

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE, etc.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report, etc.
C If the plan is a collectively-bargained plan, check here.
D Check box if filing under: Form 5558, automatic extension, the DFVC program, special extension, etc.
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

1a Name of plan: CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN
1b Three-digit plan number (PN): 010
1c Effective date of plan: 01/01/1997
2a Plan sponsor's name (employer, if for a single-employer plan): COOPER UNIVERSITY HOSPITAL CAPE REGIONAL
2b Employer Identification Number (EIN): 21-0662542
2c Plan Sponsor's telephone number: 609-463-2175
2d Business code (see instructions): 622000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:		4b EIN 21-0662542	
a Sponsor's name CAPE REGIONAL MEDICAL CENTER		4d PN 010	
c Plan Name CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN			
5 Total number of participants at the beginning of the plan year	5	1361	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).			
a(1) Total number of active participants at the beginning of the plan year	6a(1)	1040	
a(2) Total number of active participants at the end of the plan year	6a(2)	1093	
b Retired or separated participants receiving benefits	6b	18	
c Other retired or separated participants entitled to future benefits	6c	306	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	1417	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	8	
f Total. Add lines 6d and 6e	6f	1425	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	1361	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	1425	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	32	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7		

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
 2E 2F 2G 2K 2L 2M 2S 2T 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)	
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(3) <input checked="" type="checkbox"/> Trust	(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor
(4) <input type="checkbox"/> General assets of the sponsor			

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules		b General Schedules	
(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> H (Financial Information)	(2) <input type="checkbox"/> I (Financial Information – Small Plan)	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>2</u>	(3) <input checked="" type="checkbox"/> C (Service Provider Information)	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>2</u>
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(4) <input checked="" type="checkbox"/> C (Service Provider Information)	(4) <input type="checkbox"/> D (DFE/Participating Plan Information)	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)	(5) <input type="checkbox"/> G (Financial Transaction Schedules)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(6) <input type="checkbox"/> G (Financial Transaction Schedules)		(6) <input type="checkbox"/> G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN	B Three-digit plan number (PN) ▶ 010
C Plan sponsor's name as shown on line 2a of Form 5500 COOPER UNIVERSITY HOSPITAL CAPE REGIONAL	D Employer Identification Number (EIN) 21-0662542

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-6071399	70688	TT069345	1425	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	378308
5	Current value of plan's interest under this contract in separate accounts at year end.....	
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 265760
c	(1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits.....	7c(2)
	(3) Interest credited during the year.....	7c(3) 7815
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶ EMPLOYER ACCOUNT ACTIVITY	7c(5) 215571
	(6) Total additions	7c(6) 223386
d	Total of balance and additions (add lines 7b and 7c(6))	7d 489146
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier.....	7e(2) 2481
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶ EMPLOYER ACCOUNT ACTIVITY	7e(4) 108357
(5) Total deductions	7e(5) 110838	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 378308

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN	B Three-digit plan number (PN) ▶ 010
C Plan sponsor's name as shown on line 2a of Form 5500 COOPER UNIVERSITY HOSPITAL CAPE REGIONAL	D Employer Identification Number (EIN) 21-0662542

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

NEW YORK LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5582869	66915	TT069345	1425	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
---	--------------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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	(c) Amount	(d) Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4204664
5	Current value of plan's interest under this contract in separate accounts at year end.....	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input checked="" type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 4096665
c	(1) Contributions deposited during the year	7c(1) 231493
	(2) Dividends and credits.....	7c(2)
	(3) Interest credited during the year.....	7c(3) 123175
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶ TRANSFERS & LOAN PAYMENTS	7c(5) 799046
	(6) Total additions	7c(6) 1153714
d	Total of balance and additions (add lines 7b and 7c(6))	7d 5250379
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 716371
	(2) Administration charge made by carrier.....	7e(2) 11921
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶ TRANSFERS & LOANS ISSUED	7e(4) 317423
(5) Total deductions	7e(5) 1045715	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 4204664

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)
	(2) Claim reserves		9d(2)
	(3) Other reserves		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN	B Three-digit plan number (PN) ▶	010
C Plan sponsor's name as shown on line 2a of Form 5500 COOPER UNIVERSITY HOSPITAL CAPE REGIONAL	D Employer Identification Number (EIN) 21-0662542	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

TRANSAMERICA RETIREMENT SOLUTIONS

13-3689044

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 15 28 37 38 50 54 59 61 62 63 64 65	RECORDKEEPER	161349	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

UBS FINANCIAL SERVICES INC.

13-2638166

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 70	CONSULTANT	88432	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name: GRANT THORNTON LLP	b EIN: 03-6605558
c Position: AUDITOR	
d Address:	e Telephone:

Explanation: MERGED WITH COOPER HEALTH AND DECIDED TO USE THEIR AUDITORS

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN	B Three-digit plan number (PN) ▶ 010
C Plan sponsor's name as shown on line 2a of Form 5500 COOPER UNIVERSITY HOSPITAL CAPE REGIONAL	D Employer Identification Number (EIN) 21-0662542

Part I	Asset and Liability Statement
---------------	--------------------------------------

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1)	1908887
(2) Participant contributions	1b(2)	86276
(3) Other	1b(3)	19543
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	
(2) U.S. Government securities	1c(2)	
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other	1c(3)(B)	
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	935613
(9) Value of interest in common/collective trusts	1c(9)	
(10) Value of interest in pooled separate accounts	1c(10)	
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	90294579
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	4362425
(15) Other	1c(15)	614691

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	97607323	108643571
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k		
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	97607323	108643571

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	2673680	
(B) Participants.....	2a(1)(B)	4841090	
(C) Others (including rollovers).....	2a(1)(C)	400539	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		7915309
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)	41905	
(F) Other.....	2b(1)(F)	130990	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		172895
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	1969263	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1969263
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		11363843
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		21421310

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	9907534	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		9907534
f Corrective distributions (see instructions)	2f		13
g Certain deemed distributions of participant loans (see instructions)	2g		227734
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	161349	
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	88432	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		249781
j Total expenses. Add all expense amounts in column (b) and enter total	2j		10385062

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		11036248
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **ERNST & YOUNG LLP**

(2) EIN: **34-6565596**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>CAPE REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION RETIREMENT PLAN</u>	B Three-digit plan number (PN)	<u>010</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COOPER UNIVERSITY HOSPITAL CAPE REGIONAL</u>	D Employer Identification Number (EIN) <u>21-0662542</u>	

Part I	Distributions
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All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	0
---	---	---

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
 EIN(s): 13-3689044

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	
--	---	--

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)
----------------	---

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... Increase Decrease Both No

Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment).....	14a	
b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14b	
c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).....	14c	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers.....	16b	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment

19 If the total number of participants is 1,000 or more, complete lines (a) and (b):

a Enter the percentage of plan assets held as:
 Public Equity: _____% Private Equity: _____% Investment-Grade Debt and Interest Rate Hedging Assets: _____%
 High-Yield Debt: _____% Real Assets: _____% Cash or Cash Equivalents: _____% Other: _____%

b Provide the average duration of the Investment-Grade Debt and Interest Rate Hedging Assets:
 0-5 years 5-10 years 10-15 years 15 years or more

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:
 Yes.
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
 No. Other. Provide explanation: _____

Part VII IRS Compliance Questions

21a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

21b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).
 Design-based safe harbor method
 "Prior year" ADP test
 "Current year" ADP test
 N/A

22 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 03 / 31 / 2017 (MM/DD/YYYY) and the Opinion Letter serial number J500863A.

FINANCIAL STATEMENTS AND
SUPPLEMENTAL SCHEDULE

Cape Regional Medical Center Defined
Contribution Retirement Plan
December 31, 2024 and 2023, and
Year Ended December 31, 2024
With Report of Independent Auditors



The better the question.
The better the answer.
The better the world works.



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Cape Regional Medical Center Defined Contribution Retirement Plan

Financial Statements and Supplemental Schedule

December 31, 2024 and 2023, and
Year Ended December 31, 2024

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Report of Independent Auditors

The Participants and the Plan Administrator of
Cape Regional Medical Center Defined Contribution
Retirement Plan

Scope and Nature of the ERISA Section 103(a)(3)(C) Audit for the 2024 Financial Statements

We were engaged to perform an audit of the financial statements of Cape Regional Medical Center Defined Contribution Retirement Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statement of net assets available for benefits as of December 31, 2024, and the related statement of changes in net assets available for benefits for the year then ended, and the related notes (collectively referred to as the “financial statements”).

Management, having determined it is permissible in the circumstances, has elected to have the audit of the financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audit need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certifications from qualified institutions as of December 31, 2024, and for the year then ended, stating that the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

Disclaimer of Opinion on the 2024 Financial Statements

We do not express an opinion on the accompanying 2024 financial statements of the Plan. Because of the significance of the matter described in the Basis for Disclaimer of Opinion on the 2024 Financial Statements section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2024 financial statements.



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Basis for Disclaimer of Opinion on the 2024 Financial Statements

The Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009. Accordingly, we were unable to apply auditing procedures sufficient to determine the extent to which the 2024 financial statements may have been affected by these conditions.

Responsibilities of Management for the 2024 Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the 2024 Financial Statements

Our responsibility is to conduct an audit of the Plan's 2024 financial statements in accordance with auditing standards generally accepted in the United States of America and to issue an auditor's report. However, because of the matter described in the Basis for Disclaimer of Opinion on the 2024 Financial Statements section of our report, we were not able to obtain sufficient appropriate evidence to provide a basis for an audit opinion on the 2024 financial statements.

We are required to be independent of the Plan, and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit.



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Other Matters

Supplemental Schedule Required by ERISA

The supplemental schedule of assets (held at end of year) as of December 31, 2024 (referred as the “supplemental schedule”) is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements.

Because of the significance of the matter described in the Basis for Disclaimer of Opinion on the 2024 Financial Statements section of our report, it is inappropriate to and we do not express an opinion on the supplemental schedule.

Report of Other Auditors on 2023 Financial Statements

Another auditor performed an audit on the financial statements of the Plan as of and for the year ended December 31, 2023. In accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA, their audit did not extend to any statements or information related to assets held for investment of the Plan that were certified by qualified institutions. In their report dated October 11, 2024, they did not express an opinion on the 2023 financial statements because the Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009.

Ernst + Young LLP

October 15, 2025

Cape Regional Medical Center Defined Contribution Retirement Plan

Statements of Net Assets Available for Benefits

	December 31	
	2024	2023
Assets		
Investments at fair value	\$101,383,811	\$ 90,294,579
Investments at contract value	4,582,972	4,362,425
 Receivables:		
Notes receivable from participants	614,691	935,613
Employer contributions receivable	2,052,192	1,908,887
Employee contribution receivable	-	86,276
Other receivables	9,905	19,543
Total receivables	2,676,788	2,950,319
Net assets available for benefits	\$108,643,571	\$ 97,607,323

See accompanying notes.

Cape Regional Medical Center Defined Contribution Retirement Plan

Statement of Changes in Net Assets Available for Benefits

Year Ended December 31, 2024

Additions

Investment income:

Interest and dividends	\$ 2,100,253
Net appreciation in fair value of investments	<u>11,363,843</u>
Total investment income	<u>13,464,096</u>

Interest income on notes receivable from participants 41,905

Contributions:

Employer match	645,934
Non-elective employer contribution	2,027,746
Participant	4,841,089
Rollover	<u>400,539</u>
Total contributions	<u>7,915,308</u>
Total additions	<u>21,421,309</u>

Deductions

Benefits paid to participants	10,135,280
Administrative expenses	<u>249,781</u>
Total deductions	<u>10,385,061</u>
Net increase	11,036,248

Net assets available for benefits:

Beginning of year	<u>97,607,323</u>
End of year	<u><u>\$ 108,643,571</u></u>

See accompanying notes

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements

December 31, 2024

1. Description of Plan

The following description of the Cape Regional Medical Center Defined Contribution Retirement Plan (the Plan) provides general information about the Plan's provisions. Cooper University Hospital Cape Regional, Inc., formerly known as Cape Regional Medical Center (the Medical Center) is the plan sponsor. Participants should refer to the Plan document and summary plan description for a more complete description of the Plan's provisions, including definitions of key items.

General

The Plan is a defined contribution plan covering substantially all employees of the Medical Center. Employees, except for leased employees and students, are eligible to enroll in the Plan immediately upon commencement of employment. Employees who are classified as Part Time Registered Nurses (PRN) are not eligible to receive the employer matching contributions, unless previously eligible prior to March 1, 2016.

The Board of the Plan Sponsor controls and manages the operation and administration of the Plan. The Plan utilizes State Street Bank and Trust Company, Inc. (State Street) as trustee and Transamerica Financial Life Insurance Company, Inc. (Transamerica) as custodian. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Contributions

Participants may make pre-tax contributions based on an elected dollar amount or percentage of eligible compensation, as defined in the Plan document, subject to certain Internal Revenue Service (IRS) limitations.

The Plan Sponsor makes a matching contribution of 25% of the first 6% of a participant's compensation deferred up to a maximum matching contribution of 1.5% of eligible compensation, on a per-pay-period basis. The Plan Sponsor's matching contribution was \$645,934 for the year ended December 31, 2024. The Plan Sponsor may also make an annual discretionary matching contribution based on operating profits as reported in the audited financial statements of the Plan Sponsor. In order to qualify for the match, participants must be employed on the last day of the Plan year, unless such participant dies, retires or becomes disabled during the Plan year. The Plan Sponsor did not make discretionary matching contributions for the year ended December 31, 2024.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

The Plan also provides for an annual non-elective employer contribution based on a percentage of salary for participants who are not accruing a benefit in the Cape Regional Health System, Inc. Pension Plan (the Pension Plan) as follows: 1-5 years of service shall receive 2%; 6-10 years of service shall receive 3%; 11-15 years of service shall receive 4%; 16-20 years of service shall receive 5%; and over 21 years of service shall receive 7%.

To be eligible for employer non-elective contributions, a participant must complete one year of service in which they are credited with 1,000 hours of service and not be accruing a benefit in the Pension Plan; participation for these contributions commences immediately once the eligibility requirements are met. The non-elective employer contribution was \$2,027,746 for the year ended December 31, 2024.

The Plan includes automatic enrollment provisions, which include a default contribution of 4% with annual escalations of 1% up to a maximum of 8%.

Effective March 1, 2019, the Plan was amended to allow participants to make Roth deferrals and direct rollovers from another qualified Roth contribution program into the Plan.

Participant Accounts

Individual accounts are maintained for each Plan participant. Each participant's account is credited with the participant's contribution, the Plan Sponsor's matching contribution, annual non-elective contribution and investment earnings, and is charged with withdrawals and an allocation of investment losses and administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Participants direct the investment of their account balances into various investment options offered by the Plan and may change their investment options at any time, subject to the terms of the funding vehicles. Plan earnings (losses) are allocated to participants' accounts on a daily basis according to the type of funding vehicle in which balances are invested.

Fund managers' fees are charged to participants' accounts as a reduction of the return earned on each investment option.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

Vesting

Participants' contributions and the Plan Sponsor's matching contribution are fully and immediately vested. A participant's allocation of annual non-elective contributions is subject to three-year cliff vesting, whereby an employee with less than three years of service is 0% vested, and after three years of service the participant is 100% vested.

Notes Receivable from Participants

Participants may borrow from their accounts a minimum of \$1,000 up to a maximum of the lesser of 50% of their vested account balance or \$50,000. Loan terms range to a maximum of five years but can extend for up to a 15-year period if used for the purchase of a primary residence. Loans to participants are secured by the balance in the participant's account, and a participant may only have one loan outstanding at a time. Interest rates are fixed at the time of borrowing at the current prime rate plus 2%. Interest rates on notes receivable from participants ranged from 5.25% to 10.50% at December 31, 2024 and 2023. Principal and interest are paid by the participants directly to the custodian based on prescribed due dates.

Payment of Benefits

Upon termination of service, retirement, death, or total permanent disability, a participant may elect to receive a distribution of his or her entire accumulated Plan balance, subject to the terms and certain limitations of the funding vehicles. Distribution options include lump-sum payments, annuities, partial payments or installments. In addition, participants may elect in-service withdrawals after reaching age 59½. Participants are also permitted to make hardship withdrawals in certain cases of immediate and heavy financial need. Rollover account balances may be withdrawn at any time. Minimum required distributions for participants who have reached age 73 also apply per IRS regulations.

Forfeited Accounts

Forfeitures may be used first to reduce future Plan Sponsor annual non-elective contributions and Plan Sponsor's matching contributions, to restore Plan forfeitures to participants' accounts, to pay Plan expenses, and to reduce future employer matching contributions. There were \$19,925 used to reduce employer contribution and \$2,481 were used to pay Plan expenses for the year ended December 31, 2024. At December 31, 2024 and 2023, forfeited non vested accounts totaled \$138,353 and \$100,560, respectively.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

Administrative Expenses

The Plan's administrative expenses are paid by either the Plan or the Plan Sponsor. The expenses paid by the Plan Sponsor are excluded from the accompanying financial statements. The expenses paid by the Plan pertain to investment consulting fees and other administrative charges incurred by the trustee and custodian in connection with the administration of the Plan. Investment management fees and operating expenses charged to the Plan are deducted from investment income earned on a daily basis and are not separately reflected. Investment management and loan processing fees and distribution fees are paid by the participants.

Plan Termination

Although it has not expressed any intention to do so, the Plan Sponsor has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants would become 100% vested in the annual non-elective Plan Sponsor contributions.

2. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements of the Plan have been prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes and supplemental schedule. Actual results could differ from those estimates.

Payment of Benefits

Benefit payments are recorded when paid.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Investment Valuation and Income Recognition

Investments held by the Plan are reported at fair value, except for fully benefit-responsive investment contracts which are reported at contract value. See Note 4 for further disclosures related to fair value measurements. Contract value is the relevant measurement attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the Plan. See Note 5 for further discussion of the New York Life (NYL) Guaranteed Interest Account.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation in fair value of investments includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Notes Receivable From Participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed when they are incurred. If a participant ceases to make loan repayments and the Plan administrator deems the participant's loan to be in default, the participant's loan balance is reduced, and a benefit payment is recorded.

Revenue Sharing Account

The Plan has a revenue sharing or expense budget account, which represents a suspense account under the Plan that is being credited by amounts received by the Plan that do not consist of earnings on Plan investments or Plan contributions and are not specifically attributable to identified participant accounts. The revenue sharing account can be used to pay expenses incurred in connection with the operation of the Plan. Also, at the discretion of the Plan Sponsor, all amounts remaining in the account as of the last day of the Plan year may be allocated to the accounts of participants and beneficiaries who have account balances as of the allocation date. Any allocation will be made on either a per capita or pro rata basis. The account balance was \$224,069 and \$149,472 at December 31, 2024 and 2023, respectively. Amounts totaling \$88,432 were allocated to participants' accounts for the year ended December 31, 2024.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

3. Investments

All information disclosed in the accompanying financial statements and supplemental schedule, including investments held and notes receivable from participants at December 31, 2024 and 2023, and net appreciation in fair value of investments, interest income on notes receivable from participants, and dividends and interest for the year ended December 31, 2024, was obtained or derived from information provided to the plan administrator and certified as complete and accurate by State Street, the trustee of the Plan, Transamerica, the custodian of the Plan, and New York Life Insurance Company, for the NYL Guaranteed Interest Account.

4. Fair Value Measurements

Fair value is defined under Accounting Standards Codification (ASC) 820, *Fair Value Measurement*, as the price that would be received to sell an asset or paid to transfer a liability in orderly transaction between market participants at the measurement date (i.e., an exit price). To measure fair value, a hierarchy has been established that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs. As such, the hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under ASC 820 are described as follows:

- Level 1 – Unadjusted quoted prices in active markets that are accessible to the reporting entity at the measurement date for identical assets and liabilities.
- Level 2 – Inputs other than quoted prices in active markets for identical assets and liabilities that are observable either directly or indirectly for substantially the full term of the asset or liability.
- Level 3 – Unobservable inputs for the asset or liability (i.e., supported by little or no market activity). These inputs reflect management’s judgment about the assumptions that a market participant would use in pricing the investment and are based on the best available information, some of which may be internally developed.

The asset’s fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

4. Fair Value Measurements (continued)

The following table sets forth by level, within the fair value hierarchy, the Plan's investments carried at fair value.

	2024			
	Level 1	Level 2	Level 3	Total
Mutual funds	\$ 101,383,811	\$ –	\$ –	\$ 101,383,811
Total	\$ 101,383,811	\$ –	\$ –	\$ 101,383,811
	2023			
	Level 1	Level 2	Level 3	Total
Mutual funds	\$ 90,294,579	\$ –	\$ –	\$ 90,294,579
Total	\$ 90,294,579	\$ –	\$ –	\$ 90,294,579

The Plan's shares of mutual funds are valued based on quoted prices of the fund in active markets.

5. Investments at Contract Value

The NYL Guaranteed Interest Account seeks to provide a low-risk, stable investment option. The fund provides the guarantee of principal and accumulated interest, subject to the terms of the contract. The fund invests in diversified fixed income portfolio within the NYL general account. The general account is invested primarily in a conservative array of securities and cash equivalent investments in accordance with the investment restrictions of New York Insurance Law.

The NYL Guaranteed Interest Account is valued at contract value. All withdrawals and transfers from the fund are payable at contract value. Contract value represents contributions made to the account plus earnings less participants' withdrawals and administrative expenses. Due to the size of the fund and the specific percentage allowance negotiated by the fund, it is highly unlikely (not probable) that any event would occur that would limit the fund's ability to transact at contract value with each issuer under these events.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

5. Investments at Contract Value (continued)

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but will always be subject to a range between 1.00% to 3.00%. Such interest rate is reviewed on a semi-annual basis. The interest rate credited to participants was 3.00% as of December 31, 2024. The estimated contract value of the amounts held in this account was \$4,204,664 and \$4,096,665 as of December 31, 2024 and 2023, respectively.

The Plan also holds certain investments in an insurance company general account managed by Transamerica with a contract value of \$378,308 and \$265,760 at December 31, 2024 and 2023, respectively.

6. Related-Party and Party in Interest Transactions

The Plan holds certain investments in an insurance company general account managed by Transamerica, the custodian of the Plan, and New York Life Insurance Company, for the NYL Guaranteed Interest Account. Certain administrative functions are performed by officers or employees of the Medical Center. No such officer or employee receives compensation from the Plan. Administrative expenses are paid from the Plan to the trustee and custodian. These transactions qualify as party-in-interest transactions that are exempt from the prohibited transaction rules under ERISA.

Participants who are active employees may borrow from their accounts and such loans qualify as exempt party-in-interest transactions under ERISA. These loans are reported as notes receivable from participants in the accompanying statements of net assets available for benefits.

7. Tax Status

The underlying pre-approved plan has received an opinion letter from the Internal Revenue Service (IRS) dated March 31, 2017, stating that the written form of the underlying pre-approved document is qualified under Section 403(b) of the Internal Revenue Code (the Code). Any employer adopting this form of the plan will be considered to have a plan qualified under the Code, and, therefore, the related custodial accounts and tax-deferred annuities are tax-exempt. Once qualified, the Plan is required to operate in conformity with the Code to maintain its qualified status. The Plan administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes the Plan is qualified and the related custodial accounts and tax-deferred annuities are tax-exempt.

Cape Regional Medical Center Defined Contribution Retirement Plan

Notes to Financial Statements (continued)

7. Tax Status (continued)

GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that there are no uncertain positions taken or expected to be taken. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

8. Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market volatility and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits.

9. Subsequent Events

Management has evaluated the need for additional disclosures and/or adjustments resulting from subsequent events for the Plan through October 15, 2025, the date the accompanying financial statements were available to be issued.

Supplemental Schedule

Cape Regional Medical Center Defined Contribution Retirement Plan

EIN 21-0662542 Plan # 010

Schedule H, Line 4i – Schedule of Assets (Held at End of Year)

December 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost**	(e) Current Value
*	New York Life Guaranteed Interest Account	Insurance Company/General Account	**	\$ 4,204,664
*	Transamerica Financial Life Ins. Co.	Insurance Company/General Account	**	378,308
	Total insurance company/general accounts			<u>4,582,972</u>
	AB Lg Cap Gr Z	Mutual Fund	**	10,453,067
	American Funds EuroPacific Gr R6	Mutual Fund	**	3,508,259
	American Funds New World R6	Mutual Fund	**	1,389,506
	Columbia Dividend Inc Inst3	Mutual Fund	**	6,530,709
	Federated Hermes Kaufmann Sm cp R6	Mutual Fund	**	639,564
	Fidelity 500 Index	Mutual Fund	**	18,919,456
	Fidelity Inflation-Prot Bd Idx	Mutual Fund	**	2,112,020
	Fidelity Total Intl Index	Mutual Fund	**	1,640,231
	Fidelity US Bd Index	Mutual Fund	**	2,209,923
	Janus Henderson Enterprise N	Mutual Fund	**	2,034,672
	JPMorgan Mid Cap Val R6	Mutual Fund	**	1,168,728
	JPMorgan Small Cap Eq R6	Mutual Fund	**	1,502,815
	Loomis Sayles Core Plus Bd N	Mutual Fund	**	3,506,478
	Macquarie Small Cap Val R6	Mutual Fund	**	1,986,571
	MFS Gbl Real Estate R6	Mutual Fund	**	554,704
	Principal MidCap R6	Mutual Fund	**	2,939,118
	Vanguard Balanced Index Instl	Mutual Fund	**	7,896,655
	Vanguard Federal Money Market	Mutual Fund	**	4,831,213
	Vanguard Target Retrmnt 2020	Mutual Fund	**	5,515,398
	Vanguard Target Retrmnt 2030	Mutual Fund	**	7,865,326
	Vanguard Target Retrmnt 2040	Mutual Fund	**	5,560,112
	Vanguard Target Retrmnt 2050	Mutual Fund	**	5,212,959
	Vanguard Target Retrmnt 2060	Mutual Fund	**	2,687,167
	Vanguard Target Retrmnt Inc	Mutual Fund	**	719,160
	Total mutual funds			<u>101,383,811</u>
	Total investments			105,966,783
*	Notes receivable from participants	Interest rates ranging from 5.25% – 10.50%; maturities between 2025-2029		614,691
				<u>\$ 106,581,474</u>

* Indicates party-in-interest to the Plan.

** Cost information is not required for participant-directed investments.

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Cape Regional Medical Center Defined Contribution Retirement Plan

EIN 21-0662542 Plan # 010

Schedule H, Line 4i – Schedule of Assets (Held at End of Year)

December 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost**	(e) Current Value
*	New York Life Guaranteed Interest Account	Insurance Company/General Account	**	\$ 4,204,664
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	Macquarie Small Cap Val R6	Mutual Fund	**	1,986,571
	MFS Gbl Real Estate R6	Mutual Fund	**	554,704
	Principal MidCap R6	Mutual Fund	**	2,939,118
	Vanguard Balanced Index Instl	Mutual Fund	**	7,896,655
	Vanguard Federal Money Market	Mutual Fund	**	4,831,213
	Vanguard Target Retrmnt 2020	Mutual Fund	**	5,515,398
	Vanguard Target Retrmnt 2030	Mutual Fund	**	7,865,326
	Vanguard Target Retrmnt 2040	Mutual Fund	**	5,560,112
	Vanguard Target Retrmnt 2050	Mutual Fund	**	5,212,959
	Vanguard Target Retrmnt 2060	Mutual Fund	**	2,687,167
	Vanguard Target Retrmnt Inc	Mutual Fund	**	719,160
	Total mutual funds			<u>101,383,811</u>
	Total investments			105,966,783
*	Notes receivable from participants	Interest rates ranging from 5.25% – 10.50%; maturities between 2025-2029		614,691
				<u>\$ 106,581,474</u>

* Indicates party-in-interest to the Plan.

** Cost information is not required for participant-directed investments.