
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

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

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

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

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Form header section containing organization name (ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES), EIN (90-0779828), address (2500 ENGLISH CREEK AVE., BLDG. 500), and principal officer (MICHAEL J. CHARLTON).

Part I Summary

Summary table with columns for Activities & Governance, Revenue, Expenses, and Net Assets or Fund Balances. Includes rows for mission statement, revenue (Total: 989,731,151), expenses (Total: 999,172,754), and net assets (Total: 1,278,100,257).

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. Form 990 (2023)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

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? [X] Yes [] No

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No

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 \$ 899,343,204. including grants of \$ 558,125.) (Revenue \$ 930,988,795.)

EXPENSES INCURRED IN PROVIDING INPATIENT, OUTPATIENT, EMERGENCY AND VARIOUS OTHER MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY AND IN FURTHERANCE OF CHARITABLE TAX-EXEMPT PURPOSES. PLEASE REFER TO THE COMMUNITY BENEFIT STATEMENT IN SCHEDULE O.

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

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

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

4e Total program service expenses 899,343,204.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors? See instructions.	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments-other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>		X
c Did the organization report an amount for investments-program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>	X	
d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>		X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>		X
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I. See instructions</i>	X	
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	X	
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	X	

Part IV Checklist of Required Schedules (continued)

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

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, W-2G forms, and backup withholding rules.

Part V Statements Regarding Other IRS Filings and Tax Compliance <i>(continued)</i>		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return 2a 6,692		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i>	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .		X
b	If "Yes," enter the name of the foreign country _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? 12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i>		
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X
17	Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? 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 (110), 1b (83), 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 (X).

Section C. Disclosure

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

HAK J. KIM 2500 ENGLISH CREEK AVE EGG HARBOR TWNSHP, NJ 08234 (609)569-7031

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

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) LORI S. HERNDON TRST-AHS PRES/CEO (TERM 6/30/23)	55.00 NONE	X		X				NONE	3,281,410.	352,156.
(2) MARILUISE VENDITTI, M.D. SVP & CMO (TERMED 7/31/23)	55.00 NONE			X				NONE	1,047,781.	15,826.
(3) BLAIR A. BERGEN, M.D. TRUSTEE (TERMED)	55.00 NONE	X						NONE	991,948.	45,011.
(4) HAK J. KIM EVP & CFO/PRESIDENT AHN	55.00 NONE			X				NONE	810,944.	113,849.
(5) MICHAEL J. CHARLTON TRST-AHS PRES/CEO (EFF 6/1/23)	55.00 NONE	X		X				NONE	554,482.	237,152.
(6) ALVARO F. GALVEZ-LIMA, M.D. PHYSICIAN	55.00 NONE					X		749,502.	NONE	27,928.
(7) MOHAMMADYASER MOURAD, M.D. CHIEF MEDICAL QUALITY OFFICER	55.00 NONE					X		638,621.	NONE	119,318.
(8) DONNA MICHAEL-ZIEREIS, ESQ. EVP ADMIN/CLO/COS & SECRETARY	55.00 NONE			X				NONE	572,959.	102,857.
(9) RICHARD ZALMAN, M.D. EXECUTIVE MEDICAL DIRECTOR	55.00 NONE			X				NONE	615,158.	46,718.
(10) CATHERINE DILLANE, M.D. PHYSICIAN	55.00 NONE					X		599,295.	NONE	14,239.
(11) JAVID IQBAL, M.D. TRUSTEE; EX-OFFICIO	55.00 NONE	X						NONE	548,146.	50,197.
(12) LARISA K. GOGANZER SVP & CHIEF HOSPITAL EXECUTIVE	55.00 NONE			X				508,918.	NONE	87,685.
(13) DENNIS LENNON VP & CHIEF PEOPLE OFFICER	55.00 NONE			X				NONE	486,755.	109,583.
(14) CHRISTOPHER A. SCANZERA SVP & CHIEF DIGITAL & INFO OFF	55.00 NONE			X				NONE	476,004.	94,163.

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) BENJAMIN J. NEGLEY VP & COO AHN	55.00 NONE			X				460,441.	NONE	106,967.
(16) KATHERINE BIRKENSTOCK VP NURSING/CNO (TERM 11/25/23)	55.00 NONE			X				516,630.	NONE	39,114.
(17) GABRIELA ANDRIES, M.D. PHYSICIAN	55.00 NONE					X		538,572.	NONE	13,432.
(18) FRANK R. CARPENTER SVP, CHIEF ADMIN INT. OFF.	55.00 NONE			X				454,197.	NONE	52,127.
(19) JAMES KILMER VP CHIEF ADMIN OFF. CITY	55.00 NONE			X				428,982.	NONE	75,012.
(20) VINEET MEGHRAJANI, M.D. PHYSICIAN	55.00 NONE					X		472,935.	NONE	25,342.
(21) DEBRA A. FOX VP CHIEF TRANSFORMATION OFF.	55.00 NONE			X				NONE	388,499.	57,716.
(22) BARBARA YOUNG VP & CHIEF SUPPLY CHAIN OFF.	55.00 NONE			X				337,481.	NONE	53,205.
(23) SAMANTHA A. KILEY VP COMM HEALTH & SOCIAL IMPACT	55.00 NONE			X				249,413.	NONE	42,389.
(24) ROBERT L. SZAPOR AVP BEHAVIORAL HEALTH	55.00 NONE			X				189,306.	NONE	27,940.
(25) MONIKA FINNEGAN SR. DIRECTOR & CONTROLLER ABH	55.00 NONE			X				194,740.	NONE	10,217.
1b Sub-total								6,339,033.	9,774,086.	1,920,143.
c Total from continuation sheets to Part VII, Section A								188,748.	102,476.	7,896.
d Total (add lines 1b and 1c)								6,527,781.	9,876,562.	1,928,039.

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 **890**

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

Section B. Independent Contractors

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

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

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

Part 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) CHRISTOPHER C. APGAR FORMER OFFICER	55.00 NONE						X	136,748.	NONE	5,946.
(27) SULIN G. YAO, M.D. TRUSTEE	40.00 NONE	X						NONE	102,476.	1,950.
(28) PRIYESH T. THAKKAR, D.O. TRUSTEE	20.00 NONE	X						45,000.	NONE	NONE
(29) THOMAS BRABSON, D.O. TRUSTEE (TERMED)	2.00 NONE	X						7,000.	NONE	NONE
(30) DAVID M. GODDARD CHAIRMAN - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(31) KENNETH R. STEINBERG, P.E. SECRETARY - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(32) MARGARET S. SYKES, R.N. TREASURER - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(33) PACIFICO AGNELLINEI, ESQ. TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(34) MANUEL E. APONTE TRUSTEE; EX-OFFICIO	1.00 NONE	X						NONE	NONE	NONE
(35) EUGENE M. ARNONE TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(36) ROSALIND E. KINCAID TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

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			
(37) BRETT MATIK TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(38) GINA MERRITT-EPPS, ESQ. TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(39) MARISSA TRAVALINE TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(40) JENNIFER TIOSECO, M.D. TRUSTEE; EX-OFFICIO	1.00 NONE	X					NONE	NONE	NONE	
(41) MICHAEL WALSH TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(42) CHRISTOPHER C. CATCHING, ED.D TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
(43) ALDALBERTO LOPEZ TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
(44) RICHARD S. MAIRONE, ESQ. TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
(45) YOLANDA N. MELVILLE, ESQ. TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
(46) PATRICIA RICH-TUOHY TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
(47) ROBERT L. HORDES CHAIRMAN - TRUSTEE	1.00 NONE	X		X			NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

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			
(48) JOHANNA PERSKIE VICE CHAIR - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(49) FATEN DIB SECRETARY - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(50) MATHEW D. FINKELSON, D.M.D. TREASURER - TRUSTEE	1.00 NONE	X		X				NONE	NONE	NONE
(51) JOHN BECHER, D.O. TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(52) LOUIS BONGIOVANNI TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(53) KRISTINA CARR TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(54) MICHAEL CONNOR, ESQ. TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(55) BERNADETTE DOUGHERTY TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(56) PAUL J. GALLAGHER, ESQ. TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(57) TIM L. GLENN TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(58) GARY L. HANSON TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

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			
(59) ROBERT A. HIMMELSTEIN TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(60) CORNELIUS P. MCPEAK TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(61) ALEXANDER ONOPCHENKO, M.D. TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(62) FABIO OROZCO, M.D. TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(63) PAUL P.J. PULLIA TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(64) T. ERIC REICH TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(65) MAUREEN SHAY TRUSTEE	1.00 NONE	X					NONE	NONE	NONE	
(66) LARRY J. KAUFMAN, M.D. TRUSTEE (TERMED)	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 446

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants, and Other Similar Amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c	488,809.				
	d	Related organizations	1d	518,850.				
	e	Government grants (contributions) . .	1e	25,818,003.				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	6,716,548.				
	g	Noncash contributions included in lines 1a-1f	1g	\$ 5,000.				
	h	Total. Add lines 1a-1f			33,542,210.			
	Program Service Revenue				Business Code			
2a		NET PATIENT SERVICE REVENUE		541900	902,863,355.	902,863,355.		
b		OTHER HEALTHCARE RELATED REVENUE		541900	28,125,440.	28,125,440.		
c								
d								
e								
f		All other program service revenue						
g	Total. Add lines 2a-2f			930,988,795.				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)			23,400,851.		23,400,851.	
	4	Income from investment of tax-exempt bond proceeds . . .			NONE			
	5	Royalties			NONE			
	6a	Gross rents	6a	(i) Real				
				(ii) Personal				
					7,500,884.			
	b	Less: rental expenses	6b		5,814,396.			
	c	Rental income or (loss)	6c		1,686,488.	NONE		
	d	Net rental income or (loss)			1,686,488.		1,686,488.	
	7a	Gross amount from sales of assets other than inventory	7a	(i) Securities				
				(ii) Other		104,041.		
	b	Less: cost or other basis and sales expenses . .	7b					
	c	Gain or (loss)	7c		104,041.			
	d	Net gain or (loss)			104,041.		104,041.	
8a	Gross income from fundraising events (not including \$ 488,809. of contributions reported on line 1c). See Part IV, line 18	8a		394,666.				
			8b	394,666.				
			c	Net income or (loss) from fundraising events		NONE		NONE
9a	Gross income from gaming activities. See Part IV, line 19	9a		19,390.				
			9b	10,624.				
			c	Net income or (loss) from gaming activities		8,766.		8,766.
10a	Gross sales of inventory, less returns and allowances	10a		NONE				
			10b	NONE				
			c	Net income or (loss) from sales of inventory		NONE		
Miscellaneous Revenue				Business Code				
	11a							
	b							
	c							
	d	All other revenue						
e	Total. Add lines 11a-11d			NONE				
12	Total revenue. See instructions				989,731,151.	930,988,795.	25,200,146.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	558,125.	558,125.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	NONE			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	NONE			
4 Benefits paid to or for members	NONE			
5 Compensation of current officers, directors, trustees, and key employees	3,834,764.	3,451,288.	383,476.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	NONE			
7 Other salaries and wages	315,188,939.	283,670,045.	31,518,894.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	19,041,602.	17,137,442.	1,904,160.	
9 Other employee benefits	78,552,223.	70,697,001.	7,855,222.	
10 Payroll taxes	24,010,116.	21,609,104.	2,401,012.	
11 Fees for services (nonemployees):				
a Management	86,899,969.	78,209,972.	8,689,997.	
b Legal	136,048.	122,443.	13,605.	
c Accounting	1,095,398.	985,858.	109,540.	
d Lobbying	128,873.	115,986.	12,887.	
e Professional fundraising services. See Part IV, line 17	42,453.			42,453.
f Investment management fees	NONE			
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.)	8,606,893.	7,746,204.	860,689.	
12 Advertising and promotion	402,857.	362,571.	40,286.	
13 Office expenses	13,952,038.	12,556,834.	1,395,204.	
14 Information technology.	1,362,226.	1,226,003.	136,223.	
15 Royalties.	NONE			
16 Occupancy	13,023,998.	11,721,598.	1,302,400.	
17 Travel	2,030,038.	1,827,034.	203,004.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	NONE			
19 Conferences, conventions, and meetings	1,153,961.	1,038,565.	115,396.	
20 Interest	9,540,108.	8,586,097.	954,011.	
21 Payments to affiliates.	NONE			
22 Depreciation, depletion, and amortization	50,382,117.	45,343,905.	5,038,212.	
23 Insurance	9,651,138.	8,686,024.	965,114.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	184,782,830.	166,304,547.	18,478,283.	
b PHYSICIAN SERVICES COST	98,635,233.	88,771,710.	9,863,523.	
c PURCHASED SERVICES	65,995,530.	59,395,977.	6,599,553.	
d REPAIRS & MAINTENANCE	4,618,563.	4,156,707.	461,856.	
e All other expenses _____	5,546,714.	5,062,164.	484,550.	
25 Total functional expenses. Add lines 1 through 24e	999,172,754.	899,343,204.	99,787,097.	42,453.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	18,631,056.	1	44,205,666.
	2 Savings and temporary cash investments	2,614,256.	2	5,006,544.
	3 Pledges and grants receivable, net	2,269,689.	3	4,703,102.
	4 Accounts receivable, net	145,523,125.	4	166,331,968.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	5	NONE
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	NONE	6	NONE
	7 Notes and loans receivable, net	NONE	7	NONE
	8 Inventories for sale or use	16,840,422.	8	15,900,549.
	9 Prepaid expenses and deferred charges	17,429,725.	9	23,789,235.
	10 a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1287775936.		
	b Less: accumulated depreciation	10b 734,355,330.		
		511,447,667.	10c	553,420,606.
	11 Investments - publicly traded securities	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11	NONE	12	NONE
	13 Investments - program-related. See Part IV, line 11	896,071,354.	13	966,829,261.
	14 Intangible assets	28,856,429.	14	34,141,180.
15 Other assets. See Part IV, line 11	72,082,773.	15	76,796,288.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	1,711,766,496.	16	1,891,124,399.	
Liabilities	17 Accounts payable and accrued expenses	133,771,079.	17	135,828,960.
	18 Grants payable	NONE	18	NONE
	19 Deferred revenue	14,834.	19	41,266.
	20 Tax-exempt bond liabilities	238,990,184.	20	294,890,469.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	7,786,063.	23	9,283,129.
	24 Unsecured notes and loans payable to unrelated third parties	NONE	24	NONE
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	116,142,032.	25	172,980,318.
	26 Total liabilities. Add lines 17 through 25	496,704,192.	26	613,024,142.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33. <input checked="" type="checkbox"/>			
	27 Net assets without donor restrictions	1,187,877,155.	27	1,250,203,537.
	28 Net assets with donor restrictions	27,185,149.	28	27,896,720.
	Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33. <input type="checkbox"/>			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	1,215,062,304.	32	1,278,100,257.
33 Total liabilities and net assets/fund balances	1,711,766,496.	33	1,891,124,399.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	989,731,151.
2	Total expenses (must equal Part IX, column (A), line 25)	2	999,172,754.
3	Revenue less expenses. Subtract line 2 from line 1	3	-9,441,603.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	1,215,062,304.
5	Net unrealized gains (losses) on investments	5	111,614,066.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-39,134,510.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	1,278,100,257.

Part XII Financial Statements and Reporting

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

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

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

Form 990 (2023)

**SCHEDULE A
(Form 990)**

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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

The organization is not a private foundation because it is: (For lines 1 through 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		
SEE SUPPLEMENTAL PAGE						
(A)						
(B)						
(C)						
(D)						
(E)						
Total					NONE	NONE

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

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3.						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2023 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2022 Schedule A, Part II, line 14	15	%
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.		<input type="checkbox"/>
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		<input type="checkbox"/>
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.		<input type="checkbox"/>
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.		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

Part III Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 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
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5.						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<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).		

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

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

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

Part VI Supplemental Information. Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

SCHEDULE A, PART I

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

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

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

ATLANTICARE HEALTH ENGAGEMENT, INC.; SCHEDULE A, PART I, LINE 12, INTERNAL REVENUE CODE SECTION 509(A)(3) PUBLIC CHARITY;

ATLANTICARE HEALTH SERVICES, INC.; SCHEDULE A, PART I, LINE 10, INTERNAL REVENUE CODE SECTION 509(A)(2) PUBLIC CHARITY; AND

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION; SCHEDULE A, PART I, LINE 12, INTERNAL REVENUE CODE SECTION 509(A)(3) PUBLIC CHARITY.

JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION; SCHEDULE A, PART I, LINE 7, INTERNAL REVENUE CODE SECTION 501(A)(1) PUBLIC

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

CHARITY.

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

SCHEDULE A, PART I - INFORMATION ABOUT SUPPORTED ORGANIZATIONS

(I) NAME OF SUPPORTED ORGANIZATION	(II) EIN	(III) TYPE OF ORGANIZATION	(IV)		(V) AMOUNT OF SUPPORT	(VI) AMOUNT OF OTHER SUPPORT
			YES	NO		
ATLANTICARE REGIONAL MEDICAL CENTER	21-0634549	3	X		NONE	NONE
TOTAL AMOUNT OF SUPPORT					NONE	NONE

**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 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 ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES	Employer identification number 90-0779828
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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.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%; text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 65%; 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.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? <input type="checkbox"/> Yes <input type="checkbox"/> No														

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total...; 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, LINE 11

ATLANTICARE REGIONAL MEDICAL CENTER; AN INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION, INCLUDED IN THIS CONSOLIDATED GROUP FORM 990, PAID OUTSIDE LOBBYING FIRMS TO PERFORM LOBBYING EFFORTS ON BEHALF OF ATLANTICARE REGIONAL MEDICAL CENTER. THE TOTAL PAYMENTS FOR LOBBYING ACTIVITIES TOTALED \$103,500 DURING 2023.

IN ADDITION, ATLANTICARE REGIONAL MEDICAL CENTER, INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 IS A MEMBER OF THE AMERICAN HOSPITAL ASSOCIATION, THE HOSPITAL ALLIANCE OF NEW JERSEY, AND THE NEW JERSEY HOSPITAL ASSOCIATION WHICH ENGAGE IN LOBBYING EFFORTS ON BEHALF OF THEIR MEMBER HOSPITALS. A PORTION OF THE DUES PAID TO THESE ORGANIZATIONS HAS BEEN ALLOCATED TO LOBBYING ACTIVITIES PERFORMED ON BEHALF OF ATLANTICARE REGIONAL MEDICAL CENTER INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. THIS ALLOCATION AMOUNTED TO \$25,373 IN 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

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

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

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

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 |
|---|-----------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII.

Part V Endowment Funds

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	27,185,149.	10,076,834.	9,252,307.	8,963,399.	9,355,390.
b Contributions	5,323,254.	22,620,487.	2,565,373.	948,897.	1,543,074.
c Net investment earnings, gains, and losses	51,640.				
d Grants or scholarships					
e Other expenditures for facilities and programs	4,663,323.	5,512,172.	1,740,846.	659,989.	1,935,065.
f Administrative expenses					
g End of year balance	27,896,720.	27,185,149.	10,076,834.	9,252,307.	8,963,399.

- 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 8.5000 %
 - c Term endowment 91.5000 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|--|---------------|----|
| (i) Unrelated organizations? | 3a(i) | X |
| (ii) Related organizations? | 3a(ii) | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		48,374,406.		48,374,406.
b Buildings		690,308,303.	357,206,126.	333,102,177.
c Leasehold improvements		5,231,998.	2,200,822.	3,031,176.
d Equipment		457,280,939.	363,531,810.	93,749,129.
e Other		86,580,290.	11,416,572.	75,163,718.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B))				553,420,606.

Part VII Investments - Other Securities

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

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

Part VIII Investments - Program Related

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) POOLED INVESTMENTS	3,630,420.	FMV
(2) CASH & CASH EQUIV; LIMITED USE	27,129,054.	FMV
(3) CASH-RESTR-BROKERAGE FUND CURR	16,985.	FMV
(4) OTHER INVESTMENTS	24,305,146.	FMV
(5) BOARD DESIGNATED INVESTMENTS	900,883,737.	FMV
(6) PERM RESTR ENDOWMENT FUND	2,260,495.	FMV
(7) ASSETS LIMITED TO USE; CURRENT	5,763,255.	FMV
(8) OTHER PROGRAM RELATED INVEST.	2,840,169.	FMV
(9)		
Total. (Column (b) must equal Form 990, Part X, line 13, col. (B)) . . .	966,829,261.	

Part IX Other Assets

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

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

Part X Other Liabilities

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) EST. 3RD PARTY PAYOR SETTLEMENT	26,278,919.
(3) OTHER LIABILITIES	47,363,938.
(4) ACCRUED INTEREST PAYABLE	4,576,806.
(5) ACCRUED RETIREMENT BENEFITS	94,760,655.
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 25, col. (B)).	172,980,318.

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

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

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

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

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

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

Part XIII Supplemental Information

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

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information *(continued)*

SCHEDULE D, PART V, QUESTION 4

RESTRICTED FUNDS ARE USED TO SUPPORT THE CHARITABLE ACTIVITIES AND PROGRAMS OF THE ORGANIZATION AND ITS AFFILIATES.

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

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 14b, 15, or 16.

Attach to Form 990.

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

Name of the organization

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

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

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

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

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
(1) CENTRAL AMERICA/CARIBBEAN	NONE	NONE	PROGRAM SERVICES	FINANCIAL VEHICLE	7,041,909.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Subtotal	NONE	NONE			7,041,909.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)	NONE	NONE			7,041,909.

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

Schedule F (Form 990) 2023

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

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

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

3 Enter total number of other organizations or entities _____

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
 Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see the Instructions for Form 926)* Yes No

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

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

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

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

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

**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.

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

Open to Public Inspection

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

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 checked="" type="checkbox"/> Mail solicitations | e <input checked="" type="checkbox"/> Solicitation of non-government grants |
| b <input checked="" type="checkbox"/> Internet and email solicitations | f <input checked="" type="checkbox"/> Solicitation of government grants |
| c <input checked="" type="checkbox"/> Phone solicitations | g <input checked="" type="checkbox"/> Special fundraising events |
| d <input checked="" 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			
SEE SUPPLEMENT INFORMATION 1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total				672,850.	42,453.	NONE

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.

FL, NJ,

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)	GOLF OUTING (event type)	NONE (total number)	(add col. (a) through col. (c))
Revenue	1	Gross receipts	644,375.	239,100.	883,475.
	2	Less: Contributions	334,344.	154,465.	488,809.
	3	Gross income (line 1 minus line 2)	310,031.	84,635.	394,666.
Direct Expenses	4	Cash prizes			
	5	Noncash prizes			
	6	Rent/facility costs	215,652.	72,148.	287,800.
	7	Food and beverages			
	8	Entertainment	19,500.		19,500.
	9	Other direct expenses	74,879.	12,487.	87,366.
	10	Direct expense summary. Add lines 4 through 9 in column (d)			394,666.
11	Net income summary. Subtract line 10 from line 3, column (d)				

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))	
		1	Gross revenue			19,390.
Direct Expenses	2	Cash prizes			6,895.	6,895.
	3	Noncash prizes			3,225.	3,225.
	4	Rent/facility costs				
	5	Other direct expenses			504.	504.
	6	Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes 100.0000 % <input type="checkbox"/> No	
7	Direct expense summary. Add lines 2 through 5 in column (d)				10,624.	
8	Net gaming income summary. Subtract line 7 from line 1, column (d)				8,766.	

9 Enter the state(s) in which the organization conducts gaming activities: NJ,
 a Is the organization licensed to conduct gaming activities in each of these states? Yes No
 b If "No," explain: _____

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

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

a The organization's facility	13a	33.3333	%
b An outside facility	13b	66.6667	%

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

Name ▶ BEATRICE SHOFF

Address ▶ 235 WEYMOUTH ROAD EGG HARBOR CITY, NJ 08215

- 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 ▶ BEATRICE SHOFF

Gaming manager compensation ▶ \$ NONE

Description of services provided ▶ MANAGING GAMING ACTIVITIES

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).

FORM 990, SCHEDULE G, LINE 2B - HIGHEST PAID INDIVIDUALS/ENTITIES

=====

NAME:

GABRIEL STAINO

ADDRESS:

601 PASADENA DRIVE
NORTHFIELD, NJ 08225

ACTIVITY :

CAMPAIGN MGMT

CUSTODY OR CONTROL OF CONTRIBUTION?

NO

GROSS RECEIPTS FROM ACTIVITY :	672,850.
AMOUNT PAID TO (OR RETAINED BY) FUNDRAISER :	42,453.
AMOUNT PAID TO (OR RETAINED BY) ORGANIZATION :	NONE

**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 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

Name of the organization ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES	Employer identification number 90-0779828
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Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		3,846.	22,303,726.	13,997,094.	8,306,632.	0.94
b Medicaid (from Worksheet 3, column a)		34,151.	204,174,413.	173,336,564.	30,837,849.	3.48
c Costs of other means-tested government programs (from Worksheet 3, column b)			NONE	NONE	NONE	NONE
d Total. Financial Assistance and Means-Tested Government Programs		37,997.	226,478,139.	187,333,658.	39,144,481.	4.42
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	6	41,610.	3,642,625.	NONE	3,642,625.	0.41
f Health professions education (from Worksheet 5)	1	NONE	11,764,862.	6,517,149.	5,247,713.	0.59
g Subsidized health services (from Worksheet 6)	4	6,872.	46,905,739.	7,282,254.	39,623,485.	4.48
h Research (from Worksheet 7)	1	NONE	661,246.	NONE	661,246.	0.07
i Cash and in-kind contributions for community benefit (from Worksheet 8)	1	NONE	274,903.	NONE	274,903.	0.03
j Total. Other Benefits	13	48,482.	63,249,375.	13,799,403.	49,449,972.	5.58
k Total. Add lines 7d and 7j	13	86,479.	289,727,514.	201,133,061.	88,594,453.	10.00

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?	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	245,779,676.
6 Enter Medicare allowable costs of care relating to payments on line 5	298,401,549.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	-52,621,873.
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 checked="" type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

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

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

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

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER/24 hours	ER-other	Other (describe)	Facility reporting group
1 ARMC - MAINLAND CAMPUS 65 W. JIMMIE LEEDS ROAD POMONA NJ 08240 WWW.ATLANTICARE.ORG	10101			X	X		X			1
2 ARMC - CITY CAMPUS 1925 PACIFIC AVENUE ATLANTIC CITY NJ 08401 WWW.ATLANTICARE.ORG	10102			X	X		X			1
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group: ARMC

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1 & 2

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		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.ATLANTICARE.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 checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>2022</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a	If "Yes," (list url): <u>WWW.ATLANTICARE.ORG</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group: ARMC

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<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>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>ATLANTICARE.ORG</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>ATLANTICARE.ORG</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>ATLANTICARE.ORG</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input 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		
j	<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: ARMC

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information (continued)

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

Name of hospital facility or letter of facility reporting group: ARMC

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

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, QUESTION 5

IN 2022, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") FOR ATLANTIC COUNTY, NEW JERSEY. IN ADDITION TO A REVIEW OF PRIMARY AND SECONDARY DATA SOURCES, THE ASSESSMENT ENSURED THAT THE ORGANIZATION RECEIVED FEEDBACK FROM COMMUNITY LEADERS THROUGH FORMAL MEETINGS WHERE FINDINGS WERE SHARED FOR VALIDATION AND INPUT. COMMUNITY RESIDENT FEEDBACK WAS ALSO COLLECTED THROUGH A FORMAL SURVEY AND A SERIES OF FOCUS GROUPS WHICH WERE CONDUCTED IN VARIOUS LOCATIONS ACROSS OUR COMMUNITY IN TWO DIFFERENT LANGUAGES. ADDITIONAL EFFORTS WERE TAKEN TO ENSURE THAT ALL MEMBERS OF OUR COMMUNITY; INCLUDING MINORITY AND UNDERSERVED MEMBERS WERE INCLUDED AS PART OF THE ASSESSMENT. A FOLLOW-UP IMPLEMENTATION STRATEGY WAS ALSO DRAFTED TO DOCUMENT HOW ATLANTICARE WILL MEET THE COMMUNITY'S IDENTIFIED NEEDS. THE 2022 CHNA EXPANDED UPON THEMES FOUND IN PRIOR ASSESSMENTS. IT ALSO TOOK INTO ACCOUNT OUR GROWING KNOWLEDGE AROUND THE SOCIAL DETERMINANTS OF HEALTH. OUR NEXT CHNA IS SCHEDULED TO OCCUR IN 2025.

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

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

[HTTPS://WWW.ATLANTICARE.ORG/FOR-OUR-COMMUNITY/PROGRAMS/COMMUNITY-NEEDS-ASSESSMENT](https://www.atlanticare.org/for-our-community/programs/community-needs-assessment)

ALL PREVIOUS ATLANTICARE REGIONAL MEDICAL CENTER'S CHNA'S CAN BE FOUND ON THE ABOVE WEBSITE AS WELL.

SCHEDULE H, PART V, SECTION B, QUESTION 8

IN 2022, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT FOR ATLANTIC COUNTY, NEW JERSEY. THROUGH THE ASSESSMENT, SIX PRIORITIZED NEEDS WITHIN THE COUNTY WERE IDENTIFIED. AS A RESULT ATLANTICARE, ALONG WITH SUPPORT FROM ITS COMMUNITY PARTNERS, WORKS TO FIND SOLUTIONS FOR THOSE PRIORITIZED NEEDS. ONE STRATEGY PER PRIORITIZED NEED WAS IDENTIFIED AND CONTINUED IMPLEMENTATION AND REVISIONS OF PROPOSED STRATEGIES CONTINUES TO BE ONGOING.

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 2022 ASSESSMENT IDENTIFIED ACCESS TO CARE, SUBSTANCE USE, MENTAL HEALTH, HOUSING, TRANSPORTATION AND FOOD SECURITY AS KEY COMMUNITY NEEDS. ATLANTICARE REGIONAL MEDICAL CENTER IS ACTIVELY SEEKING OUT PARTNERSHIPS TO BETTER UNDERSTAND THE ROOT CAUSES OF THESE SOCIAL DETERMINANTS OF HEALTH. IT IS ALSO WORKING TO IDENTIFY OPPORTUNITIES AND PARTNERS TO ACCELERATE AND SUPPORT ONGOING EFFORTS TO MAKE A GREATER IMPACT AND IMPROVE THE HEALTH OF OUR COMMUNITY. AS A RESULT OF OUR PVIOUS CHNA, PROGRAMS SUCH AS OUR OPIOID RESPONSE, FOOD SECURITY INITIATIVES AND COMMUNITY HOUSING EFFORTS WERE LAUNCHED IN RESPONSE.

ATLANTICARE REGIONAL MEDICAL CENTER WILL CONDUCT ITS NEXT ASSESSMENT IN 2025.

SCHEDULE H, PART V, SECTION B, QUESTION 10

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

[HTTPS://WWW.ATLANTICARE.ORG/FOR-OUR-COMMUNITY/PROGRAMS/COMMUNITY-NEEDS-ASSESSMENT](https://www.atlanticare.org/for-our-community/programs/community-needs-assessment)

SCHEDULE H, PART V, SECTION B, QUESTION 11

IN 2013, ATLANTICARE REGIONAL MEDICAL CENTER CONDUCTED ITS INITIAL REQUIRED CHNA IN COLLABORATION WITH BACHARACH INSTITUTE FOR REHABILITATION, WHICH IS ALSO LOCATED IN ATLANTIC COUNTY, NEW JERSEY. IT HAS CONTINUED TO CONDUCT THE REQUIRED ASSESSMENTS EVERY THREE YEARS- 2016, 2019, AND 2022 RESPECTIVELY. IN ADDITION TO A REVIEW OF PRIMARY AND SECONDARY DATA SOURCES, ATLANTICARE REGIONAL MEDICAL CENTER ENSURED THAT FEEDBACK FROM COMMUNITY LEADERS THROUGH FORMAL MEETINGS WHERE FINDINGS WERE SHARED FOR VALIDATION AND INPUT WAS OBTAINED. COMMUNITY RESIDENT FEEDBACK WAS ALSO COLLECTED THROUGH A SERIES OF FOCUS GROUPS AND THROUGH THE IMPLEMENTATION OF A RESIDENT SURVEY. ADDITIONAL EFFORTS WERE TAKEN TO ENSURE THAT ALL MEMBERS OF OUR COMMUNITY; INCLUDING MINORITY AND UNDERSERVED MEMBERS, WERE INCLUDED AS PART OF THESE FEEDBACK EFFORTS.

COMMUNITY NEEDS THAT EMERGED FROM THIS ASSESSMENT WERE REVIEWED AND WERE PRIORITIZED FOR GREATER ORGANIZATIONAL SUPPORT IN ORDER TO ADDRESS. THE 2022 CHNA IDENTIFIED THE FOLLOWING NEEDS: SUBSTANCE USE, MENTAL HEALTH SERVICES, FOOD INSECURITY/ACCESS TO HEALTHY FOODS, TRANSPORTATION, ACCESS

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.

TO CARE AND AFFORDABLE HOUSING. AN UPDATED IMPLEMENTATION STRATEGY WILL BE ADOPTED TO SHARE OUR PROGRESS ON PREVIOUSLY STATED NEEDS, AND TO INCORPORATE OUR ACTIONS TO THE NEW NEEDS THAT HAVE EMERGED AS COMMUNITY PRIORITIES. WEAVED INTO OUR IMPLEMENTATION STRATEGY IS THE UNDERSTANDING THAT, IN ORDER TO HAVE A GREATER IMPACT ON OUR COMMUNITY, MORE FORMALIZED PARTNERSHIPS NEED TO BE ESTABLISHED WITH OUR LOCAL SOCIAL SERVICE AND GOVERNMENT AGENCIES TO DEVELOP A MORE COMPREHENSIVE APPROACH TO MEETING THE STATED NEEDS OF OUR COMMUNITY.

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

SCH H, PART V, SECT B, Q'S 2, 3J, 6A&B, 13B&H, 15E, 16J, 18E, 19E, 20E, 21C&D, 23, 24

NOT APPLICABLE.

SCHEDULE H, PART V, SECTION B, QUESTION 16

THE ORGANIZATION IS AN AFFILIATE WITHIN ATLANTICARE HEALTH SYSTEM ("ATLANTICARE"); A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. DUE TO CHARACTER LIMITATIONS, THE WEBSITE LISTED IN PART V, SECTION B, QUESTIONS 16A, 16B AND 16C, IS THE ABBREVIATED WEBSITE FOR ATLANTICARE.

THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION AND PLAIN LANGUAGE SUMMARY CAN BE ACCESSED AT THE FOLLOWING URL WHICH IS INCLUDED IN ATLANTICARE'S WEBSITE:

[HTTPS://WWW.ATLANTICARE.ORG/PATIENTS-AND-VISITORS/FOR-PATIENTS/BILLING-AND-INSURANCE/FINANCIAL-ASSISTANCE/](https://www.atlanticare.org/patients-and-visitors/for-patients/billing-and-insurance/financial-assistance/)

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? 10

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

Schedule H (Form 990) 2023

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

IN ADDITION TO THE NET COMMUNITY BENEFIT COSTS INCURRED BY THE ORGANIZATION AS REPORTED IN SCHEDULE H, PART I, LINE 7; PLEASE REFER TO SCHEDULE O OF THIS FORM 990 FOR THE ORGANIZATION'S NARRATIVE COMMUNITY BENEFIT STATEMENT FOR ADDITIONAL INFORMATION ON HOW THE ORGANIZATION PROMOTES HEALTH AND PROVIDES HEALTHCARE SERVICES TO THE COMMUNITY REGARDLESS OF AN INDIVIDUAL'S ABILITY TO PAY IN FURTHERANCE OF ITS CHARITABLE TAX-EXEMPT PURPOSES.

SCHEDULE H, PART I; LINE 3C

THE INCOME BASED CRITERIA USED TO DETERMINE ELIGIBILITY IS PER NEW JERSEY ADMINISTRATIVE CODE 10:52 SUB CHAPTERS 11, 12 AND 13, AND BASED UPON THE 2022 POVERTY GUIDELINES (DEPARTMENT OF HEALTH AND SENIOR SERVICES). FEDERAL POVERTY GUIDELINES ARE INCLUDED IN THE CRITERIA FOR DETERMINING ELIGIBILITY FOR CHARITY AND DISCOUNTED 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.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN ADDITION TO THE FEDERAL POVERTY GUIDELINES ELIGIBILITY CRITERIA NOTED
ELIGIBILITY FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR THOSE
INDIVIDUALS WHO ARE UNINSURED, INELIGIBLE FOR ANY GOVERNMENT HEALTHCARE
BENEFIT PROGRAM, AND THOSE WHO ARE UNABLE TO PAY FOR THEIR CARE, BASED
UPON DETERMINATION OF FINANCIAL NEED IN ACCORDANCE WITH THE FINANCIAL
ASSISTANCE POLICY.

PATIENTS WHOSE FAMILY INCOME EXCEEDS 300% OF THE FPL MAY BE ELIGIBLE TO
RECEIVE DISCOUNTED RATES ON A CASE-BY-CASE BASIS BASED ON THEIR SPECIFIC
CIRCUMSTANCES, SUCH AS CATASTROPHIC ILLNESS OR MEDICAL INDIGENCE, AT THE
DISCRETION OF ATLANTICARE.

ATLANTICARE PROVIDES, WITHOUT DISCRIMINATION, CARE FOR ALL EMERGENCY
MEDICAL CONDITIONS TO INDIVIDUALS REGARDLESS OF THEIR FINANCIAL
ASSISTANCE ELIGIBILITY OR ABILITY TO PAY. IT IS THE POLICY OF ATLANTICARE
TO COMPLY WITH THE STANDARDS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT
AND ACTIVE LABOR TRANSPORT ACT OF 1986 ("EMTALA") AND THE EMTALA
REGULATIONS IN PROVIDING A MEDICAL SCREENING EXAMINATION AND SUCH FURTHER

Part VI Supplemental Information

Provide the following information.

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

TREATMENT AS MAY BE NECESSARY TO STABILIZE AN EMERGENCY MEDICAL CONDITION
FOR ANY INDIVIDUAL COMING TO THE EMERGENCY DEPARTMENT SEEKING TREATMENT.

SCHEDULE H, PART I; QUESTION 6A

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

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART I, QUESTION 7

THE ORGANIZATION UTILIZED SYNTELLIS'S PERFORMANCE SOLUTION COST ACCOUNTING SYSTEM TO ESTIMATE COSTS.

SCHEDULE H, PART I, QUESTION 7B

ATLANTICARE REGIONAL 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 FEDERAL MATCHING FUNDS IN ORDER TO BETTER SERVE THE NEEDS IN THE COMMUNITY. THE ADDITIONAL FUNDS RECEIVED FROM THE PROGRAM DURING 2023 TOTALED APPROXIMATELY \$66M 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 \$22M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; MEDICAID TOTAL COMMUNITY BENEFIT EXPENSE. IN

Part VI Supplemental Information

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

ADDITION, ATLANTICARE REGIONAL 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 \$9M AND ARE INCLUDED IN SCHEDULE H, PART I; LINE 7B; DIRECT OFFSETTING MEDICAID REVENUE. IF ATLANTICARE REGIONAL MEDICAL CENTER DID NOT RECEIVE THESE ADDITIONAL FUNDS, THE NET COMMUNITY BENEFIT EXPENSE REPORTED ON SCHEDULE H, PART I; LINE 7K WOULD BE \$142,496,633 AND THE NET COMMUNITY BENEFIT PERCENTAGE REPORTED ON SCHEDULE H, PART I; LINE K WOULD BE 16.09%.

SCHEDULE H, PART I, QUESTION 7G

SUBSIDIZED HEALTH SERVICES INCLUDE PRIMARY CARE, OB-GYN, BEHAVIORAL HEALTH, ADDICTION MEDICINE, PSYCHIATRIC INTERVENTION, HIV COUNSELING, ENDOCRINOLOGY, RHEUMATOLOGY AND OUTPATIENT DIALYSIS. THOSE PROGRAMS ARE IDENTIFIED AS NEEDS IN THE COMMUNITY AND ARE SUBSIDIZED BY EXTERNAL AND INTERNAL FUNDS.

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART III, SECTION A; QUESTION 4

ATLANTICARE REGIONAL MEDICAL CENTER IS AN AFFILIATE WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). ATLANTICARE HEALTH SYSTEM AND AFFILIATES ("ATLANTICARE") PREPARE AND ISSUE AUDITED CONSOLIDATED FINANCIAL STATEMENTS. THE SYSTEM'S ALLOWANCE FROM DOUBTFUL ACCOUNTS (BAD DEBT EXPENSE) METHODOLOGY AND CHARITY CARE POLICIES ARE CONSISTENTLY APPLIED ACROSS ALL HOSPITAL AFFILIATES. THE ATTACHED TEXT WAS OBTAINED FROM THE FOOTNOTES TO THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF ATLANTICARE HEALTH SYSTEM, INC. AND AFFILIATES.

NET PATIENT SERVICE REVENUE

ATLANTICARE RECORDS NET PATIENT SERVICE REVENUE BASED ON STANDARD CHARGES FOR SERVICES PROVIDED, REDUCED BY EXPLICIT CONTRACTUAL ADJUSTMENTS PROVIDED TO THIRD-PARTY PAYORS AND IMPLICIT PRICE CONCESSIONS PROVIDED TO PATIENTS AS REDUCTIONS FROM ESTABLISHED BILLING RATES. ATLANTICARE

Part VI Supplemental Information

Provide the following information.

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DETERMINES ITS ESTIMATES OF EXPLICIT AND IMPLICIT PRICE CONCESSIONS BASED ON CONTRACTUAL TERMS AND HISTORICAL DATA, WHICH CONSIDERS EXPERIENCE, MARKET CONDITIONS, AND OTHER FACTORS UTILIZING A PORTFOLIO APPROACH CONSISTING OF MAJOR PAYOR CLASSES.

EXPLICIT AND IMPLICIT PRICE CONCESSIONS TO NET PATIENT SERVICE REVENUE ARE RECORDED AT THE TIME THE PERFORMANCE OBLIGATIONS ARE SATISFIED. SUBSTANTIALLY ALL CHANGES TO THESE CONCESSIONS, AS A RESULT OF SUBSEQUENT REASSESSMENT, ARE RECOGNIZED IN THE PERIOD THE CHANGE IS IDENTIFIED AS ADJUSTMENTS TO NET PATIENT SERVICE REVENUE. AMOUNTS RECOGNIZED DUE TO CHANGES IN ESTIMATES OF EXPLICIT AND IMPLICIT PRICE CONCESSIONS FOR THE YEARS ENDED DECEMBER 31, 2023 AND DECEMBER 31, 2022 WERE NOT SIGNIFICANT. SUBSEQUENT CHANGES THAT ARE DETERMINED TO BE THE RESULT OF AN ADVERSE CHANGE IN THE PATIENT'S OR PAYOR'S ABILITY TO PAY, IF MATERIAL, ARE RECORDED AS BAD DEBT EXPENSE. NO BAD DEBT EXPENSE WAS RECORDED FOR THE YEARS ENDED DECEMBER 31, 2023 AND DECEMBER 31, 2022, RELATED TO NET PATIENT SERVICE REVENUE.

Part VI Supplemental Information

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SCHEDULE H, PART III, SECTION B; QUESTION 8

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

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

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

Part VI Supplemental Information

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STANDARD IS THE CURRENT STANDARD FOR A HOSPITAL FOR RECOGNITION AS A TAX-EXEMPT AND CHARITABLE ORGANIZATION UNDER INTERNAL REVENUE CODE ("IRC") §501(C)(3).

THE ORGANIZATION IS RECOGNIZED AS A TAX-EXEMPT ENTITY AND CHARITABLE ORGANIZATION UNDER §501(C)(3) OF THE IRC. ALTHOUGH THERE IS NO DEFINITION IN THE TAX CODE FOR THE TERM "CHARITABLE" A REGULATION PROMULGATED BY THE DEPARTMENT OF THE TREASURY PROVIDES SOME GUIDANCE AND STATES THAT "THE TERM CHARITABLE IS USED IN §501(C)(3) IN ITS GENERALLY ACCEPTED LEGAL SENSE," AND PROVIDES EXAMPLES OF CHARITABLE PURPOSES, INCLUDING THE RELIEF OF THE POOR OR UNPRIVILEGED; THE PROMOTION OF SOCIAL WELFARE; AND THE ADVANCEMENT OF EDUCATION, RELIGION, AND SCIENCE. NOTE IT DOES NOT 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

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BENEFIT STANDARD WHICH IS THE CURRENT STANDARD.

CHARITY CARE STANDARD

IN 1956, THE IRS ISSUED REVENUE RULING 56-185, WHICH ADDRESSED THE REQUIREMENTS HOSPITALS NEEDED TO MEET IN ORDER TO QUALIFY FOR IRC §501(C)(3) STATUS. ONE OF THESE REQUIREMENTS IS KNOWN AS THE "CHARITY CARE STANDARD." UNDER THE STANDARD, A HOSPITAL HAD TO PROVIDE, TO THE EXTENT OF ITS FINANCIAL ABILITY, FREE OR REDUCED-COST CARE TO PATIENTS UNABLE TO PAY FOR IT. A HOSPITAL THAT EXPECTED FULL PAYMENT DID NOT, ACCORDING TO THE RULING, PROVIDE CHARITY CARE BASED ON THE FACT THAT SOME PATIENTS ULTIMATELY FAILED TO PAY. THE RULING EMPHASIZED THAT A LOW LEVEL 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

Part VI Supplemental Information

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SURROUNDING COMMUNITY'S LACK OF CHARITABLE DEMANDS.

COMMUNITY BENEFIT STANDARD

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

THE RULING INVOLVED A HOSPITAL THAT ONLY ADMITTED INDIVIDUALS WHO COULD 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

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

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

THE IRS CONCLUDED THAT THE HOSPITAL WAS "PROMOTING THE HEALTH OF A CLASS OF PERSONS THAT IS BROAD ENOUGH TO BENEFIT THE COMMUNITY" BECAUSE ITS 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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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INDEPENDENT CIVIC LEADERS; AND HOSPITAL MEDICAL STAFF PRIVILEGES WERE
AVAILABLE TO ALL QUALIFIED PHYSICIANS.

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

THE AMERICAN HOSPITAL ASSOCIATION ("AHA") BELIEVES THAT MEDICARE
UNDERPAYMENTS (SHORTFALL) AND BAD DEBT ARE COMMUNITY BENEFIT AND THUS
INCLUDABLE ON THE FORM 990, SCHEDULE H, PART I. THIS ORGANIZATION AGREES
WITH THE AHA POSITION. AS OUTLINED IN THE AHA LETTER TO THE IRS DATED
AUGUST 21, 2007 WITH RESPECT TO THE FIRST PUBLISHED DRAFT OF THE NEW FORM
990 AND SCHEDULE H, THE AHA FELT THAT THE IRS SHOULD INCORPORATE THE FULL
VALUE OF THE COMMUNITY BENEFIT THAT HOSPITALS PROVIDE BY COUNTING
MEDICARE UNDERPAYMENTS (SHORTFALL) AS QUANTIFIABLE COMMUNITY BENEFIT FOR
THE FOLLOWING REASONS:

- PROVIDING CARE FOR THE ELDERLY AND SERVING MEDICARE PATIENTS IS AN
ESSENTIAL PART OF THE COMMUNITY BENEFIT STANDARD.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- MEDICARE, LIKE MEDICAID, DOES NOT PAY THE FULL COST OF CARE. RECENTLY, MEDICARE REIMBURSES HOSPITALS ONLY 92 CENTS FOR EVERY DOLLAR THEY SPEND TO TAKE CARE OF MEDICARE PATIENTS. THE MEDICARE PAYMENT ADVISORY COMMISSION ("MEDPAC") IN ITS MARCH 2007 REPORT TO CONGRESS CAUTIONED THAT UNDERPAYMENT WILL GET EVEN WORSE, WITH MARGINS REACHING A 10-YEAR LOW AT NEGATIVE 5.4 PERCENT.

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

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

Part VI Supplemental Information

Provide the following information.

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

CONTINUE TREATING THE COMMUNITY'S ELDERLY AND POOR. THESE UNDERPAYMENTS REPRESENT A REAL COST OF SERVING THE COMMUNITY AND SHOULD COUNT AS A QUANTIFIABLE COMMUNITY BENEFIT.

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

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

Part VI Supplemental Information

Provide the following information.

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

- THE REPORT ALSO NOTED THAT A SUBSTANTIAL PORTION OF BAD DEBT IS PENDING CHARITY CARE. UNLIKE BAD DEBT IN OTHER INDUSTRIES, HOSPITAL BAD DEBT IS COMPLICATED BY THE FACT THAT HOSPITALS FOLLOW THEIR MISSION TO THE COMMUNITY AND TREAT EVERY PATIENT THAT COMES THROUGH THEIR EMERGENCY DEPARTMENT, REGARDLESS OF ABILITY TO PAY. PATIENTS WHO HAVE OUTSTANDING BILLS ARE NOT TURNED AWAY, UNLIKE OTHER INDUSTRIES. BAD DEBT IS FURTHER COMPLICATED BY THE AUDITING INDUSTRY'S STANDARDS ON REPORTING CHARITY CARE. MANY PATIENTS CANNOT OR DO NOT PROVIDE THE NECESSARY, EXTENSIVE DOCUMENTATION REQUIRED TO BE DEEMED CHARITY CARE BY AUDITORS. AS A RESULT, ROUGHLY 40% OF BAD DEBT IS PENDING CHARITY CARE.

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

AS OUTLINED BY THE AHA, DESPITE THE HOSPITALS' BEST EFFORTS AND DUE

Part VI Supplemental Information

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

DILIGENCE, PATIENT BAD DEBT IS A PART OF THE HOSPITAL'S MISSION AND CHARITABLE PURPOSES. BAD DEBT REPRESENTS PART OF THE BURDEN HOSPITALS SHOULDER IN SERVING ALL PATIENTS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. IN ADDITION, THE HOSPITAL INVESTS SIGNIFICANT RESOURCES IN SYSTEMS AND STAFF TRAINING TO ASSIST PATIENTS THAT ARE IN NEED OF FINANCIAL ASSISTANCE.

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

ATLANTICARE MANAGEMENT DEVELOPED POLICIES AND PROCEDURES FOR INTERNAL AND EXTERNAL COLLECTION PRACTICES THAT TAKE INTO ACCOUNT THE EXTENT TO WHICH THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, A PATIENT'S GOOD FAITH EFFORT TO APPLY FOR A GOVERNMENTAL PROGRAM OR FINANCIAL ASSISTANCE FROM ATLANTICARE AND A PATIENT'S GOOD FAITH EFFORT TO COMPLY WITH HIS OR HER PAYMENT AGREEMENTS.

BILLING & COLLECTION POLICY

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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THE BILLING AND COLLECTION POLICY IS ADMINISTERED IN ACCORDANCE WITH THE MISSION AND VALUES OF THE HOSPITAL AS WELL AS FEDERAL AND STATE LAW. THE POLICY IS DESIGNED TO PROMOTE APPROPRIATE ACCESS TO MEDICAL CARE FOR ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY WHILE MAINTAINING ATLANTICARE'S FISCAL RESPONSIBILITY TO MAXIMIZE REIMBURSEMENT AND MINIMIZE BAD DEBT.

THE ORGANIZATION'S BILLING AND COLLECTION POLICY IS INTENDED TO TAKE INTO ACCOUNT EACH INDIVIDUAL'S ABILITY TO CONTRIBUTE TO THE COST OF HIS OR HER CARE. THE ORGANIZATION MAKES SURE THAT PATIENTS ARE ASSISTED IN OBTAINING HEALTH INSURANCE COVERAGE FROM PRIVATELY AND PUBLICLY FUNDED SOURCES, WHENEVER POSSIBLE.

ALL BUSINESS OFFICE CUSTOMER SERVICE DEPARTMENT REPRESENTATIVES ARE EDUCATED ON ALL ASPECTS OF THE BILLING AND COLLECTION POLICY AND ARE EXPECTED TO ADMINISTER THE POLICY ON A REGULAR AND CONSISTENT BASIS. BUSINESS OFFICE CUSTOMER SERVICE REPRESENTATIVES ARE HELD ACCOUNTABLE TO

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TREAT ALL PATIENTS WITH COURTESY, RESPECT, CONFIDENTIALITY AND CULTURAL SENSITIVITY.

THE BILLING AND COLLECTION POLICY IS ADMINISTERED IN CONJUNCTION WITH THE PROCEDURES OUTLINED IN INTERNAL ADMINISTRATIVE POLICIES. THE CHIEF FINANCIAL OFFICER AND VICE PRESIDENT FINANCIAL PLANNING HAVE OVERALL RESPONSIBILITY FOR THE BILLING AND COLLECTION ACTIVITIES OF THE HOSPITAL. THE BUSINESS OFFICE CUSTOMER SERVICE DEPARTMENT STAFF IS RESPONSIBLE FOR THE DAY-TO-DAY ENFORCEMENT OF APPROVED POLICIES AND PROCEDURES.

ATLANTICARE MAY OFFER EXTENDED PAYMENT PLANS TO PATIENTS WHO ARE COOPERATING IN GOOD FAITH TO RESOLVE THEIR HOSPITAL BILLS.

EMERGENCY & MEDICALLY NECESSARY SERVICES

ATLANTICARE DOES NOT ENGAGE IN ANY ACTIONS THAT DISCOURAGE INDIVIDUALS FROM SEEKING EMERGENCY MEDICAL CARE. THE ORGANIZATION WILL NEVER DEMAND

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THAT AN EMERGENCY DEPARTMENT PATIENT PAY BEFORE RECEIVING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS. ADDITIONALLY, ATLANTICARE DOES NOT PERMIT DEBT COLLECTION ACTIVITIES IN THE EMERGENCY DEPARTMENT OR OTHER AREAS WHERE SUCH ACTIVITIES COULD INTERFERE WITH THE PROVISION OF EMERGENCY CARE ON A NONDISCRIMINATORY BASIS.

ALL MEDICALLY NECESSARY HOSPITAL SERVICES ARE PROVIDED WITHOUT CONSIDERATION OF ABILITY TO PAY AND ARE NOT DELAYED PENDING APPLICATION OR APPROVAL OF MEDICAL ASSISTANCE OR THE ATLANTICARE FINANCIAL ASSISTANCE PROGRAM. ADVANCE PAYMENT IS NOT REQUIRED FOR ANY MEDICALLY NECESSARY SERVICES.

COMPLIANCE WITH INTERNAL REVENUE CODE SECTION 501(R)(6)

ATLANTICARE DOES NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTIONS ("ECAS") AS DEFINED BY INTERNAL REVENUE CODE SECTION 501(R)(6) PRIOR TO THE EXPIRATION OF THE NOTIFICATION PERIOD. THE NOTIFICATION PERIOD IS

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DEFINED AS A 120-DAY PERIOD OR GREATER, WHICH BEGINS ON THE DATE OF THE
1ST POST-DISCHARGE BILLING STATEMENT, IN WHICH NO ECAS ARE INITIATED
AGAINST THE PATIENT.

SUBSEQUENT TO THE NOTIFICATION PERIOD ATLANTICARE, OR ANY THIRD PARTIES
ACTING ON ITS BEHALF, MAY INITIATE THE FOLLOWING ECAS AGAINST A PATIENT
FOR AN UNPAID BALANCE IF THE FINANCIAL ASSISTANCE ELIGIBILITY
DETERMINATION HAS NOT BEEN MADE OR IF AN INDIVIDUAL IS INELIGIBLE FOR
FINANCIAL ASSISTANCE. ATLANTICARE MAY AUTHORIZE THIRD PARTIES TO REPORT
ADVERSE INFORMATION ABOUT THE INDIVIDUAL TO CONSUMER CREDIT REPORTING
AGENCIES OR CREDIT BUREAUS ON DELINQUENT PATIENT ACCOUNTS AFTER THE
NOTIFICATION PERIOD.

THE ORGANIZATION ENSURES REASONABLE EFFORTS HAVE BEEN TAKEN TO DETERMINE
WHETHER AN INDIVIDUAL IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE
FINANCIAL ASSISTANCE POLICY AND ENSURES THE FOLLOWING ACTIONS ARE TAKEN
AT LEAST 30 DAYS PRIOR TO INITIATING ANY ECA:

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1) THE PATIENT IS PROVIDED WITH WRITTEN NOTICE WHICH:

- INDICATES THAT FINANCIAL ASSISTANCE IS AVAILABLE FOR ELIGIBLE PATIENTS;
- IDENTIFIES THE ECA(S) THAT ATLANTICARE INTENDS TO INITIATE TO OBTAIN PAYMENT FOR THE CARE; AND
- STATES A DEADLINE AFTER WHICH SUCH ECAS MAY BE INITIATED.

2) THE PATIENT IS PROVIDED WITH A COPY OF THE PLAIN LANGUAGE SUMMARY; AND

3) REASONABLE EFFORTS ARE MADE TO ORALLY NOTIFY THE PATIENT ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE AND HOW THE INDIVIDUAL MAY OBTAIN ASSISTANCE WITH THE FINANCIAL ASSISTANCE APPLICATION PROCESS.

ATLANTICARE ACCEPTS AND PROCESSES ALL APPLICATIONS FOR FINANCIAL ASSISTANCE SUBMITTED DURING THE APPLICATION PERIOD. THE APPLICATION PERIOD BEGINS ON THE DATE THE CARE IS PROVIDED AND ENDS ON THE 240TH DAY AFTER THE DATE OF THE FIRST POST-DISCHARGE BILLING STATEMENT.

Part VI Supplemental Information

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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SCHEDULE H, PART VI; QUESTION 2

IN ADDITION TO THE INTERNAL REVENUE CODE SECTION 501(R) COMMUNITY HEALTH NEEDS ASSESSMENT INFORMATION OUTLINED IN THE FORM 990, SCHEDULE H, PART V, SECTION B, AND ATLANTICARE REGIONAL MEDICAL CENTER PARTICIPATES IN A COUNTY WIDE COMMUNITY NEEDS ASSESSMENT IN CONJUNCTION WITH THE ATLANTIC COUNTY DIVISION OF PUBLIC HEALTH WHICH OCCURS ON A REGULARLY SCHEDULED BASIS. THIS DATA ALSO AIDS ATLANTICARE IN PREDICTING FUTURE HEALTH ISSUES AND BEHAVIORS THAT OUR PROVIDERS WILL NEED TO ADDRESS.

SCHEDULE H, PART VI; QUESTION 3

ATLANTICARE IS COMMITTED TO PROVIDING THE HIGHEST QUALITY HEALTHCARE SERVICES TO OUR COMMUNITY. ATLANTICARE IS COMMITTED TO A SERVICE EXCELLENCE PHILOSOPHY THAT STRIVES TO MEET OR EXCEED PATIENT EXPECTATIONS. ALL PATIENTS WILL RECEIVE A UNIFORM STANDARD OF CARE THROUGHOUT ALL ATLANTICARE FACILITIES, REGARDLESS OF SOCIAL, CULTURAL, FINANCIAL, RELIGIOUS, RACIAL, GENDER OR SEXUAL ORIENTATION FACTORS.

Part VI Supplemental Information

Provide the following information.

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

ATLANTICARE STRIVES TO ENSURE THAT ALL PATIENTS RECEIVE ESSENTIAL EMERGENCY AND OTHER MEDICALLY NECESSARY HEALTHCARE SERVICES REGARDLESS OF THEIR ABILITY TO PAY.

ATLANTICARE IS COMMITTED TO PROVIDING FINANCIAL ASSISTANCE TO PERSONS WHO HAVE HEALTHCARE NEEDS AND ARE UNINSURED, INELIGIBLE FOR GOVERNMENT ASSISTANCE, OR OTHERWISE UNABLE TO PAY, FOR MEDICALLY NECESSARY CARE BASED ON THEIR INDIVIDUAL FINANCIAL SITUATION. ALL PERSONS WHO PRESENT THEMSELVES FOR EMERGENCY OR OTHER MEDICALLY NECESSARY HEALTHCARE SERVICES ARE ADMITTED AND TREATED; THEY ARE REGISTERED AS PATIENTS OF THE HOSPITAL AND RECEIVE ANY NECESSARY SERVICES AS PRESCRIBED BY THE PATIENT'S PHYSICIAN. A PROSPECTIVE PATIENT OF ATLANTICARE IS NEVER DENIED NECESSARY HEALTHCARE SERVICES ON THE BASIS OF THEIR ABILITY TO PAY.

ATLANTICARE DOES ITS BEST TO EDUCATE AND INFORM PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE. FOR THE BENEFIT OF THE PATIENTS, THE FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION AND PLAIN LANGUAGE SUMMARY ARE ALL AVAILABLE ON-LINE. ADDITIONALLY, PAPER

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.

COPIES ARE AVAILABLE UPON REQUEST WITHOUT CHARGE BY MAIL AND ARE AVAILABLE THE HOSPITAL FACILITY REGISTRATION AREAS WHICH INCLUDE EMERGENCY ROOMS, ADMITTING AND REGISTRATION DEPARTMENTS, HOSPITAL BASED CLINICS AND PATIENT FINANCIAL SERVICES.

THE FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION AND PLAIN LANGUAGE SUMMARY ARE AVAILABLE IN ENGLISH AND IN THE PRIMARY LANGUAGE OF POPULATIONS WITH LIMITED PROFICIENCY IN ENGLISH ("LEP") THAT CONSTITUTES THE LESSER OF 1,000 INDIVIDUALS OR 5% OF THE ATLANTICARE'S PRIMARY SERVICE AREA.

SIGNS OR DISPLAYS ARE CONSPICUOUSLY POSTED IN PUBLIC HOSPITAL LOCATIONS INCLUDING THE EMERGENCY DEPARTMENT, ADMISSIONS DEPARTMENT AND REGISTRATION DEPARTMENT THAT NOTIFY AND INFORM PATIENTS ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE.

ATLANTICARE ALSO MAKES REASONABLE EFFORTS TO INFORM MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY 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.

FINANCIAL ASSISTANCE REFERRALS CAN BE MADE BY A MEMBER OF THE HOSPITAL STAFF OR MEDICAL STAFF, INCLUDING PHYSICIANS, NURSES, FINANCIAL COUNSELORS, SOCIAL WORKERS, CASE MANAGERS, CHAPLAINS AND RELIGIOUS SPONSORS.

ALL PATIENTS ARE OFFERED A COPY OF THE PLAIN LANGUAGE SUMMARY AS PART OF THE INTAKE OR DISCHARGE PROCESS. ADDITIONALLY, FINANCIAL COUNSELORS AND CUSTOMER SERVICE REPRESENTATIVES ARE AVAILABLE TO ASSIST PATIENTS WITH QUESTIONS CONCERNING CHARGES, PAYMENTS OR ANY OTHER CONCERNS.

SCHEDULE H, PART VI; QUESTION 4

ATLANTICARE REGIONAL MEDICAL CENTER PROVIDES URGENT AND EMERGENT HEALTHCARE SERVICES TO ALL INDIVIDUALS AND ALSO PROVIDES ELECTIVE PROCEDURES TO APPROXIMATELY 690,000 MEMBERS IN THE SOUTH JERSEY COMMUNITY IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, CREED, AGE, SEX, LIFESTYLE OR ABILITY TO PAY. THE PRIMARY SERVICE AREA IS

Part VI Supplemental Information

Provide the following information.

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

ATLANTIC COUNTY (32 ZIP CODES). THE SECONDARY SERVICE AREAS ARE COMPRISED
OF SOUTHERN SSA-CAPE MAY COUNTY AND NORTHERN SSA-SOUTHERN OCEAN COUNTY
(18 ZIP CODES).

SCHEDULE H, PART VI; QUESTION 5

ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS A TAX-EXEMPT
ORGANIZATION LOCATED IN ATLANTIC CITY, NEW JERSEY. AH SYSTEM IS THE SOLE
CORPORATE MEMBER OF VARIOUS HEALTHCARE RELATED ORGANIZATIONS, THE
MAJORITY OF WHICH ARE TAX-EXEMPT ENTITIES (COLLECTIVELY "ATLANTICARE").
PLEASE REFER TO FORM 990, SCHEDULE O, WHICH CONTAINS THE AH SYSTEM'S
COMMUNITY BENEFIT STATEMENT AND SUMMARY OF ALL ENTITIES WHICH COMPRISE
ATLANTICARE FOR FURTHER INFORMATION ON HOW THE ORGANIZATION'S HOSPITALS
AND OTHER HEALTHCARE FACILITIES FURTHER ATLANTICARE'S CHARITABLE
TAX-EXEMPT PURPOSES BY PROMOTING THE HEALTH OF THE COMMUNITY AND MEET THE
CRITERIA OUTLINED IN REVENUE RULING 69-545.

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART VI; QUESTION 6

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

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

ATLANTICARE HEALTH SYSTEM, INC.

ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS THE TAX-EXEMPT PARENT OF THE ATLANTICARE HEALTH SYSTEM, INC. AND AFFILIATES SYSTEM ("SYSTEM"). THIS INTEGRATED HEALTHCARE DELIVERY SYSTEM CONSISTS OF A GROUP OF AFFILIATED HEALTHCARE ORGANIZATIONS. THE SOLE MEMBER OR STOCKHOLDER OF

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

EACH ENTITY IS EITHER AH SYSTEM OR ANOTHER SYSTEM AFFILIATE CONTROLLED BY AH SYSTEM. SYSTEM IS AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS THROUGHOUT THE STATE OF NEW JERSEY. ATLANTICARE HEALTH SYSTEM, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3) AND AS A SUPPORTING ORGANIZATION PURSUANT TO INTERNAL REVENUE CODE §509(A)(3).

AH SYSTEM ENSURES THAT ITS SYSTEM PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OF ABILITY TO PAY. NO INDIVIDUALS ARE DENIED NECESSARY MEDICAL CARE, TREATMENT OR SERVICES. AH SYSTEM IS THE SOLE CORPORATE MEMBER OF ATLANTICARE REGIONAL MEDICAL CENTER ("AMRC"); A HOSPITAL PROVIDING COMPREHENSIVE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES. AMRC OPERATES CONSISTENTLY WITH THE FOLLOWING CRITERIA OUTLINED IN IRS REVENUE RULING 69-545:

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

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

AND MEDICAID PATIENTS;

2. OPERATES AN ACTIVE EMERGENCY DEPARTMENT FOR ALL PERSONS; WHICH IS OPEN

24 HOURS A DAY, 7 DAYS A WEEK, 365 DAYS PER YEAR;

3. MAINTAINS AN OPEN MEDICAL STAFF, WITH PRIVILEGES AVAILABLE TO ALL

QUALIFIED PHYSICIANS;

4. CONTROL OF IT RESTS WITH ITS BOARD OF TRUSTEES AND THE BOARD OF

TRUSTEES OF ATLANTICARE HEALTH SYSTEM, INC. BOTH BOARDS ARE COMPRISED OF

INDEPENDENT CIVIC LEADERS AND OTHER PROMINENT MEMBERS OF THE COMMUNITY;

AND

5. SURPLUS FUNDS ARE USED TO IMPROVE THE QUALITY OF PATIENT CARE, EXPAND

AND RENOVATE FACILITIES AND ADVANCE MEDICAL CARE; PROGRAMS AND

ACTIVITIES.

ATLANTICARE REGIONAL MEDICAL CENTER

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.
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- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ATLANTICARE REGIONAL MEDICAL CENTER ("AMC") IS COMPRISED OF TWO ACUTE CARE MEDICAL CENTERS, ONE LOCATED IN ATLANTIC CITY, NEW JERSEY AND ONE LOCATED IN POMONA, NEW JERSEY, WHICH HAVE A COMBINED 593-BEDS. AMC IS RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS AN INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION. PURSUANT TO ITS CHARITABLE PURPOSES, AMC 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, AMC OPERATES CONSISTENTLY WITH THE CRITERIA OUTLINED IN IRS REVENUE RULING 69-545.

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT CORPORATION

ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY NONPROFIT ORGANIZATION IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE CODE §509(A)(3).

Part VI Supplemental Information

Provide the following information.

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

ATLANTICARE BEHAVIORAL HEALTH, INC.

ATLANTICARE BEHAVIORAL HEALTH, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE CODE §509(A)(1). THE ORGANIZATION PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. ATLANTICARE BEHAVIORAL HEALTH, INC. MANAGES A 34-BED ACUTE CARE PSYCHIATRIC FACILITY LOCATED IN THE ARMC MAINLAND CAMPUS IN ATLANTIC COUNTY, NEW JERSEY AND OPERATES 26 LOCATIONS THROUGHOUT THE REGION. THE ORGANIZATION PROVIDES INPATIENT, PARTIAL HOSPITALIZATION, AND INTENSIVE OUTPATIENT PROGRAMS FOR ADULTS AND OLDER ADULTS DIAGNOSED WITH PSYCHIATRIC AND DUAL DISORDERS. ATLANTICARE BEHAVIORAL HEALTH, INC. IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION FOR HEALTHCARE ORGANIZATIONS.

ATLANTICARE FOUNDATION

Part VI Supplemental Information

Provide the following information.

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

ATLANTICARE FOUNDATION, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE CODE §509(A)(1). THROUGH FUNDRAISING ACTIVITIES THE ORGANIZATION SUPPORTS THE CHARITABLE PURPOSES, PROGRAMS AND SERVICES OF ATLANTICARE REGIONAL MEDICAL CENTER; A RELATED INTERNAL REVENUE CODE §501(C)(3) TAX-EXEMPT ORGANIZATION, THAT PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY.

ATLANTICARE HEALTH ENGAGEMENT, INC.

ATLANTICARE HEALTH ENGAGEMENT, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3). THE ORGANIZATION SUPPORTS AND DEPLOYS HEALTH STATUS IMPROVEMENT INITIATIVES AND STRATEGIES RELATED TO POPULATION HEALTH FOR THE COMMUNITY IT SERVES.

Part VI Supplemental Information

Provide the following information.

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

ATLANTICARE HEALTH SERVICES, INC.

ATLANTICARE HEALTH SERVICES, INC. IS AN ORGANIZATION RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO INTERNAL REVENUE CODE §501(C)(3) AND AS A NON-PRIVATE FOUNDATION PURSUANT TO INTERNAL REVENUE CODE §509(A)(2). THE ORGANIZATION IS PRIMARILY AN AMBULATORY CARE NETWORK THAT REACHES BEYOND ATLANTICARE REGIONAL MEDICAL CENTER TO ADDRESS THE HEALTH AND WELLNESS NEEDS FOR THE REGIONS RESIDENTS THROUGHOUT ALL STAGES OF LIFE.

ATLANTICARE PHYSICIAN GROUP, P.A.

ATLANTICARE PHYSICIAN GROUP, P.A. IS AN ORGANIZATION RECOGNIZED BY THE 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 SUPPORTS ATLANTICARE HEALTH SYSTEM; PRIMARILY ARMC, WHICH PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO

Part VI Supplemental Information

Provide the following information.

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

ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. IN ADDITION, THE ORGANIZATION PROVIDES SERVICES OUTSIDE OF THE HOSPITAL ATMOSPHERE TO SPECIALIZE IN PREVENTIVE CARE AND IN DIAGNOSING AND TREATING VARIOUS ILLNESSES.

JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION

JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT 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)(1). THE ORGANIZATION PROVIDES MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. THE ORGANIZATION PROVIDES INPATIENT AND OUTPATIENT REHABILITATION SERVICES FOR ALCOHOL AND SUBSTANCE USE DISORDERS. THE ORGANIZATION RECEIVES FUNDING PREDOMINANTLY FROM FEDERAL AND STATE GRANTS AND FROM PROGRAM SERVICE FEES AND CONTRACTS.

Part VI Supplemental Information

Provide the following information.

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

THE FOLLOWING ARE OTHER ATLANTICARE HEALTH SYSTEM, INC. ENTITIES:

ATLANTICARE ASSURANCE ALLIANCE, INC.

AN ENTITY WHOSE SOLE SHAREHOLDER IS AH SYSTEM. THE ORGANIZATION IS CURRENTLY INACTIVE.

ATLANTICARE HEALTH SOLUTIONS, INC.

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

ATLANTICARE SURGERY CENTER, L.L.C.

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP LOCATED IN EGG HARBOR TOWNSHIP, ATLANTIC COUNTY, NEW JERSEY. THIS ORGANIZATION ENGAGES IN HEALTHCARE SERVICES WHICH ARE HIGH QUALITY AND COST EFFECTIVE 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.
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- 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 PURPOSES OF

ATLANTICARE HEALTH SYSTEM.

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

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP MAJORITY OWNED BY

ATLANTICARE HEALTH SYSTEM, INC. THE ORGANIZATION SUPPORTS ATLANTICARE

HEALTH SYSTEM.

ENGLISH CREEK ASSURANCE, LTD.

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

ORGANIZATION WAS FORMED AND OPERATES SOLELY IN BERMUDA WITH NO U.S.

ACTIVITIES OR PRESENCE.

SOUTH JERSEY ONCOLOGY PROPERTIES, L.L.C.

A LIMITED LIABILITY COMPANY TAXED AS A PARTNERSHIP WITH A PERCENTAGE

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.

OWNED BY ATLANTICARE HEALTH SERVICES, INC. THE ORGANIZATION IS CURRENTLY
INACTIVE.

SCHEDULE H, PART III, SECTION B; QUESTION 7

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

**SCHEDULE I
(Form 990)**

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

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

Attach to Form 990.

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

Part I General Information on Grants and Assistance

- 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
- 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) ATLANTICARE FOUNDATION 2500 ENGLISH CREEK AVE	22-2148992	501(C)(3)	500,000.				PROGRAM SUPPORT
(2) ATLANTIC CITY ARTS FOUNDATION 126 SOUTH BELLVUE AVENUE	54-1295612	501(C)(3)	10,250.				PROGRAM SUPPORT
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

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

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

**Open to Public
Inspection**

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

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 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
1a		
1b		
2		
3		
4a	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4b	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4c	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5a	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5b	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6a	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6b	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9	<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				
LORI S. HERNDON	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
1 TRST-AHS PRES/CEO (TERM 6/30/23)	(ii)	517,136.	1,410,623.	1,353,651.	327,297.	24,859.	3,633,566.	NONE
MARILUISE VENDITTI, M	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
2 SVP & CMO (TERMED 7/31/23)	(ii)	346,766.	360,388.	340,627.	4,750.	11,076.	1,063,607.	6,974.
BLAIR A. BERGEN, M.D.	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
3 TRUSTEE (TERMED)	(ii)	487,798.	473,590.	30,560.	11,374.	33,637.	1,036,959.	NONE
HAK J. KIM	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
4 EVP & CFO/PRESIDENT AHN	(ii)	579,438.	170,547.	60,959.	67,035.	46,814.	924,793.	NONE
MICHAEL J. CHARLTON	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
5 TRST-AHS PRES/CEO (EFF 6/1/23)	(ii)	549,129.	NONE	5,353.	217,447.	19,705.	791,634.	NONE
ALVARO F. GALVEZ-LIMA,	(i)	435,939.	313,090.	473.	9,753.	18,175.	777,430.	NONE
6 PHYSICIAN	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
MOHAMMADYASER MOURAD,	(i)	437,340.	93,695.	107,586.	72,631.	46,687.	757,939.	79,266.
7 CHIEF MEDICAL QUALITY OFFICER	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DONNA MICHAEL-ZIEREIS,	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
8 EVP ADMIN/CLO/COS & SECRETARY	(ii)	432,364.	105,050.	35,545.	52,005.	50,852.	675,816.	NONE
RICHARD ZALMAN, M.D.	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
9 EXECUTIVE MEDICAL DIRECTOR	(ii)	518,152.	92,650.	4,356.	12,534.	34,184.	661,876.	NONE
CATHERINE DILLANE, M.D	(i)	477,266.	99,001.	23,028.	9,716.	4,523.	613,534.	NONE
10 PHYSICIAN	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JAVID IQBAL, M.D.	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
11 TRUSTEE; EX-OFFICIO	(ii)	320,999.	202,490.	24,657.	9,115.	41,082.	598,343.	NONE
LARISA K. GOGANZER	(i)	379,688.	76,000.	53,230.	42,798.	44,887.	596,603.	NONE
12 SVP & CHIEF HOSPITAL EXECUTIVE	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DENNIS LENNON	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
13 VP & CHIEF PEOPLE OFFICER	(ii)	424,838.	30,022.	31,895.	69,136.	40,447.	596,338.	NONE
CHRISTOPHER A. SCANZER	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
14 SVP & CHIEF DIGITAL & INFO OFF	(ii)	369,253.	72,088.	34,663.	62,861.	31,302.	570,167.	NONE
BENJAMIN J. NEGLEY	(i)	344,697.	65,143.	50,601.	63,008.	43,959.	567,408.	NONE
15 VP & COO AHN	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KATHERINE BIRKENSTOCK	(i)	299,557.	82,635.	134,438.	5,246.	33,868.	555,744.	4,824.
16 VP NURSING/CNO (TERM 11/25/23)	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE

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				
1 GABRIELA ANDRIES, M.D. PHYSICIAN	(i)	477,500.	37,978.	23,094.	9,716.	3,716.	552,004.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
2 FRANK R. CARPENTER SVP, CHIEF ADMIN INT. OFF.	(i)	323,323.	82,915.	47,959.	42,474.	9,653.	506,324.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
3 JAMES KILMER VP CHIEF ADMIN OFF. CITY	(i)	279,328.	65,750.	83,904.	36,481.	38,531.	503,994.	25,000.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
4 VINEET MEGHRAJANI, M.D. PHYSICIAN	(i)	458,214.	14,234.	487.	8,081.	17,261.	498,277.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
5 DEBRA A. FOX VP CHIEF TRANSFORMATION OFF.	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	274,787.	67,915.	45,797.	35,667.	22,049.	446,215.	NONE
6 BARBARA YOUNG VP & CHIEF SUPPLY CHAIN OFF.	(i)	214,484.	48,360.	74,637.	30,379.	22,826.	390,686.	19,167.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
7 SAMANTHA A. KILEY VP COMM HEALTH & SOCIAL IMPACT	(i)	222,170.	23,676.	3,567.	30,114.	12,275.	291,802.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
8 ROBERT L. SZAPOR AVP BEHAVIORAL HEALTH	(i)	166,339.	22,760.	207.	4,198.	23,742.	217,246.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
9 MONIKA FINNEGAN SR. DIRECTOR & CONTROLLER ABH	(i)	176,040.	17,009.	1,691.	7,166.	3,051.	204,957.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
10 CHRISTOPHER C. APGAR FORMER OFFICER	(i)	132,419.	4,070.	259.	4,162.	1,784.	142,694.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

PART VII AND SCHEDULE J

IN ACCORDANCE WITH INTERNAL REVENUE SERVICE FORM 990 RULES, REGULATIONS AND INSTRUCTIONS, THE TAXABLE COMPENSATION REPORTED IN CORE FORM, PART VII AND SCHEDULE J, PART II OF THIS FORM 990 IS DERIVED FROM 2023 FORMS W-2 AND FORMS 1099 (IF APPLICABLE).

SCHEDULE J, PART I; QUESTION 4A

THE FOLLOWING INDIVIDUAL RECEIVED A SEPARATION OF EMPLOYMENT PAYMENT DURING CALENDAR YEAR 2023 WHICH WAS INCLUDED HER 2023 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: LORI S. HERNDON, \$1,096,133.

THE FOLLOWING INDIVIDUALS RECEIVED A SEVERANCE PAYMENT DURING CALENDAR YEAR 2023 WHICH WAS INCLUDED IN EACH INDIVIDUAL'S 2023 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: MARILOUISE VENDITTI, M.D., \$217,178 AND KATHERINE BIRKENSTOCK, \$24,574.

Part III Supplemental Information

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

SCHEDULE J, PART I; QUESTION 4B

THE AMOUNT REFLECTED IN COLUMN B(III) FOR THE FOLLOWING INDIVIDUALS INCLUDES VESTED BENEFITS IN AN INTERNAL REVENUE CODE SECTION 457(F) PLAN (NON-QUALIFIED DEFERRED COMPENSATION PLAN) WHICH ARE NO LONGER SUBJECT TO A SUBSTANTIAL RISK OF COMPLETE FORFEITURE. THE AMOUNTS OUTLINED HEREIN WERE INCLUDED IN EACH INDIVIDUAL'S 2023 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: MARILUISE VENDITTI, M.D., \$6,974; MOHAMMADYASER MOURAD; \$79,266; KATHERINE BIRKENSTOCK, \$4,824; JAMES KILMER, \$31,265 AND BARBARA YOUNG, \$22,636.

THE DEFERRED COMPENSATION AMOUNT IN COLUMN (C) FOR THE FOLLOWING INDIVIDUALS INCLUDES 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, THE INDIVIDUALS MAY NEVER ACTUALLY RECEIVE THIS UNVESTED BENEFIT AMOUNT. THE AMOUNTS OUTLINED HEREIN WERE NOT INCLUDED IN EACH INDIVIDUAL'S 2023 FORM W-2, BOX 5, AS TAXABLE MEDICARE WAGES: LORI S. HERNDON, \$321,421; HAK J.

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.

KIM, \$54,167; MICHAEL J. CHARLTON, \$210,000; MOHAMMADYASER MOURAD, M.D.,
\$65,800; DONNA MICHAEL-ZIEREIS, ESQ., \$39,250; LARISA K. GOGANZER,
\$34,500; DENNIS LENNON, \$60,900; CHRISTOPHER A. SCANZERA, \$54,600;
BENJAMIN J. NEGLEY, \$53,480; FRANK R. CARPENTER, \$33,333; JAMES KILMER,
\$26,500; DEBRA A. FOX, \$25,833; BARBARA YOUNG, \$21,250 AND SAMANTHA
KILEY, \$20,833.

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, BOX 5, AS TAXABLE MEDICARE
WAGES. PLEASE REFER TO THIS SECTION OF THE FORM 990, SCHEDULE J FOR THIS
INFORMATION BY PERSON BY AMOUNT.

Part III Supplemental Information

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

SCHEDULE J, PART II, COLUMN F

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

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds
Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions,
explanations, and any additional information in Part VI.
Attach to Form 990.

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Employer identification number

90-0779828

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A NJ HEALTH CARE FACILITIES FINANCING AUTHORITY	22-1987084	645790PE0	09/15/2021	216,995,000.	LOAN REFI, CONSTR PROJECT COSTS		X		X		X
B TD BANK N.A		CT1694464	09/15/2023	61,705,000.	LOAN REFI, CONST PROJECT COSTS		X		X		X
C											
D											

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired								
2 Amount of bonds legally defeased								
3 Total proceeds of issue	213,055,000.		61,705,000.					
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds	1,655,757.		414,774.					
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds								
12 Other unspent proceeds								
13 Year of substantial completion	2021		2023					
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X				
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X				
16 Has the final allocation of proceeds been made?	X		X					
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

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

Schedule K (Form 990) 2023

Part III Private Business Use

TAX-EXEMPT BONDS

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?	X		X					
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	NONE %		NONE %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government	NONE %		NONE %					
6 Total of lines 4 and 5	NONE %		NONE %					
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	NONE %		NONE %					
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?	X		X					
b Exception to rebate?	X		X					
c No rebate due?		X		X				
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X				

Part IV Arbitrage (continued)

TAX-EXEMPT BONDS

Table with 9 columns: Question, A (Yes/No), B (Yes/No), C (Yes/No), D (Yes/No). Rows include questions about qualified hedge, provider name, term of hedge, superintegrated status, terminated status, GIC investment, and regulatory safe harbor.

Part V Procedures To Undertake Corrective Action

Table with 9 columns: Question, A (Yes/No), B (Yes/No), C (Yes/No), D (Yes/No). Row: Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions.

Lined area for providing supplemental information for responses to questions on Schedule K.

**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 for instructions and the latest information.

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Inspection**

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

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)													
Total							\$						

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) NATASHA E. POSTAL	FAMILY MEMBER OF TRUSTEE	54,607.	ARMC EMPLOYEE		X
(2) IVENNY D. LOPEZ	FAMILY MEMBER OF TRUSTEE	44,992.	AH SERVICES EMPLOYEE		X
(3) ATLANTIC EMERGENCY ASSOC, PA	COMPANY - TRUSTEE	139,694.	MEDICAL SERVICES		X
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

SCHEDULE L, PART IV

THOMAS BRABSON, M.D. SERVED AS A TRUSTEE OF ATLANTICARE REGIONAL MEDICAL CENTER. ATLANTICARE REGIONAL MEDICAL CENTER UTILIZED THE SERVICES OF HIS COMPANY, ATLANTIC EMERGENCY ASSOCIATES, PA, DURING 2023. TOTAL FEES PAID BY ATLANTICARE REGIONAL MEDICAL CENTER TO ATLANTIC EMERGENCY ASSOCIATES, PA AMOUNTED TO \$139,694 IN 2023. SERVICES WERE RENDERED AT FAIR MARKET VALUE RATES PURSUANT TO ARM'S LENGTH NEGOTIATIONS.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

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.

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CORE FORM, PART I; SUMMARY

THE TOTAL VOTING AND INDEPENDENT VOTING MEMBERS DISCLOSED ON PAGE 1 OF THIS FORM 990 IS THE TOTAL FOR ALL ORGANIZATIONS INCLUDED IN THE GROUP EXEMPTION RULING AND IN THIS CONSOLIDATED GROUP FORM 990. OUTLINED BELOW IS THE VOTING AND INDEPENDENT VOTING DISCLOSURE INFORMATION FOR ALL ORGANIZATIONS INCLUDED IN THE GROUP EXEMPTION:

- ATLANTICARE BEHAVIORAL HEALTH, INC.; 15 VOTING, 11 INDEPENDENT;
- ATLANTICARE FOUNDATION; 20 VOTING, 17 INDEPENDENT;
- ATLANTICARE HEALTH ENGAGEMENT; 15 VOTING, 11 INDEPENDENT;
- ATLANTICARE HEALTH SERVICES, INC.; 15 VOTING, 11 INDEPENDENT;
- ATLANTICARE REGIONAL HEALTH SERVICES A NEW JERSEY NONPROFIT CORPORATION; 15 VOTING, 11 INDEPENDENT;
- ATLANTICARE REGIONAL MEDICAL CENTER; 15 VOTING, 11 INDEPENDENT;
- JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION; 15 VOTING, 11 INDEPENDENT.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

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

Department of the Treasury
Internal Revenue Service

Name of the organization

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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

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ATLANTICARE HEALTH SYSTEM, INC.

FEID: 22-3265213

ATLANTICARE HEALTH SYSTEM, INC. ("SYSTEM") IS A TAX-EXEMPT ORGANIZATION LOCATED IN ATLANTIC CITY, NEW JERSEY. THE SYSTEM IS THE SOLE CORPORATE MEMBER OF VARIOUS HEALTHCARE RELATED ORGANIZATIONS, THE MAJORITY OF WHICH ARE TAX-EXEMPT ENTITIES (COLLECTIVELY "ATLANTICARE"). THE SYSTEM PROVIDES LEADERSHIP, MANAGERIAL AND SUPPORT SERVICES TO A NUMBER OF AFFILIATED HEALTHCARE RELATED ORGANIZATIONS. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED THE SYSTEM AS BEING A TAX-EXEMPT ORGANIZATION UNDER INTERNAL REVENUE CODE ("IRC") CODE §501(C)(3).

SYSTEM AND AFFILIATES ("ATLANTICARE") ARE PART OF AN INTEGRATED HEALTHCARE DELIVERY SYSTEM DEDICATED TO TRANSFORMING HEALTHCARE AT THE REGIONAL LEVEL BY PROVIDING HIGH QUALITY HEALTH AND WELLNESS SERVICES. ATLANTICARE INCLUDES THE SYSTEM, ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC" AND FORMERLY THE ATLANTIC CITY MEDICAL CENTER), ATLANTICARE BEHAVIORAL HEALTH ("ABH"), ATLANTICARE FOUNDATION ("FOUNDATION"), ATLANTICARE HEALTH SERVICES ("SERVICES"), ATLANTICARE HEALTH SOLUTIONS ("HEALTH SOLUTIONS") AND ATLANTICARE HEALTH ENGAGEMENT ("ENGAGEMENT"). ADDITIONALLY, OTHER ATLANTICARE ENTITIES PARTICIPATE IN OTHER HEALTHCARE RELATED ACTIVITIES IN COLLABORATION WITH OTHER MEMBERS OF THE COMMUNITY.

THE REGION'S LARGEST HEALTHCARE ORGANIZATION AND LARGEST NON-CASINO EMPLOYER, ATLANTICARE'S NEARLY 6,000 EMPLOYEES SERVE THE COMMUNITY IN

**SCHEDULE O
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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

MORE THAN 100 LOCATIONS. ATLANTICARE AND ITS AFFILIATED ORGANIZATIONS ARE
GOVERNED BY MORE THAN 50 VOLUNTEER COMMUNITY LEADERS WHO DEDICATE
CONSIDERABLE TIME AND ENERGY TOWARD THE ULTIMATE ACHIEVEMENT OF
ATLANTICARE'S MISSION, VISION AND VALUES:

MISSION STATEMENT

=====

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

VISION

=====

ATLANTICARE BUILDS HEALTHY COMMUNITIES TOGETHER.

VALUES

=====

ATLANTICARE STRESSES THE FOLLOWING VALUES:

INTEGRITY

=====

OUR BEHAVIORS CONSISTENTLY REFLECT THE HIGHEST ETHICAL STANDARDS.

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

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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

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RESPECT

=====

WE TREAT EACH OTHER WITH KINDNESS, DIGNITY AND COMPASSION.

SAFETY

=====

SAFETY OF PATIENTS AND STAFF IS OUR TOP PRIORITY.

SERVICE

=====

SERVICE IS DEFINED AND MEASURED BY OUR CUSTOMERS. ATLANTICARE STRIVES TO
DELIVER EXCELLENCE IN EVERY INTERACTION.

TEAMWORK

=====

WE WORK TOGETHER TO ACHIEVE OUR GOALS.

INCLUSION

=====

**SCHEDULE O
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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

WE CREATE A SENSE OF BELONGING BY EMBRACING THE DIVERSITY OF OUR
ATLANTICARE FAMILY AND COMMUNITY.

CHARITABLE PURPOSE

=====

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

ATLANTICARE REGIONAL MEDICAL CENTER ("ARMC") IS ONE OF TWO "SAFETY NET"
HOSPITALS IN SOUTHERN NEW JERSEY PROVIDING APPROXIMATELY \$22.0 MILLION IN
CHARITY CARE, AT COST, WHICH REPRESENTS APPROXIMATELY 90% OF THE CHARITY
CARE PROVIDED IN ATLANTIC COUNTY. WITHIN THE REGION, ATLANTICARE PROVIDES
MORE CHARITY CARE THAN THE 7 CLOSEST HOSPITALS COMBINED. TO FURTHER
ENSURE THAT OUR COMMUNITY'S HEALTHCARE NEEDS ARE MEET, ATLANTICARE ALSO
PROVIDES FREE CARE TO PATIENTS THAT DO NOT MEET THE STATE ELIGIBILITY
REQUIREMENTS FOR CHARITY CARE DESIGNATION OR WHO ARE NOT COMPLIANT IN
PURSUING ELIGIBILITY STATUS.

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WHILE THE ABOVE STATISTICS ALONE DIFFERENTIATE ATLANTICARE'S COMMITMENT TO THE COMMUNITY IT SERVES, IT RECOGNIZES THAT HEALTH AND THE ASSURANCE OF GOOD HEALTH ARE TRULY CULTIVATED BEYOND THE WALLS OF ITS CLINICAL SETTINGS. AS SUCH, ATLANTICARE HAS ESTABLISHED ITSELF WITHIN ITS SERVICE AREA AS A COLLABORATOR AND PARTNER TO AGENCIES AND SERVICES THAT IMPROVE THE QUALITY OF LIFE FOR OUR AREA RESIDENTS. ATLANTICARE SPONSORS MANY CHARITABLE AGENCIES AND THEIR PROGRAMS, WHICH PROVIDE SUBSTANTIAL BENEFIT AND CLOSE EVIDENT SERVICE GAPS. THESE PROGRAMS INCLUDE SERVICES FOR OLDER ADULTS, COMMUNITY OUTREACH PROGRAMS FOR AT-RISK POPULATIONS, SUPPORT INITIATIVES FOR THE CONTINUED HEALING OF PATIENTS AND THEIR CAREGIVERS POST DISCHARGE, IN ADDITION TO HEALTH PROMOTION AND DISEASE PREVENTION CAMPAIGNS TO IMPROVE OVERALL HEALTH AND WELL-BEING. EXAMPLES INCLUDE ATLANTICARE'S SUPPORT OF THE AMERICAN HEART ASSOCIATION, BOYS AND GIRLS CLUB OF ATLANTIC CITY, JEWISH FAMILY SERVICES OF ATLANTIC AND CAPE MAY COUNTY, RUTH NEWMAN SHAPIRO HEART & CANCER MEMORIAL FUND, SHIRLEY MAE BREAST CANCER ASSISTANCE FUND, GILDA'S CLUB OF SOUTH JERSEY, MARCH OF DIMES, AND THE RED CROSS.

ATLANTICARE HOSTS AND SUPPORTS VARIOUS PROFESSIONAL AND HIGHER EDUCATIONAL PROGRAMS AND STRONGLY BELIEVES IN INVESTING IN THE INDIVIDUALS WHO ONE DAY WILL BECOME HEALTHCARE PROFESSIONALS. EMPLOYEES PARTICIPATE IN JOB SHADOW DAYS AND CONDUCT CAREER PRESENTATIONS AND SKILLS FAIRS AT LOCAL SCHOOLS. IN ADDITION, ATLANTICARE OFFERS SCHOLARSHIPS AND OTHER FORMS OF SUPPORT TO LOCAL STUDENTS WHO WISH TO

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PURSUE NURSING AND ALLIED HEALTH DEGREES AND SPONSORS TECHNICAL HONOR SOCIETIES. IN TOTAL, ANNUALLY A MINIMUM OF 18 SCHOLARSHIPS WERE AWARDED.

ATLANTICARE OFFERS A BROAD ARRAY OF MONTHLY COMMUNITY EVENTS, LECTURES, AND/OR DEMONSTRATIONS TO THE COMMUNITY VIA IN-PERSON OR VIRTUAL PLATFORMS. IT PROMOTES THEM THROUGH TRADITIONAL NEWS MEDIA, SOCIAL MEDIA, THE ATLANTICARE WEBSITE, WORD OF MOUTH, AND COMMUNITY NETWORKING.

EXAMPLES OF EVENTS INCLUDE:

- DIABETES, BREAST CANCER, AND STROKE SUPPORT GROUPS
- WEIGHT LOSS SURGERY SEMINARS & SUPPORT GROUPS
- FIRST AID AND CPR COURSES
- HEALTHY BABY CLASSES INCLUDING CHILDBIRTH AND BREASTFEEDING CLASSES
- HEALTHY COOKING DEMONSTRATIONS
- SENIOR UNIVERSITY, AN EDUCATIONAL LECTURE SERIES FOR OLDER ADULTS
- MATTER OF BALANCE FALL PREVENTION SERIES
- FAMILY CLASSES AND EVENTS RANGING FROM RESUME-WRITING ASSISTANCE TO ENGAGEMENT ACTIVITIES

ATLANTICARE BRINGS HEALTH AND WELLNESS SERVICES TO THE COMMUNITY THROUGH RISK-BASED SCREENINGS (E.G., BLOOD PRESSURE, BODY MASS INDEX, AND CHOLESTEROL). SPECIALLY TRAINED NURSES AND HEALTH CARE PROFESSIONALS PROVIDE HEALTH ASSESSMENTS IN AN EFFORT TO DETECT HEALTH CONDITIONS EARLY WHEN THEY ARE EASIER TO TREAT, EDUCATE PARTICIPANTS ABOUT HEALTHY LIFESTYLE BEHAVIORS, AND TO REFER INDIVIDUALS TO NEEDED PROGRAMS AND

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SUPPORT SERVICES. ADDITIONALLY, ITS REPRESENTATIVES ADDRESS SENIOR CENTERS, FAITH-BASED ORGANIZATIONS, MUNICIPALITIES, AND OTHER COMMUNITY ORGANIZATIONS/AGENCIES UPON REQUEST.

ATLANTICARE OPERATES FOUR SIGNATURE COMMUNITY PROGRAMS WHOSE SOLE FOCUS IS TO IMPROVE THE HEALTH AND WELL-BEING OF OUR COMMUNITY. THESE INNOVATIVE PROGRAMS ARE HEALTHY SCHOOLS, HEALTHY CHILDREN, HEALING ARTS, AND OUR MOBILE MARKET. ALL OF ATLANTICARE'S SIGNATURE COMMUNITY PROGRAMS ALLOW US TO SERVE DISTINCT AUDIENCES: CHILDREN AND THEIR CARETAKERS, THOSE WITH LIMITED ACCESS TO HEALTHY FOODS, AND THOSE SEEKING RESPITE AND HEALING.

HEALTHY SCHOOLS, HEALTHY CHILDREN PARTNERS WITH MORE THAN 110 SCHOOLS IN A VARIETY OF DIFFERENT MODALITIES TO TEACH CHILDREN, PARENTS, AND STAFF ABOUT THE IMPORTANCE OF HEALTHY EATING, PHYSICAL ACTIVITY, AND MENTAL WELLBEING. SIGNATURE COMPONENTS OF THIS PROGRAM ARE THE SCHOOL NURSE LECTURE SERIES AND PROFESSIONAL DEVELOPMENT WORKSHOPS THAT PROVIDE EDUCATION AND RESOURCES TO SCHOOL PERSONNEL. IN RECENT YEARS, WE WORKED TO EXPAND OUR OFFERINGS TO ADDRESS THE RESILIENCY NEEDS OF CHILDREN AS WELL. IN 2023, ATLANTICARE DISTRIBUTED OVER \$65,000 IN GRANTS TO LOCAL SCHOOLS.

ATLANTICARE IS ALSO PROUD TO HOST TWO FOOD PANTRIES ONSITE AT THEIR FACILITIES. ONE IS LOCATED AT THE HEALTHPLEX IN ATLANTIC CITY. THE OTHER IS LOCATED AT THE HAMMONTON SUCCESS CENTER. THE PANTRIES ADDRESS FOOD

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INSECURITY WHILE PROMOTING HEALTHFUL FOOD CHOICES. COLLECTIVELY THE PANTRIES SERVE OVER 300 FAMILIES EACH MONTH. ATLANTICARE ALSO OFFERS A SUMMER MEALS PROGRAM, TO PROVIDE A HEALTHY LUNCHESES AND HEALTH EDUCATION TO MORE THAN 200 CHILDREN AND THEIR FAMILIES DURING THE SUMMER WHEN SCHOOL LUNCHESES ARE NOT AVAILABLE. WE RECENTLY ALSO LAUNCHED A MOBILE MARKET TO FURTHER EXPAND OUR EFFORTS TO IMPROVE ACCESS TO HEALTHY FOODS. OUR MARKET OFFERS REDUCED GROCERY ITEMS TO COMMUNITIES WITH VERY LIMITED ACCESS.

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

HEALING ARTS IS A UNIQUE INITIATIVE DESIGNED TO SHOWCASE LOCAL, ORIGINAL ARTWORK THROUGHOUT OUR FACILITIES. BY INTEGRATING THE ARTS WITHIN AND NEAR OUR FACILITIES, WE VISIBLY DEMONSTRATE OUR INTENT TO CREATE A HEALING PRESENCE IN OUR COMMUNITY. BEYOND ART ON WALLS, ATLANTICARE'S HEALING ARTS INITIATIVE ALSO CELEBRATED AND EXTENDED THERAPEUTIC ART SERVICES TO OUR FRONT-LINE RESPONDERS. COLLECTIVELY, THESE OFFERINGS CONTINUE TO ENSURE THAT OUR HEALING SPACES ARE SERENE AND CALMING FOR BOTH OUR STAFF AND OUR PATIENTS.

ATLANTICARE EMBRACES ITS STRATEGIC COMMITMENT TO DIVERSITY AND INCLUSION. WE HAVE POSITIONED INCLUSION AS A STRATEGIC BUSINESS PRIORITY THAT ALIGNS WITH OUR OVERALL VISION, MISSION AND VALUES. AT THE HEART OF OUR DIVERSITY AND INCLUSION EFFORTS, ARE OUR DEDICATED AND ENGAGED EMPLOYEE RESOURCE GROUPS ("ERGS"). THESE GROUPS OF PHYSICIANS AND STAFF HELP US WITH CULTURAL AND COMMUNITY AWARENESS ACTIVITIES, EDUCATION, AND

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COMMUNITY OUTREACH, THUS IMPACTING EMPLOYEE ENGAGEMENT, CUSTOMER EXPERIENCES, AND COMMUNITY CONNECTIVITY. THE GROUPS ARE FORMED AROUND COMMON INTERESTS BUT ARE OPEN TO ALL EMPLOYEES. THE GROUPS CONTINUE TO EXPERIENCE MEMBERSHIP GROWTH. IN TOTAL THERE ARE 11 GROUPS WHICH INCLUDE AFRICAN AMERICAN ("LEGACY"), ASIAN-PACIFIC ("APEG"), DISABILITIES ("CAARE"), INTERFAITH ("PATHS"), LATINO ("ALMA"), LGBTQ ("PRIDE"), MILITARY ("HONORS"), FITNESS AND WELLBEING, RECOVERY, AND WOMEN ("LEADS") AMONG OTHERS.

OUR ERGS ARE ABLE TO PROVIDE FINANCIAL AND IN-KIND SUPPORT TO COMMUNITY PROGRAMS AND ORGANIZATIONS. ADDITIONALLY, THEY SUPPORTED VARIOUS COMMUNITY ORGANIZATIONS THROUGH PARTICIPATION IN WALKS, HEALTH AND CAREER FAIRS, AS WELL AS OTHER IN-KIND DONATIONS. THEY ALSO PROVIDE SCHOLARSHIP OPPORTUNITIES TO THOSE PURSING HEALTHCARE CAREERS.

AS THE LARGEST NON-CASINO EMPLOYER IN THE REGION, ATLANTICARE PROVIDES A SIGNIFICANT POSITIVE ECONOMIC CONTRIBUTION TO THE COMMUNITY. ATLANTICARE DIRECTLY IMPACTS THE COMMUNITY IN A POSITIVE MANNER BY VIRTUE OF EMPLOYING NEARLY 6,500 AREA RESIDENTS. ATLANTICARE SUPPORTS THE LOCAL BUSINESS COMMUNITY BY PURCHASING GOODS AND SERVICES FROM MANY LOCAL AREA BUSINESSES AS WELL AS PARTICIPATING IN COMMUNITY-BASED ORGANIZATIONS AS VOLUNTEERS OR BOARD MEMBERS. LEVERAGING OUR ANCHOR INSTITUTION STATUS, WE CONTINUE TO FIND WAYS TO DEEPLY ROOT OURSELVES INTO THE COMMUNITY.

ATLANTICARE REGIONAL MEDICAL CENTER

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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

FEID: 21-0634549

BACKGROUND

=====

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

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

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

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

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

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AND

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

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

ARMC'S CITY CAMPUS IS LOCATED IN ATLANTIC CITY WHERE THE HOSPITAL WAS FOUNDED AND IS A BUSY METROPOLITAN HOSPITAL SERVING A GROWING RESIDENT POPULATION AND MORE THAN 27 MILLION VISITORS EACH YEAR. ARMC'S MAINLAND CAMPUS, WHICH OPENED IN 1975, IS LOCATED IN GALLOWAY, NEW JERSEY. ARMC ALSO HAS A SATELLITE EMERGENCY DEPARTMENT IN HAMMONTON, NJ. ARMC OFFERS A NUMBER OF OUTPATIENT SERVICES SPREAD OUT OVER 100 LOCATIONS. ONE OF THESE LOCATIONS, THE WILLIAM L. GORMLEY ATLANTICARE HEALTHPLEX AND THE NEWLY OPENED MEDICAL ARTS PAVILION BOTH LOCATED IN ATLANTIC CITY, OFFER SERVICES REGARDLESS OF THE ABILITY TO PAY AND IS HOME TO ONE OF ATLANTICARE'S FEDERALLY QUALIFIED HEALTH CENTER LOCATIONS. IT HAS A SATELLITE OPERATION IN GALLOWAY.

ARMC IS A TEACHING HOSPITAL. IN 2023 IT PROVIDED TRAINING FOR MORE THAN

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120 MEDICAL AND PHARMACY RESIDENTS, STUDENTS AND FELLOWS.

ATLANTICARE ALSO ANNUALLY HOSTS CONFERENCES AND OTHER EDUCATIONAL EVENTS.

WHILE MANY OF OUR EDUCATIONAL OFFERINGS WERE UNABLE TO BE HELD IN PERSON
THIS YEAR, AS A RESULT OF THE PANDEMIC. ATLANTICARE STILL CONTINUED TO BE
A SOURCE OF MEDICAL EDUCATION TO OUR COMMUNITY VIA VIRTUAL EDUCATION
OPPORTUNITIES.

ARMC IS HOME TO MANY CENTERS OF EXCELLENCE AND SPECIALIZED SERVICES,
SEVERAL OF WHICH ARE EXCLUSIVE TO THE REGION.

- LEVEL II REGIONAL TRAUMA CENTER
- JOINT COMMISSION-DESIGNATED COMPREHENSIVE STROKE CENTER
- HEART AND VASCULAR INSTITUTE - THE REGION'S ONLY FULL-SERVICE CARDIAC
SURGERY PROGRAM
- THE MUSCULOSKELETAL INSTITUTE
- STANLEY M. GROSSMAN PEDIATRIC CENTER
- THE CANCER CARE INSTITUTE
- CENTER FOR SURGICAL WEIGHT LOSS AND WELLNESS
- ROGER B. HANSEN CENTER FOR CHILDBIRTH, INCLUDING LEVEL III NEONATAL
INTENSIVE CARE UNIT
- MATERNAL FETAL MEDICINE PROGRAM
- FAMILY PLANNING CLINIC
- PSYCHIATRIC UNIT AND CRISIS INTERVENTION PROGRAM
- NEUROSCIENCES INSTITUTE

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- WOUND HEALING CENTER

ARMC IS PROUD OF ITS AFFILIATIONS WITH RENOWNED HEALTHCARE ORGANIZATIONS
INCLUDING BUT NOT LIMITED TO ROTHMAN INSTITUTE; GLOBAL NEUROSCIENCES
INSTITUTE; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; AND CLEVELAND CLINIC

MISSION, VISION AND VALUES

=====

MISSION STATEMENT

=====

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

VISION

=====

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

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CHARITABLE PURPOSE

=====

ARMC PROVIDES URGENT AND EMERGENT HEALTHCARE SERVICES TO ALL INDIVIDUALS AND ALSO PROVIDES ELECTIVE PROCEDURES TO INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF MEDICAL CONDITION, RACE, COLOR, CREED, SEX, NATIONAL ORIGINS, HANDICAP, AGE, LIFESTYLE, FINANCIAL STATUS OR ABILITY TO PAY. MOREOVER, ARMC PROVIDES HEALTHCARE SERVICES TO PATIENTS WHO MEET CERTAIN CRITERIA DEFINED BY THE NEW JERSEY DEPARTMENT OF HEALTH AND HUMAN SERVICES WITHOUT CHARGE OR AT AMOUNTS LESS THAN ESTABLISHED RATES. THE COST OF PROVIDING THESE SERVICES AND SUPPLIES TO PATIENTS WHO MEET THE STATE-MANDATED CHARITY CARE ELIGIBILITY REQUIREMENTS APPROXIMATED \$22.3 MILLION FOR 2023. THE SIGNIFICANT REDUCTION IN THE COST OF PROVIDING CHARITY CARE IS THE RESULT OF ARMC'S EFFORTS IN ASSISTING PATIENTS TO ENROLL IN THE STATE MEDICAID PROGRAM. THE ESTIMATED UNREIMBURSED COST OF PROVIDING CARE TO MEDICAID PATIENTS WAS \$30.8 MILLION IN 2023. BECAUSE ARMC DOES NOT PURSUE COLLECTIONS OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. ARMC ALSO PROVIDES FREE CARE TO PATIENTS WHO DO NOT MEET THE STATE ELIGIBILITY REQUIREMENTS OR ARE NOT COMPLIANT IN PURSUING ELIGIBILITY STATUS. SUCH AMOUNTS ARE INCLUDED IN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS AS PART OF THE PROVISION FOR UNCOLLECTIBLES, NET OF ANY RECOVERIES REALIZED THROUGH COLLECTION EFFORTS.

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

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

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

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

ATLANTICARE, RECOGNITIONS AND DESIGNATIONS

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FOLLOWING IS A SAMPLING OF THE MANY AWARDS, RECOGNITIONS, AND
DESIGNATIONS ATLANTICARE HAS EARNED AS OF DECEMBER 31, 2023:

- 2022- ATLANTICARE REGIONAL MEDICAL CENTER EMERGENCY MEDICAL SERVICES
EARNS AMERICAN HEART ASSOCIATION'S MISSION: LIFELINE - EMS - SILVER PLUS
ACHIEVEMENT AWARD.

- 2021- ATLANTICARE EARNS NEW JERSEY HOSPITAL ASSOCIATION'S CONNECT AWARD
FOR OUTSTANDING COMMUNICATIONS IN PROTECTING STAFF, PATIENTS AND
COMMUNITIES AGAINST COVID.

- 2020 - ATLANTICARE EARNS DESIGNATION AS ANTICOAGULATION CENTER OF
EXCELLENCE FROM ANTICOAGULATION FORM.

- 2019 - ARMC'S WOUND HEALING CENTER EARNS UNDERSEA AND HYPERBARIC
MEDICAL SOCIETY'S (UHMS) FULL ACCREDITATION. THE CERTIFICATION RECOGNIZES
HEALTHCARE ORGANIZATIONS THAT PROVIDE CLINICAL PROGRAMS ACROSS THE
CONTINUUM OF CARE FOR DIABETES.

- 2019 - ATLANTICARE EARNS AMERICAN HEART ASSOCIATION'S (AHA) WORKPLACE
HEALTH ACHIEVEMENT INDEX GOLD LEVEL RECOGNITION FOR TAKING SIGNIFICANT
STEPS TO BUILD A CULTURE OF HEALTH IN THE WORKPLACE. THE AHA RECOGNIZED
ATLANTICARE AT THE SILVER LEVEL IN 2018 AND BRONZE LEVEL IN 2017.

- 2019 - ARMC EARNS THE JOINT COMMISSION'S GOLD SEAL OF APPROVAL FOR
ADVANCED CERTIFICATION FOR INPATIENT DIABETES CARE. THE GOLD SEAL IS A
SYMBOL OF QUALITY THAT REFLECTS A HEALTHCARE ORGANIZATION'S COMMITMENT TO

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PROVIDING SAFE AND QUALITY PATIENT CARE. ATLANTICARE IS ONE OF ONLY 81 ORGANIZATIONS ACROSS THE COUNTRY, AND FOUR IN NEW JERSEY THAT HAD THEN EARNED THE CERTIFICATION.

- 2019 - FOR THE SEVENTH YEAR IN A ROW, ATLANTICARE EARNS HUMAN RIGHTS CAMPAIGN (HRC) FOUNDATION RECOGNITION AS A "LEADER IN LGBTQ HEALTHCARE EQUALITY." THE HRC IS THE EDUCATIONAL ARM OF THE COUNTRY'S LARGEST LESBIAN, GAY, BISEXUAL AND TRANSGENDER CIVIL RIGHTS ORGANIZATION.

- 2019 - ARMC'S ATLANTIC CITY CAMPUS AGAIN EARNS THE JOINT COMMISSION'S GOLD SEAL OF APPROVAL AND THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION'S HEART-CHECK MARK FOR ADVANCED CERTIFICATION FOR COMPREHENSIVE STROKE CENTERS. THE GOLD SEAL OF APPROVAL AND THE HEART-CHECK MARK REPRESENT SYMBOLS OF QUALITY FROM THEIR RESPECTIVE ORGANIZATIONS. ATLANTICARE FIRST EARNED THE DESIGNATION IN MAY 2017.

- 2019 - BLUE CROSS, BLUE SHIELD NAMES ARMC A BLUE DISTINCTION CENTER FOR CARDIAC CARE (ALSO NAMED IN 2014).

- 2018 - ARMC IS RE-DESIGNATED AS A MAGNET FACILITY. ARMC BECAME THE 105TH HOSPITAL IN THE NATION TO ATTAIN STATUS AS A MAGNET DESIGNATED HOSPITAL IN 2004 AND WAS RE-DESIGNATED IN 2008, 2013 AND 2018.

- 2018 - ARMC'S SATELLITE EMERGENCY DEPARTMENT IN HAMMONTON EARNS THE EMERGENCY NURSES ASSOCIATION'S LANTERN AWARD FOR EXCELLENCE. THE AWARD

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RECOGNIZES EXCEPTIONAL AND INNOVATIVE PERFORMANCE IN LEADERSHIP,
PRACTICE, EDUCATION, ADVOCACY AND RESEARCH AND THE ORGANIZATION'S
COMMITMENT TO PROVIDING QUALITY ARE IN A SAFE AND HEALTHY WORK
ENVIRONMENT.

- 2018 - BLUE CROSS, BLUE SHIELD NAMES ARMC A BLUE DISTINCTION CENTER+
FOR BARIATRIC SURGERY.

- 2017 - ARMC'S NEONATAL INTENSIVE CARE UNIT EARNS THE AMERICAN
ASSOCIATION OF CRITICAL CARE NURSES' GOLD BEACON AWARD FOR EXCELLENCE.
THE RECOGNITION HONORS INDIVIDUAL UNITS THAT DISTINGUISH THEMSELVES BY
IMPROVING EVERY FACET OF PATIENT CARE.

ATLANTICARE BEHAVIORAL HEALTH ("ABH")

FEID: 21-0721208

ABH IS SOUTHEASTERN NEW JERSEY'S LARGEST PROVIDER OF BEHAVIORAL HEALTH
AND SUBSTANCE ABUSE/ADDICTION RECOVERY SERVICES. WITH 17 LOCATIONS
THROUGHOUT THE REGION, ABH OFFERS A BROAD RANGE OF SERVICES TO HELP
INDIVIDUALS AND THEIR FAMILIES WITH SERIOUS MENTAL ILLNESSES, SUBSTANCE
USE TREATMENT, AND MARRIAGE COUNSELING SERVICES. ABH ALSO PROVIDES
EMPLOYEE ASSISTANCE PROGRAMS FOR AREA EMPLOYERS, WHICH INCLUDE EMPLOYEE
COUNSELING SERVICES, BEHAVIORAL HEALTH AND WELLNESS PROGRAMS AND CRITICAL
INCIDENT DEBRIEFING SERVICES. ABH MANAGES A 34-BED PSYCHIATRIC INPATIENT
PROGRAM LOCATED AT THE MAINLAND CAMPUS AND A PSYCHIATRIC CRISIS

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INTERVENTION PROGRAM AT THE CITY CAMPUS OF ARMC. THE INTERNAL REVENUE SERVICE HAS RECOGNIZED ABH AS A TAX-EXEMPT ORGANIZATION UNDER IRC CODE §501(C)(3).

THE MAJORITY OF ABH'S PATIENTS ARE UNDERINSURED (MEDICAID/MEDICARE) OR UNINSURED. ABH PROVIDES SERVICES TO CLIENTS WITHOUT INSURANCE COVERAGE AND CHARGES RATES BASED ON A SLIDING SCALE FEE BASED ON INCOME AND FAMILY SIZE. THE COST OF PROVIDING THESE SERVICES AND SUPPLIES TO PATIENTS THAT MEET THE ESTABLISHED CRITERIA APPROXIMATED \$3,315,638 FOR 2023.

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

- ADULT OUTPATIENT PROGRAM.
- INTENSIVE OUTPATIENT TREATMENT.
- ADULT PARTIAL CARE.
- ADULT EARLY INTERVENTION PROGRAM.
- RESIDENTIAL INTENSIVE SUPPORT TEAM.
- SUPPORTED EMPLOYMENT.
- SUBSTANCE USE DISORDER OUTPATIENT TREATMENT
- SUBSTANCE USE BRIDGE CLINIC
- PROGRAM ASSERTIVE COMMUNITY TREATMENT.
- VIOLENCE INTERVENTION PROGRAM
- SCHOOL BASED YOUTH SERVICE PROGRAMS
- CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

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ATLANTICARE FOUNDATION ("FOUNDATION")

FEID: 22-2148992

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

CORE FORM, PART III; STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

ATLANTICARE HEALTH SERVICES ("SERVICES")

FEID: 22-3265214

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

- ATLANTICARE SURGERY CENTER LLC, FULL SERVICE, FREESTANDING AMBULATORY
SURGERY CENTERS.

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- ATLANTICARE LIFE CENTER, OFFERING A FULL SPECTRUM OF HEALTH AND WELLNESS, PHYSICAL AND REHABILITATIVE CONDITIONING.

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

THE PROGRAMS OUTLINED ABOVE ENGAGE IN HEALTHCARE SERVICES WHICH ARE HIGH QUALITY AND COST EFFECTIVE FOR THE BENEFIT OF THE COMMUNITY AND IN SUPPORT OF THE CHARITABLE PURPOSES OF ATLANTICARE HEALTH SYSTEM.

ATLANTICARE PHYSICIAN GROUP, P.A. ("APG")

FEID: 02-0701782

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

- ATLANTICARE PRIMARY/URGENT CARE CENTERS (LOCATED IN ATLANTIC, CAPE MAY, BURLINGTON, AND CCEAN COUNTIES) OFFER PRIMARY CARE AND URGENT CARE AS AN ALTERNATIVE TO MORE EXPANSIVE EMERGENCY ROOM TREATMENT.

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

- SELECT SPECIALTY PRACTICES INCLUDING SURGICAL, ENT, DIABETES, NEUROLOGY
AND UROLOGY.

ATLANTICARE INFORMATION TECHNOLOGY ("AIT")

ATLANTICARE INFORMATION TECHNOLOGY (A DIVISION OF ATLANTICARE HEALTH
SYSTEM, INC.) SUPPORTS ALL OTHER ATLANTICARE AFFILIATES TO ACHIEVE
MAXIMUM RESULTS THROUGH THE USE OF INFORMATION TECHNOLOGY. AIT'S
INNOVATIVE NETWORKING TECHNOLOGY ENHANCES THE SPEED AND EFFICIENCY OF
PATIENT'S DIAGNOSIS AND TREATMENT WHILE MAINTAINING PATIENT
CONFIDENTIALITY AND SAFETY. IN RECENT YEARS, AIT HAS BEEN INSTRUMENTAL IN
SUPPORTING MORE DIGITAL TECHNOLOGIES, INCLUDING ATLANTICARE'S PATIENT
PORTAL.

ATLANTICARE HEALTH ENGAGEMENT, INC.

FEID: 61-1608389

AT THE END OF 2009 ATLANTICARE HEALTH ENGAGEMENT, INC. WAS ESTABLISHED TO
SUPPORT THE DEVELOPMENT OF HEALTH MANAGEMENT CAPABILITIES AND STRUCTURES,
AND HEALTH STATUS IMPROVEMENT INITIATIVES FOR THE BENEFIT OF THE BROADER
COMMUNITY. ARMC CONTRIBUTED FOR THE YEAR ENDED DECEMBER 31, 2012, AND
2013 \$2,000,000 AND \$5,000,000 RESPECTIVELY, AND AN ADDITIONAL
\$10,000,000 IN 2014. IN 2015, THE MEDICAL CENTER CONTRIBUTED \$15,000,000

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TO SUPPORT THE ONGOING MISSION OF HEALTH ENGAGEMENT. TODAY, HEALTH
ENGAGEMENT NOT ONLY PROVIDES HEALTH AND WELLNESS SERVICES TO MEMBERS OF
THE ATLANTICARE FAMILY, IT ALSO SUPPORTS LOCAL EMPLOYERS MANAGE AND MEET
THE HEALTHCARE NEEDS OF THEIR WORKFORCE.

JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION
FEID: 22-1901742

JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION ("JBRC")
WAS FOUNDED IN 1969 AND THE INTERNAL REVENUE SERVICE HAS RECOGNIZED JBRC
AS BEING A TAX-EXEMPT ORGANIZATION UNDER THE IRC CODE §501(C)(3). JBRC IS
ORGANIZED TO PROVIDE INPATIENT AND OUTPATIENT REHABILITATION SERVICES FOR
ALCOHOL AND SUBSTANCE USE DISORDERS. JBRC RECEIVES FUNDING PREDOMINANTLY
FROM FEDERAL AND STATE GRANTS AND FROM PROGRAM SERVICE FEES AND
CONTRACTS.

JBRC OFFERS A VARIETY OF INDIVIDUALIZED TREATMENT PROGRAMS:

- RESIDENTIAL PROGRAMS.
- OUTPATIENT PROGRAMS.
- PRIMARY CARE.
- MEDICATION-ASSISTED TREATMENT.
- GAMBLING TREATMENT PROGRAM.
- INMATE RE-ENTRY PROGRAM.
- ALL ROAD RECOVERY.

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CORE FORM, PART III; QUESTION 2

EFFECTIVE JANUARY 1, 2023, JOHN BROOKS RECOVERY CENTER, A NEW JERSEY
NONPROFIT CORPORATION (EIN: 22-1901742); AN INTERNAL REVENUE CODE SECTION
501(C)(3) TAX-EXEMPT ORGANIZATION, COMPLETED AND SUBMITTED THE NECESSARY
DOCUMENTATION TO BE ADDED TO THE ATLANTICARE HEALTH SYSTEM, INC. GROUP
EXEMPTION RULING. ACCORDINGLY, EFFECTIVE JANUARY 1, 2023, ALL THE
ACTIVITIES AND OPERATIONS OF JOHN BROOKS RECOVERY CENTER, A NEW JERSEY
NONPROFIT CORPORATION ARE INCLUDED ON THIS CONSOLIDATED GROUP FORM 990.

CORE FORM, PART V, QUESTION 1A AND CORE FORM, PART VII; SECTION B

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE
AFFILIATES WITHIN THE ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A
TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. ATLANTICARE REGIONAL
MEDICAL CENTER, AN INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT
ORGANIZATION, WHICH IS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990, PAYS
ALL OUTSTANDING ACCOUNTS PAYABLE INVOICES ON BEHALF OF THE ORGANIZATIONS
INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. IN CONJUNCTION WITH THIS
SERVICE, ATLANTICARE REGIONAL MEDICAL CENTER ALSO PREPARES AND ISSUES
FORMS 1099 TO THESE VENDORS RECEIVING PAYMENTS WHERE APPLICABLE AND FILES
THESE FORMS 1099 WITH THE IRS. ATLANTICARE REGIONAL MEDICAL CENTER
ALLOCATES THESE PAYMENTS TO THE ORGANIZATIONS INCLUDED IN THIS
CONSOLIDATED GROUP FORM 990 VIA AN INTERCOMPANY ACCOUNT.

CORE FORM, PART V; QUESTION 15

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PRIOR TO HER RETIREMENT, LORI S. HERNDON SERVED AS AN OFFICER AND MEMBER OF THE ORGANIZATION'S BOARD OF TRUSTEES; AN UNCOMPENSATED POSITION, FOR THE PERIOD JANUARY 1, 2023 THROUGH JUNE 30, 2023. ACCORDINGLY, HER COMMON LAW EMPLOYER/EMPLOYEE RELATIONSHIP WAS WITH ATLANTICARE HEALTH SYSTEM, INC. (EIN: 22-3265213). ATLANTICARE HEALTH SYSTEM, INC. FILED A 2023 FEDERAL FORM 4720 WHICH INCLUDED A REMITTANCE OF EXCISE TAX RELATED TO HER COMPENSATION IN EXCESS OF \$1M.

MARILUISE VENDITTI, M.D. IS INCLUDED WITHIN THIS FORM 990, PART VII AND SERVED AS AN OFFICER OF THE ORGANIZATION FOR THE PERIOD OF JANUARY 1, 2023 THROUGH JULY 31, 2023. ACCORDINGLY, HER COMMON LAW EMPLOYER/EMPLOYEE RELATIONSHIP WAS WITH ATLANTICARE HEALTH SYSTEM, INC. (EIN: 22-3265213). HER COMMON LAW EMPLOYER WAS NOT REQUIRED TO FILE A FORM 4720 FOR ANY REMITTANCE OF EXCISE TAX RELATED TO DR. VENDITTI BECAUSE HER REMUNERATION PROVIDED FOR UNDER INTERNAL REVENUE CODE SECTION 4960 WAS NOT IN EXCESS OF \$1M.

CORE FORM, PART VI, SECTION A; QUESTION 3

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM. ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS AN INTERNAL REVENUE CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION AND SERVES AS THE PARENT ORGANIZATION OF THE SYSTEM. AS THE PARENT ORGANIZATION OF THE SYSTEM AH SYSTEM PROVIDES VARIOUS CORPORATE RELATED SERVICES FOR THE BENEFIT OF VARIOUS SYSTEM ENTITIES, INCLUDING

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THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. THESE CORPORATE SERVICES INCLUDE, BUT ARE NOT LIMITED TO, EXECUTIVE, LEGAL AND RISK MANAGEMENT, COMPLIANCE AND GOVERNANCE, HUMAN RESOURCES AND FINANCE. THESE TRANSACTIONS ARE RECORDED ON THE REVENUE/EXPENSE AND BALANCE SHEET STATEMENTS OF THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 AND OTHER AFFILIATES WITHIN THE SYSTEM.

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

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

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

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM") IS THE TAX-EXEMPT PARENT ENTITY OF THE SYSTEM.

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THE ORGANIZATION'S FEDERAL FORM 990 WAS PROVIDED TO EACH VOTING MEMBER OF THE ORGANIZATION'S GOVERNING BODY PRIOR TO FILING OF THE FORM 990 WITH THE INTERNAL REVENUE SERVICE ("IRS").

AS PART OF THE TAX RETURN PREPARATION PROCESS THE ORGANIZATION HIRED A PROFESSIONAL CERTIFIED PUBLIC ACCOUNTING ("CPA") FIRM WITH EXPERIENCE AND EXPERTISE IN BOTH HEALTHCARE AND NOT FOR-PROFIT TAX RETURN PREPARATION TO PREPARE THE FEDERAL FORM 990. THE CPA FIRM'S TAX PROFESSIONALS WORKED CLOSELY WITH THE SYSTEM'S FINANCE PERSONNEL AND VARIOUS OTHER 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 SYSTEM'S INTERNAL WORKING GROUP FOR THEIR REVIEW. THE 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 INTERNAL WORKING GROUP FOR FINAL REVIEW. FOLLOWING THIS REVIEW, THE FORM 990 WAS THEN PRESENTED TO THE ATLANTICARE HEALTH SYSTEM, INC. AUDIT, COMPLIANCE AND RISK COMMITTEE AND PROVIDED TO THE ORGANIZATION'S GOVERNING BODY PRIOR TO FILING WITH THE IRS.

CORE FORM, PART VI, SECTION B; QUESTION 12

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE AFFILIATES WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT

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

CORE FORM, PART VI, SECTION B; QUESTION 15

THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990 ARE
AFFILIATES WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT
INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM") WHICH INCLUDES
ATLANTICARE HEALTH SYSTEM, INC. ("AH SYSTEM"); A RELATED INTERNAL REVENUE
CODE SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION. THE EXECUTIVE
COMPENSATION COMMITTEE ("COMMITTEE") OF THE BOARD OF TRUSTEES ("BOARD")
OF AH SYSTEM REVIEWS AND APPROVES THE COMPENSATION PROVIDED TO THE
EXECUTIVE STAFF. THE COMPENSATION DECISIONS OF THE COMMITTEE ARE SET
WITHIN THE FRAMEWORK OF A FORMAL COMPENSATION PHILOSOPHY THAT IS APPROVED
BY THE BOARD. THE COMPENSATION PHILOSOPHY APPROVES THE USE OF A NATIONAL

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

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

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

THE COMMITTEE APPROVES THE PAY OF ALL EXECUTIVES. IT SETS THE
COMPENSATION FOR THE PRESIDENT AND CHIEF EXECUTIVE OFFICER ("PRESIDENT").

THE PRESIDENT RECOMMENDS SALARY ADJUSTMENTS AND INCENTIVE AWARD PAYMENTS
TO THE COMMITTEE. THE COMMITTEE CAN APPROVE, MODIFY OR REJECT THE
PRESIDENT'S RECOMMENDATIONS AS APPROPRIATE.

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

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

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

- COMPENSATION FOR ALL EXECUTIVES IS APPROVED IN ADVANCE BY A COMMITTEE
MADE UP ENTIRELY OF INDEPENDENT DIRECTORS WITH NO CONFLICT OF INTEREST
WITH REGARD TO THE COMPENSATION DECISIONS.

- THE COMMITTEE OBTAINS AND RELIES ON APPROPRIATE COMPARABILITY DATA ON
TOTAL COMPENSATION IN MAKING THESE DECISIONS. ("APPROPRIATE" MEANS DATA
ON PAY FOR LIKE JOBS IN LIKE ORGANIZATIONS AND LIKE CIRCUMSTANCES).

- THE COMMITTEE DOCUMENTS ITS PROCESS AND THE TERMS OF ITS DECISIONS IN
TIMELY MINUTES.

CORE FORM, PART VI, SECTION C; QUESTION 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:

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2H-5.1B), THIS ORGANIZATION HAS POSTED ON ITS INTERNET WEBSITE A COPY OF THIS INTERNAL REVENUE SERVICE (IRS) FORM 990 AND ALL SCHEDULES AND SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED TO THE IRS IN CONJUNCTION WITH THE FORM 990 WITH THE EXCEPTION OF THOSE SCHEDULES NOT OPEN FOR PUBLIC INSPECTION. SAID FORM 990 WAS POSTED BY THE ORGANIZATION AFTER FILING ITS FORM 990 WITH THE IRS.

CORE FORM, PART VI, SECTION C; QUESTION 19

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

CORE FORM, PART VII

CORE FORM, PART VII INCLUDES, AS OF DECEMBER 31, 2023, THE MEMBERS OF THE BOARD OF TRUSTEES, OFFICERS, AND KEY EMPLOYEES OF EACH OF THE ORGANIZATIONS INCLUDED IN THIS CONSOLIDATED GROUP FORM 990. OUTLINED BELOW IS A SUMMARY BY ORGANIZATION:

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THE BOARD OF TRUSTEES FOR EACH OF THE FOLLOWING SUBORDINATES INCLUDED IN
THIS CONSOLIDATED GROUP FORM 990, AS OF DECEMBER 31, 2023, IS IDENTICAL.

THESE SUBORDINATES ARE:

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

THE BOARD OF TRUSTEE LIST REFLECTED IN PART VII FOR THESE SUBORDINATES
INCLUDES THE FOLLOWING INDIVIDUALS:

- DAVID M. GODDARD;
- KENNETH R. STEINBERG;
- MARGARET S. SYKES, R.N.;
- PACIFICO S. AGNELLINI, ESQ.;
- MANUEL E. APONTE;
- EUGENE M. ARNONE;
- MICHAEL J. CHARLTON;
- JAVID IQBAL, M.D.;

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- ROSALIND E. KINCAID;
- BRETT H. MATIK;
- GINA MERRITT-EPPS, ESQ.;
- PRIYESH T. THAKKAR, D.O.;
- MARISSA TRAVALINE;
- JENNIFER TIOSECO, M.D.;
- MICHAEL WALSH;
- BLAIR A. BERGEN, M.D. (TERMED);
- THOMAS BRABSON, D.O. (TERMED);
- CHRISTOPHER C. CATCHING, ED.D. (TERMED);
- LORI S. HERNDON (TERMED 6/30/23);
- ALDALBERTO LOPEZ (TERMED);
- RICHARD S. MAIRONE, ESQ. (TERMED);
- YOLANDA N. MELVILLE, ESQ. (TERMED); AND
- PATRICIA RICH-TUOHY (TERMED).

ATLANTICARE FOUNDATION'S BOARD OF TRUSTEES INCLUDES THE FOLLOWING
INDIVIDUALS:

- ROBERT L. HORDES;
- JOHANNA PERSKIE;
- FATEN DIB;
- MATHEW FINKELSON, D.M.D.;
- JOHN BECHER, D.O.;
- LOUIS BONGIOVANNI;

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- KRISTINA CARR;
- MICHAEL CONNOR, ESQ.;
- BERNADETTE DOUGHERTY;
- PAUL J. GALLAGHER, ESQ.;
- TIM L. GLENN;
- GARY L. HANSON;
- ROBERT A. HIMMELSTEIN;
- CORNELIUS P. MCPEAK;
- ALEXANDER ONOPCHENKO, M.D.;
- FABIO R. OROZCO, M.D.;
- PAUL PULLIA;
- T. ERIC REICH;
- MAUREEN C. SHAY;
- SULIN YAO, M.D.; AND
- LORI S. HERNDON (TERMED 6/30/23); AND
- LARRY J. KAUFMAN, M.D. (TERMED).

THE OFFICERS OF ATLANTICARE REGIONAL HEALTH SERVICES, A NEW JERSEY
NONPROFIT CORPORATION INCLUDE THE FOLLOWING INDIVIDUALS:

- MICHAEL J. CHARLTON;
- DEBRA A. FOX;
- LARISA K. GOGANZER;
- HAK J. KIM;
- DONNA MICHAEL-ZIEREIS, ESQ.;

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- CHRISTOPHER A. SCANZERA;
- DENNIS LENNON;
- BARBARA YOUNG;
- KATHERINE BIRKENSTOCK (TERMED 11/25/23);
- LORI S. HERNDON (TERMED 6/30/23); AND
- MARILUISE VENDITTI, M.D. (TERMED 7/31/23).

THE OFFICERS OF ATLANTICARE REGIONAL MEDICAL CENTER INCLUDE THE FOLLOWING
INDIVIDUALS:

- MICHAEL J. CHARLTON;
- FRANK R. CARPENTER;
- DEBRA A. FOX;
- LARISA K. GOGANZER;
- JAMES KILMER;
- HAK J. KIM;
- DENNIS LENNON;
- DONNA MICHAEL-ZIEREIS, ESQ.;
- BENJAMIN J. NEGLEY;
- CHRISTOPHER A. SCANZERA;
- BARBARA YOUNG;
- KATHERINE BIRKENSTOCK (TERMED 11/25/23);
- LORI S. HERNDON (TERMED 6/30/23); AND
- MARILUISE VENDITTI, M.D. (TERMED 7/31/23).

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

Name of the organization

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

THE OFFICERS OF ATLANTICARE HEALTH SERVICES, INC. INCLUDE THE FOLLOWING
INDIVIDUALS:

- MICHAEL J. CHARLTON;
- DEBRA A. FOX;
- HAK J. KIM;
- DONNA MICHAEL-ZIEREIS, ESQ.;
- BENJAMIN J. NEGLEY;
- BARBARA YOUNG;
- RICHARD ZALMAN, M.D.;
- KATHERINE BIRKENSTOCK (TERMED 11/25/23);
- LORI S. HERNDON (TERMED 6/30/23); AND
- MARILOUISE VENDITTI, M.D. (TERMED 7/31/23).

THE OFFICERS OF ATLANTICARE BEHAVIORAL HEALTH, INC. INCLUDE THE FOLLOWING
INDIVIDUALS:

- MICHAEL J. CHARLTON;
- MONIKA FINNEGAN;
- DENNIS LENNON;
- DONNA MICHAEL-ZIEREIS, ESQ.;
- BENJAMIN J. NEGLEY;
- ROBERT L. SZAPOR;
- BARBARA YOUNG;
- KATHERINE BIRKENSTOCK (TERMED 11/25/23);

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

- LORI S. HERNDON (TERMED 6/30/23); AND
- MARILOUISE VENDITTI, M.D. (TERMED 7/31/23).

THE OFFICERS OF ATLANTICARE FOUNDATION INCLUDE THE FOLLOWING INDIVIDUALS:

- MICHAEL J. CHARLTON;
- HAK J. KIM;
- DENNIS LENNON;
- SAMANTHA A. KILEY;
- DONNA MICHAEL-ZIEREIS, ESQ.; AND
- LORI S. HERNDON (TERMED 6/30/23).

THE OFFICERS OF ATLANTICARE HEALTH ENGAGEMENT INCLUDE THE FOLLOWING
INDIVIDUALS:

- MICHAEL J. CHARLTON;
- HAK J. KIM;
- DENNIS LENNON;
- LARISA K. GOGANZER; AND
- DONNA MICHAEL-ZIEREIS, ESQ.
- LORI S. HERNDON (TERMED 6/30/23).

THE OFFICERS OF JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT
CORPORATION, INCLUDE THE FOLLOWING INDIVIDUALS:

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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OMB No. 1545-0047

2023

**Open to Public
Inspection**

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

- MICHAEL J. CHARLTON;
- DEBRA A. FOX;
- HAK J. KIM;
- DONNA MICHAEL-ZIEREIS, ESQ.;
- BENJAMIN J. NEGLEY;
- BARBARA YOUNG;
- RICHARD ZALMAN, M.D.; AND
- KATHERINE BIRKENSTOCK (TERMED 11/25/23).

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 AND/OR RELATED ORGANIZATIONS. PLEASE NOTE THIS REMUNERATION WAS FOR SERVICES RENDERED AS FULL-TIME EMPLOYEES OF THIS ORGANIZATION OR A RELATED ORGANIZATION AND NOT FOR SERVICES RENDERED AS A VOTING MEMBER OR OFFICER OF THIS ORGANIZATION'S BOARD OF TRUSTEES.

CORE FORM, PART VII AND SCHEDULE J

CHRISTOPHER C. APGAR, FORMER DIRECTOR OF FINANCE OF ATLANTICARE BEHAVIORAL HEALTH, INC., IS STILL EMPLOYED WITHIN ATLANTICARE HEALTH SYSTEM AS THE DIRECTOR OF FINANCE FQHC AND GRANT COMPLIANCE.

CORE FORM, PART VII, SECTION A, COLUMN B

THIS ORGANIZATION IS AN AFFILIATE WITHIN ATLANTICARE 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

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

Supplemental Information to Form 990 or 990-EZ

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Form 990 or 990-EZ or to provide any additional information.

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OMB No. 1545-0047

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**Open to Public
Inspection**

Employer identification number

90-0779828

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

CORE FORM, PART XI; QUESTION 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCE INCLUDE:

- EXPECTED RETURN ON PLAN ASSETS AND OTHER COMPONENTS OF NET PENSION AND OTHER POSTRETIREMENT COSTS - \$6,087,754;
- PENSION LIABILITY ADJUSTMENTS - (\$48,719,009);
- CONTRIBUTIONS RECEIVED FOR CAPITAL PURCHASES - \$687,562;
- NET ASSETS TRANSFERS AND NET ASSETS RELEASED FROM RESTRICTION FOR CAPITAL PURPOSES, NET - \$1,618,254;
- NET ASSETS RELEASED FROM TEMPORARY RESTRICTION - (\$4,663,322);

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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▶ Attach to Form 990 or 990-EZ.

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Inspection**

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ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

- NET CHANGE IN PERMANENTLY RESTRICTED NET ASSETS - \$51,640;
- NET ASSETS RELEASED FROM RESTRICTION UNITED WAY - (\$15,060); AND
- EQUITY TRANSFER FROM RELATED 501(C)(3) ENTITY - \$5,817,671.

CORE FORM, PART XII; QUESTION 2

THE ORGANIZATION IS AN AFFILIATE WITHIN ATLANTICARE HEALTH SYSTEM AND AFFILIATES; A TAX-EXEMPT INTEGRATED HEALTHCARE DELIVERY SYSTEM ("SYSTEM"). THE SYSTEM'S TAX-EXEMPT PARENT ENTITY IS ATLANTICARE HEALTH SYSTEM, INC. AN INDEPENDENT CPA FIRM AUDITED THE CONSOLIDATED FINANCIAL STATEMENTS OF ATLANTICARE HEALTH SYSTEM, INC. AND ALL AFFILIATES WITHIN THE SYSTEM 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 THE ATLANTICARE HEALTH SYSTEM, INC. AUDIT AND COMPLIANCE COMMITTEE HAS ASSUMED RESPONSIBILITY FOR THE OVERSIGHT OF THE AUDIT OF THE CONSOLIDATED FINANCIAL STATEMENTS AND THE SELECTION OF AN INDEPENDENT AUDITOR.

CORE FORM, PART XII; QUESTION 3

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

**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.

Name of the organization

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

WIDE A-133 AUDIT.

SCHEDULE B

THE GIFTS, GRANTS AND CONTRIBUTIONS REFLECTED ON SCHEDULE B ARE AMOUNTS
RECEIVED BY ALL ENTITIES INCLUDED IN THIS CONSOLIDATED GROUP FORM 990.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE REGIONAL MEDICAL
CENTER ARE REFLECTED IN NUMBERS 1 THROUGH 4 AND 39.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE BEHAVIORAL
HEALTH, INC. ARE REFLECTED IN NUMBERS 5 THROUGH 14 AND 39.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE FOUNDATION ARE
REFLECTED IN NUMBERS 15 THROUGH 20 AND 34 THROUGH 38.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY ATLANTICARE HEALTH SERVICES,
INC. ARE REFLECTED IN NUMBERS 21 THROUGH 28 AND 39.

GIFTS, GRANTS AND CONTRIBUTIONS RECEIVED BY JOHN BROOKS RECOVERY CENTER,
A NEW JERSEY NONPROFIT CORPORATION ARE REFLECTED IN NUMBERS 29 THROUGH 33
AND 39.

FORM 990, LINE H(B)

FORM 990, LINE H(B) - SUBORDINATES INCLUDED

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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**Open to Public
Inspection**

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

1. ATLANTICARE BEHAVIORAL HEALTH, INC. (FEID: 21-0721208)

6010 BLACK HORSE PIKE

EGG HARBOR TOWNSHIP, NJ 08234

2. ATLANTICARE FOUNDATION (FEID: 22-2148992)

2500 ENGLISH CREEK AVENUE, BUILDING 600

EGG HARBOR TOWNSHIP, NJ 08234

3. ATLANTICARE HEALTH ENGAGEMENT, INC. (FEID: 61-1608389)

2500 ENGLISH CREEK AVENUE, BUILDING 500

EGG HARBOR TOWNSHIP, NJ 08234

4. ATLANTICARE HEALTH SERVICES, INC. (FEID: 22-3265214)

2500 ENGLISH CREEK AVENUE, BUILDING 600

EGG HARBOR TOWNSHIP, NJ 08234

5. ATLANTICARE REGIONAL MEDICAL CENTER (FEID: 21-0634549)

1925 PACIFIC AVENUE

ATLANTIC CITY, NJ 08401

6. ATLANTICARE REGIONAL HEALTH SERVICES, INC. (FEID: 80-0834222)

2500 ENGLISH CREEK AVENUE, BUILDING 500

EGG HARBOR TOWNSHIP, NJ 08234

7. JOHN BROOKS RECOVERY CENTER, A NEW JERSEY NONPROFIT CORPORATION (FEID:

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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OMB No. 1545-0047

2023

**Open to Public
Inspection**

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

22-1901742)

660 BLACKHORSE PIKE

PLEASANTVILLE, NJ 08232

FORM 990, LINE H(B) - SUBORDINATES NOT INCLUDED

1. ATLANTICARE PHYSICIAN GROUP, P.A. (FEID: 20-0701782)

2500 ENGLISH CREEK AVENUE, BLDG. C

EGG HARBOR TOWNSHIP, NJ 08234

2. COOPERATIVE HOME HEALTH CARE ATLANTIC COUNTY (FEID: 22-3836022)

6550 DELILAH ROAD, SUITE 304

EGG HARBOR TOWNSHIP, NJ 08234

Name of the organization

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

90-0779828

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

=====

THE ORGANIZATIONS ARE COMMITTED TO IMPROVING THE HEALTH AND WELL-BEING OF THE RESIDENTS OF NEW JERSEY BY PROVIDING QUALITY, PATIENT-CENTERED HEALTHCARE SERVICES. THE ENTITIES WORK TOGETHER TO PROVIDE MEDICALLY NECESSARY HEALTHCARE SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN OR ABILITY TO PAY. PLEASE REFER TO THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT INCLUDED IN SCHEDULE O.

Name of the organization

Employer identification number

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES**90-0779828**

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
ATLANTICARE HEALTH SYSTEM, INC. 2500 ENGLISH CREEK AVENUE, BLDG. 500 EGG HARBOR TOWNSHIP, NJ 08234	MANAGEMENT	86,899,969.
P. AGNES, INC. 2101 PENROSE AVENUE PHILADELPHIA, PA 19145	CONSTRUCTION	36,682,763.
MEDLINE P.O. BOX 382075 PITTSBURG, PA 15251	MEDICAL	16,653,372.
SYMMETRY WORKFORCE SOLUTIONS LLC P.O. BOX 392800 PITTSBURG, PA 15251	STAFFING	15,422,801.
MED-METRIX, LLC 9 ENTIN ROAD PARSIPPANY, NJ 07054	REVENUE CYCLE	9,495,774.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

Related Organizations and Unrelated Partnerships

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

Attach to Form 990.

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

Employer identification number

90-0779828

ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) ATLANTICARE HEALTH SYSTEM, INC. 22-3265213 2500 ENGLISH CREEK AVE., BLDG. EGG HARBOR TOWNSHIP, NJ 08	SUPPORT ARMC	NJ	501(C)(3)	509(A)(3)	N/A		X
(2) ATLANTICARE PHYSICIAN GROUP, P.A. 02-0701782 2500 ENGLISH CREEK AVE., BLDG. EGG HARBOR TOWNSHIP, NJ 08	HEALTH SVCS.	NJ	501(C)(3)	509(A)(3)	AH SYSTEM		X
(3) COOPERATIVE HOME HLTH CARE ATLANTIC CO 22-3836022 6550 DELILAH ROAD, SUITE 304 EGG HARBOR TOWNSHIP, NJ 08	HEALTH SVCS.	NJ	501(C)(3)	509(A)(2)	AH SYSTEM		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) COOP HLTH SVS OF SJ 22-3619231 2500 ENGLISH CREEK AVENUE EGG	WHOLESALE PURCH.	NJ	N/A									
(2) S JERSEY ONCOL PROP 94-3463625 2500 ENGLISH CREEK AVE EGG HAR	HEALTHCARE SVCS.	NJ	N/A									
(3) ATL SURGERY CTR LLC 22-3491867 2500 ENGLISH CREEK AVENUE EGG	HEALTHCARE SVCS.	NJ	N/A									
(4) SOUTHERN JERSEY MEDICAL PROPER 2500 ENGLISH CREEK AVENUE EGG	RENTAL	NJ	N/A									
(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) ENGLISH CREEK ASSURANCE LTD 98-0656394 44 CHURCH STREET HAMILTON, BERMUDA BD HM 12	FINANCIAL VEHICLE	BD	N/A	FOREIGN CORP.					X
(2) ATLANTICARE HEALTH SOLUTIONS, INC. 38-3856295 2500 ENGLISH CREEK AVE, BLDG 500 EGG HARBOR TOWNSHIP, NJ	ACO/HEALTH	NJ	N/A	C CORP.					X
(3) ATLANTICARE ASSURANCE ALLIANCE, INC. 46-3730123 2500 ENGLISH CREEK AVE, BLDG 500 EGG HARBOR TOWNSHIP, NJ	HEALTHCARE SVCS.	NJ	N/A	C CORP.					X
(4)									
(5)									
(6)									
(7)									

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

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

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

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

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

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

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

Part VII Supplemental Information

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

SCHEDULE R, PART V

THIS ORGANIZATION IS A MEMBER OF ATLANTICARE 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. THESE ENTITIES WORK TOGETHER TO DELIVER HIGH-QUALITY COST-EFFECTIVE HEALTHCARE AND WELLNESS SERVICES TO THEIR COMMUNITIES REGARDLESS OF ABILITY TO PAY AND IN FURTHERANCE OF CHARITABLE TAX-EXEMPT PURPOSES.

RENT AND ROYALTY INCOME

Taxpayer's Name ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES	Identifying Number 90-0779828
---	---

DESCRIPTION OF PROPERTY
RENTAL INCOME

	Yes	No	Did you actively participate in the operation of the activity during the tax year?
--	-----	----	--

TYPE OF PROPERTY:
REAL RENTAL INCOME

OTHER INCOME: RENTAL INCOME		7,500,884.
TOTAL GROSS INCOME		7,500,884.

OTHER EXPENSES:

INSURANCE		116,646.
MANAGEMENT FEES		215,428.
OTHER EXPENSES		1,325,812.

DEPRECIATION (SHOWN BELOW)		4,156,510.
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		5,814,396.
TOTAL RENT OR ROYALTY INCOME (LOSS)		1,686,488.

Less Amount to

Rent or Royalty		
Depreciation		
Depletion		
Investment Interest Expense		
Other Expenses		
Net Income (Loss) to Others		
Net Rent or Royalty Income (Loss)		1,686,488.

Deductible Rental Loss (if Applicable)

SCHEDULE FOR DEPRECIATION CLAIMED

(a) Description of property	(b) Cost or unadjusted basis	(c) Date acquired	(d) ACRS des.	(e) Bus. %	(f) Basis for depreciation	(g) Depreciation in prior years	(h) Method	(i) Life or rate	(j) Depreciation for this year
SEE STATEMENT									
Totals									4,156,510.

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE
=====

OTHER INCOME

RENTAL INCOME	7,500,884.

	7,500,884.
	=====

OTHER DEDUCTIONS

RENTAL EXPENSES	1,325,812.

	1,325,812.
	=====

RENT AND ROYALTY SUMMARY
 =====

PROPERTY -----	TOTAL INCOME -----	DEPLETION/ DEPRECIATION -----	OTHER EXPENSES -----	ALLOWABLE NET INCOME -----
RENTAL INCOME	7,500,884.	4,156,510.	1,657,886.	1,686,488.
TOTALS	7,500,884. =====	4,156,510. =====	1,657,886. =====	1,686,488. =====

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.

Go to www.irs.gov/Form4797 for instructions and the latest information.

Name(s) shown on return ATLANTICARE HEALTH SYSTEM, INC - SUBORDINATES		Identifying number 90-0779828
1a	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	
1b	Enter the total amount of gain that you are including on lines 2, 10, and 24 due to the partial dispositions of MACRS assets	
1c	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)
3	Gain, if any, from Form 4684, line 39						3
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37						4
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824						5
6	Gain, if any, from line 32, from other than casualty or theft						6
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows						7
	Partnerships and S corporations. 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.						
	Individuals, partners, S corporation shareholders, and all others. 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.						
8	Nonrecaptured net section 1231 losses from prior years. See instructions						8
9	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						9

Part II Ordinary Gains and Losses (see instructions)

10	Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):							
11	Loss, if any, from line 7						11	()
12	Gain, if any, from line 7 or amount from line 8, if applicable.						12	
13	Gain, if any, from line 31						13	
14	Net gain or (loss) from Form 4684, lines 31 and 38a						14	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36						15	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824						16	
17	Combine lines 10 through 16.						17	104,041.
18	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.							
	a 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						18a	
	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.						18b	

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>		Property A	Property B
20	Gross sales price (Note: See line 1a before completing.)	20	
21	Cost or other basis plus expense of sale	21	
22	Depreciation (or depletion) allowed or allowable	22	
23	Adjusted basis. Subtract line 22 from line 21	23	
24	Total gain. Subtract line 23 from line 20.	24	
25	If section 1245 property:		
a	Depreciation allowed or allowable from line 22	25a	
b	Enter the smaller of line 24 or 25a.	25b	
26	If section 1250 property: 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	26a	
b	Applicable percentage multiplied by the smaller of line 24 or line 26a. See instructions	26b	
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	26c	
d	Additional depreciation after 1969 and before 1976	26d	
e	Enter the smaller of line 26c or 26d	26e	
f	Section 291 amount (corporations only)	26f	
g	Add lines 26b, 26e, and 26f	26g	
27	If section 1252 property: 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	27a	
b	Line 27a multiplied by applicable percentage. See instructions	27b	
c	Enter the smaller of line 24 or 27b	27c	
28	If section 1254 property:		
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion. See instructions	28a	
b	Enter the smaller of line 24 or 28a	28b	
29	If section 1255 property:		
a	Applicable percentage of payments excluded from income under section 126. See instructions	29a	
b	Enter the smaller of line 24 or 29a. See instructions	29b	

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

30	Total gains for all properties. Add property columns A through D, line 24	30
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31
32	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	32

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)
33	Section 179 expense deduction or depreciation allowable in prior years	33
34	Recomputed depreciation. See instructions	34
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35

