ARE PERMITTED TO  
ENTER INTO A HOSPITAL-APPROVED PAYMENT ARRANGEMENT. PAYMENT ARRANGEMENTS  
ARE DETERMINED BASED UPON THE FINANCIAL CONDITION OF THE PATIENT AND PAID  
OVER TIME USING OUR EXISTING PAYMENT ARRANGEMENT METHODOLOGY.

AS A NON-PROFIT HEALTHCARE PROVIDER, IT IS THE MEDICAL CENTER'S  
RESPONSIBILITY TO DELIVER HIGH-QUALITY HEALTHCARE REGARDLESS OF THE  
PATIENT'S ABILITY TO PAY. THE MEDICAL CENTER IS COMMITTED TO THE  
COMMUNITY THAT IT SERVES. THE CHALLENGE OF MEETING THE HIGH COSTS OF  
PROVIDING QUALITY HEALTH SERVICES IS MADE POSSIBLE THROUGH THE DEDICATION  
OF PHYSICIANS, STAFF AND VOLUNTEERS.

**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.

**2023**

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

AFFILIATIONS

=====

SHORE PHYSICIANS GROUP

-----

SHORE MEDICAL CENTER IS ALIGNED WITH SHORE PHYSICIANS GROUP (SPG), A MULTI-SPECIALTY PHYSICIAN GROUP THAT IS COMMITTED TO CHANGING THE WAY PEOPLE ARE CARED FOR IN THE COMMUNITY. THIS GROUP FEATURES SPECIALISTS IN THE FIELDS OF ENDOCRINOLOGY, NEUROLOGY, NON-OPERATIVE SPORTS MEDICINE, PRIMARY CARE, AND RHEUMATOLOGY. THE SURGICAL DIVISION, WHICH IS A PENN SURGICAL AFFILIATE, OFFERS GENERAL SURGERY, ENDOVASCULAR SURGERY, VASCULAR SURGERY, NEUROSURGERY, AND UROLOGY. SPG ALSO CARES FOR ITS COMMUNITY THROUGH ITS ORTHOPEDIC DIVISION IN SOMERS POINT AND ITS URGENT CARE CENTER IN NORTHFIELD.

PENN MEDICINE

-----

THE MEDICAL CENTER'S LONG-STANDING AFFILIATION WITH PENN MEDICINE CONTINUES TO BE A VALUABLE PARTNERSHIP, PROVIDING PATIENTS WITH ACCESS TO ADVANCED TREATMENT IN MULTIPLE DISCIPLINES, INCLUDING CANCER CARE, MATERNAL-FETAL MEDICINE, CARDIAC CARE, AND PULMONOLOGY.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

- IN DECEMBER 2019, SHORE CANCER CENTER BECAME A MEMBER OF THE PENN  
CANCER NETWORK. AS PART OF THIS NETWORK, CLINICIANS AT THE SHORE CANCER  
CENTER HAVE EXPANDED ACCESS TO ADVANCED EXPERTISE AND A VARIETY OF  
RESOURCES.

- THE PENN MATERNAL-FETAL MEDICINE PROGRAM AT SHORE PROVIDES EXTRA CARE  
TO MOTHERS-TO-BE AND THEIR CHILDREN. WOMEN FACING HIGH-RISK PREGNANCIES  
CAN BE TREATED FOR A VARIETY OF CONDITIONS, INCLUDING HEART DISEASE,  
PLACENTAL PROBLEMS, DIABETES, MULTIPLE GESTATION PREGNANCY AND LATER-AGE  
PREGNANCY.

- THROUGH A CARDIOLOGY AFFILIATION WITH PENN MEDICINE, SHORE OFFERS  
PATIENTS WITH CARDIOVASCULAR DISEASE THE HIGHEST LEVELS OF MEDICAL  
EXPERTISE AND CARE, AS WELL AS ACCESS TO PENN'S LEADING INTERVENTIONAL  
CARDIOLOGISTS.

- PENN PULMONOLOGY'S SOMERS POINT OFFICE IS LOCATED IN THE SHORE MEDICAL  
CENTER MEDICAL OFFICE BUILDING WHERE IT OFFERS INTERVENTIONAL PULMONOLOGY  
CAPABILITIES.

- SHORE MEDICAL CENTER IS AFFILIATED WITH PENN MEDICINE TELENEUROLOGY AND  
TELESTROKE. THE SHORE NEUROSCIENCE CENTER'S EXTRAORDINARY HIGH-TECH  
DIAGNOSIS AND TREATMENT OPTIONS, WHICH ARE ENHANCED THROUGH THE ADVANCED  
TECHNOLOGY FOUND WITHIN THE SHORE SURGICAL PAVILION, ARE DELIVERED WITH  
THE CARING TOUCH EXPECTED FROM THE MEDICAL CENTER. WITH THE PENN MEDICINE

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

TELENEUROLOGY AFFILIATION, SPECIALISTS FROM THE SHORE NEUROSCIENCES  
CENTER AND PENN COLLABORATE USING A MULTI-DISCIPLINARY APPROACH TO  
EVALUATION, DIAGNOSIS AND TREATMENT. HIGHLY COMPLEX CASES CAN BE REFERRED  
WITH ACCURACY AND SPEED, AIDED BY A SEAMLESS EXCHANGE OF INFORMATION,  
24/7.

MAYO MEDICAL LABORATORIES  
-----

SHORE CONTINUES TO UTILIZE MAYO MEDICAL LABORATORIES AS ITS PRIMARY  
REFERENCE LABORATORY, A RELATIONSHIP ESTABLISHED IN 2014 THAT GIVES THE  
MEDICAL CENTER ACCESS TO MAYO CLINIC'S EXTENSIVE MENU OF LABORATORY TESTS  
AND CLINICAL EXPERTISE, WHILE ENHANCING THE EFFICIENCY AND AFFORDABILITY  
OF ADVANCED LABORATORY TESTING.

ADDITIONAL CLINICAL PARTNERSHIPS  
-----

- ADVANCED RADIOLOGY SOLUTIONS ("ARS") FOR DIAGNOSTIC IMAGING SERVICES.
  - ENVISION HEALTHCARE TO PROVIDE 24/7 ANESTHESIOLOGIST COVERAGE.
  - ONSITE NEONATAL PARTNERS PROVIDES NEONATOLOGISTS IN THE HOSPITAL.
- ONSITE PHYSICIANS ALSO PROVIDE STAFFING FOR SHORE'S PEDIATRIC CARE  
CENTER.
- ADVANTAGE WOMEN'S HEALTH FOR ITS LABORIST PROGRAM.

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

SPIRIT OF SHORE

=====

HOSPITALS ARE BUSY PLACES, BUT THE STAFF AT THE MEDICAL CENTER IS NEVER  
TOO BUSY TO PAY ATTENTION TO THE THOUGHTFUL GESTURES AND KIND ACTS THAT  
CAN MAKE A MEANINGFUL DIFFERENCE TO PATIENTS AND THEIR FAMILY MEMBERS.  
THIS PHILOSOPHY IS THE DRIVING FORCE BEHIND THE SPIRIT OF SHORE  
INITIATIVE AT THE MEDICAL CENTER.

THE SPIRIT OF SHORE REFLECTS THE CULTURE OF CARING THAT IS UNIQUE TO  
SHORE.

SINCE THE IMPLEMENTATION OF ITS SPIRIT OF SHORE PROGRAM IN 2008, THE  
MEDICAL CENTER HAS BEEN ON A JOURNEY TO CREATE AND NURTURE AN  
INSTITUTIONAL CULTURE OF PATIENT-CENTERED CLINICAL, EMOTIONAL AND  
SPIRITUAL CARE FOR ITS PATIENTS, THEIR FAMILIES AND STAFF. INITIATIVES  
TOUCH EVERY CORNER OF THE MEDICAL CENTER'S COMMUNITY, PROMOTING AN  
ENVIRONMENT WHERE EVERYONE IS A CAREGIVER, REGARDLESS OF THEIR POSITION  
WITHIN THE ORGANIZATION.

**FORM 990, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS**

OUR MANY PROGRAMS AND INITIATIVES INCLUDE, BUT ARE NOT LIMITED TO, THE  
FOLLOWING:



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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

- SHARED MEDICAL RECORDS
- COMFORTABLE FAMILY LOUNGES
- PATIENT DIRECTED VISITATION
- HOURLY ROUNDS
- LEADERSHIP ROUNDS
- BEDSIDE REPORTS
- E-ICU
- NO PASSING ZONE
- MOTORIZED SCOOTERS FOR PATIENTS
- PATIENT PARTNER PROGRAM
- PET THERAPY
- COMMUNITY EDUCATION; AND
- PRAYER CIRCLES HELD TWICE A MONTH.

SHORE ALSO PARTNERS WITH THE COMMUNITY ON TWO COUNCILS, ITS SPIRITUALITY COUNCIL AND THE PATIENT AND FAMILY ADVISORY COUNCIL.

SHORE'S SPIRITUALITY COUNCIL WAS CREATED TO HELP PROVIDE STRENGTH, COMFORT AND SUPPORT FOR VISITING LOVED ONES AND MEMBERS OF THE SHORE FAMILY IN THEIR TIME OF NEED. THIS COUNCIL IS COMPRISED OF LOCAL CLERGY, STAFF AND VOLUNTEERS. SHORE'S NON-DENOMINATIONAL CHAPEL, LOCATED ON THE 5TH FLOOR OF THE HOSPITAL, PROVIDES A SPACE FOR QUIET CONTEMPLATION AND REFLECTION. SHORE ALSO HAS A EUCHARISTIC MINISTRY PROGRAM STAFFED BY VOLUNTEERS.

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

THE PATIENT AND FAMILY ADVISORY COUNCIL IS MADE UP OF FORMER SHORE PATIENTS AND FAMILY MEMBERS, COMMUNITY MEMBERS AND VOLUNTEERS. GROUP MEMBERS SHARE STORIES, PROVIDE VALUABLE FEEDBACK ON THEIR HOSPITAL EXPERIENCES AND ASSIST LEADERSHIP IN DECISION MAKING BY INCORPORATING THEIR EXPERIENCES INTO SHORE'S PHILOSOPHY AND OPERATION. THE MEDICAL CENTER STAFF MEMBERS ALSO USE THESE MEETINGS TO EDUCATE THE COUNCIL ABOUT THE MEDICAL CENTER AND HEALTHCARE ISSUES IN GENERAL.

CENTERS OF EXCELLENCE

=====

THE MEDICAL CENTER'S RECOGNIZED CENTERS OF EXCELLENCE INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

CANCER CENTER

-----

A CANCER DIAGNOSIS IS AN EXPERIENCE THAT IS UNIQUE TO EVERY INDIVIDUAL. AT SHORE CANCER CENTER, A MEMBER OF THE PENN CANCER NETWORK, WE RESPOND TO EACH PATIENT WITH OPTIMISM AND REAL SOLUTIONS: A COMPREHENSIVE, NATIONALLY RECOGNIZED PROGRAM COMBINING THE BEST AVAILABLE TECHNOLOGY, EXPERTS IN THE FIELD AND QUALITY SERVICES, INCLUDING OUR STATE-OF-THE-ART FACILITY.

THE SHORE CANCER CENTER WAS DESIGNED WITH ONE GOAL IN MIND: FULFILLING

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

OUR CONTINUING MISSION TO PROVIDE THE MOST ADVANCED HEALTHCARE SERVICES  
BY USING A MULTIDISCIPLINARY APPROACH FOR YOU AND YOUR FAMILY IN A WARM  
AND CARING ENVIRONMENT.

THE SHORE MEDICAL CENTER RADIATION ONCOLOGY DEPARTMENT IS ACCREDITED BY  
THE AMERICAN COLLEGE OF RADIOLOGY (ACR). ACR ACCREDITATION ENSURES THAT  
SHORE'S PROGRAM MEETS THE MOST CURRENT AND STRINGENT STANDARDS IN  
STAFFING, EQUIPMENT, QUALITY CONTROL AND TECHNICAL CAPABILITY.

CARDIOVASCULAR SERVICES  
-----

THE MEDICAL CENTER'S CARDIOVASCULAR SERVICES BRING UNIVERSITY-SETTING  
CARDIAC AND VASCULAR SERVICES TO THE COMMUNITY. THE FACILITY HOUSES  
SOPHISTICATED TECHNOLOGY FOR THE DIAGNOSIS AND TREATMENT OF DISORDERS OF  
THE HEART AND CIRCULATORY SYSTEM. THE MEDICAL CENTER'S COMPREHENSIVE  
CARDIAC CARE PROGRAM INCLUDES ADVANCED DIAGNOSTIC CAPABILITIES AND  
TREATMENT OPTIONS, AS WELL AS PREVENTION, REHABILITATION AND EDUCATION  
FOR THOSE WITH CORONARY AND VASCULAR DISEASE. THE MEDICAL CENTER'S  
138,000-SQUAREFOOT SURGICAL PAVILION INCLUDES A STATE-OF-THE-ART  
CARDIOVASCULAR SERVICES SUITE FOR INVASIVE PROCEDURES SUCH AS CARDIAC  
CATHETERIZATIONS. PATIENTS IN NEED OF LESS INVASIVE TESTING, INCLUDING  
EKGS AND ECHOCARDIOGRAMS, CAN ALSO HAVE THEIR TESTING DONE IN THE  
CARDIOVASCULAR SUITE. THE MEDICAL CENTER ALSO OFFERS A NON-INVASIVE HEART  
AND LUNG TESTING CENTER, FEATURING CARDIAC STRESS TESTING,

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

HOLTER-MONITORING AND TRANSESOPHAGEAL ECHOCARDIOGRAPHY.

PENN HEART AND VASCULAR AT SHORE MEDICAL CENTER

-----

AS A MEMBER OF PENN HEART AND VASCULAR, THE MEDICAL CENTER PROVIDES  
RESIDENTS OF THE COMMUNITY WITH ACCESS TO A NUMBER OF HIGH-TECH  
DIAGNOSES, TREATMENTS AND SERVICES. OUR AFFILIATION WITH THIS NATIONAL  
LEADER IN HEART CARE ENHANCES THE LEVEL OF EXTRAORDINARY CARDIAC CARE  
AVAILABLE IN OUR CARDIOVASCULAR SUITE - AND PROVIDES QUICK, COORDINATED  
ACCESS TO A WIDE RANGE OF WORLD-CLASS CARDIAC SERVICES. THE MEDICAL  
CENTER ALSO PROVIDES 24-HOUR, SEVEN-DAY-A-WEEK EMERGENCY TRANSPORT TO  
PHILADELPHIA VIA AMBULANCE OR PENNSTAR HELICOPTER FOR CARDIAC PATIENTS IN  
NEED.

EMERGENCY SERVICES

-----

(1) EMERGENCY DEPARTMENT

WHETHER IT'S A SPRAINED ANKLE FROM A RUN ON THE BOARDWALK OR A  
LIFE-THREATENING HEART ATTACK OR STROKE, THE EMERGENCY STAFF AT THE  
MEDICAL CENTER IS READY, WILLING AND ABLE TO HELP. BOARD CERTIFIED  
EMERGENCY MEDICINE PHYSICIANS, WHO ARE SPECIALLY TRAINED IN CARDIOLOGY,  
NEUROSCIENCES, ORTHOPEDICS, OBSTETRICS, PEDIATRICS AND MORE, STAFF THE

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

SHORE MEDICAL CENTER EMERGENCY DEPARTMENT.

(2) NATIONALLY RECOGNIZED PRIMARY STROKE CENTER

HAVING RECEIVED ADVANCED CERTIFICATION AS A PRIMARY STROKE CENTER BY THE JOINT COMMISSION, OUR EMERGENCY DEPARTMENT STAFF AND PHYSICIANS ARE TRAINED IN THE CARE AND TREATMENT OF STROKE PATIENTS AND SKILLED IN ADMINISTERING TPA, THE "CLOT BUSTING" MEDICATION THAT CAN PROVIDE FULL COGNITIVE AND PHYSICAL RECOVERY WHEN ADMINISTERED IN TIME. WE ALSO PROVIDE 24-HOUR NEUROLOGY AND NEUROSURGERY PHYSICIAN CARE. THROUGH OUR AFFILIATION WITH PENN MEDICINE IN TELENEUROLOGY AND TELESTROKE, PENN NEUROSCIENCE SPECIALISTS ARE AVAILABLE VIRTUALLY 24/7 TO EVALUATE PATIENTS, SPEAK WITH THEIR FAMILIES AND, IF NEEDED, FACILITATE THEIR TRANSFER TO ANOTHER FACILITY FOR CARE.

(3) PENN HEART RESCUE

THROUGH THE PENN HEART RESCUE PROGRAM, PATIENTS WHO ARRIVE AT THE SHORE EMERGENCY DEPARTMENT WITH SYMPTOMS OF A HEART ATTACK CAN IMMEDIATELY BE REFERRED AND TRANSPORTED VIA HELICOPTER TO PENN PRESBYTERIAN MEDICAL CENTER IN PHILADELPHIA, A PART OF PENN MEDICINE. WHILE THE HELICOPTER IS EN ROUTE, A FLIGHT NURSE AND PARAMEDIC PERFORM THE ESSENTIAL TESTS NEEDED TO PREPARE THE PATIENT FOR AN EMERGENCY ANGIOPLASTY SO THAT NO TIME IS LOST DURING THE 25-MINUTE HELICOPTER FLIGHT.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

NEUROSCIENCE CENTER  
-----

THE MEDICAL CENTER HAS RECEIVED ADVANCED CERTIFICATION AS A PRIMARY STROKE CENTER BY THE JOINT COMMISSION, EARNING THE ORGANIZATION'S GOLD SEAL OF APPROVAL FOR STRICT ADHERENCE TO THE NATIONAL STANDARDS AND GUIDELINES THAT HELP DIAGNOSE AND TREAT STROKE FASTER WITH BETTER OUTCOMES FOR OUR PATIENTS. USING STATE-OF-THE-ART TECHNOLOGY, INCLUDING LEADING-EDGE, COMPUTER-ASSISTED IMAGE GUIDANCE AND MICROSURGICAL INSTRUMENTATION, SHORE'S BOARD-CERTIFIED NEUROSURGEONS, NEUROLOGISTS, SPECIALLY TRAINED NURSES AND TECHNICAL STAFF ARE ABLE TO DIAGNOSE AND TREAT NEUROLOGICAL INJURIES AND DISORDERS WITH AMAZING PRECISION.

THE MEDICAL CENTER'S NEUROSCIENCES CENTER PROVIDES EXTRAORDINARY HIGH-TECH DIAGNOSIS AND TREATMENT SERVICES, WHICH ARE ENHANCED THROUGH THE ADVANCED TECHNOLOGY FOUND WITHIN THE SHORE SURGICAL PAVILION AND DELIVERED WITH THE CARING TOUCH YOU EXPECT FROM THE MEDICAL CENTER. THE MEDICAL CENTER AFFILIATION WITH PENN MEDICINE TELENEUROLOGY FURTHER ENSURES THE HIGHEST QUALITY CARE FOR AREA RESIDENTS. SPECIALISTS FROM THE SHORE NEUROSCIENCES CENTER AND PENN NEUROSCIENCE SPECIALISTS COLLABORATE USING A MULTI-DISCIPLINARY APPROACH TO EVALUATION, DIAGNOSIS AND TREATMENT. THIS TEAM APPROACH PROVIDES UNMATCHED SERVICES AND MEDICAL SOPHISTICATION TO OUR COMMUNITY, A SEAMLESS DELIVERY OF CARE AND REHABILITATION DESIGNED TO PRODUCE THE BEST MEDICAL OUTCOMES POSSIBLE.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

MATERNITY CARE CENTER

-----

THE MEDICAL CENTER HAS A FAMILY-CENTERED APPROACH WHEN IT COMES TO  
CHILDBIRTH AND THE HOSPITALIZATION OF A CHILD. THE MATERNITY CARE CENTER  
PROVIDES PATIENTS WITH A SPECIAL COMBINATION OF COMPASSION, EXPERTISE AND  
ADVANCED TECHNOLOGY. SPECIAL ATTENTION IS PAID TO HELPING PREGNANT  
MOTHERS AND NEW FAMILIES DEVELOP AND MAINTAIN THOSE EARLY BONDS. THE  
MEDICAL CENTER'S FAMILY CENTERED APPROACH TO CARE IS ALSO EVIDENT IN THE  
INPATIENT PEDIATRIC CARE CENTER. IN 2023, 1,044 BABIES WERE BORN AT THE  
MEDICAL CENTER.

MATERNAL-FETAL MEDICINE PROGRAM

-----

SOMETIMES A WOMAN NEEDS ADDITIONAL EXPERTISE IN THE FORM OF A  
MATERNAL-FETAL MEDICINE SPECIALIST - AN OBSTETRICIAN WHO IS TRAINED IN  
FETAL MEDICINE AND HIGH-RISK PREGNANCIES. THROUGH OUR AFFILIATION WITH  
PENN MEDICINE AND RENOWNED SPECIALIST DR. ROBERT DEBBS, D.O., THE PENN  
MATERNAL-FETAL MEDICINE PROGRAM AT THE MEDICAL CENTER PROVIDES THESE  
EXPECTANT MOTHERS WITH THE SPECIALIZED CARE THEY NEED.

THE MEDICAL CENTER'S LABORIST PROGRAM ENSURES THAT A HIGHLY TRAINED  
OBSTETRICIAN-GYNECOLOGIST IS ON SITE AT SHORE 24 HOURS A DAY, SEVEN DAYS  
A WEEK TO ASSIST PATIENTS IN LABOR UNTIL THEIR OWN PHYSICIAN ARRIVES. THE

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

LABORIST PROGRAM FEATURES SEVEN SKILLED LABORISTS WHO ROTATE TO ASSIST WITH GYNECOLOGICAL EMERGENCIES, INPATIENT CONSULTATIONS, EMERGENCY C-SECTIONS AND OTHER NEEDS. THANKS TO THE LABORIST PROGRAM, BIRTHS AT SHORE ARE ON THE RISE, AND WE'VE SEEN A SIGNIFICANT REDUCTION IN THE HOSPITAL'S C-SECTION RATES.

PEDIATRIC CARE CENTER

-----

THE MEDICAL CENTER'S CHILD-FRIENDLY PEDIATRIC CARE CENTER WAS THE FIRST OF ITS KIND IN NEW JERSEY, FEATURING A DEDICATED AND SEPARATE PEDIATRIC TREATMENT AREA FOR MINOR ILLNESSES AND INJURIES, AS WELL AS INPATIENT ROOMS. CHILDREN ARE SEEN BY EXPERT EMERGENCY DEPARTMENT PHYSICIANS IN CONSULTATION WITH THE PHYSICIANS OF ONSITE NEONATAL PARTNERS.

**FORM 990, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS**

IN PARTNERSHIP WITH THE ATLANTIC COUNTY SPECIAL SERVICES SCHOOL DISTRICT, SHORE MEDICAL CENTER DEVELOPED A SENSORY FRIENDLY PEDIATRIC EMERGENCY CARE PROGRAM DESIGNED TO HELP CHILDREN WITH AUTISM HAVE A BETTER EXPERIENCE WHEN COMING TO THE HOSPITAL, FROM DOOR TO DISCHARGE. THE PROGRAM OFFICIALLY LAUNCHED IN APRIL 2021 ON WORLD AUTISM AWARENESS DAY AND HAS PROVEN TO BE A SUCCESS FOR HELPING CHILDREN AND FAMILIES WITH SENSORY PROCESSING DIFFERENCES GET THE CARE THEY NEED. (SEE ARTICLE: [HTTPS://SHOREMEDICALCENTER.ORG/NEWS/WOodbINE-MOM-DISCOVERS-LIFE-CHANGING](https://shoremedicalcenter.org/news/woodbine-mom-discovers-life-changing))



**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

ENSORY-FRIENDLY-EMERGENCY-CARE-SON-AUTISM-SHORE-MEDICAL) SHORE CONTINUES  
TO WORK WITH ATLANTIC COUNTY SPECIAL SERVICES SCHOOL TO PROVIDE TRAINING  
TO NEW STAFF AND MAKE ADJUSTMENTS TO THE PROGRAM WHERE IT IS NEEDED.

IN 2022, THE PEDIATRIC CARE CENTER LAUNCHED A NEW "OUCHLESS" PROGRAM TO  
HELP REDUCE THE PAIN AND DISCOMFORT CHILDREN FEEL DURING MEDICAL  
PROCEDURES. THROUGH A WIDE VARIETY OF MODALITIES AND TECHNIQUES AND  
ONGOING STAFF TRAINING, THE PEDIATRIC CARE CENTER TEAM IS ABLE TO HELP  
IMPROVE THE EXPERIENCE CHILDREN AND FAMILIES HAVE AT THE HOSPITAL AND  
REDUCE THE LIKELIHOOD OF TRAUMA FROM POTENTIALLY PAINFUL PROCEDURES.

ADVANCED SPINE & ORTHOPEDIC INSTITUTE  
-----

THE MEDICAL CENTER'S ADVANCED SPINE & ORTHOPEDIC INSTITUTE (ASOI) OFFERS  
A COMPREHENSIVE CONTINUUM OF CARE WITHIN A HIGHLY INTEGRATED HEALTHCARE  
DELIVERY NETWORK THAT TAKES OUR PATIENTS FROM DIAGNOSIS THROUGH TREATMENT  
AND REHABILITATION. WE HELP PATIENTS DEAL WITH EVERYTHING FROM EVERYDAY  
ACHES AND STRAINS TO SPORTS INJURIES, SERIOUS SPINE AND ORTHOPEDIC  
INJURIES AND DISEASE, AS WELL AS JOINT REPLACEMENT AND RECONSTRUCTION.  
OUR GOAL IS TO RETURN OUR PATIENTS TO NORMAL FUNCTION AS QUICKLY AND  
SAFELY AS POSSIBLE.

THE MEDICAL CENTER'S SPINE SURGERY AND HIP AND KNEE REPLACEMENT PROGRAMS  
HAVE RECEIVED THE GOLD SEAL OF APPROVAL FOR HEALTHCARE QUALITY BY THE

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

JOINT COMMISSION.

ADVANCED CARE FROM THE REGION'S TOP PHYSICIANS

-----

THE EXCEPTIONAL SPINE SURGEONS AT THE MEDICAL CENTER HAVE ACCESS TO SOME OF THE MOST ADVANCED TECHNOLOGY AVAILABLE IN THEIR FIELDS. WHEN A PATIENT'S PROBLEM EXCEEDS OUR ADVANCED CAPABILITIES, THE MEDICAL CENTER'S AFFILIATION WITH PENN MEDICINE ALLOWS FOR A SEAMLESS TRANSFER OF CARE TO SPECIALISTS AT THESE TWO LEADING PHILADELPHIA HEALTHCARE PROVIDERS, IN ADDITION TO THE AREA'S MOST EXCEPTIONAL AND PASSIONATE PHYSICIANS.

JOINT REPLACEMENT & SPINE EDUCATION

-----

JOINT AND SPINE EDUCATION CLASSES ARE OFFERED REGULARLY FOR PATIENTS ABOUT TO UNDERGO JOINT REPLACEMENT OR SPINE SURGERY, AS WELL AS FOR THE COMMUNITY AT LARGE THROUGH THE MEDICAL CENTER'S ADVANCED SPINE & ORTHOPEDIC INSTITUTE.

MEDICAL SERVICES

-----

CONSISTENT WITH REVENUE RULING 69-545, ALL QUALIFIED PHYSICIANS ARE ELIGIBLE FOR MEDICAL STAFF PRIVILEGES. DURING 2023, THE MEDICAL CENTER

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

HAD APPROXIMATELY 480 PHYSICIANS ON ITS MEDICAL STAFF COMPRISED OF THE  
FOLLOWING MEDICAL SPECIALTIES:

- ALCOHOL & DRUG DEPENDENCY;
- ALLERGY/IMMUNOLOGY;
- ANESTHESIOLOGY;
- CARDIOLOGY;
- CRITICAL CARE MEDICINE;
- DERMATOLOGY;
- EMERGENCY MEDICINE;
- ENDOCRINOLOGY;
- FAMILY PRACTICE;
- GASTROENTEROLOGY;
- GYNECOLOGY;
- HEMATOLOGY;
- HOSPITAL MEDICINE;
- INTERNAL MEDICINE;
- INFECTIOUS DISEASE;
- MATERNAL & FETAL MEDICINE;
- MEDICAL ONCOLOGY;
- NEONATOLOGY
- NEPHROLOGY;
- NEUROLOGICAL SURGERY;
- NEUROLOGY;
- OBSTETRICS;

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

- OPHTHALMOLOGY;
- ORAL SURGERY
- ORTHOPEDIC SURGERY;
- OTORHINOLARYNGOLOGY;
- PAIN MANAGEMENT;
- PALLIATIVE CARE MEDICINE
- PATHOLOGY;
- PEDIATRICS;
- PHYSICAL MEDICINE/REHABILITATION;
- PLASTIC SURGERY;
- PODIATRY;
- PSYCHIATRY;
- PSYCHOLOGY;
- PULMONARY MEDICINE;
- RADIATION THERAPY;
- RADIOLOGY;
- RHEUMATOLOGY;
- GENERAL SURGERY;
- VASCULAR SURGERY; AND
- UROLOGY.

COMMUNITY PROGRAMS AND MEDICAL SCREENINGS

=====

1. SHORE SPEAKERS BUREAU - A FREE PROGRAM WHERE SHORE HEALTHCARE

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

SPECIALISTS AND EDUCATORS PROVIDE SCREENINGS, GIVE PRESENTATIONS AND  
PROVIDE QUESTION AND ANSWER SESSIONS FOR COMMUNITY GROUPS WHO REQUEST  
THEM.

2. CANCER SCREENINGS FOR THE UNINSURED FUNDED BY THE NJ CEED/OCCP GRANT.  
(BREAST, CERVICAL, COLORECTAL AND PROSTATE)

3. MAMMOGRAMS - FREE MAMMOGRAM EVENT ON 10-21-23

4. LDCT LUNG CANCER SCREENING - FREE LUNG CANCER SCREENING EVENTS ON  
3-25-23 AND 11-18-23

5. PROSTATE CANCER - FREE PROSTATE CANCER SCREENING EVENTS ON 3-31-23,  
9-29-23, AND 12-29-23

PLEASE NOTE THAT THE AFOREMENTIONED LIST OF MEDICAL SCREENING PROGRAMS IS  
NOT AN ALL-INCLUSIVE LIST.

LECTURES AND SEMINARS

=====

THE MEDICAL CENTER PROVIDES NUMEROUS LECTURES, SEMINARS AND OTHER  
EDUCATIONAL PROGRAMS TO THE COMMUNITY IN FURTHERANCE OF ITS TAX-EXEMPT  
PURPOSES, INCLUDING THE FOLLOWING:

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

1. BE WELL CONNECTED EVENTS. SHORE MEDICAL CENTER OFTEN PROVIDES EXPERTS TO SPEAK AT SHORE PHYSICIANS GROUP'S "BE WELL CONNECTED" HEALTH EDUCATION BREAKFAST EVENTS, FEATURING PHYSICIANS AND CLINICAL STAFF PRESENTING TO AUDIENCES RANGING FROM 50-125 PEOPLE.

2. SHORE BEGINNINGS: PRENATAL AND WELLNESS

- LAMAZE-INSPIRED CHILDBIRTH CLASSES;
- BREASTFEEDING YOUR BABY; AND
- MATERNAL CHILD HEALTH COMMUNITY OUTREACH.

3. ADULT SUPPORT GROUPS:

- FAMILY CAREGIVER ONE-ON-ONE SUPPORT
- ALZHEIMER'S ASSOCIATION CAREGIVER SUPPORT GROUP;
- CARING TOGETHER, LIVING WELL; AND
- VET 2 VET CAFE.

4. FREE SURGICAL EDUCATION PROGRAMS (NECK & SPINE SURGERY, JOINT REPLACEMENT EDUCATION)

5. CANCER SURVIVORSHIP WORKSHOPS

- CANCER: THRIVING AND SURVIVING (AN EVIDENCE BASED SIX-WEEK SUPPORTIVE WORKSHOP SERIES): FOCUSES ON CANCER SURVIVORSHIP; CANCER SIDE EFFECTS; LIFE AFTER CANCER; ETC.

- MEDITATION RETREAT PROGRAM: ONE TIME PROGRAM FOCUSING ON MEDITATION TO

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

ASSIST CANCER PATIENTS, SURVIVORS, AND CAREGIVERS.

6. SUMMER PROJECT WITH BEACH TAGGERS

- POUCH GIVEN TO BEACH TAGGERS IN ATLANTIC AND CAPE MAY COUNTY. INCLUDED EDUCATION WITH A SURVEY, SUNSCREEN, AND SUN STICK. FOCUSED ON SUN SAFETY FOR HIGH-RISK SUMMER JOBS.

7. WEBINARS:

- MULTIPLE WEBINARS OFFERED ON DIFFERENT HEALTH TOPICS. THE WEBINARS WERE HELD LIVE AND RECORDED FOR FUTURE VIEWING ON YOUTUBE.

PRESENTATIONS TO HEALTHCARE PROFESSIONALS

-----

SHORE MEDICAL CENTER MAKES EVERY EFFORT TO PASS ALONG VALUABLE INFORMATION ACQUIRED THROUGH PILOT PROGRAMS TO HELP OTHER HEALTHCARE PROFESSIONALS IMPROVE CARE TO ITS COMMUNITY. IN 2022, EMERGENCY DEPARTMENT LEADERSHIP ATTENDED THE EMERGENCY NURSES ASSOCIATION CONFERENCE WHERE THEY PRESENTED THE RESULTS OF A 2021 PILOT PROJECT TO IMPROVE THE TIME IT TAKES TO GET A PATIENT WHO IS EXHIBITING SIGNS OF A STROKE FROM DOOR TO TREATMENT, WITH A GOAL OF HELPING OTHER HEALTHCARE PROFESSIONALS DUPLICATE THEIR RESULTS IN THEIR COMMUNITIES AND HOSPITALS. PLEASE NOTE THAT THE AFOREMENTIONED LIST OF COMMUNITY EDUCATION PROGRAMS IS NOT AN ALL-INCLUSIVE LIST.

**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.

**2023**

▶ Attach to Form 990 or 990-EZ.

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

COMMUNITY INVOLVEMENT

=====

GIVING BACK TO THE COMMUNITY

IN 2022, SHORE STAFF CONTINUED THEIR ANNUAL TRADITION OF PROVIDING GIFTS  
AT THE HOLIDAYS TO RESIDENTS OF THE LINWOOD CARE CENTER. MORE THAN 100  
RESIDENTS BENEFITED FROM THEIR GENEROSITY.

SHORE MEDICAL CENTER TYPICALLY SUPPORTS THE FOLLOWING ANNUAL COMMUNITY  
EVENTS:

- AMERICAN HEART ASSOCIATION HEART WALK;
- NATIONAL NIGHT OUT IN SOMERS POINT AND MAYS LANDING;
- THE SOMERS POINT MEMORIAL DAY PARADE;
- SOMERS POINT BAYFEST AND GOOD OLD DAYS FESTIVAL;
- RESIDENTS OF LINWOOD CARE CENTER THROUGH AN ANNUAL HOLIDAY GIFT DRIVE

THE MEDICAL CENTER ALSO TYPICALLY PROVIDES HEALTH SCREENINGS AT THESE  
EVENTS AND OTHER COMMUNITY HEALTH FAIRS AT 55 AND OVER COMMUNITIES,  
FITNESS CENTERS AND SOME OF OUR AREA'S LARGER EMPLOYERS.

**CORE FORM, PART III, QUESTION 4D**

EXPENSES INCURRED IN PROVIDING VARIOUS OTHER MEDICALLY NECESSARY



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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

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

**CORE FORM, PART V; QUESTION 15**

RONALD JOHNSON IS AN OFFICER AND INVOLVED IN THE LEADERSHIP AND  
MANAGEMENT OF THIS ORGANIZATION. MR. JOHNSON IS EMPLOYED BY THIS  
ORGANIZATION AND RECEIVES A FEDERAL FORM W-2. ACCORDINGLY, HIS COMMON LAW  
EMPLOYER/EMPLOYEE RELATIONSHIP IS WITH SHORE MEMORIAL HOSPITAL (EIN:  
21-0660835). SHORE MEMORIAL HOSPITAL FILED A 2023 FORM 4720 WHICH  
INCLUDED A REMITTANCE OF EXCISE TAX RELATED TO MR. JOHNSON'S COMPENSATION  
IN EXCESS OF \$1M.

DAVID R. HUGHES IS AN OFFICER AND INVOLVED IN THE LEADERSHIP AND  
MANAGEMENT OF THIS ORGANIZATION. MR. HUGHES IS EMPLOYED BY THIS  
ORGANIZATION AND RECEIVES A FEDERAL FORM W-2. ACCORDINGLY, HIS COMMON LAW  
EMPLOYER/EMPLOYEE RELATIONSHIP IS WITH SHORE MEMORIAL HOSPITAL (EIN:  
21-0660835). SHORE MEMORIAL HOSPITAL FILED A 2023 FORM 4720 WHICH  
INCLUDED A REMITTANCE OF EXCISE TAX RELATED TO MR. HUGHES'S COMPENSATION  
IN EXCESS OF \$1M.

**CORE FORM, PART VI, QUESTION 2**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

MICHAEL BRAY & ROBERT J. BRAY, DDS - FAMILY RELATIONSHIP

**CORE FORM, PART VI, QUESTION 4**

EFFECTIVE JANUARY 1, 2022 THE ORGANIZATION'S BYLAWS WERE AMENDED. THE FOLLOWING SECTIONS WERE AMENDED TO INCLUDE SIGNIFICANT CHANGES, AS DEFINED BY THE IRS FORM 990 INSTRUCTIONS:

ARTICLE III, SECTION 6 - POWERS RESERVED TO THE MEMBER

ARTICLE IV, SECTION 2 - NUMBER OF TRUSTEES

ARTICLE IV, SECTION 5 - ELECTION OF TRUSTEES

ARTICLE IV, SECTION 11 - QUORUM

ARTICLE V, SECTION 4 - POWERS AND DUTIES

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

SHORE MEMORIAL HEALTH SYSTEM ("SYSTEM") IS THE SOLE MEMBER OF THIS ORGANIZATION. SYSTEM 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.

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

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. THIS ORGANIZATION'S FEDERAL FORM 990 WAS PROVIDED TO EACH VOTING MEMBER OF ITS GOVERNING BODY (ITS BOARD OF TRUSTEES) PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE ("IRS"). THE ORGANIZATION'S AUDIT AND FINANCE COMMITTEE ASSUMED THE RESPONSIBILITY TO OVERSEE AND COORDINATE THE FEDERAL FORM 990 PREPARATION, REVIEW AND FILING PROCESS.

AS PART OF THE ORGANIZATION'S FEDERAL FORM 990 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 SYSTEM INDIVIDUALS ("INTERNAL WORKING GROUP") TO OBTAIN THE INFORMATION NEEDED IN ORDER TO PREPARE A COMPLETE AND ACCURATE TAX RETURN.

THE CPA FIRM PREPARED A DRAFT FEDERAL FORM 990 AND FURNISHED IT TO THE ORGANIZATION'S INTERNAL WORKING GROUP FOR REVIEW. THE ORGANIZATION'S 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 INTERNAL WORKING GROUP FOR FINAL REVIEW AND APPROVAL. A MEETING WITH THE ORGANIZATION'S AUDIT AND FINANCE COMMITTEE WAS ALSO HELD TO REVIEW THE FINAL DRAFT OF THE FEDERAL FORM 990. AT THIS MEETING, THE CPA FIRM GAVE A FORM 990 PRESENTATION TO THE

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

COMMITTEE. THEREAFTER, THE FINAL FEDERAL FORM 990 WAS MADE AVAILABLE TO EACH VOTING MEMBER OF THE ORGANIZATION'S GOVERNING BODY PRIOR TO FILING WITH THE IRS.

**CORE FORM, PART VI, SECTION B; QUESTION 12**

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. THIS ORGANIZATION AND THE SYSTEM REGULARLY MONITOR AND ENFORCE COMPLIANCE WITH ITS CONFLICT OF INTEREST POLICY. ANNUALLY ALL MEMBERS OF THE BOARD OF TRUSTEES, OFFICERS AND SENIOR MANAGEMENT PERSONNEL ARE REQUIRED TO REVIEW THE EXISTING CONFLICT OF INTEREST POLICY AND COMPLETE A QUESTIONNAIRE. THE COMPLETED QUESTIONNAIRES ARE RETURNED TO THE ORGANIZATION AND ITS CHIEF COMPLIANCE OFFICER FOR REVIEW. THE CHIEF COMPLIANCE OFFICER PREPARES A SUMMARY OF THE COMPLETED QUESTIONNAIRES WHICH CONTAINS INFORMATION DISCLOSED ON AN INDIVIDUAL BY INDIVIDUAL BASIS AND PRESENTS THIS SUMMARY TO THE ORGANIZATION'S AUDIT AND FINANCE COMMITTEE FOR ITS REVIEW AND DISCUSSION. THEREAFTER, ANY SIGNIFICANT DISCLOSURES OF A MATERIAL NATURE INVOLVING THE ORGANIZATION'S GOVERNING BODY OR SENIOR LEADERSHIP IS REPORTED TO THE SYSTEM'S GOVERNANCE COMMITTEE FOR ITS REVIEW AND DISCUSSION.

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

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. SHORE MEMORIAL HEALTH SYSTEM'S BOARD OF TRUSTEES HAS A LEADERSHIP DEVELOPMENT AND COMPENSATION COMMITTEE ("COMMITTEE"). THE COMMITTEE HAS ADOPTED A WRITTEN EXECUTIVE COMPENSATION PHILOSOPHY WHICH IT FOLLOWS WHEN IT REVIEWS AND APPROVES OF THE COMPENSATION AND BENEFITS OF THE ORGANIZATION'S SENIOR MANAGEMENT PERSONNEL INCLUDING THE PRESIDENT/CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER/CHIEF DEVELOPMENT OFFICER, CHIEF OPERATING OFFICER/CHIEF NURSING OFFICER, CHIEF MEDICAL OFFICER, CHIEF INFORMATION OFFICER AND VICE PRESIDENT OF HUMAN RESOURCES ("SENIOR LEADERSHIP"). THE COMMITTEE REVIEWS THE "TOTAL COMPENSATION" OF THE INDIVIDUALS WHICH IS INTENDED TO INCLUDE BOTH CURRENT AND DEFERRED COMPENSATION AND ALL EMPLOYEE BENEFITS, BOTH QUALIFIED AND NON-QUALIFIED. THE COMMITTEE'S REVIEW IS DONE ON AT LEAST AN ANNUAL BASIS AND ENSURES THAT THE "TOTAL COMPENSATION" OF SENIOR MANAGEMENT OF THE ORGANIZATION IS REASONABLE.

THE ACTIONS TAKEN BY THE COMMITTEE ENABLE THE ORGANIZATION TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS FOR PURPOSES OF INTERNAL REVENUE CODE SECTION 4958 WITH RESPECT TO THE TOTAL COMPENSATION OF THE ORGANIZATION'S SENIOR LEADERSHIP. THE THREE FACTORS WHICH MUST BE SATISFIED IN ORDER TO RECEIVE THE REBUTTABLE PRESUMPTION OF REASONABLENESS ARE THE FOLLOWING:

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

1. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY AN "AUTHORIZED BODY" OF THE APPLICABLE TAX-EXEMPT ORGANIZATION WHICH IS COMPOSED ENTIRELY OF INDIVIDUALS WHO DO NOT HAVE A "CONFLICT OF INTEREST" WITH RESPECT TO THE COMPENSATION ARRANGEMENT;

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

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

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

THE COMMITTEE RELIED UPON 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 SIMILAR SIZED HOSPITALS, # OF LICENSED BEDS AND NET PATIENT SERVICE REVENUE.

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

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

WAS REVIEWED AND SUBSEQUENTLY APPROVED.

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

**CORE FORM, PART VI, SECTION C; QUESTION 18**

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

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

**CORE FORM, PART VI, SECTION C; QUESTION 19**

THE ORGANIZATION HAS ISSUED TAX-EXEMPT BONDS TO FINANCE VARIOUS CAPITAL IMPROVEMENT PROJECTS, RENOVATIONS AND EQUIPMENT. IN CONJUNCTION WITH THE ISSUANCE OF THESE TAX-EXEMPT BONDS, THE ORGANIZATION'S FINANCIAL STATEMENTS WERE INCLUDED WITH THE TAX-EXEMPT BOND PROSPECTUS WHICH WAS MADE AVAILABLE TO THE GENERAL PUBLIC FOR REVIEW. IN ADDITION, 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. THE ORGANIZATION'S GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST.

**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 OR INDEPENDENT CONTRACTORS 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, SECTION A, COLUMN B**

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND



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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. CERTAIN BOARD OF TRUSTEE MEMBERS AND OFFICERS 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 ON CORE FORM, PART VII OF THIS FORM 990. THE HOURS REFLECTED ON CORE FORM, PART VII OF THIS FORM 990, FOR BOARD MEMBERS WHO RECEIVE COMPENSATION FOR SERVICES RENDERED IN A NON-BOARD CAPACITY, PAID OFFICERS AND KEY EMPLOYEES, REFLECT TOTAL HOURS WORKED PER WEEK ON BEHALF OF SHORE MEMORIAL HEALTH SYSTEM; NOT SOLELY THIS ORGANIZATION.

**CORE FORM, PART XI; QUESTION 9**

OTHER CHANGES IN FUND BALANCE INCLUDE:

- OTHER ACCRUED RETIREMENT COST - (\$1,183,331);
- OTHER CHANGES IN PENSION & POSTRETIREMENT BENEFITS - \$8,372,635;
- DONOR RESTRICTED NET INVESTMENT RETURN - \$124,945;
- CHANGE IN DONOR RESTRICTED BENEFICIAL INTEREST IN PERPETUAL TRUST -

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

\$160,057;

- CHANGES IN DONOR RESTRICTED NET ASSETS - (\$120,824); AND
- EARLY EXTINGUISHMENT OF DEBT - (\$376,885).

**CORE FORM, PART XI; QUESTION 2**

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). SHORE MEMORIAL HEALTH SYSTEM IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM. AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF SHORE MEMORIAL HEALTH SYSTEM AND ITS AFFILIATES FOR THE YEARS ENDED DECEMBER 31, 2023 AND DECEMBER 31, 2022; RESPECTIVELY. THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS CONTAIN CONSOLIDATING SCHEDULES ON AN ENTITY BY ENTITY BASIS. THE INDEPENDENT CPA FIRM ISSUED AN UNMODIFIED OPINION WITH RESPECT TO THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS FOR EACH YEAR.

THE ORGANIZATION'S AUDIT AND FINANCE COMMITTEE HAS ASSUMED RESPONSIBILITY FOR THE OVERSIGHT OF THE AUDIT OF THE CONSOLIDATED FINANCIAL STATEMENTS, WHICH INCLUDES THIS ORGANIZATION, AND THE SELECTION OF AN INDEPENDENT AUDITOR.

**CORE FORM, PART XII; QUESTION 3A**

THE ORGANIZATION IS AN AFFILIATE WITHIN SHORE MEMORIAL HEALTH SYSTEM AND

**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.

**2023**

**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](http://www.irs.gov/form990).

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM  
("SYSTEM"). AS A RESULT OF FEDERAL AWARDS RECEIVED, THE ORGANIZATION WAS  
INCLUDED IN A SYSTEM WIDE CONSOLIDATED AUDIT AS SET FORTH IN THE UNIFORM  
GUIDANCE, 2 C.F.R., PART 200, SUBPART F. THE SYSTEM ENGAGED AN  
INDEPENDENT ACCOUNTING FIRM TO PREPARE AND ISSUE THE UNIFORM GUIDANCE  
AUDIT.

Name of the organization

Employer identification number

SHORE MEMORIAL HOSPITAL

21-0660835

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

=====

THE MISSION OF SHORE MEDICAL CENTER IS TO CARE FOR AND RESPECT ALL PATIENTS, THEIR FAMILIES AND EACH OTHER. THE ORGANIZATION PROVIDES EMERGENCY AND MEDICAL NECESSARY HEALTHCARE SERVICES FOR ALL INDIVIDUALS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. FOR ADDITIONAL INFORMATION, PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O.

Name of the organization

SHORE MEMORIAL HOSPITAL

Employer identification number

21-0660835

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
UNIDINE CORPORATION 1000 WASHINGTON STREET, SUITE 510 BOSTON, MA 02118	FOOD MANAGEMENT	4,620,405.
XANITOS, INC. 3809 WEST CHESTER PIKE NEWTON SQUARE, PA 19073	CLEANING	3,919,132.
VARIAN MEDICAL SYSTEMS 3100 HANSEN WAY PALO ALTO, CA 94304	MEDICAL	2,549,646.
TRUSTEES OF THE UNIVERSITY OF PA 1ST FLOOR SOUTH PAVILION EXTENSION PHILADELPHIA, PA 19104	MEDICAL	2,486,513.
SOUTHERN ONCOLOGY HEMATOLOGY OF PA 1505 W SHERMAN AVENUE, SUITE 101 VINELAND, NJ 08360	MEDICAL	2,360,168.

Name of the organization

Employer identification number

**SHORE MEMORIAL HOSPITAL**

**21-0660835**

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
PURCHASED SERVICES	18,500,368.	12,968,284.	5,467,732.	64,352.
CARE MANAGEMENT FEES	12,122,006.	8,462,286.	3,617,148.	42,572.
PHYSICIANS FEES	12,814,995.	8,787,880.	3,980,270.	46,845.
COLLECTION FEES	1,511,546.	1,036,428.	469,591.	5,527.
PROFESSIONAL FEES	557,399.	494,871.	61,801.	727.
OTHER FEES	1,224,680.	950,286.	271,202.	3,192.
 TOTALS	 ----- 46,730,994. -----	 ----- 32,700,035. -----	 ----- 13,867,744. -----	 ----- 163,215. -----

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE MEMORIAL HOSPITAL

**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](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Employer identification number

21-0660835

**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) BRIGHTON BAY, LLC 45-4335590 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HOLDING/MGMT	NJ	598,747.	2,728,990.	SMH
(2) SHORE QUALITY PARTNERS, LLC 46-4384840 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTH SVCS.	NJ	2,044,474.	92,909.	SMH
(3) SHORE QUALITY PARTNERS ACO, LLC 84-2099293 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTH SVCS.	NJ	NONE	NONE	SMH
(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) SHORE HEALTH SERVICES CORPORATION 22-2866335 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HOLDING CO.	NJ	501(C)(3)	509(A)(3)	SMHS		X
(2) SHORE MEMORIAL HEALTH SYSTEM 22-2866326 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTH SVCS.	NJ	501(C)(3)	509(A)(3)	N/A		X
(3) SHORE MEMORIAL HEALTH FOUNDATION, INC. 34-2027846 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	INACTIVE	NJ	501(C)(3)	509(A)(1)	SMH	X	
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2023

**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) SHORE HEALTH ENTERPRISES, INC. 22-3501680 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	RENTAL REAL EST.	NJ	N/A	C CORP.					X
(2) SHORE MEMORIAL PHYSICIAN'S GROUP, P.C. 27-5440611 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTHCARE SVCS.	NJ	SMH	C CORP.	11,631,986.	4,806,184.	100.0000	X	
(3) BAYFRONT URGENT CARE, PA 27-4211365 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTHCARE SVCS.	NJ	SMH	C CORP.	1,985,055.	945,395.	100.0000	X	
(4) SHORE HOSPITALISTS ASSOCIATES, PA 47-2173802 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTHCARE SVCS.	NJ	SMH	C CORP.	3,182,126.	926,330.	100.0000	X	
(5) SHORE PATHOLOGY ASSOCIATES, P.C. 46-4221478 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTHCARE SVCS.	NJ	SMH	C CORP.	488,986.	56,735.	100.0000	X	
(6) SHORE SPECIALTY CONSULTANTS, PA 47-2248436 100 MEDICAL CENTER WAY SOMERS POINT, NJ 08244	HEALTHCARE SVCS.	NJ	SMH	C CORP.	11,793,103.	1,627,258.	100.0000	X	
(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
<b>1</b> 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?		
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity.		X
<b>b</b> Gift, grant, or capital contribution to related organization(s)		X
<b>c</b> Gift, grant, or capital contribution from related organization(s)		X
<b>d</b> Loans or loan guarantees to or for related organization(s)	X	
<b>e</b> Loans or loan guarantees by related organization(s)	X	
<b>f</b> Dividends from related organization(s)		X
<b>g</b> Sale of assets to related organization(s)		X
<b>h</b> Purchase of assets from related organization(s)		X
<b>i</b> Exchange of assets with related organization(s)		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s)		X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s)		X
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s)		X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s)		X
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	X	
<b>o</b> Sharing of paid employees with related organization(s)	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses		X
<b>q</b> Reimbursement paid by related organization(s) for expenses		X
<b>r</b> Other transfer of cash or property to related organization(s)	X	
<b>s</b> 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, PART V

THE ORGANIZATION IS A MEMBER OF SHORE MEMORIAL HEALTH SYSTEM AND AFFILIATES; 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. THE SYSTEM'S 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	1,063,173.
	-----
	1,063,173.
	=====

OTHER DEDUCTIONS

OTHER EXPENSES	189,294.
	-----
	189,294.
	=====

RENT AND ROYALTY SUMMARY  
 =====

PROPERTY -----	TOTAL INCOME -----	DEPLETION/ DEPRECIATION -----	OTHER EXPENSES -----	ALLOWABLE NET INCOME -----
RENTAL INCOME	1,063,173.		189,294.	873,879.
TOTALS	1,063,173. =====		189,294. =====	873,879. =====

**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](http://www.irs.gov/Form1041) for instructions and the latest information.

OMB No. 1545-0092

**2023**

Name of estate or trust <b>SHORE MEMORIAL HOSPITAL</b>	Employer identification number <b>21-0660835</b>
---	---

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)
<b>1a</b> 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.				
<b>1b</b> Totals for all transactions reported on Form(s) 8949 with <b>Box A</b> checked.				
<b>2</b> Totals for all transactions reported on Form(s) 8949 with <b>Box B</b> checked.				
<b>3</b> Totals for all transactions reported on Form(s) 8949 with <b>Box C</b> checked.				
<b>4</b> Short-term capital gain or (loss) from Forms 4684, 6252, 6781, and 8824				<b>4</b>
<b>5</b> Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts				<b>5</b>
<b>6</b> Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2022 Capital Loss Carryover Worksheet				<b>6</b> ( )
<b>7</b> <b>Net short-term capital gain or (loss).</b> Combine lines 1a through 6 in column (h). Enter here and on Part III, line 17, column (3).				<b>7</b>

**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)
<b>8a</b> 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.				
<b>8b</b> Totals for all transactions reported on Form(s) 8949 with <b>Box D</b> checked.	5,627,262.			5,627,262.
<b>9</b> Totals for all transactions reported on Form(s) 8949 with <b>Box E</b> checked.				
<b>10</b> Totals for all transactions reported on Form(s) 8949 with <b>Box F</b> checked.				
<b>11</b> Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824				<b>11</b>
<b>12</b> Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts.				<b>12</b>
<b>13</b> Capital gain distributions.				<b>13</b>
<b>14</b> Gain from Form 4797, Part I.				<b>14</b>
<b>15</b> Long-term capital loss carryover. Enter the amount, if any, from line 14 of the 2022 Capital Loss Carryover Worksheet				<b>15</b> ( )
<b>16</b> <b>Net long-term capital gain or (loss).</b> Combine lines 8a through 15 in column (h). Enter here and on Part III, line 18a, column (3).				<b>16</b> 5,627,262.

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

Schedule D (Form 1041) 2023

<b>Part III Summary of Parts I and II</b>		(1) Beneficiaries' (see instr.)	(2) Estate's or trust's	(3) Total
<b>Caution:</b> Read the instructions <b>before</b> completing this part.				
<b>17</b>	<b>Net short-term gain or (loss)</b> . . . . .	<b>17</b>		
<b>18</b>	<b>Net long-term gain or (loss):</b>			
a	Total for year . . . . .	<b>18a</b>		5,627,262.
b	Unrecaptured section 1250 gain (see line 18 of the worksheet) . . . . .	<b>18b</b>		
c	28% rate gain . . . . .	<b>18c</b>		
<b>19</b>	<b>Total net gain or (loss).</b> Combine lines 17 and 18a. . . . .	<b>19</b>		5,627,262.

**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.

<b>Part IV Capital Loss Limitation</b>		
<b>20</b>	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 <b>smaller</b> of:	
a	The loss on line 19, column (3); or <b>b</b> \$3,000 . . . . .	<b>20</b> ( )

**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.

<b>21</b>	Enter taxable income from Form 1041, line 23 (or Form 990-T, Part I, line 11)	<b>21</b>		
<b>22</b>	Enter the <b>smaller</b> of line 18a or 19 in column (2) but not less than zero. . . . .	<b>22</b>		
<b>23</b>	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) . . . . .	<b>23</b>		
<b>24</b>	Add lines 22 and 23 . . . . .	<b>24</b>		
<b>25</b>	If the estate or trust is filing Form 4952, enter the amount from line 4g; otherwise, enter -0- . . . . .	<b>25</b>		
<b>26</b>	Subtract line 25 from line 24. If zero or less, enter -0- . . . . .	<b>26</b>		
<b>27</b>	Subtract line 26 from line 21. If zero or less, enter -0- . . . . .	<b>27</b>		
<b>28</b>	Enter the <b>smaller</b> of the amount on line 21 or \$3,000 . . . . .	<b>28</b>		
<b>29</b>	Enter the <b>smaller</b> of the amount on line 27 or line 28 . . . . .	<b>29</b>		
<b>30</b>	Subtract line 29 from line 28. If zero or less, enter -0-. This amount is taxed at 0% . . . . .	<b>30</b>		
<b>31</b>	Enter the <b>smaller</b> of line 21 or line 26 . . . . .	<b>31</b>		
<b>32</b>	Subtract line 30 from line 26 . . . . .	<b>32</b>		
<b>33</b>	Enter the <b>smaller</b> of line 21 or \$14,650 . . . . .	<b>33</b>		
<b>34</b>	Add lines 27 and 30 . . . . .	<b>34</b>		
<b>35</b>	Subtract line 34 from line 33. If zero or less, enter -0- . . . . .	<b>35</b>		
<b>36</b>	Enter the <b>smaller</b> of line 32 or line 35 . . . . .	<b>36</b>		
<b>37</b>	Multiply line 36 by 15% (0.15) . . . . .	<b>37</b>		
<b>38</b>	Enter the amount from line 31 . . . . .	<b>38</b>		
<b>39</b>	Add lines 30 and 36 . . . . .	<b>39</b>		
<b>40</b>	Subtract line 39 from line 38. If zero or less, enter -0- . . . . .	<b>40</b>		
<b>41</b>	Multiply line 40 by 20% (0.20) . . . . .	<b>41</b>		
<b>42</b>	Figure the tax on the amount on line 27. Use the 2023 Tax Rate Schedule for Estates and Trusts. See the Schedule G instructions in the Instructions for Form 1041 . . . . .	<b>42</b>		
<b>43</b>	Add lines 37, 41, and 42 . . . . .	<b>43</b>		
<b>44</b>	Figure the tax on the amount on line 21. Use the 2023 Tax Rate Schedule for Estates and Trusts. See the Schedule G instructions in the Instructions for Form 1041 . . . . .	<b>44</b>		
<b>45</b>	<b>Tax on all taxable income.</b> Enter the <b>smaller</b> 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) . . . . .	<b>45</b>		



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

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 <b>Note</b> 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). <b>See the separate instructions.</b>		(h) <b>Gain or (loss)</b> Subtract column (e) from column (d) and combine the result with column (g).
						(f) Code(s) from instructions	(g) Amount of adjustment	
	SECURITIES	VARIOUS	VARIOUS	5,627,262.00				5,627,262.00
<b>2 Totals.</b> Add the amounts in columns (d), (e), (g), and (h) (subtract negative amounts). Enter each total here and include on your Schedule D, <b>line 8b</b> (if <b>Box D</b> above is checked), <b>line 9</b> (if <b>Box E</b> above is checked), or <b>line 10</b> (if <b>Box F</b> above is checked) . . .				5,627,262.				5,627,262.

**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.

**Sales of Business Property**  
(Also Involuntary Conversions and Recapture Amounts  
Under Sections 179 and 280F(b)(2))

Department of the Treasury  
Internal Revenue Service

Attach to your tax return.

Attachment  
Sequence No. **27**

Go to [www.irs.gov/Form4797](http://www.irs.gov/Form4797) for instructions and the latest information.

Name(s) shown on return <b>SHORE MEMORIAL HOSPITAL</b>		Identifying number <b>21-0660835</b>
<b>1a</b>	Enter the gross proceeds from sales or exchanges reported to you for 2023 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20. See instructions . . . . .	
<b>1b</b>	Enter the total amount of gain that you are including on lines 2, 10, and 24 due to the partial dispositions of MACRS assets . . . . .	
<b>1c</b>	Enter the total amount of loss that you are including on lines 2 and 10 due to the partial dispositions of MACRS assets . . . . .	

**Part I Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year** (see instructions)

2	(a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)
<b>3</b>	Gain, if any, from Form 4684, line 39 . . . . .						<b>3</b>
<b>4</b>	Section 1231 gain from installment sales from Form 6252, line 26 or 37 . . . . .						<b>4</b>
<b>5</b>	Section 1231 gain or (loss) from like-kind exchanges from Form 8824 . . . . .						<b>5</b>
<b>6</b>	Gain, if any, from line 32, from other than casualty or theft . . . . .						<b>6</b>
<b>7</b>	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows . . . . .						<b>7</b>
	<b>Partnerships and S corporations.</b> Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120-S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.						
	<b>Individuals, partners, S corporation shareholders, and all others.</b> If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you didn't have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.						
<b>8</b>	Nonrecaptured net section 1231 losses from prior years. See instructions . . . . .						<b>8</b>
<b>9</b>	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is not zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return. See instructions . . . . .						<b>9</b>

**Part II Ordinary Gains and Losses** (see instructions)

<b>10</b>	Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):						
							9,012.
<b>11</b>	Loss, if any, from line 7 . . . . .						<b>11</b> ( )
<b>12</b>	Gain, if any, from line 7 or amount from line 8, if applicable. . . . .						<b>12</b>
<b>13</b>	Gain, if any, from line 31 . . . . .						<b>13</b>
<b>14</b>	Net gain or (loss) from Form 4684, lines 31 and 38a . . . . .						<b>14</b>
<b>15</b>	Ordinary gain from installment sales from Form 6252, line 25 or 36 . . . . .						<b>15</b>
<b>16</b>	Ordinary gain or (loss) from like-kind exchanges from Form 8824 . . . . .						<b>16</b>
<b>17</b>	Combine lines 10 through 16. . . . .						<b>17</b> 9,012.
<b>18</b>	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below.						
	<b>a</b> If the loss on line 11 includes a loss from Form 4684, line 35, column (b)(ii), enter that part of the loss here. Enter the loss from income-producing property on Schedule A (Form 1040), line 16. (Do not include any loss on property used as an employee.) Identify as from "Form 4797, line 18a." See instructions . . . . .						<b>18a</b>
	<b>b</b> Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Schedule 1 (Form 1040), Part I, line 4 . . . . .						<b>18b</b>

For Paperwork Reduction Act Notice, see separate instructions.

**Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255**  
(see instructions)

19 (a) Description of section 1245, 1250, 1252, 1254, or 1255 property:		(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
A			
B			
C			
D			
<i>These columns relate to the properties on lines 19A through 19D.</i>		<b>Property A</b>	<b>Property B</b>
<b>20</b>	Gross sales price <b>(Note: See line 1a before completing.)</b> . . . . .	<b>20</b>	
<b>21</b>	Cost or other basis plus expense of sale . . . . .	<b>21</b>	
<b>22</b>	Depreciation (or depletion) allowed or allowable . . . . .	<b>22</b>	
<b>23</b>	Adjusted basis. Subtract line 22 from line 21 . . . . .	<b>23</b>	
<b>24</b>	Total gain. Subtract line 23 from line 20. . . . .	<b>24</b>	
<b>25</b>	<b>If section 1245 property:</b>		
a	Depreciation allowed or allowable from line 22 . . . . .	<b>25a</b>	
b	Enter the <b>smaller</b> of line 24 or 25a. . . . .	<b>25b</b>	
<b>26</b>	<b>If section 1250 property:</b> If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.		
a	Additional depreciation after 1975. See instructions . . . . .	<b>26a</b>	
b	Applicable percentage multiplied by the <b>smaller</b> of line 24 or line 26a. See instructions . . . . .	<b>26b</b>	
c	Subtract line 26a from line 24. If residential rental property or line 24 isn't more than line 26a, skip lines 26d and 26e . . . . .	<b>26c</b>	
d	Additional depreciation after 1969 and before 1976 . . . . .	<b>26d</b>	
e	Enter the <b>smaller</b> of line 26c or 26d . . . . .	<b>26e</b>	
f	Section 291 amount (corporations only) . . . . .	<b>26f</b>	
g	Add lines 26b, 26e, and 26f . . . . .	<b>26g</b>	
<b>27</b>	<b>If section 1252 property:</b> Skip this section if you didn't dispose of farmland or if this form is being completed for a partnership.		
a	Soil, water, and land clearing expenses . . . . .	<b>27a</b>	
b	Line 27a multiplied by applicable percentage. See instructions . . . . .	<b>27b</b>	
c	Enter the <b>smaller</b> of line 24 or 27b . . . . .	<b>27c</b>	
<b>28</b>	<b>If section 1254 property:</b>		
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion. See instructions . . . . .	<b>28a</b>	
b	Enter the <b>smaller</b> of line 24 or 28a . . . . .	<b>28b</b>	
<b>29</b>	<b>If section 1255 property:</b>		
a	Applicable percentage of payments excluded from income under section 126. See instructions . . . . .	<b>29a</b>	
b	Enter the <b>smaller</b> of line 24 or 29a. See instructions . . . . .	<b>29b</b>	

**Summary of Part III Gains.** Complete property columns A through D through line 29b before going to line 30.

<b>30</b>	Total gains for all properties. Add property columns A through D, line 24 . . . . .	<b>30</b>
<b>31</b>	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13 . . . . .	<b>31</b>
<b>32</b>	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 33. Enter the portion from other than casualty or theft on Form 4797, line 6 . . . . .	<b>32</b>

**Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less**  
(see instructions)

	(a) Section 179	(b) Section 280F(b)(2)
<b>33</b>	Section 179 expense deduction or depreciation allowable in prior years . . . . .	<b>33</b>
<b>34</b>	Recomputed depreciation. See instructions . . . . .	<b>34</b>
<b>35</b>	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report . . . . .	<b>35</b>

