

Form **990**

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

2020

Department of the Treasury
Internal Revenue Service

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

A For the **2020** calendar year, or tax year beginning **JUL 1, 2020** and ending **JUN 30, 2021**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization CEDARS-SINAI MEDICAL CENTER Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 8700 BEVERLY BOULEVARD City or town, state or province, country, and ZIP or foreign postal code LOS ANGELES, CA 90048	D Employer identification number 95-1644600 E Telephone number (310) 423-3277
F Name and address of principal officer: THOMAS M. PRISELAC 8700 BEVERLY BLVD., L.A., CA 90048		G Gross receipts \$ 4,483,395,405.
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions H(c) Group exemption number
J Website: WWW.CEDARS-SINAI.ORG		L Year of formation: 1902 M State of legal domicile: CA
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other		

Part I Summary

1	Briefly describe the organization's mission or most significant activities: PROVIDING QUALITY HEALTHCARE IS OUR PRIORITY. WE ALSO IMPROVE HEALTH THROUGH BIOMEDICAL RESEARCH,		
2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
3	Number of voting members of the governing body (Part VI, line 1a)	3	38
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	30
5	Total number of individuals employed in calendar year 2020 (Part V, line 2a)	5	17096
6	Total number of volunteers (estimate if necessary)	6	1591
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	29,006,654.
7b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	381,697,404.	485,370,389.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	3,301,918,165.	3,755,748,269.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	24,284,107.	185,661,511.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	70,133,936.	56,521,587.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,778,033,612.	4,483,301,756.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	26,842,129.	31,150,887.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	1,666,028,484.	1,806,425,007.
	b Total fundraising expenses (Part IX, column (D), line 25)	40,643.	74,929.
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	12,258,218.	1,615,350,660.
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	1,615,350,660.	1,786,721,318.
Net Assets or Fund Balances	19 Revenue less expenses. Subtract line 18 from line 12	3,308,261,916.	3,624,372,141.
	20 Total assets (Part X, line 16)	469,771,696.	858,929,615.
	21 Total liabilities (Part X, line 26)	Beginning of Current Year	End of Year
	22 Net assets or fund balances. Subtract line 21 from line 20	7,523,813,961.	8,483,105,195.

Part II Signature Block

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

Sign Here	Signature of officer COPY DAVID M. WRIGLEY, SVP, FINANCE & CFO Type or print name and title	Date			
Paid Preparer Use Only	Print/Type preparer's name KARA ADAMS	Preparer's signature <i>Kara Adams</i>	Date 05/14/2021	Check <input type="checkbox"/> Self-employed	PTIN P00023315
	Firm's name ERNST & YOUNG U.S. LLP	Firm's EIN 34-656596	Phone no. (949) 794-2300		

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

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:

CEDARS-SINAI MEDICAL CENTER, A NONPROFIT, INDEPENDENT HEALTH CARE ORGANIZATION IS COMMITTED TO: (SEE SCHEDULE O FOR CONTINUATION)

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

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

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

4a (Code:) (Expenses \$ 2,822,305,917. including grants of \$ 28,876,194.) (Revenue \$ 3,590,340,599.) CLINICAL CARE:

CEDARS-SINAI IS A NONPROFIT ACADEMIC HEALTHCARE ORGANIZATION SERVING THE DIVERSE LOS ANGELES COMMUNITY AND BEYOND. WITH PIONEERING MEDICAL RESEARCH ACHIEVEMENTS, EDUCATION PROGRAMS DEFINING THE FUTURE OF HEALTHCARE, AND WIDE-RANGING COMMUNITY BENEFIT ACTIVITIES, CEDARS-SINAI IS SETTING NEW STANDARDS FOR QUALITY AND INNOVATION INPATIENT CARE. (SEE SCHEDULE O FOR CONTINUATION)

4b (Code:) (Expenses \$ 254,224,014. including grants of \$ 538,000.) (Revenue \$ 152,569,623.) RESEARCH:

CEDARS-SINAI SCIENTISTS AND PHYSICIAN-RESEARCHERS WERE ENGAGED IN MORE THAN 2,300 ACTIVE RESEARCH PROJECTS AND 759 CLINICAL TRIALS AIMED AT ADVANCING NEW TREATMENTS FOR PATIENTS SUFFERING FROM HEART DISEASE, BRAIN DISORDERS, CANCERS AND INNUMERABLE OTHER CONDITIONS. CEDARS-SINAI IS ALSO PIONEERING RESEARCH THAT IMPROVES THE QUALITY AND EFFICIENCY OF HEALTHCARE DELIVERY IN UNDERSERVED COMMUNITIES. CEDARS-SINAI PHYSICIAN SCIENTISTS PUBLISHED OVER 2,700 FACULTY PEER-REVIEWED PUBLICATIONS. (SEE SCHEDULE O FOR CONTINUATION)

4c (Code:) (Expenses \$ 114,523,018. including grants of \$ 1,736,693.) (Revenue \$ 12,838,047.) TRAINING FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS:

FROM THE CLASSROOM TO THE CLINIC, FROM HIGH SCHOOLERS TO GRADUATE STUDENTS AND RESIDENTS, CEDARS-SINAI IS AN EPICENTER OF EDUCATION, MENTORING AND INSPIRATION FOR YOUNG PEOPLE AND FUTURE LEADERS. CEDARS-SINAI'S EDUCATIONAL MISSION IS KEY TO ENSURING A LEGACY OF HIGH-QUALITY SCIENCE AND PATIENT CARE FOR GENERATIONS TO COME. IN FISCAL YEAR 2021, CEDARS-SINAI'S NET COST OF PROVIDING THESE TRAINING PROGRAMS WAS \$101,684,971. (SEE SCHEDULE O FOR CONTINUATION)

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

4e Total program service expenses 3,191,052,949.

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Yes, No. Rows include questions 1 through 21 regarding organizational requirements, such as political activities, lobbying, and financial reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows 22-38. Includes questions about grants, compensation, tax-exempt bonds, excess benefit transactions, and contributions.

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 ID, Question Text, Yes, No. Rows 1a, 1b, 1c. Includes questions about Form 1096, Forms W-2G, and backup withholding rules.

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

Table with columns for question number, question text, and Yes/No columns. Includes questions 2a through 16 regarding employee reporting, tax returns, unrelated business income, foreign accounts, prohibited transactions, and charitable contributions.

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 (38), 1b (30), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed CA, AL, AK, CO, DC, FL, IL, KY, MD, MA, MI, MN
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 DAVID M. WRIGLEY - (310)423-3277

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations. See 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 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			
(1) THOMAS M. PRISELAC PRESIDENT/CEO	65.00 11.00	X		X				4,777,520.	0.	1,345,577.
(2) EDUARDO MARBAN, MD DIRECTOR-HEART INSTITUTE	60.00 1.00					X		3,574,751.	0.	363,688.
(3) KEITH BLACK, MD CHAIR-NEUROSURGERY	60.00 0.00					X		3,360,156.	0.	164,290.
(4) SHLOMO MELMED, MD CHIEF ACADEMIC OFFICER	60.00 1.00				X			2,619,362.	0.	702,481.
(5) RAJENDRA MAKKAR, MD EXEC DIRECTOR-CARDIAC INTERVENTIONAL	60.00 0.00					X		2,823,995.	0.	141,164.
(6) EDWARD M. PRUNCHUNAS TREASURER	60.00 9.00			X				2,315,836.	0.	404,743.
(7) JOANNA CHIKWE, MD CHAIR, CARDIAC SURGERY	60.00 0.00					X		2,499,401.	0.	167,692.
(8) BRUCE GEWERTZ, MD CHAIR-DEPT OF SURGERY	60.00 0.00					X		2,198,157.	0.	373,497.
(9) JEFFREY SMITH MD, JD, MMM CHIEF OPERATING OFFICER	60.00 4.00				X			1,749,907.	0.	57,487.
(10) DAVID M. WRIGLEY CHIEF FINANCIAL OFFICER	60.00 2.00			X				1,569,827.	0.	222,027.
(11) KIMBERLY GREGORY, MD STAFF PHYS./BOARD MEMBER	60.00 0.00	X						592,068.	0.	76,391.
(12) PEGGY MILES, MD STAFF PHYS./BOARD MEMBER	60.00 0.00	X						403,735.	0.	74,059.
(13) ZURI MURRELL, MD MEDICAL DIRECTOR/BOARD MEMBER	8.00 0.00	X						25,901.	0.	777.
(14) SONU AHLUWALIA, MD CLINICAL CHIEF/BOARD MEMBER	5.00 0.00	X						8,000.	0.	0.
(15) MOHAMED (MIKE) AHMAR BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(16) JOHN BENDHEIM BOARD MEMBER	5.00 1.00	X						0.	0.	0.
(17) LAURA W. BRILL BOARD MEMBER	5.00 2.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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			
(18) DALE COCHRAN BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(19) MARC EDELSTEIN, MD CHIEF OF STAFF/BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(20) ARI ENGELBERG BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(21) ABBY FEINMAN BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(22) DEBORAH FREUND, PHD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(23) RUSSELL GOLDSMITH BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(24) MARK S. GREENFIELD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(25) ANDY HEYWARD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(26) ERIC HOLOMAN BOARD MEMBER	5.00 0.00	X						0.	0.	0.
1b Subtotal								28,518,616.	0.	4,093,873.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								28,518,616.	0.	4,093,873.

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 5,516

	Yes	No
3 Did the organization list any former officer, director, 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
COMMUNITY URGENT CARE MED GRP., 9440 SANTA MONICA BLVD., BEVERLY HILLS, CA 90210	URGENT CARE MEDICAL SERVICES	19,694,298.
DVA RENAL HEALTHCARE, INC. 2000 16TH STREET, DENVER, CO 80202	HEMODIALYSIS SERVICES	12,750,847.
AYA HEALTHCARE INC., 5930 CORNERSTONE COURT WEST, SAN DIEGO, CA 92121	STAFFING SERVICES	9,909,838.
BRIGHT HORIZONS 200 TALCOTT AVE., WATERTOWN, MA 02472	EMPLOYEE FAMILY CARE SERVICES	9,751,409.
NTT DATA SERVICES, LLC 100 CITY SQUARE, BOSTON, MA 02129	IT CONSULTING SERVICES	7,778,499.
2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization		386

SEE PART VII, SECTION A CONTINUATION SHEETS

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 line)	(C) Position (check all that apply)						(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			
(27) DAVID B. KAPLAN BOARD MEMBER/SECRETARY	5.00 0.00	X		X				0.	0.	0.
(28) JEFFREY KATZENBERG BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(29) MICHELLE KITTLESON, MD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(30) STEWART KWOH BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(31) THOMAS J. LEANSE, ESQ. BOARD MEMBER	5.00 1.00	X						0.	0.	0.
(32) DAVID B. LEE, MD, MPH, MBA BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(33) DEBRA LEE, ESQ. BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(34) JOSE DE JESUS LEGASPI BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(35) JAMES M. LIPPMAN BOARD MEMBER/CHAIRMAN	10.00 3.00	X						0.	0.	0.
(36) JOSHUA LOBEL BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(37) CHRISTOPHER NG, MD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(38) PATRICIA SALAS PINEDA BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(39) LAWRENCE B. PLATT BOARD MEMBER	5.00 3.00	X						0.	0.	0.
(40) MARC H. RAPAPORT BOARD MEMBER	5.00 3.00	X						0.	0.	0.
(41) STEVEN ROMICK BOARD MEMBER	5.00 2.00	X						0.	0.	0.
(42) DAVID SADKIN BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(43) MARK S. SIEGEL BOARD MEMBER	5.00 2.00	X						0.	0.	0.
(44) G. GABRIELLE "GABI" STARR, PHD BOARD MEMBER	5.00 0.00	X						0.	0.	0.
(45) LESLIE F. VERMUT BOARD MEMBER/VICE CHAIR	5.00 4.00	X						0.	0.	0.
(46) EMMELINE WIDJAJA BOARD MEMBER	5.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c										

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	1,309,547.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	203,485,563.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	280,575,279.				
	g Noncash contributions included in lines 1a-1f	1g	\$ 6,262,025.				
	h Total. Add lines 1a-1f		485,370,389.				
	Program Service Revenue	2 a COMMERCIAL AND MANAGED CARE	Business Code				
		622110	2,568,271,109.	2,568,271,109.			
b MEDICARE & MEDICAID		622110	925,986,780.	925,986,780.			
c SELF PAY AND OTHERS		622110	192,029,381.	192,029,381.			
d PREMIUM REVENUE		622110	27,330,533.	27,330,533.			
e OTHER OPERATING REVENUE		622110	21,900,478.	21,900,478.			
f All other program service revenue		622110	20,229,988.	20,229,988.			
g Total. Add lines 2a-2f		3,755,748,269.					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		45,089,775.			45,089,775.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties		17,489,543.			17,489,543.	
	6 a Gross rents	6a	(i) Real				
			(ii) Personal				
	b Less: rental expenses	6b					
	c Rental income or (loss)	6c					
	d Net rental income or (loss)						
	7 a Gross amount from sales of assets other than inventory	7a	(i) Securities	140,571,736.			
			(ii) Other				
	b Less: cost or other basis and sales expenses	7b	0.				
	c Gain or (loss)	7c	140,571,736.				
d Net gain or (loss)		140,571,736.			140,571,736.		
8 a Gross income from fundraising events (not including \$ 1,309,547. of contributions reported on line 1c). See Part IV, line 18	8a		36,900.				
b Less: direct expenses	8b	93,649.					
c Net income or (loss) from fundraising events		-56,749.			-56,749.		
9 a Gross income from gaming activities. See Part IV, line 19	9a						
b Less: direct expenses	9b						
c Net income or (loss) from gaming activities							
10 a Gross sales of inventory, less returns and allowances	10a						
b Less: cost of goods sold	10b						
c Net income or (loss) from sales of inventory							
Miscellaneous Revenue	11 a LABORATORY REVENUE	Business Code					
		621511	26,473,269.		26,473,269.		
	b PARKING REVENUE	531310	10,082,139.			10,082,139.	
	c ALTERNATIVE INVEST INC	523999	1,014,524.		1,014,524.		
	d All other revenue	541900	1,518,861.		1,518,861.		
e Total. Add lines 11a-11d		39,088,793.					
12 Total revenue. See instructions		4,483,301,756.	3,755,748,269.	29,006,654.	213,176,444.		

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	31,064,584.	31,064,584.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	86,303.	86,303.		
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	16,159,473.	7,896,388.	8,263,085.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	924,445.	924,445.		
7 Other salaries and wages	1,399,308,470.	1,240,130,426.	151,370,037.	7,808,007.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	150,579,970.	131,608,159.	18,971,811.	
9 Other employee benefits	137,934,987.	125,646,099.	10,021,078.	2,267,810.
10 Payroll taxes	101,517,662.	88,632,123.	12,885,539.	
11 Fees for services (nonemployees):				
a Management	19,822,298.	19,822,298.		
b Legal	27,791,411.	10,744,431.	17,046,980.	
c Accounting	1,411,663.	1,918.	1,409,745.	
d Lobbying	632,166.	632,166.		
e Professional fundraising services. See Part IV, line 17	74,929.			74,929.
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	300,949,310.	204,184,753.	95,757,517.	1,007,040.
12 Advertising and promotion	17,836,146.	5,081,892.	12,754,254.	
13 Office expenses	34,918,632.	32,553,691.	2,259,309.	105,632.
14 Information technology	175,356,813.	139,206,945.	36,149,868.	
15 Royalties	11,158,950.	11,158,950.		
16 Occupancy	67,732,544.	53,395,181.	14,337,363.	
17 Travel	2,559,127.	1,682,837.	874,590.	1,700.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	666,183.	476,278.	162,964.	26,941.
20 Interest	29,551,662.	26,316,230.	3,235,432.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	179,563,373.	158,945,336.	20,114,885.	503,152.
23 Insurance	35,602,651.	31,109,626.	4,493,025.	
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	517,799,283.	517,799,283.		
b RESTRICTED FUND EXPENSE	185,857,857.	185,857,857.		
c MEDI-CAL PROGRAM FEE	93,766,752.	93,766,752.		
d MISCELLANEOUS	68,168,268.	61,153,805.	6,762,534.	251,929.
e All other expenses	15,576,229.	11,174,193.	4,190,958.	211,078.
25 Total functional expenses. Add lines 1 through 24e	3,624,372,141.	3,191,052,949.	421,060,974.	12,258,218.
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 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	1,145,156,781.	1	1,078,614,881.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net	169,900,815.	3	272,406,370.
	4 Accounts receivable, net	527,124,137.	4	666,361,777.
	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	2,044,110.	5	2,081,950.
	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)		6	
	7 Notes and loans receivable, net	17,566,730.	7	22,903,065.
	8 Inventories for sale or use	41,550,807.	8	40,591,397.
	9 Prepaid expenses and deferred charges	40,249,627.	9	46,711,731.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 4,737,561,674.		
	b Less: accumulated depreciation	10b 2,199,725,309.	2,481,352,329.	10c 2,537,836,365.
	11 Investments - publicly traded securities	1,849,795,444.	11	2,604,236,959.
	12 Investments - other securities. See Part IV, line 11	416,033,662.	12	406,535,919.
	13 Investments - program-related. See Part IV, line 11	132,330,073.	13	217,542,746.
	14 Intangible assets	100,632,003.	14	54,041,153.
	15 Other assets. See Part IV, line 11	600,077,443.	15	533,240,882.
16 Total assets. Add lines 1 through 15 (must equal line 33)	7,523,813,961.	16	8,483,105,195.	
Liabilities	17 Accounts payable and accrued expenses	736,987,290.	17	784,960,521.
	18 Grants payable		18	
	19 Deferred revenue	853,366.	19	0.
	20 Tax-exempt bond liabilities	1,118,343,942.	20	1,072,715,307.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	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		22	
	23 Secured mortgages and notes payable to unrelated third parties	68,708,794.	23	60,295,302.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	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	467,351,187.	25	386,472,712.
	26 Total liabilities. Add lines 17 through 25	2,392,244,579.	26	2,304,443,842.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	4,351,423,231.	27	5,241,503,300.
	28 Net assets with donor restrictions	780,146,151.	28	937,158,053.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	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	5,131,569,382.	32	6,178,661,353.
33 Total liabilities and net assets/fund balances	7,523,813,961.	33	8,483,105,195.	

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	4,483,301,756.
2	Total expenses (must equal Part IX, column (A), line 25)	2	3,624,372,141.
3	Revenue less expenses. Subtract line 2 from line 1	3	858,929,615.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	5,131,569,382.
5	Net unrealized gains (losses) on investments	5	371,001,728.
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	-182,839,372.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	6,178,661,353.

Part XII Financial Statements and Reporting

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

	Yes	No
1 Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
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: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
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.	X	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? _____	X	
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 _____	X	

Form **990** (2020)

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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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 2020 (line 6, column (f), divided by line 11, column (f)).....	14	%
15 Public support percentage from 2019 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2020. 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 - 2019. 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 - 2020. 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 - 2019. 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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First 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 2020 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2019 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2019 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2020. 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 - 2019. 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 in line 12 on 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 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</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 in 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 in 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 in lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described in line 11a above?		
c A 35% controlled entity of a person described in line 11a or 11b above? If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI .		
11a		
11b		
11c		

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? 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.		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		
1		
2		

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)? 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).		
1		

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? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
3 By reason of the relationship described in 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? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		
1		
2		
3		

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).			
2 Activities Test. Answer lines 2a and 2b below.			
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.	Yes	No	
b Did the activities described in 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? 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.			
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? If "Yes" or "No" provide details in Part VI .			
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.			
2a			
2b			
3a			
3b			

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 - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	8
9	Distributable amount for 2020 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-2020	(iii) Distributable Amount for 2020
1 Distributable amount for 2020 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2020 (reasonable cause required - explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2020			
a From 2015			
b From 2016			
c From 2017			
d From 2018			
e From 2019			
f Total of lines 3a through 3e			
g Applied to underdistributions of prior years			
h Applied to 2020 distributable amount			
i Carryover from 2015 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2020 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2020 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7 Excess distributions carryover to 2021. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2016			
b Excess from 2017			
c Excess from 2018			
d Excess from 2019			
e Excess from 2020			

Schedule A (Form 990 or 990-EZ) 2020

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.)

Multiple horizontal lines for supplemental information.

Schedule B

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2020

Name of the organization

CEDARS-SINAI MEDICAL CENTER

Employer identification number

95-1644600

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000; or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	<hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	<hr/> <hr/> <hr/>	\$ 5,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	<hr/> <hr/> <hr/>	\$ 100,638.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	<hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	<hr/> <hr/> <hr/>	\$ 23,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	<hr/> <hr/> <hr/>	\$ 53,818.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	<hr/> <hr/> <hr/>	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	<hr/> <hr/> <hr/>	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	<hr/> <hr/> <hr/>	\$ 49,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	<hr/> <hr/> <hr/>	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	<hr/> <hr/> <hr/>	\$ 10,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	<hr/> <hr/> <hr/>	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	<hr/> <hr/> <hr/>	\$ 1,004,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	<hr/> <hr/> <hr/>	\$ 14,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	 <hr/> <hr/> <hr/>	\$ 24,644.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	 <hr/> <hr/> <hr/>	\$ 26,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	 <hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	<hr/> <hr/> <hr/>	\$ 2,768,796.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
34	<hr/> <hr/> <hr/>	\$ 19,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	<hr/> <hr/> <hr/>	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	<hr/> <hr/> <hr/>	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	<hr/> <hr/> <hr/>	\$ 27,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	<hr/> <hr/> <hr/>	\$ 18,040.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	<hr/> <hr/> <hr/>	\$ 953,612.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	<hr/> <hr/> <hr/>	\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	<hr/> <hr/> <hr/>	\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	<hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57	<hr/> <hr/> <hr/>	\$ 15,050.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58	<hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59	<hr/> <hr/> <hr/>	\$ 5,264.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61	<hr/> <hr/> <hr/> <hr/>	\$ 9,771.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62	<hr/> <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63	<hr/> <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64	<hr/> <hr/> <hr/> <hr/>	\$ 49,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65	<hr/> <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66	<hr/> <hr/> <hr/> <hr/>	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
67	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68	<hr/> <hr/> <hr/>	\$ 5,625.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
69	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
70	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
73	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
74	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
75	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
76	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
77	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
78	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
79	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
80	<hr/> <hr/> <hr/>	\$ 1,463,147.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
81	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
82	<hr/> <hr/> <hr/>	\$ 50,208.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
83	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
84	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
86	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
87	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
88	<hr/> <hr/> <hr/>	\$ 49,463.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
89	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
90	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
91	<hr/> <hr/> <hr/>	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
92	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
93	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
94	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
95	<hr/> <hr/> <hr/>	\$ 9,985.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
96	<hr/> <hr/> <hr/>	\$ 3,571,175.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
97	<hr/> <hr/> <hr/>	\$ 7,009.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
98	<hr/> <hr/> <hr/>	\$ 255,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
99	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
100	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
101	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
102	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
103	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
104	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
105	<hr/> <hr/> <hr/>	\$ 77,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
106	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
107	<hr/> <hr/> <hr/>	\$ 26,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
108	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
109	 <hr/> <hr/> <hr/>	\$ 17,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
110	 <hr/> <hr/> <hr/>	\$ 6,016.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
111	 <hr/> <hr/> <hr/>	\$ 88,227.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
112	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
113	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
114	 <hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
115	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
116	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
117	<hr/> <hr/> <hr/>	\$ 50,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
118	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
119	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
120	<hr/> <hr/> <hr/>	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
121	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
122	<hr/> <hr/> <hr/>	\$ 5,029.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
123	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
124	<hr/> <hr/> <hr/>	\$ 14,133.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
125	<hr/> <hr/> <hr/>	\$ 14,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
126	<hr/> <hr/> <hr/>	\$ 8,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
127	<hr/> <hr/> <hr/>	\$ 11,125.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
128	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
129	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
130	<hr/> <hr/> <hr/>	\$ 25,176.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
131	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
132	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
133	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
134	<hr/> <hr/> <hr/>	\$ 14,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
135	<hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
136	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
137	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
138	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
139		\$ 550,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
140		\$ 83,032.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
141		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
142		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
143		\$ 798,207.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
144		\$ 11,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
145	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
146	<hr/> <hr/> <hr/>	\$ 9,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
147	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
148	<hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
149	<hr/> <hr/> <hr/>	\$ 70,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
150	<hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
151	<hr/> <hr/> <hr/>	\$ 50,788.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
152	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
153	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
154	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
155	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
156	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
157	<hr/> <hr/> <hr/>	\$ 59,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
158	<hr/> <hr/> <hr/>	\$ 1,497,011.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
159	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
160	<hr/> <hr/> <hr/>	\$ 52,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
161	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
162	<hr/> <hr/> <hr/>	\$ 100,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
163	<hr/> <hr/> <hr/>	\$ 23,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
164	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
165	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
166	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
167	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
168	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
169	 <hr/> <hr/> <hr/>	\$ 25,099.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
170	 <hr/> <hr/> <hr/>	\$ 15,123.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
171	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
172	 <hr/> <hr/> <hr/>	\$ 21,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
173	 <hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
174	 <hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
175	 <hr/> <hr/> <hr/>	\$ 28,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
176	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
177	 <hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
178	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
179	 <hr/> <hr/> <hr/>	\$ 45,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
180	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
181	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
182	 <hr/> <hr/> <hr/>	\$ 135,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
183	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
184	 <hr/> <hr/> <hr/>	\$ 171,260.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
185	 <hr/> <hr/> <hr/>	\$ 3,500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
186	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
187	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
188	<hr/> <hr/> <hr/>	\$ 59,398.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
189	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
190	<hr/> <hr/> <hr/>	\$ 30,450.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
191	<hr/> <hr/> <hr/>	\$ 33,041.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
192	<hr/> <hr/> <hr/>	\$ 11,227.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
193	<hr/> <hr/> <hr/>	\$ 526,051.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
194	<hr/> <hr/> <hr/>	\$ 171,139.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
195	<hr/> <hr/> <hr/>	\$ 87,442.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
196	<hr/> <hr/> <hr/>	\$ 213,352.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
197	<hr/> <hr/> <hr/>	\$ 16,325.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
198	<hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
199	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
200	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
201	<hr/> <hr/> <hr/>	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
202	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
203	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
204	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
205	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
206	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
207	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
208	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
209	<hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
210	<hr/> <hr/> <hr/>	\$ 7,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
211	<hr/> <hr/> <hr/>	\$ 9,305,803.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
212	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
213	<hr/> <hr/> <hr/>	\$ 14,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
214	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
215	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
216	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
217	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
218	<hr/> <hr/> <hr/>	\$ 115,932.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
219	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
220	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
221	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
222	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
223	_____ _____ _____	\$ 1,200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
224	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
225	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
226	_____ _____ _____	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
227	_____ _____ _____	\$ 297,363.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
228	_____ _____ _____	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
229	<hr/> <hr/> <hr/>	\$ 50,958.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
230	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
231	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
232	<hr/> <hr/> <hr/>	\$ 61,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
233	<hr/> <hr/> <hr/>	\$ 8,868.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
234	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
235	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
236	<hr/> <hr/> <hr/>	\$ 1,300,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
237	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
238	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
239	<hr/> <hr/> <hr/>	\$ 50,354.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
240	<hr/> <hr/> <hr/>	\$ 175,170.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
241	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
242	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
243	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
244	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
245	<hr/> <hr/> <hr/>	\$ 13,422.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
246	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
247	<hr/> <hr/> <hr/>	\$ 60,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
248	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
249	<hr/> <hr/> <hr/>	\$ 10,150.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
250	<hr/> <hr/> <hr/>	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
251	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
252	<hr/> <hr/> <hr/>	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
253		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
254		\$ 98,221.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
255		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
256		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
257		\$ 229,064.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
258		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
259	 	\$ 12,518.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
260	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
261	 	\$ 41,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
262	 	\$ 49,671.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
263	 	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
264	 	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
265	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
266	<hr/> <hr/> <hr/>	\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
267	<hr/> <hr/> <hr/>	\$ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
268	<hr/> <hr/> <hr/>	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
269	<hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
270	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
271	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
272	 	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
273	 	\$ 52,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
274	 	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
275	 	\$ 1,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
276	 	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
277	_____ _____ _____	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
278	_____ _____ _____	\$ 1,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
279	_____ _____ _____	\$ 49,369.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
280	_____ _____ _____	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
281	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
282	_____ _____ _____	\$ 18,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
283	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
284	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
285	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
286	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
287	<hr/> <hr/> <hr/>	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
288	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
289		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
290		\$ 10,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
291		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
292		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
293		\$ 50,788.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
294		\$ 51,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
295	<hr/> <hr/> <hr/>	\$ 160,244.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
296	<hr/> <hr/> <hr/>	\$ 400,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
297	<hr/> <hr/> <hr/>	\$ 495,535.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
298	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
299	<hr/> <hr/> <hr/>	\$ 49,908.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
300	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
301		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
302		\$ 103,107.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
303		\$ 59,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
304		\$ 62,900.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
305		\$ 50,026.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
306		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
307	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
308	<hr/> <hr/> <hr/>	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
309	<hr/> <hr/> <hr/>	\$ 29,409.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
310	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
311	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
312	<hr/> <hr/> <hr/>	\$ 50,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
313	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
314	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
315	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
316	<hr/> <hr/> <hr/>	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
317	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
318	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
319	<hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
320	<hr/> <hr/> <hr/>	\$ 12,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
321	<hr/> <hr/> <hr/>	\$ 6,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
322	<hr/> <hr/> <hr/>	\$ 5,353.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
323	<hr/> <hr/> <hr/>	\$ 51,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
324	<hr/> <hr/> <hr/>	\$ 98,221.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
325	<hr/> <hr/> <hr/>	\$ 27,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
326	<hr/> <hr/> <hr/>	\$ 5,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
327	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
328	<hr/> <hr/> <hr/>	\$ 155,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
329	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
330	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
331	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
332	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
333	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
334	<hr/> <hr/> <hr/>	\$ 104,601.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
335	<hr/> <hr/> <hr/>	\$ 122,677.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
336	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
337	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
338	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
339	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
340	<hr/> <hr/> <hr/>	\$ 48,818.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
341	<hr/> <hr/> <hr/>	\$ 24,625.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
342	<hr/> <hr/> <hr/>	\$ 9,169.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
343		\$ 49,290.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
344		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
345		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
346		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
347		\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
348		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
349	<hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
350	<hr/> <hr/> <hr/>	\$ 49,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
351	<hr/> <hr/> <hr/>	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
352	<hr/> <hr/> <hr/>	\$ 50,788.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
353	<hr/> <hr/> <hr/>	\$ 6,291.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
354	<hr/> <hr/> <hr/>	\$ 49,708.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
355	 	\$ 49,709.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
356	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
357	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
358	 	\$ 49,709.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
359	 	\$ 987,303.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
360	 	\$ 705,384.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
361	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
362	<hr/> <hr/> <hr/>	\$ 61,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
363	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
364	<hr/> <hr/> <hr/>	\$ 50,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
365	<hr/> <hr/> <hr/>	\$ 12,625.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
366	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
367	 <hr/> <hr/> <hr/>	\$ 75,764.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
368	 <hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
369	 <hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
370	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
371	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
372	 <hr/> <hr/> <hr/>	\$ 50,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
373	 	\$ 25,148.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
374	 	\$ 50,038.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
375	 	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
376	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
377	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
378	 	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
379	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
380	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
381	 <hr/> <hr/> <hr/>	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
382	 <hr/> <hr/> <hr/>	\$ 28,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
383	 <hr/> <hr/> <hr/>	\$ 14,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
384	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
385	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
386	<hr/> <hr/> <hr/>	\$ 50,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
387	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
388	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
389	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
390	<hr/> <hr/> <hr/>	\$ 13,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
391	 	\$ 5,142.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
392	 	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
393	 	\$ 59,464.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
394	 	\$ 13,166.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
395	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
396	 	\$ 25,247.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
397	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
398	 	\$ 32,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
399	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
400	 	\$ 3,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
401	 	\$ 90,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
402	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
403	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
404	 <hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
405	 <hr/> <hr/> <hr/>	\$ 14,218,212.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
406	 <hr/> <hr/> <hr/>	\$ 100,050.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
407	 <hr/> <hr/> <hr/>	\$ 12,482.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
408	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
409	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
410	 <hr/> <hr/> <hr/>	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
411	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
412	 <hr/> <hr/> <hr/>	\$ 12,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
413	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
414	 <hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
415	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
416	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
417	_____ _____ _____	\$ 55,028.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
418	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
419	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
420	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
421	 <hr/> <hr/> <hr/>	\$ 3,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
422	 <hr/> <hr/> <hr/>	\$ 201,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
423	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
424	 <hr/> <hr/> <hr/>	\$ 9,556.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
425	 <hr/> <hr/> <hr/>	\$ 1,340,392.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
426	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
427	 	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
428	 	\$ 60,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
429	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
430	 	\$ 75,018.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
431	 	\$ 150,121.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
432	 	\$ 23,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
433	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
434	_____ _____ _____	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
435	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
436	_____ _____ _____	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
437	_____ _____ _____	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
438	_____ _____ _____	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
439	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
440	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
441	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
442	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
443	 <hr/> <hr/> <hr/>	\$ 73,932.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
444	 <hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
445	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
446	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
447	 <hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
448	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
449	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
450	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
451	 <hr/> <hr/> <hr/>	\$ <u>7,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
452	 <hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
453	 <hr/> <hr/> <hr/>	\$ <u>54,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
454	 <hr/> <hr/> <hr/>	\$ <u>5,400.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
455	 <hr/> <hr/> <hr/>	\$ <u>50,458.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
456	 <hr/> <hr/> <hr/>	\$ <u>27,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
457	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
458	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
459	 <hr/> <hr/> <hr/>	\$ 24,854.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
460	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
461	 <hr/> <hr/> <hr/>	\$ 54,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
462	 <hr/> <hr/> <hr/>	\$ 3,342,915.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
463		\$ 4,970,839.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
464		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
465		\$ 18,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
466		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
467		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
468		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
469	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
470	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
471	 <hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
472	 <hr/> <hr/> <hr/>	\$ 5,017.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
473	 <hr/> <hr/> <hr/>	\$ 592,883.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
474	 <hr/> <hr/> <hr/>	\$ 29,644.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
475	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
476	 	\$ 160,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
477	 	\$ 400,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
478	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
479	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
480	 	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
481	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
482	 <hr/> <hr/> <hr/>	\$ 5,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
483	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
484	 <hr/> <hr/> <hr/>	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
485	 <hr/> <hr/> <hr/>	\$ 39,788.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
486	 <hr/> <hr/> <hr/>	\$ 20,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
487	 <hr/> <hr/> <hr/>	\$ 9,150.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
488	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
489	 <hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
490	 <hr/> <hr/> <hr/>	\$ 300,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
491	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
492	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
493	_____ _____ _____	\$ _____ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
494	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
495	_____ _____ _____	\$ _____ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
496	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
497	_____ _____ _____	\$ _____ 10,400.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
498	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
499	 	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
500	 	\$ 6,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
501	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
502	 	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
503	 	\$ 120,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
504	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
505		\$ 26,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
506		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
507		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
508		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
509		\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
510		\$ 50,208.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
511	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
512	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
513	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
514	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
515	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
516	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
517	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
518	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
519	<hr/> <hr/> <hr/>	\$ 6,657.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
520	<hr/> <hr/> <hr/>	\$ 57,812.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
521	<hr/> <hr/> <hr/>	\$ 99,138.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
522	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
523	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
524	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
525	<hr/> <hr/> <hr/>	\$ 252,574.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
526	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
527	<hr/> <hr/> <hr/>	\$ 24,909.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
528	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
529	 <hr/> <hr/> <hr/>	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
530	 <hr/> <hr/> <hr/>	\$ 5,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
531	 <hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
532	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
533	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
534	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
535	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
536	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
537	<hr/> <hr/> <hr/>	\$ 51,208.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
538	<hr/> <hr/> <hr/>	\$ 100,956.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
539	<hr/> <hr/> <hr/>	\$ 159,888.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
540	<hr/> <hr/> <hr/>	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
541	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
542	<hr/> <hr/> <hr/>	\$ 23,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
543	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
544	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
545	<hr/> <hr/> <hr/>	\$ 60,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
546	<hr/> <hr/> <hr/>	\$ 23,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
547		\$ 495,535.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
548		\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
549		\$ 76,977.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
550		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
551		\$ 10,118.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
552		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
553	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
554	<hr/> <hr/> <hr/>	\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
555	<hr/> <hr/> <hr/>	\$ 4,995,124.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
556	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
557	<hr/> <hr/> <hr/>	\$ 12,711.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
558	<hr/> <hr/> <hr/>	\$ 25,288.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
559	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
560	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
561	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
562	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
563	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
564	_____ _____ _____	\$ _____ 5,643.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
565	<hr/> <hr/> <hr/> <hr/>	\$ 50,208.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
566	<hr/> <hr/> <hr/> <hr/>	\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
567	<hr/> <hr/> <hr/> <hr/>	\$ 190,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
568	<hr/> <hr/> <hr/> <hr/>	\$ 1,775,027.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
569	<hr/> <hr/> <hr/> <hr/>	\$ 986,480.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
570	<hr/> <hr/> <hr/> <hr/>	\$ 9,472.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
571	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
572	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
573	<hr/> <hr/> <hr/>	\$ 53,818.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
574	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
575	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
576	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
577	 	\$ 350,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
578	 	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
579	 	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
580	 	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
581	 	\$ 8,025,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
582	 	\$ 149,402.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
583	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
584	<hr/> <hr/> <hr/>	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
585	<hr/> <hr/> <hr/>	\$ 53,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
586	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
587	<hr/> <hr/> <hr/>	\$ 103,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
588	<hr/> <hr/> <hr/>	\$ 61,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
589		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
590		\$ 99,382,924.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
591		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
592		\$ 5,104.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
593		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
594		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
595		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
596		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
597		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
598		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
599		\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
600		\$ 150,121.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
601	_____ _____ _____	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
602	_____ _____ _____	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
603	_____ _____ _____	\$ 6,728.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
604	_____ _____ _____	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
605	_____ _____ _____	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
606	_____ _____ _____	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
607	 	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
608	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
609	 	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
610	 	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
611	 	\$ 6,125.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
612	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
613	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
614	_____ _____ _____	\$ 10,710.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
615	_____ _____ _____	\$ 49,854.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
616	_____ _____ _____	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
617	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
618	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
619	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
620	<hr/> <hr/> <hr/>	\$ 15,705.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
621	<hr/> <hr/> <hr/>	\$ 48,818.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
622	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
623	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
624	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
625	<hr/> <hr/> <hr/>	\$ 51,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
626	<hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
627	<hr/> <hr/> <hr/>	\$ 16,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
628	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
629	<hr/> <hr/> <hr/>	\$ 11,625.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
630	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
631	 	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
632	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
633	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
634	 	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
635	 	\$ 24,409.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
636	 	\$ 1,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
637	 <hr/> <hr/> <hr/>	\$ 6,225.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
638	 <hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
639	 <hr/> <hr/> <hr/>	\$ 52,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
640	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
641	 <hr/> <hr/> <hr/>	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
642	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
643		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
644		\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
645		\$ 240,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
646		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
647		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
648		\$ 24,854.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
649	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
650	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
651	<hr/> <hr/> <hr/>	\$ 24,022.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
652	<hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
653	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
654	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
655	<hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
656	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
657	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
658	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
659	<hr/> <hr/> <hr/>	\$ 43,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
660	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
661	<hr/> <hr/> <hr/>	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
662	<hr/> <hr/> <hr/>	\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
663	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
664	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
665	<hr/> <hr/> <hr/>	\$ 33,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
666	<hr/> <hr/> <hr/>	\$ 150,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
667	 <hr/> <hr/> <hr/>	\$ 325,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
668	 <hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
669	 <hr/> <hr/> <hr/>	\$ 95,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
670	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
671	 <hr/> <hr/> <hr/>	\$ 5,215,840.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
672	 <hr/> <hr/> <hr/>	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
673	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
674	 <hr/> <hr/> <hr/>	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
675	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
676	 <hr/> <hr/> <hr/>	\$ 45,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
677	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
678	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
679	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
680	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
681	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
682	 <hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
683	 <hr/> <hr/> <hr/>	\$ 3,672,363.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
684	 <hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
685	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
686	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
687	<hr/> <hr/> <hr/>	\$ 62,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
688	<hr/> <hr/> <hr/>	\$ 350,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
689	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
690	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
691	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
692	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
693	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
694	<hr/> <hr/> <hr/>	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
695	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
696	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
697	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
698	<hr/> <hr/> <hr/>	\$ 300,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
699	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
700	<hr/> <hr/> <hr/>	\$ 14,824.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
701	<hr/> <hr/> <hr/>	\$ 1,979,238.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
702	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
703	<hr/> <hr/> <hr/>	\$ 150,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
704	<hr/> <hr/> <hr/>	\$ 23,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
705	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
706	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
707	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
708	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
709	_____ _____ _____	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
710	_____ _____ _____	\$ 350,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
711	_____ _____ _____	\$ 293,040.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
712	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
713	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
714	_____ _____ _____	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
715	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
716	_____ _____ _____	\$ 16,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
717	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
718	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
719	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
720	_____ _____ _____	\$ 146,456.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
721	<hr/> <hr/> <hr/>	\$ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
722	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
723	<hr/> <hr/> <hr/>	\$ 77,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
724	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
725	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
726	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
727	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
728	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
729	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
730	<hr/> <hr/> <hr/>	\$ 703,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
731	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
732	<hr/> <hr/> <hr/>	\$ 39,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
733		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
734		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
735		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
736		\$ 42,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
737		\$ 18,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
738		\$ 14,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
739	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
740	<hr/> <hr/> <hr/>	\$ 93,553.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
741	<hr/> <hr/> <hr/>	\$ 55,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
742	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
743	<hr/> <hr/> <hr/>	\$ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
744	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
745	<hr/> <hr/> <hr/>	\$ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
746	<hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
747	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
748	<hr/> <hr/> <hr/>	\$ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
749	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
750	<hr/> <hr/> <hr/>	\$ 225,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
751	<hr/> <hr/> <hr/>	\$ 479,070.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
752	<hr/> <hr/> <hr/>	\$ 13,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
753	<hr/> <hr/> <hr/>	\$ 26,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
754	<hr/> <hr/> <hr/>	\$ 48,425.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
755	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
756	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
757	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
758	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
759	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
760	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
761	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
762	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
763	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
764	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
765	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
766	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
767	<hr/> <hr/> <hr/>	\$ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
768	<hr/> <hr/> <hr/>	\$ 52,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
769	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
770	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
771	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
772	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
773	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
774	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
775	<hr/> <hr/> <hr/>	\$ 49,288.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
776	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
777	<hr/> <hr/> <hr/>	\$ 80,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
778	<hr/> <hr/> <hr/>	\$ 400,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
779	<hr/> <hr/> <hr/>	\$ 53,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
780	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
781	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
782	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
783	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
784	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
785	<hr/> <hr/> <hr/>	\$ 327,032.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
786	<hr/> <hr/> <hr/>	\$ 700,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
787	_____ _____ _____	\$ 150,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
788	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
789	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
790	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
33	VARIOUS STOCKS _____ _____ _____	\$ 606,422.	12/28/20
97	VARIOUS STOCKS _____ _____ _____	\$ 7,009.	01/14/21
122	VARIOUS STOCKS _____ _____ _____	\$ 5,029.	12/14/20
124	VARIOUS STOCKS _____ _____ _____	\$ 11,133.	12/29/20
130	VARIOUS STOCKS _____ _____ _____	\$ 25,176.	12/07/20
140	VARIOUS STOCKS _____ _____ _____	\$ 37,032.	05/24/21

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
169	VARIOUS STOCKS _____ _____ _____	\$ 24,978.	06/23/21
170	VARIOUS STOCKS _____ _____ _____	\$ 15,123.	01/11/21
197	VARIOUS STOCKS _____ _____ _____	\$ 16,325.	03/12/21
227	VARIOUS STOCKS _____ _____ _____	\$ 297,363.	11/11/20
233	VARIOUS STOCKS _____ _____ _____	\$ 8,868.	09/23/20
245	VARIOUS STOCKS _____ _____ _____	\$ 9,922.	06/25/21

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
259	VARIOUS STOCKS _____ _____ _____	\$ 12,468.	03/11/21
262	VARIOUS STOCKS _____ _____ _____	\$ 49,671.	12/07/20
279	VARIOUS STOCKS _____ _____ _____	\$ 49,369.	12/22/20
295	VARIOUS STOCKS _____ _____ _____	\$ 20,244.	12/23/20
305	VARIOUS STOCKS _____ _____ _____	\$ 10,738.	01/25/21
335	VARIOUS STOCKS _____ _____ _____	\$ 110,177.	06/03/21

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
343	VARIOUS STOCKS _____ _____ _____	\$ 10,146.	03/19/21
360	VARIOUS STOCKS _____ _____ _____	\$ 705,384.	07/02/20
367	VARIOUS STOCKS _____ _____ _____	\$ 75,764.	12/30/20
373	VARIOUS STOCKS _____ _____ _____	\$ 25,148.	12/14/20
391	VARIOUS STOCKS _____ _____ _____	\$ 5,142.	12/30/20
396	VARIOUS STOCKS _____ _____ _____	\$ 25,247.	12/18/20

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
417	VARIOUS STOCKS _____ _____ _____	\$ 55,028.	12/24/20
430	VARIOUS STOCKS _____ _____ _____	\$ 48,918.	05/11/21
431	VARIOUS STOCKS _____ _____ _____	\$ 75,121.	12/24/20
462	VARIOUS STOCKS _____ _____ _____	\$ 3,342,915.	05/03/21
557	VARIOUS STOCKS _____ _____ _____	\$ 9,996.	04/19/21
558	VARIOUS STOCKS _____ _____ _____	\$ 25,288.	12/14/20

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
564	VARIOUS STOCKS _____ _____ _____	\$ 3,143.	02/11/21
570	VARIOUS STOCKS _____ _____ _____	\$ 9,472.	01/20/21
600	VARIOUS STOCKS _____ _____ _____	\$ 75,121.	12/24/20
614	VARIOUS STOCKS _____ _____ _____	\$ 10,710.	09/01/20
620	VARIOUS STOCKS _____ _____ _____	\$ 15,454.	06/29/21
751	VARIOUS STOCKS _____ _____ _____	\$ 51,524.	12/17/20

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
754	VARIOUS STOCKS _____ _____ _____	\$ 48,425.	03/04/21
785	VARIOUS STOCKS _____ _____ _____	\$ 327,032.	07/24/20
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____

Name of organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2020

Department of the Treasury
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
▶ 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 <p style="text-align: center;">CEDARS-SINAI MEDICAL CENTER</p>	Employer identification number <p style="text-align: center;">95-1644600</p>
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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.
- 2 Political campaign activity expenditures ▶ \$ _____
- 3 Volunteer hours for political campaign activities _____

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-.

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2020

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%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="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?														

Yes 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) 2017	(b) 2018	(c) 2019	(d) 2020	(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				

Schedule C (Form 990 or 990-EZ) 2020

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?	X		507,614.
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		124,552.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total. Add lines 1c through 1i			632,166.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

PART II-B, LINE 1, LOBBYING ACTIVITIES:

FORM 990, SCHEDULE C, PART II-B, LINE 1F: THESE GRANTS INCLUDE

CEDARS-SINAI'S MEMBERSHIP DUES TO LOCAL, STATE, AND NATIONAL

ORGANIZATIONS SUCH AS THE AMERICAN HOSPITAL ASSOCIATION, COALITION TO

TRANSFORM ADVANCED CARE, AND HOSPITAL ASSOCIATION OF SOUTHERN

CALIFORNIA, AS WELL AS CONSULTING FIRMS. THESE ORGANIZATIONS HELP

Part IV Supplemental Information (continued)

INFORM US ABOUT PENDING CHANGES IN LEGISLATION AND REGULATIONS, PROVIDE

EDUCATION AND ADVOCACY ON ISSUES THAT ARE CRITICAL TO THE ACHIEVEMENT

OF OUR MISSION, AND PROVIDE OTHER GUIDANCE ON LEGISLATIVE AND

REGULATORY ISSUES AND COMMUNITY CONCERNS.

FORM 990, SCHEDULE C, PART II-B, LINE 1G: MEETING WITH ELECTED

OFFICIALS ON THE FEDERAL, STATE AND CITY LEVEL AS WELL AS FEDERAL AND

STATE OFFICIALS AND CITY AGENCY EXECUTIVES TO INFORM AND EDUCATE

REGARDING ISSUES IMPORTANT TO THE HEALTH OF THE CITY'S AND REGION'S

RESIDENTS, AS WELL AS THEIR QUALITY OF LIFE AND ECONOMIC DEVELOPMENT.

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization CEDARS-SINAI MEDICAL CENTER **Employer identification number** 95-1644600

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (for example, recreation or education) Preservation of a historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under 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.

b 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

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 CONTRIBUTES TO PATIENT HEALING
- 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 on Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	923,370,443.	867,508,124.	809,720,406.	753,750,120.	686,147,333.
b Contributions	64,822,110.	36,483,139.	30,702,771.	24,099,928.	17,226,958.
c Net investment earnings, gains, and losses	206,650,800.	32,119,212.	30,851,444.	35,532,478.	53,795,841.
d Grants or scholarships					
e Other expenditures for facilities and programs	13,764,803.	12,740,032.	3,766,497.	3,662,120.	3,420,012.
f Administrative expenses					
g End of year balance	1,181,078,550.	923,370,443.	867,508,124.	809,720,406.	753,750,120.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment 31.7700 %
 - b Permanent endowment 68.2300 %
 - c Term endowment %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|--|-----|----|
| (i) Unrelated organizations | | X |
| (ii) Related organizations | | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		146,085,449.		146,085,449.
b Buildings		2,914,787,381.	1,107,872,823.	1,806,914,558.
c Leasehold improvements		45,326,616.	34,036,104.	11,290,512.
d Equipment		1,381,044,162.	1,057,816,382.	323,227,780.
e Other		250,318,066.		250,318,066.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				2,537,836,365.

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. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

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)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	112,666,997.
(2) OPERATING LEASE ROU ASSET	187,367,592.
(3) FINANCING LEASE ROU ASSET	12,657,539.
(4) SUPPLEMENTAL LIFE INSURANCE ASSET	17,286,376.
(5) WORKERS' COMPENSATION STOP LOSS INSURANCE	15,200,000.
(6) MALPRACTICE STOP LOSS INSURANCE	26,417,000.
(7) OTHER INVESTMENTS	161,645,378.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	533,240,882.

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) WORKERS' COMPENSATION LIABILITY PROGRAM	92,851,000.
(3) MALPRACTICE AND GENERAL LIABILITY PROGRAM	65,478,000.
(4) PENSION LIABILITY	29,536,898.
(5) DUE TO AFFILIATES	4,974,085.
(6) LONG TERM OPERATING LEASE LIABILITY	184,048,242.
(7) LONG TERM FINANCE LEASE LIABILITY	9,584,487.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	386,472,712.

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.

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

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

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

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

Part XIII Supplemental Information.

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

PART III, LINE 1A:

THE ORGANIZATION HAS ELECTED, AS PERMITTED UNDER ACCOUNTING STANDARDS

CODIFICATION 958, NOT TO REPORT ON ITS REVENUE STATEMENT AND BALANCE SHEET

WORKS OF ART HELD FOR PUBLIC EXHIBITION.

PART III, LINE 4:

CEDARS-SINAI'S ART COLLECTION IS DESIGNED TO BE PART OF THE OVERALL

HEALING ENVIRONMENT FOR OUR PATIENTS. DISPLAYED THROUGHOUT THE HOSPITAL,

THE ART PROVIDES PATIENTS AND THEIR FAMILIES WITH A FOCAL POINT TO HELP

ALLEVIATE THE STRESS OF HOSPITALIZATION AND ALSO CAN BE HELPFUL IN THE

REHABILITATION PROCESS FOR PATIENTS WITH NEUROLOGICAL AND OTHER DISORDERS.

THE ART COLLECTION COMES FROM DONATIONS, AND PIECES ARE CHOSEN FOR THE

Part XIII Supplemental Information (continued)

COLLECTION BY A VOLUNTEER JURY OF ARTS EXPERTS. THE COLLECTION IS
DESIGNED TO BE A PERMANENT PART OF CEDARS-SINAI'S HEALING ENVIRONMENT FOR
PATIENTS, SO PIECES FROM THE COLLECTION ARE GENERALLY NOT SOLD BY THE
HOSPITAL.

PART V, LINE 4:

THE MEDICAL CENTER'S ENDOWMENT CONSISTS OF APPROXIMATELY 244 INDIVIDUAL
FUNDS FOR A VARIETY OF PURPOSES. THE INTENDED USES ARE FOR RESEARCH,
DONOR-DESIGNATED, OR FOR GENERAL PURPOSES.

PART X, LINE 2:

THE MEDICAL CENTER COMPLETED AN ANALYSIS OF ITS TAX POSITIONS, IN
ACCORDANCE WITH ASC 740, INCOME TAXES, AND DETERMINED THAT THERE ARE NO
UNCERTAIN TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN. THE MEDICAL CENTER
HAS RECOGNIZED NO INTEREST OR PENALTIES RELATED TO UNCERTAIN TAX
POSITIONS. THE MEDICAL CENTER IS SUBJECT TO ROUTINE AUDITS BY TAXING
JURISDICTIONS; HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS
IN PROGRESS. THE MEDICAL CENTER BELIEVES IT IS NO LONGER SUBJECT TO INCOME
TAX EXAMINATIONS FOR YEARS PRIOR TO 2017.

**SCHEDULE F
(Form 990)**

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2020

Open to Public
Inspection

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
---	--

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

- 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
- For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.
- 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
CENTRAL AMERICA AND THE CARIBBEAN - ANTIGUA & BARBUDA, ARUBA, BAHAMAS,	0	0	INVESTMENTS	N/A	187,678,752.
EAST ASIA AND THE PACIFIC - AUSTRALIA, BRUNEI, BURMA, CAMBODIA,	1	1	PROGRAM SERVICES	SEE PART V NARRATIVE	336,262.
NORTH AMERICA - CANADA AND MEXICO, BUT NOT THE UNITED STATES	0	2	PROGRAM SERVICES	SEE PART V NARRATIVE	487,151.
EUROPE (INCLUDING ICELAND & GREENLAND) - ALBANIA, ANDORRA, AUSTRIA, BELGIUM	0	0	PROGRAM SERVICES	SEE PART V NARRATIVE	630,225.
MIDDLE EAST AND NORTH AFRICA - ALGERIA, BAHRAIN, DJIBOUTI, EGYPT,	0	0	PROGRAM SERVICES	SEE PART V NARRATIVE	36,166.
RUSSIA AND NEIGHBORING STATES - ARMENIA, AZERBAIJAN, BELARUS, GEORGIA,	0	0	GRANT MAKING	N/A	10,000.
SOUTH ASIA - AFGHANISTAN, BANGLADESH, BHUTAN, INDIA, MALDIVES,	0	0	GRANT MAKING	N/A	25,000.
NORTH AMERICA - CANADA AND MEXICO, BUT NOT THE UNITED STATES	0	0	GRANT MAKING	N/A	50,000.
3 a Subtotal	1	3			189,253,556.
b Total from continuation sheets to Part I	0	0			8,453.
c Totals (add lines 3a and 3b)	1	3			189,262,009.

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

Schedule F (Form 990) 2020

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)
		SOUTH ASIA - AFGHANISTAN, BANGLADESH, BHUTAN, INDIA,	SUPPORT FOR COVID-19 EMERGENCY RESPONSE RELIEF IN INDIA	25,000.	CHECK	0.		
		RUSSIA AND NEIGHBORING STATES	SUPPORT FOR NAGORNO-KARABAKH HUMANITARIAN RELIEF	10,000.	CHECK	0.		
		NORTH AMERICA	SUPPORT FOR BROAD INTERNATIONAL COVID-19 EMERGENCY RESPONSE EFFORTS	50,000.	CHECK	0.		

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**

3 Enter total number of other organizations or entities **0**

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 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 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 Instructions for Form 5471)* Yes No

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

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

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

Schedule F (Form 990) 2020

Part V Supplemental Information

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

SCHEDULE F, PART I, LINE 2

THE ORGANIZATION CONSISTENTLY CONTRIBUTES TO WELL-ESTABLISHED EXEMPT

ORGANIZATIONS AND RELIES ON THE GOVERNING BODY OF EACH OF THESE

ORGANIZATIONS TO ENSURE THAT GRANT FUNDS DONATED TO EACH AND EVERY

ORGANIZATION ARE USED FOR PROPER PURPOSES AND NOT OTHERWISE DIVERTED

FROM THE INTENDED USE.

SCHEDULE F, PART I, LINE 3

REGION: EAST ASIA AND THE PACIFIC - THE ORGANIZATION IS PROVIDING

FUNDING FOR THE FOLLOWING:

1. AUSTRALIA - THE ORGANIZATION IS PROVIDING FUNDING FOR TREATMENT OF PANCREATITIS RESULTING FROM ALCOHOL ABUSE AND SMOKING RESEARCH AT THE UNIVERSITY OF NEW SOUTH WALES.

2. NEW ZEALAND - THE ORGANIZATION IS PROVIDING FUNDING FOR PANCREATOGENIC DISEASE RESEARCH AT THE UNIVERSITY OF AUCKLAND.

3. CHINA - AN OFFICE IS MAINTAINED WITHIN SHANGHAI TO EXPAND ACCESS TO CEDARS-SINAI'S HEALTHCARE SERVICES TO PATIENTS IN CHINA REFERRED BY THEIR PHYSICIANS.

REGION: NORTH AMERICA - THE ORGANIZATION IS PROVIDING FUNDING FOR THE

FOLLOWING:

1. CANADA - THE ORGANIZATION IS PROVIDING FUNDING TO THE UNIVERSITY OF BRITISH COLUMBIA FOR CARDIOVASCULAR IMAGING RESEARCH AND UNIVERSITY HEALTH NETWORK FOR RESEARCH ON NEURONAL MECHANISMS OF HUMAN EPISODIC

Part V Supplemental Information

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

MEMORY.

2. MEXICO - CONSULTANTS ARE MAINTAINED IN MEXICO AND EXPENSES WERE

INCURRED FOR COMMUNITY ENGAGEMENT, BRAND PLACEMENT, AND TO EXPAND

ACCESS TO CEDARS-SINAI'S HEALTHCARE SERVICES TO PATIENTS ACROSS LATIN

AMERICA ON A REFERRAL BASIS.

REGION: EUROPE (INCLUDING ICELAND & GREENLAND) - THE ORGANIZATION IS

PROVIDING FUNDING FOR THE FOLLOWING:

1. SPAIN - THE ORGANIZATION IS PROVIDING FUNDING FOR THE DETERMINATION

OF THE ROLE OF S-ADENOSYL METHIONINE IN PATHOGENESIS AND MECHANISTIC

BASIS FOR CONSTITUTIONAL MLH1 METHYLATION (EPIMUTATION).

2. GREAT BRITAIN - THE ORGANIZATION IS PROVIDING FUNDING FOR THE

RESEARCH OF FUNCTIONAL EFFECTS OF OVARIAN CANCER RISK VARIANTS AT THE

UNIVERSITY OF CAMBRIDGE. FUNDING IS ALSO PROVIDED FOR THE RESEARCH OF

INTEGRATED ANALYSIS OF CORONARY ANATOMY AND BIOLOGY AT THE UNIVERSITY

OF EDINBURGH.

3. CZECH REPUBLIC - THE ORGANIZATION IS PROVIDING FUNDING FOR THE

REGIONAL COOPERATION FOR HEALTH, SCIENCE AND TECHNOLOGY (RECOOP HST)

ASSOCIATION TO EXPLORE AND ENHANCE LOCAL SCIENTIFIC OUTPUTS, CREATE A

CRITICAL MASS OF SCIENTIFICALLY SOUND INNOVATIVE RESEARCH AT THE

REGIONAL LEVEL AND EXPLOIT THE RESEARCH OUTCOMES AT THE GLOBAL LEVEL.

4. GERMANY - THE ORGANIZATION IS PROVIDING FUNDING FOR ONCIMMUNE

GERMANY GMBH FOR AUTOANTIBODY PROFILING WITH NAVIGAID IN COVID-19

PATIENTS. FUNDING IS ALSO PROVIDED FOR THE RESEARCH OF NOVEL BIOMARKERS

FOR CANCER-RELATED FATIGUE AT THE UNIVERSITY HOSPITAL HEIDELBERG.

REGION: THE MIDDLE EAST AND NORTH AFRICA - THE ORGANIZATION IS

Part V Supplemental Information

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

PROVIDING FUNDING FOR THE FOLLOWING:

1. UNITED ARAB EMIRATES - THE ORGANIZATION INCURRED EXPENSES IN THE REGION TO EXPLORE COLLABORATIVE OPPORTUNITIES, TO ATTEND ARAB HEALTH (LARGEST ANNUAL HEALTHCARE CONFERENCE IN THE REGION), AND TO EXPAND ACCESS TO CEDARS-SINAI'S HEALTHCARE SERVICES TO PATIENTS IN UAE ON A REFERRAL BASIS.

PART I, LINE 3, COLUMN F

REGION: CENTRAL AMERICA AND THE CARIBBEAN

VALUE OF INVESTMENTS MADE: 187,678,752

AMOUNT OF INVESTMENT FEES: 11,569,553

PART I, LINE 3, COLUMN F

THE AMOUNT OF EXPENDITURES REPORTED HERE IS BASED ON THE METHOD USED ON

THE ORGANIZATION'S FINANCIAL STATEMENTS WHICH IS THE ACCRUAL METHOD OF

ACCOUNTING.

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 (add col. (a) through col. (c))
		BOARD OF GOVERNORS GALA (event type)	TOM COLLIER MEMORIAL REGATTA (event type)	NONE (total number)	
Revenue	1 Gross receipts	1,337,222.	9,225.		1,346,447.
	2 Less: Contributions	1,300,322.	9,225.		1,309,547.
	3 Gross income (line 1 minus line 2)	36,900.			36,900.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages	30,180.			30,180.
	8 Entertainment				
	9 Other direct expenses	63,469.			63,469.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				93,649.
11 Net income summary. Subtract line 10 from line 3, column (d)				-56,749.	

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

Name ▶ _____

Address ▶ _____

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

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

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

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

- Director/officer Employee Independent contractor

17 Mandatory distributions:

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

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

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

SCHEDULE G, PART I, LINE 2B, LIST OF TEN HIGHEST PAID FUNDRAISERS:

(I) NAME OF FUNDRAISER: TRACI HOFFBERG EVENTS

(I) ADDRESS OF FUNDRAISER: 4138 VNTAGE AVE, STUIDO CITY, CA 91604

PART I, LINE 2B, COLUMN (V):

TRACI HOFFBERG EVENTS WAS HIRED TO ASSIST WITH THE PLANNING AND DELIVERY

OF ACTIVITIES IN SUPPORT OF THE ANNUAL BOARD OF GOVERNORS GENERAL ASSEMBLY AND GALA EVENTS. SERVICES INCLUDE THE MANAGEMENT OF PROGRAMMING,

Part IV Supplemental Information *(continued)*

INTERDEPARTMENTAL INFORMATION MANAGEMENT AND COMMUNICATION WITH PARTNERS,

LEADERS AND POTENTIAL SERVICE PARTNERS.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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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	1a	X	
b If "Yes," was it a written policy?	1b	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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 400 %			
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	X	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 600 %			
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"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			38,548,815.	0.	38,548,815.	1.05%
b Medicaid (from Worksheet 3, column a)			414,770,946.	382,384,292.	32,386,654.	.88%
c Costs of other means-tested government programs (from Worksheet 3, column b)			18,068,081.	14,534,467.	3,533,614.	.10%
d Total. Financial Assistance and Means-Tested Government Programs			471,387,842.	396,918,759.	74,469,083.	2.03%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			19,400,706.	137,699.	19,263,007.	.53%
f Health professions education (from Worksheet 5)			114,523,018.	12,838,047.	101,684,971.	2.78%
g Subsidized health services (from Worksheet 6)			446,288,070.	417,853,961.	28,434,109.	.78%
h Research (from Worksheet 7)			254,224,014.	152,569,623.	101,654,391.	2.77%
i Cash and in-kind contributions for community benefit (from Worksheet 8)			28,145,300.	0.	28,145,300.	.77%
j Total. Other Benefits			862,581,108.	583,399,330.	279,181,778.	7.63%
k Total. Add lines 7d and 7j			1333968950.	980,318,089.	353,650,861.	9.66%

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 CEDARS-SINAI MEDICAL CENTER

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

	Yes	No
Community Health Needs Assessment		
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 checked="" type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: <u>20 18</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	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		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>HTTPS://WWW.CEDARS-SINAI.ORG/COMMUNITY/COMMUNITY-BENEFIT.HTML</u>		
b <input type="checkbox"/> Other website (list url):		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 19</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>HTTPS://WWW.CEDARS-SINAI.ORG/COMMUNITY/COMMUNITY-BENEFIT.HTML</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 CEDARS-SINAI MEDICAL CENTER

		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?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>400</u> % and FPG family income limit for eligibility for discounted care of <u>600</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?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her 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 checked="" 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?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</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)		

Schedule H (Form 990) 2020

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group CEDARS-SINAI MEDICAL CENTER

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written 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?		x
If "Yes," check all actions in which the hospital facility or a third party engaged:		
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?	x	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

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 CEDARS-SINAI MEDICAL CENTER

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input 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.	23	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.	24	x

Schedule H (Form 990) 2020

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.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 3J: THE CHNA HELPS TO IDENTIFY THE UNMET HEALTH

NEEDS OF THE COMMUNITIES SERVED BY CEDARS-SINAI MEDICAL CENTER AND

PROVIDES A FRAMEWORK FOR PRIORITIZING HOW THE HOSPITAL WILL ADDRESS UNMET

COMMUNITY NEEDS THROUGH THE PROVISION OF COMMUNITY HEALTH SERVICES.

CEDARS-SINAI'S MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT FOR JULY 1,

2019 THROUGH JUNE 30, 2022 WAS APPROVED BY ITS GOVERNING BODY IN MAY 2019.

THE NEXT COMMUNITY HEALTH NEEDS ASSESSMENT COVERS THE THREE YEAR PERIOD

BEGINNING ON JULY 1, 2022.

COMMUNITY BENEFIT SERVICE AREA:

CEDARS-SINAI IS LOCATED AT 8700 BEVERLY BOULEVARD, LOS ANGELES, CALIFORNIA

90048. ITS COMMUNITY BENEFIT SERVICE AREA FOR 2019-2022 INCLUDES LARGE

PORTIONS OF SERVICE PLANNING AREAS (SPAS): 4 (METRO), 5 (WEST) AND 6

(SOUTH), AND A SMALLER PORTION OF SPA 8 (SOUTH BAY). THE COMMUNITY BENEFIT

SERVICE AREA CAN ALSO BE VIEWED BY LOS ANGELES CITY COUNCIL DISTRICTS,

COVERING ALL OR PART OF DISTRICTS 1, 4, 5, 8, 9, 10, 13, 14 AND 15. THE

COMMUNITY BENEFIT SERVICE AREA INCLUDES 52 ZIP CODES, REPRESENTING 25

CITIES OR NEIGHBORHOODS. HOWEVER, TWO ZIP CODES (90071 AND 90079 IN

DOWNTOWN LOS ANGELES) HAVE NO RESIDENT POPULATION FROM THE CENSUS AND WILL

NOT BE EXAMINED WITHIN THIS REPORT. CEDARS-SINAI DETERMINES THE COMMUNITY

BENEFIT SERVICE AREA BY ASSIGNING ZIP CODES BASED UPON PATIENT DISCHARGES;

THE CURRENT UNDERSTANDING OF COMMUNITY NEED BASED ON THE MOST RECENT CHNA;

AND LONG-STANDING COMMUNITY PROGRAMS AND PARTNERSHIPS.

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.

CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA (CURRENT):

THE TOTAL POPULATION FOR CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA

(CURRENT) IS 1,814,274. THE TOTAL POPULATION FOR LOS ANGELES COUNTY

10,057,155.

RACE/ETHNICITY

THE POPULATION CHARACTERISTICS FOR CEDARS-SINAI COMMUNITY BENEFIT SERVICE

AREA (CURRENT) ARE AS FOLLOWS: HISPANIC/LATINO (49.1%), WHITE (19.8%),

BLACK/AFRICAN AMERICAN (18.4%), ASIAN (10.1%), AMERICAN INDIAN/ALASKAN

NATIVE (0.1%), NATIVE HAWAIIAN/PACIFIC ISLANDER (0.1%), OTHER (2.4%)

AGE

LESS THAN 18 YEARS (22%), 18-24 (12%), 25-64 (55.6%), GREATER THAN 65

YEARS (10.3%)

GENDER

FEMALE (50.8%), MALE (49.2%)

SOCIOECONOMIC STATUS

POVERTY THRESHOLDS ARE USED FOR CALCULATING ALL OFFICIAL POVERTY

POPULATION STATISTICS. THE CENSUS BUREAU ANNUALLY UPDATES OFFICIAL POVERTY

POPULATION STATISTICS. FOR 2016, THE FEDERAL POVERTY LEVEL (FPL) WAS AN

ANNUAL INCOME OF \$11,880 FOR ONE PERSON AND \$24,300 FOR A FAMILY OF FOUR.

FAMILIES LIVING BELOW THE POVERTY LINE IN CEDARS-SINAI SERVICE AREA

(26.3%); LOS ANGELES COUNTY (17.8%)

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.

HOUSEHOLDS

IN THE CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA THERE ARE 646,268

HOUSEHOLDS AND 696,830 HOUSING UNITS. OVER THE LAST FIVE YEARS, THE

POPULATION GREW BY 3.6% AND HOUSEHOLDS GREW BY 3.3%. HOUSING UNITS GREW AT

A LOWER RATE (2.6%) AND VACANT UNITS DECREASED BY 5.2%. HOME-OWNERSHIP

ALSO DECREASED, WITH 1.5% FEWER UNITS OCCUPIED BY OWNERS, WHILE

RENTER-OCCUPIED UNITS INCREASED BY 7.3%.

HOUSEHOLD INCOME

THE MEDIAN HOUSEHOLD INCOME IN THE COMMUNITY BENEFIT SERVICE AREA IS

\$48,046 AND THE AVERAGE HOUSEHOLD INCOME IS \$72,501.

UNEMPLOYMENT

THE UNEMPLOYMENT RATES OF CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA

CITIES RANGE FROM 3.3% IN CULVER CITY TO 7.2% IN INGLEWOOD. LOS ANGELES

HAS AN UNEMPLOYMENT RATE OF 4.8%, WHICH IS THE SAME AS THE STATE

UNEMPLOYMENT RATE.

EDUCATIONAL ATTAINMENT

AMONG AREA ADULTS, AGES 25 AND OLDER, 27.5% LACK A HIGH SCHOOL DIPLOMA.

19.2% OF ADULTS ARE HIGH SCHOOL GRADUATES AND 35.7% OF AREA ADULTS ARE

COLLEGE GRADUATES.

DATA COLLECTION

SECONDARY DATA

SECONDARY DATA WERE COLLECTED FROM A VARIETY OF LOCAL, COUNTY AND STATE

SOURCES TO PRESENT COMMUNITY DEMOGRAPHICS, SOCIAL DETERMINANTS OF HEALTH,

Part V Facility Information (continued)

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

HEALTH CARE ACCESS, BIRTH INDICATORS, LEADING CAUSES OF DEATH, ACUTE AND

CHRONIC DISEASE, HEALTH BEHAVIORS, MENTAL HEALTH, SUBSTANCE USE AND

MISUSE, AND PREVENTIVE PRACTICES. WHEN AVAILABLE, DATA SETS ARE PRESENTED

IN THE CONTEXT OF LOS ANGELES COUNTY AND CALIFORNIA TO HELP FRAME THE

SCOPE OF AN ISSUE AS IT RELATES TO THE BROADER COMMUNITY.

SOURCES OF DATA INCLUDE: THE U.S. CENSUS AMERICAN COMMUNITY SURVEY,

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, CALIFORNIA HEALTH INTERVIEW

SURVEY, LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH, THINK HEALTH LA,

COUNTY HEALTH RANKINGS, CALIFORNIA DEPARTMENT OF EDUCATION, CALIFORNIA

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT AND CALIFORNIA

DEPARTMENT OF JUSTICE, AMONG OTHERS.

SECONDARY DATA FOR THE SERVICE AREA WERE COLLECTED AND DOCUMENTED IN DATA

TABLES WITH NARRATIVE EXPLANATION. THE TABLES PRESENT THE DATA INDICATOR,

THE GEOGRAPHIC AREA REPRESENTED, THE DATA MEASUREMENT (E.G. RATE, NUMBER,

OR PERCENT), COUNTY AND STATE COMPARISONS (WHEN AVAILABLE), THE DATA

SOURCE, DATA YEAR AND AN ELECTRONIC LINK TO THE DATA SOURCE. ANALYSIS OF

SECONDARY DATA INCLUDES AN EXAMINATION AND REPORTING OF HEALTH DISPARITIES

FOR SOME HEALTH INDICATORS. THE REPORT INCLUDES BENCHMARK COMPARISON DATA

THAT MEASURE THE DATA FINDINGS AS COMPARED TO HEALTHY PEOPLE 2020

OBJECTIVES, WHERE APPROPRIATE. HEALTHY PEOPLE 2020 OBJECTIVES ARE A

NATIONAL INITIATIVE TO IMPROVE THE PUBLIC'S HEALTH BY PROVIDING MEASURABLE

OBJECTIVES AND GOALS THAT ARE APPLICABLE AT NATIONAL, STATE, AND LOCAL

LEVELS.

SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED FROM SECONDARY DATA USING THE

Part V Facility Information (continued)

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

SIZE OF THE PROBLEM (RELATIVE PORTION OF POPULATION AFFLICTED BY THE PROBLEM) AND THE SERIOUSNESS OF THE PROBLEM (IMPACT AT INDIVIDUAL, FAMILY, AND COMMUNITY LEVELS). TO DETERMINE SIZE OR SERIOUSNESS OF THE PROBLEM, THE HEALTH NEED INDICATORS THAT WERE IDENTIFIED IN THE SECONDARY DATA WERE MEASURED AGAINST BENCHMARK DATA; SPECIFICALLY, COUNTY RATES, STATE RATES AND/OR HEALTHY PEOPLE 2020 OBJECTIVES. INDICATORS RELATED TO THE HEALTH NEEDS, WHICH PERFORMED POORLY AGAINST ONE OR MORE OF THESE BENCHMARKS MET THIS CRITERION TO BE CONSIDERED A HEALTH NEED. THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE DETERMINED:

- *ACCESS TO CARE
- *CHRONIC DISEASES (ASTHMA, CANCER, DIABETES, HEART DISEASE, STROKE, HIV)
- *COMMUNITY SAFETY (CRIME AND VIOLENCE)
- *DENTAL CARE
- *ECONOMIC INSECURITY
- *FOOD INSECURITY
- *HOUSING AND HOMELESSNESS
- *MENTAL HEALTH
- *OVERWEIGHT AND OBESITY (HEALTHY EATING AND PHYSICAL ACTIVITY)
- *PREVENTIVE PRACTICES
- *SEXUALLY TRANSMITTED INFECTIONS
- *SUBSTANCE USE AND MISUSE

THE LIST OF SIGNIFICANT HEALTH NEEDS INFORMED PRIMARY DATA COLLECTION. THE PRIMARY DATA COLLECTION PROCESS WAS DESIGNED TO VALIDATE SECONDARY DATA FINDINGS, IDENTIFY ADDITIONAL COMMUNITY ISSUES, SOLICIT INFORMATION ON DISPARITIES AMONG SUBPOPULATIONS, ASCERTAIN COMMUNITY ASSETS TO ADDRESS NEEDS AND DISCOVER GAPS IN RESOURCES. COMMUNITY STAKEHOLDER INTERVIEWS

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.

WERE USED TO GATHER INPUT AND PRIORITIZE THE SIGNIFICANT HEALTH NEEDS.

ACUTE AND CHRONIC DISEASE

AMBULATORY CARE SENSITIVE CONDITIONS

AMBULATORY CARE SENSITIVE (ACS) CONDITIONS ARE DEFINED AS "THOSE

CONDITIONS RESULTING IN HOSPITAL ADMISSIONS THAT WITH IMPROVED HIGH

QUALITY OUTPATIENT CARE COULD OTHERWISE HAVE BEEN AVOIDED, RESULTING IN

LOWER COST TO THE HOSPITAL AND BETTER QUALITY OF LIFE FOR THE PATIENT"

(AHRQ, 2004). IN THE COMMUNITY BENEFIT SERVICE AREA, THE TOP FOUR ACS

CONDITIONS RESULTING IN HOSPITALIZATION WERE CONGESTIVE HEART FAILURE,

DIABETES, COPD, AND URINARY TRACT INFECTIONS. WHEN COMPARED TO

HOSPITALIZATION RATES IN LA COUNTY, ALL AREA RATES FOR HOSPITALIZATIONS

EXCEEDED THE COUNTY RATES FOR THE ACS CONDITIONS WITH THE EXCEPTION OF

BACTERIAL PNEUMONIA.

DIABETES

THE PERCENT OF ADULTS DIAGNOSED WITH DIABETES IN COMMUNITY BENEFIT SERVICE

AREA CITIES AND LA CITY COUNCIL DISTRICTS (WHERE DATA WERE AVAILABLE)

RANGED FROM A LOW OF 5% IN DISTRICT 5 TO A HIGH OF 15% IN DISTRICT 8.

AMONG ADULTS IN SPA 4, 10.1% HAVE BEEN DIAGNOSED WITH DIABETES, 6.3% IN

ADULTS IN SPA 5, AND 12.7% OF ADULTS IN SPA 6 REPORTED THEY HAVE BEEN

DIAGNOSED WITH DIABETES. FOR ADULTS WITH DIABETES, 74.7% IN SPA 5 FELT

VERY CONFIDENT THEY COULD CONTROL THEIR DIABETES, 57.4% OF ADULTS WITH

DIABETES IN SPA 6 AND 41.4% OF ADULTS WITH DIABETES IN SPA 4 FELT VERY

CONFIDENT THEY COULD CONTROL THEIR DIABETES.

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.

AMONG AFRICAN AMERICAN ADULTS, 15.8% HAVE BEEN DIAGNOSED WITH DIABETES,
10.2% OF ASIAN RESIDENTS OF SPAS 4, 5 AND 6 HAVE BEEN DIAGNOSED WITH
DIABETES. 10.9% OF LATINO ADULTS AND 6% OF WHITE ADULTS HAVE BEEN
DIAGNOSED WITH DIABETES.

DIABETES IS AN AMBULATORY CARE SENSITIVE (ACS) CONDITION. HOSPITALIZATIONS
FOR DIABETES IN THE COMMUNITY BENEFIT SERVICE AREA OCCUR AT A RATE OF 24.5
PER 10,000 PERSONS AND THE ER VISITS FOR DIABETES OCCUR AT A RATE OF 30.1
PER 10,000 PERSONS. THESE RATES ARE HIGHER THAN THE DIABETES
HOSPITALIZATION AND ER RATES IN LA COUNTY.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 3J: (CONTINUED)

HIGH BLOOD PRESSURE

A CO-MORBIDITY FACTOR FOR DIABETES AND HEART DISEASE IS HYPERTENSION (HIGH
BLOOD PRESSURE). IN SPA 4, 27.7% OF ADULTS ARE DIAGNOSED WITH HIGH BLOOD
PRESSURE. 24.3% OF ADULTS IN SPA 5 AND 32.7% OF ADULTS IN SPA 6 HAVE BEEN
DIAGNOSED WITH HIGH BLOOD PRESSURE. OF THOSE DIAGNOSED WITH HIGH BLOOD
PRESSURE, 60.6% IN SPA 4, 69.9% IN SPA 5, AND 63.9% IN SPA 6 REPORTED
TAKING MEDICATION TO MANAGE THEIR HIGH BLOOD PRESSURE.

IN SPAS 4, 5 AND 6, 47% OF AFRICAN AMERICANS ADULTS INDICATED THEY HAVE
HIGH BLOOD PRESSURE; THIS IS HIGHER THAN THE RATES OF HIGH BLOOD PRESSURE
REPORTED AMONG AFRICAN AMERICANS IN LA COUNTY AND CALIFORNIA. 27.9% OF
WHITES, 24.9% OF LATINOS, AND 23.4% OF ASIANS REPORTED HIGH BLOOD
PRESSURE.

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 HOSPITALIZATION RATE FOR HYPERTENSION AMONG ADULTS IN THE COMMUNITY

BENEFIT SERVICE AREA IS 7.7 PER 10,000 PERSONS AND THE ER RATE FOR

HYPERTENSION IS 30.5 PER 10,000 PERSONS. THESE RATES ARE HIGHER THAN FOUND

IN THE COUNTY.

HEART DISEASE

FOR ADULTS IN SPA 4, 3.8% REPORTED THEY HAVE BEEN DIAGNOSED WITH HEART

DISEASE. 5.3% OF ADULTS IN SPA 5, AND 5.4% OF SPA 6 ADULTS REPORTED THEY

HAVE BEEN DIAGNOSED WITH HEART DISEASE. AMONG ADULTS DIAGNOSED WITH HEART

DISEASE, 88.7% IN SPA 5 WERE GIVEN A MANAGEMENT CARE PLAN BY A HEALTH CARE

PROVIDER, 66% IN SPA 6 WERE GIVEN A MANAGEMENT CARE PLAN BY A HEALTH CARE

PROVIDER, AND 66.5% IN SPA 4 WERE GIVEN A MANAGEMENT CARE PLAN BY A HEALTH

CARE PROVIDER.

SPAS 4, 5 AND 6 HAVE HIGHER RATES OF HEART DISEASE AMONG AFRICAN AMERICANS

(6.9%) THAN WERE REPORTED IN THE COUNTY (6.2%) OR STATE (5.6%).

ASTHMA

THE POPULATION DIAGNOSED WITH ASTHMA IN SPA 4 IS 11.7%, IN SPA 5 7% OF THE

POPULATION HAS ASTHMA, AND IN SPA 6 6.8% HAS ASTHMA. AMONG THOSE WITH

ASTHMA, 56.9% IN SPA 4, 28.6% IN SPA 5 AND 39.8% IN SPA 6 TAKE MEDICATION

TO CONTROL THEIR SYMPTOMS. AMONG YOUTH IN SPA 4, 10.6% HAVE BEEN DIAGNOSED

WITH ASTHMA, 7.8% OF YOUTH IN SPA 5 AND 9.5% OF YOUTH IN SPA 6 HAVE BEEN

DIAGNOSED WITH ASTHMA.

ASTHMA-RELATED HOSPITALIZATIONS AMONG CHILDREN IN THE COMMUNITY BENEFIT

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.

SERVICE AREA ARE HIGHER (12.7 ADMISSIONS PER 10,000 CHILDREN) THAN LA

COUNTY RATES (10.9 ADMISSIONS PER 10,000 CHILDREN).

CANCER

CANCER INCIDENCE RATES ARE AVAILABLE AT THE COUNTY LEVEL. IN LOS ANGELES

COUNTY, CANCER RATES ARE LOWER OVERALL THAN AT THE STATE LEVEL; HOWEVER,

THE RATES OF COLORECTAL CANCER (36.3 PER 100,000 PERSONS), UTERINE

CANCERS, (25.9 PER 100,000), THYROID CANCER (13.6 PER 100,000 PERSONS),

AND OVARIAN CANCER (12.0 PER 100,000) EXCEED THE STATE RATES.

RATES OF NEWLY DIAGNOSED BREAST CANCER PER 100,000 FEMALES, RANGED FROM A

LOW OF 79.3 PER 100,000 WOMEN IN CITY COUNCIL DISTRICT 15 TO A HIGH OF

193.5 IN BEVERLY HILLS.

HIV

THE HIV RATE IN LA COUNTY HAS DECREASED SINCE 2007. IN 2015, 626 CASES OF

HIV WERE DIAGNOSED IN SPA 4 (54 PER 100,000 PERSONS), 90 CASES WERE

DIAGNOSED IN SPA 5 (14 PER 100,000 PERSONS), AND 291 CASES OF HIV WERE

DIAGNOSED IN SPA 6 (28 PER 100,000 PERSONS). THE RATE OF HIV DIAGNOSED IN

2015 HAS DECREASED FROM 2014 FOR SPAS 4, 5 AND THE COUNTY, WHILE RISING

SLIGHTLY FOR SPA 6. RATES OF NEW HIV DIAGNOSES ARE HIGHEST AMONG MALES,

YOUNG ADULTS 20-29, AND BLACKS/AFRICAN AMERICANS.

AMONG THE COMMUNITY BENEFIT SERVICE AREA SPAS, SPA 4 HAS THE HIGHEST RATE

OF PERSONS LIVING WITH HIV (1,531 PER 100,000 PERSONS). IN SPA 6 THE RATE

IS 565 PER 100,000 PERSONS, AND IN SPA 5 THE RATE IS 378 PER 100,000

PERSONS LIVING WITH HIV.

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.

IDENTIFYING AND PRIORITIZING COMMUNITY HEALTH NEEDS

CEDARS-SINAI DEVELOPED AND APPROVED AN IMPLEMENTATION STRATEGY TO ADDRESS

SIGNIFICANT HEALTH NEEDS IDENTIFIED IN THE 2019-2022 COMMUNITY HEALTH

NEEDS ASSESSMENT. THE IMPLEMENTATION STRATEGY ADDRESSED THE FOLLOWING

HEALTH NEEDS THROUGH A COMMITMENT OF COMMUNITY BENEFIT PROGRAMS AND

RESOURCES.

HEALTH FOCUS AREAS

ACCESS TO CARE: COMMUNITY BENEFIT EFFORTS FOCUS ON INCREASING AND

SUPPORTING ACCESS TO ESSENTIAL HEALTH CARE SERVICES FOR THE UNDERSERVED

THROUGH DIRECT PROGRAMS AND PARTNERSHIPS WITH LOCAL COMMUNITY-BASED

ORGANIZATIONS. PROGRAMS, PARTNERSHIPS AND STRATEGIES ADDRESS THE FOLLOWING

ACCESS TO CARE PRIORITY HEALTH NEEDS:

*PRIMARY CARE

*MENTAL HEALTH

*PREVENTIVE CARE

CHRONIC DISEASE: COMMUNITY BENEFIT EFFORTS FOCUS ON PREVENTING CHRONIC

HEALTH CONDITIONS AND THEIR UNDERLYING RISK FACTORS. PROGRAMS,

PARTNERSHIPS AND STRATEGIES ADDRESS THE FOLLOWING PRIORITY HEALTH NEEDS

RELATED TO CHRONIC DISEASE:

*CANCER

*CARDIOVASCULAR DISEASE

*DIABETES

*OVERWEIGHT AND OBESITY: HEALTHY FOOD CHOICES AND PHYSICAL ACTIVITY

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.

HOMELESSNESS: COMMUNITY BENEFIT EFFORTS FOCUS ON CONNECTING PEOPLE

EXPERIENCING HOMELESSNESS TO COMMUNITY-BASED PROGRAMS AND SERVICES AS WELL

AS BUILDING STRATEGIES TO IMPROVE THE HEALTH AND HOUSING STABILITY OF

HOMELESS INDIVIDUALS.

IMPACT

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS WERE IDENTIFIED AND IMPACT

MEASURES TRACKED.

PART V, SECTION B, LINE 3E: THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED

DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND

IDENTIFIED THROUGH THE CHNA.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 5: IN CONDUCTING CEDARS-SINAI'S MOST RECENT

CHNA, THE HOSPITAL FACILITY TOOK 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.

TARGETED INTERVIEWS WERE USED TO GATHER INFORMATION AND OPINIONS FROM

PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE

HOSPITAL. INTERVIEWS WERE COMPLETED FROM NOVEMBER 2018 TO JANUARY 2019.

INTERVIEWEES INCLUDED INDIVIDUALS WHO ARE LEADERS AND/OR REPRESENTATIVES

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.

OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS, AS WELL AS REPRESENTATIVES FROM LOCAL GOVERNMENT AGENCIES, INCLUDING THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 6A: CEDARS-SINAI MEDICAL CENTER PARTICIPATED IN A COLLABORATIVE PROCESS FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT IN PARTNERSHIP WITH CEDARS-SINAI MARINA DEL REY HOSPITAL, KAISER PERMANENTE WEST LOS ANGELES MEDICAL CENTER, PROVIDENCE ST. JOHN'S HEALTH CENTER, AND UCLA HEALTH. GIVEN THAT THESE HOSPITAL FACILITIES SHARE AN OVERLAPPING SERVICE AREA, A COLLABORATIVE EFFORT REDUCED REDUNDANCIES AND INCREASED DATA COLLECTION EFFICIENCY.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 11: ADDRESSING HEALTH FOCUS AREAS IDENTIFIED AND PRIORITIZED IN THE 2019-2022 CHNA: IN FY21, CEDARS-SINAI MEDICAL CENTER ENGAGED IN ACTIVITIES AND PROGRAMS THAT ADDRESSED THE HEALTH FOCUS AREAS PRIORITIZED FROM THE IDENTIFIED HEALTH NEEDS IN THE 2019-2022 CHNA. CEDARS-SINAI HAS COMMITTED TO COMMUNITY BENEFIT EFFORTS THAT ADDRESS: 1) ACCESS TO CARE, 2) CHRONIC DISEASES, AND 3) HOMELESSNESS. SELECTED ACTIVITIES AND PROGRAMS THAT HIGHLIGHT CEDARS-SINAI'S COMMITMENT TO THE COMMUNITY ARE DETAILED BELOW. FOR FY21 REPORTING, RESPONSES TO COVID-19 NEEDS HAVE BEEN ADDED AS AN ADDITIONAL HEALTH FOCUS AREA.

Part V Facility Information (continued)

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

HEALTH FOCUS AREAS:

1) ACCESS TO CARE:

* CEDARS-SINAI COACH FOR KIDS: COACH FOR KIDS IS A MOBILE MEDICAL UNIT

DEDICATED TO MEETING THE IMMEDIATE MEDICAL, BEHAVIORAL HEALTH, AND

COMMUNITY NEEDS OF THE SOUTH LOS ANGELES UNDERSERVED PEDIATRIC PATIENT

POPULATION, WHILE EFFECTIVELY TRANSITIONING PATIENTS TO THE CARE OF A

PARTNER FEDERALLY QUALIFIED HEALTH CENTER AND OTHER COMMUNITY RESOURCES,

WHICH CAN PROVIDE CARE FOR THEIR ENTIRE FAMILY. THE STATE-OF-THE-ART

MOBILE CLINIC, STAFFED BY AN EXPERT TEAM OF BILINGUAL ENGLISH/SPANISH

NURSE PRACTITIONERS, REGISTERED NURSES, SOCIAL WORKERS, AND OTHER HEALTH

CARE PROFESSIONALS, PROVIDES PREVENTIVE SERVICES INCLUDING: WELL-CHILD AND

IMMUNIZATION CLINICS FOR CHILDREN, DIAGNOSIS, AND TREATMENT OF MINOR

ILLNESSES FOR CHILDREN.

* SHARE & CARE: SINCE 1981, CEDARS-SINAI'S SCHOOL-BASED MENTAL HEALTH

PROGRAMS, CALLED SHARE & CARE, HELP VICTIMS OF TRAUMA, FILLING CRUCIAL

NEEDS FOR PREVENTION, CRISIS INTERVENTION, AND TRAINING THAT WOULD

OTHERWISE BE UNMET. PROGRAMS AND TRAININGS - FOR CHILDREN, TEACHERS,

PARENTS AND SCHOOL PRINCIPALS - RUN BY LICENSED MENTAL HEALTH

PRACTITIONERS, ENHANCE AN AT-RISK CHILD'S ABILITY TO LEARN IN THE

CLASSROOM, CHANGE DESTRUCTIVE BEHAVIORS AND ENVISION A BRIGHTER AND

HAPPIER FUTURE. SHARE & CARE COUNSELORS FACILITATE 12-WEEK ART-THERAPY

GROUPS THAT PROVIDE IMPROVE STUDENTS' ABILITIES TO CONCENTRATE AND LEARN.

THERAPY GROUPS FOCUS ON TRAUMA, LOSS AND GRIEF, SELF-ESTEEM, BULLYING,

SOCIALIZATION, ANGER MANAGEMENT, DIVORCE, SHYNESS, STUDENTS WITH AN

INCARCERATED PARENT AND SUBSTANCE ABUSE.

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.

* PRIMARY ADULT CARE SERVICES: CEDARS-SINAI'S PRIMARY ADULT CARE SERVICES

CLINIC PROVIDES PRIMARY CARE SERVICES TO RESIDENTS WHO LIVE WITHIN THE FIVE MILES RADIUS OF THE MEDICAL CENTER. MEDICAL RESIDENTS AND FELLOWS ARE SUPERVISED BY ATTENDING PHYSICIANS WHO ARE MEMBERS OF CSMC MEDICAL STAFF.

* ACCESS TO FINANCIAL ASSISTANCE AND HEALTH INSURANCE ENROLLMENT:

CEDARS-SINAI PROVIDES FREE CARE TO PEOPLE WHO EARNED UP TO 400% OF THE FEDERAL POVERTY LEVEL (\$103,000 FOR A FAMILY OF FOUR) AND SIGNIFICANTLY DISCOUNTED CARE TO THOSE WHO EARNED UP TO 600% OF THE FEDERAL POVERTY LEVEL (\$154,500 FOR A FAMILY OF FOUR). WHILE MORE PEOPLE NOW HAVE INSURANCE COVERAGE THROUGH THE AFFORDABLE CARE ACT AND COVERED CALIFORNIA, MANY COMMERCIAL INSURANCE PLANS CARRY A HIGH DEDUCTIBLE OR COPAY, CAUSING FINANCIAL HARDSHIP FOR PATIENTS. EXPANDED ELIGIBILITY CRITERIA FOR FREE OR DISCOUNTED CARE ENABLED MORE PEOPLE TO RECEIVE FINANCIAL ASSISTANCE. IN ADDITION, ASSISTANCE WAS PROVIDED TO ENROLL LOW-INCOME PERSONS IN HEALTH INSURANCE PROGRAMS.

* ACCESS TO CARE GRANTMAKING: IN FY21, CEDARS-SINAI'S ACCESS TO CARE

GRANTS TOTALED OVER \$10 MILLION. THE ACCESS TO CARE GRANTMAKING PORTFOLIO AIMS TO INCREASE THE CAPACITY OF ORGANIZATIONS TO IMPROVE ACCESS TO COMPREHENSIVE, QUALITY HEALTH CARE SERVICES FOR UNDERSERVED POPULATIONS. ACCESS TO CARE GRANTMAKING INCLUDES THE COMMUNITY CLINIC INITIATIVE, WITH A FOCUS ON STRENGTHENING LEADERSHIP AND EFFECTIVENESS WITHIN SAFETY NET CLINICS, AND THE BEHAVIORAL HEALTH INITIATIVE, WITH THE GOAL OF INCREASING ACCESS TO BEHAVIORAL HEALTH SERVICES THROUGH AN EMPHASIS ON INTEGRATION AND SUPPORTIVE PATIENT NAVIGATION. ACCESS TO CARE GRANTS THIS YEAR FOCUSED ON COVID-19 CAPACITY RECOVERY EFFORTS, PREPARATION FOR STATEWIDE MEDI-CAL

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.

REFORM, AND BOLSTERING BEHAVIORAL HEALTH SERVICES.

* COLLABORATIVE EFFORTS: CEDARS-SINAI TEAM MEMBERS PARTICIPATE IN

COLLABORATIVE EFFORTS THAT ADDRESS IMPROVING HEALTH OUTCOMES AND

INCREASING ACCESS TO CARE, FOR EXAMPLE:

** THE CEDARS-SINAI LED LOS ANGELES COUNTY COORDINATED FLU VACCINATION

COLLABORATIVE ENGAGED STAFF FROM THE LA COUNTY DEPARTMENT OF PUBLIC HEALTH

AND LOCAL HOSPITALS. COLLABORATIVE MEMBERS WORKED TOGETHER TO LEVERAGE

RELATIONSHIPS AND PARTNERED TO INCREASE CAPACITY, ADDRESS NEEDS AND SHARE

RESOURCES. THE COLLABORATIVE PROVIDED MORE THAN 5,000 FLU VACCINES. THE

GRASSROOTS ORGANIZING EFFORT BECAME A MODEL FOR THE CALIFORNIA HOSPITAL

ASSOCIATION AND WAS SHARED WITH STATEWIDE PARTNERS AND STAKEHOLDERS.

** CEDARS-SINAI LAUNCHED THE LOS ANGELES SOCIAL DETERMINANTS OF HEALTH

CONVENING, A COLLABORATIVE GROUP OF HEALTH SYSTEMS, HOSPITALS, INSURANCE

PROVIDERS AND COMMUNITY CLINICS. THE COLLABORATIVE IS COMMITTED TO SHARING

BEST PRACTICES IN ADDRESSING HEALTH-RELATED SOCIAL NEEDS TO IMPROVE HEALTH

OUTCOMES OF PATIENTS AND COMMUNITIES. THE GROUP MEETS QUARTERLY WITH

DISCUSSIONS FOCUSED ON STRATEGIES FOR SCREENING, FACILITATING CONNECTIONS

TO CARE, PARTNERING WITH COMMUNITY-BASED PROVIDERS, AND CROSS-SECTOR

COLLABORATION.

** THE LA PARTNERSHIP IS A COLLABORATION AMONG LOCAL HEALTH DEPARTMENTS,

THE HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA, THE CALIFORNIA COMMUNITY

FOUNDATION, AND OVER 20 NONPROFIT HEALTH SYSTEMS IN LA COUNTY. THE GROUP

AIMS TO PROMOTE BEST PRACTICES AND ALIGNMENT OF CHNAS AND IMPLEMENTATION

STRATEGIES AMONG HOSPITALS AND COMMUNITY PARTNERS.

2) CHRONIC DISEASE:

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.

* CANCER RESEARCH CENTER FOR HEALTH EQUITY/COMMUNITY OUTREACH AND

ENGAGEMENT (CRCHE): THE CRCHE AIMS TO INCREASE CANCER AWARENESS, SCREENING

AND CAPACITY OF COMMUNITIES TO ADDRESS DISPARITIES. THE PROGRAM POPULATION

FOCUS IS ON UNDERSERVED COMMUNITIES, IN PARTICULAR: HISPANICS, ASIANS

(FILIPINOS AND KOREANS), AFRICAN-AMERICANS, IMMIGRANTS, AND LGBTQ+.

PROGRAMS INCLUDE: 7 STEPS TO REDUCE CANCER RISK, A COMPREHENSIVE EDUCATION

PROGRAM GEARED TOWARD LOW-LITERACY POPULATIONS; TRAINING PROGRAMS FOR

COMMUNITY HEALTH WORKERS INCLUDING TOOLS AND RESOURCES TO LINK INDIVIDUALS

TO FREE AND LOW-COST CANCER SCREENINGS; AS WELL AS CAPACITY BUILDING,

TRAINING AND PILOT FUNDING FOR COMMUNITY ORGANIZATIONS THAT SERVE

COMMUNITIES AT THE HIGHEST RISK FOR CANCER AND DELAYED DIAGNOSIS.

ADDITIONALLY, TO IMPROVE HPV VACCINE UPTAKE AND CANCER SCREENINGS,

CEDARS-SINAI PROVIDED \$200,000 IN GRANTS FOR CAPACITY BUILDING AND

TRAINING TO 10 COMMUNITY ORGANIZATIONS THAT SERVE THE TARGET POPULATIONS

OF FOCUS.

* CANCER SURVIVORSHIP SERVICES: CANCER SURVIVORSHIP SERVICES PROVIDED

REHABILITATION MEDICINE TO CANCER SURVIVORS.

* HEALTHY HABITS: THE HEALTHY HABITS PROGRAMS HELP CHILDREN AND FAMILIES

LEARN ABOUT HEALTHY EATING AND PHYSICAL ACTIVITY WITH A WIDE RANGE OF

EDUCATION, CAPACITY BUILDING AND TECHNICAL ASSISTANCE PROGRAMS RUN BY

TRAINED HEALTH EDUCATORS. HEALTHY HABITS SERVES ELEMENTARY SCHOOL STUDENTS,

PARENTS, AND FAMILIES IN UNDERSERVED COMMUNITIES. THE GOAL OF HEALTHY

HABITS IS TO REDUCE THE RISKS AND IMPACTS OF OBESITY IN UNDERSERVED

COMMUNITIES. PROGRAMS INCLUDE AN EVIDENCE-BASED AND EVALUATED CURRICULUM

FOR 2ND, 3RD AND 4TH GRADES, HEALTHY HABITS FOR FAMILIES, COOKING HEALTHY

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.

HABITS, BUILDING HEALTHY HABITS, HEALTHY HABITS FOR TEACHERS, STEP & SWEAT

WALKING CLUBS, EXERCISE IN THE PARK, SUMMER PROGRAMS AND SCHOOL-WIDE

EVENTS. HEALTHY HABITS PARTNERS WITH 23 ELEMENTARY AND MIDDLE SCHOOLS IN

LOS ANGELES' MID-CITY NEIGHBORHOOD AND SURROUNDING COMMUNITIES TO PROVIDE

PROGRAMS. IN THE WAKE OF COVID-19, HEALTHY HABITS BUILT A VIRTUAL

CURRICULUM FOR STUDENTS AND SCHOOLS WHICH INCLUDED: VIRTUAL

LESSONS/WORKSHOPS, PARENT WORKSHOPS, VIRTUAL EXERCISE PROGRAMS, VIRTUAL

COOKING DEMONSTRATIONS, "THE LEARNING TABLE" VIRTUAL EDUCATION SESSIONS,

AND ENSURING FOOD SECURITY BY CONNECTING FAMILIES TO CALFRESH.

* COMMUNITY HEALTH IMPROVEMENT: COMMUNITY HEALTH IMPROVEMENT (CHI) SERVES

THE MOST VULNERABLE RESIDENTS OF LOS ANGELES, PARTICULARLY OLDER ADULTS.

DURING THE PAST YEAR, COMMUNITY HEALTH IMPROVEMENT WAS IMPACTED BY

COVID-19 AND OUR FOCUS SHIFTED ENTIRELY TO INFLUENZA (FLU) AND COVID-19.

IN FY21 WE PROVIDED 1,367 FLU VACCINES AND 1,509 COVID-19 VACCINATIONS

THROUGH 10 CLINIC SITES. WE FORMED AND FACILITATED A COMMUNITY HEALTH

ADVISORY COUNCIL TO ENGAGE INTERNAL STAKEHOLDERS AND ADDITIONAL INITIATED

AND LEAD A BI-WEEKLY FLU/COVID-19 COALITION MEETING FOR LA AREA HOSPITALS

AND HEALTH SYSTEMS.

CEDARS-SINAI MEDICAL CENTER:

PART V, SECTION B, LINE 11: (CONTINUED)

* CHRONIC DISEASE GRANTMAKING: CEDARS-SINAI'S CIVIC ENGAGEMENT GRANTS

ADDRESS UNMET NEEDS THAT IMPACT HEALTH AND WELLBEING THROUGH STRATEGIC

COORDINATION WITH LOCAL COMMUNITY ORGANIZATIONS. OVER \$4 MILLION WAS

DISBURSED THROUGH THE CIVIC ENGAGEMENT PORTFOLIO THIS YEAR, WHICH INCLUDED

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.

CONTINUED FUNDING FOR COVID-19 RELIEF AND RECOVERY, FIRST RESPONDERS,

EMERGENCY RELIEF, FOOD ACCESS, AND RACIAL EQUITY.

ADDITIONALLY, THE HEALTH EQUITY GRANT PROGRAM AWARDED GRANTS TO 87

ORGANIZATIONS, TOTALING \$6 MILLION. THE SELECTION OF GRANTEE PRIORITIZED

WORKFORCE DEVELOPMENT AND TRAINING, STRATEGIC PLANNING AND INTEGRATION,

OPERATIONALIZATION, AND DATA COLLECTION RELATED TO EQUITY. EXAMPLES OF

FUNDED PROGRAMS INCLUDED: CHARLES R. DREW UNIVERSITY OF MEDICINE AND

SCIENCE'S LAUNCHED A BLACK MATERNAL HEALTH CENTER OF EXCELLENCE; AND OUR

HOUSE GRIEF SUPPORT'S EVALUATED THE GRIEF SUPPORT GROUP EXPERIENCE AMONG

MEMBERS OF THE LATINX, BLACK, AND LGBTQ+ COMMUNITIES.

3) HOMELESSNESS:

* HOMELESSNESS GRANTMAKING: CEDARS-SINAI CONTINUED ITS COMMITMENT TO

ADDRESSING "UPSTREAM" HEALTH FACTORS (SUCH AS HOMELESSNESS, ECONOMIC

STABILITY, AND WORKFORCE DEVELOPMENT) BY DEEPENING ITS SUPPORT FOR THE

HOMELESSNESS AND HOUSING INITIATIVE THAT LAUNCHED WITHIN THE SOCIAL

DETERMINANTS OF HEALTH GRANTMAKING PORTFOLIO. THE GOAL OF THIS FUNDING IS

TO INCREASE COMMUNITY ORGANIZATIONS' CAPACITY TO PROMOTE HEALTHY

ENVIRONMENTS IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK AND AGE. THIS

YEAR'S SOCIAL DETERMINANTS OF HEALTH GRANTS FOCUSED ON BRIDGING THE HEALTH

AND HOMELESSNESS SECTORS TO ESTABLISH LINKAGES AND IMPROVE CONTINUITY OF

CARE. OVER \$15 MILLION IN GRANTMAKING WAS ALLOCATED TO SUPPORT MORE THAN

20 ORGANIZATIONS SERVING VULNERABLE POPULATIONS.

* HEALTHCARE AND SUPPORTIVE SERVICES: THE CEDARS-SINAI EMERGENCY

DEPARTMENT EMPLOYED TWO FULL-TIME HOMELESS PATIENT NAVIGATORS TO CONNECT

PATIENTS EXPERIENCING HOMELESSNESS WITH LOCAL RESOURCES - INCLUDING CASE

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.

MANAGEMENT, FOOD AND SHELTER - TO ENHANCE EMERGENCY DEPARTMENT PROTOCOLS

FOR HOMELESS PATIENTS.

CEDARS-SINAI ALSO SUPPORTED HOMELESS PATIENTS BY CONNECTING PATIENTS TO

SHELTER AND PROVIDING FOOD AND CLOTHING. CEDARS-SINAI TRANSITIONED

PATIENTS REQUIRING ADDITIONAL ASSISTANCE POST-DISCHARGE TO RECUPERATIVE

CARE FACILITIES DESIGNED TO CARE FOR PATIENTS AND CONNECT THEM TO

RESOURCES, INCLUDING LONGER-TERM HOUSING SOLUTIONS AND GOVERNMENTAL

BENEFITS.

4) ADDITIONAL FY21 FOCUS ON COVID-19:

* SCHOOL TESTING AND TRACING: CEDARS-SINAI SUPPORTED THE LOS ANGELES

UNIFIED SCHOOL DISTRICT (LAUSD) THROUGH A PLANNING GRANT TO DEVELOP A

COVID-19 TESTING AND CONTACT-TRACING PROGRAM IN PREPARATION FOR THE

EVENTUAL, SAFE RETURN OF STUDENTS AND STAFF TO IN-CLASS INSTRUCTION.

THROUGH THIS WORK WE FACILITATED MORE THAN 40,000 VACCINATIONS FOR

EDUCATORS, CREATING A PARTNERSHIP BETWEEN LAUSD AND LOS ANGELES' NEW

SOFI/HOLLYWOOD PARK STADIUM. THE PARTNERSHIP WAS A FIRST "MEGA-SITE"

LAUNCHED TO GET EDUCATORS BACK IN THE CLASSROOM TO COMPLETE THE 2020

ACADEMIC YEAR.

* NUTRITION AND WELLNESS: COMMUNITY HEALTH EDUCATORS FROM CEDARS-SINAI'S

HEALTHY HABITS PROGRAM DELIVERED VITAL HEALTH AND WELLNESS INFORMATION TO

AT-RISK FAMILIES DURING THE LAUSD CLOSURE. EVERY WEEKDAY MORNING AT GRAB &

GO FOOD CENTERS IN MID-CITY, KOREATOWN AND WINNETKA-WHERE FAMILIES PICK UP

MEALS-HEALTHY HABITS STAFF DISTRIBUTED RESOURCE GUIDES ABOUT NUTRITION AND

EXERCISE AS WELL AS MINDFULNESS INFORMATION FROM THE CEDARS-SINAI SHARE &

CARE PROGRAM. 91% OF STUDENTS IN THE HEALTHY HABITS PROGRAM RECEIVED FREE

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.

OR REDUCED-COST MEALS FROM LAUSD.

* AGING AND ISOLATION PREVENTION: CEDARS-SINAI'S LEVERAGING EXERCISE IN

PLACE (LEAP) PROGRAM PROMOTES PHYSICAL FITNESS FOR OLDER PEOPLE WHILE

FIGHTING THE DAMAGING EFFECTS OF LONELINESS. WHEN COVID-19 MADE IN-PERSON

GATHERINGS UNSAFE, THE PROGRAM MOVED ITS FREE EXERCISE CLASSES ONLINE AND

THE LEAP TEAM BEGAN REGULARLY REACHING OUT TO PARTICIPANTS VIA VIDEO

CONFERENCING AND PHONE CALLS TO HELP THEM FEEL SOCIALLY CONNECTED.

SUPPORTED BY THE AARP FOUNDATION, LEAP IS AN EVIDENCE-BASED MODEL FOR

REDUCING SOCIAL ISOLATION AMONG SENIORS AND IS JUST ONE REASON WHY

CEDARS-SINAI HAS BEEN NAMED AN AGE-FRIENDLY HEALTH SYSTEM BY THE JOHN A.

HARTFORD FOUNDATION AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT.

* COMMUNITY HEALTH IMPROVEMENT PROGRAMS: FOCUSED ON COVID-19 IN FY21,

COMMUNITY HEALTH IMPROVEMENT PROGRAMS PROVIDED COVID-19 VACCINATIONS AT 10

CLINIC SITES TO 1,509 INDIVIDUALS; INITIATED AND CONTINUED TO LEAD A

COORDINATED EFFORT AMONG LA HOSPITALS AND HEALTH SYSTEMS BY MAINTAINING 16

BI-WEEKLY FLU/COVID-19 COALITION MEETINGS; AND IMPLEMENTED THE "COVID-19

COMMUNITY CONVERSATIONS" SERIES WITH THE INTENT OF PROMOTING VACCINE

ACCEPTANCE AMONG 7 DIFFERENT POPULATIONS, WHICH INCLUDED A TOTAL OF 409

PARTICIPANTS.

* YOUTH EMPLOYMENT DEVELOPMENT (YED) HEALTH CAREERS ACADEMY: THE YED

HEALTH CAREERS ACADEMY IS A PARTNERSHIP WITH THE LOS ANGELES UNIFIED

SCHOOL DISTRICT, REGIONAL OCCUPATIONAL PROGRAM AND CALIFORNIA TECHNICAL

EDUCATION. THE PROGRAM INCLUDES WORK-SITE LEARNING AT CEDARS-SINAI,

SCHOOL-BASED LEARNING AT FAIRFAX HIGH SCHOOL AND MENTORING WHICH IS DONE

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.

BY EMPLOYEES WHO ARE PART OF THE PROGRAM. THIS YEAR'S PROJECT WAS ON

COVID-19. TOPICS INCLUDED: MYTHS AND TRUTHS, MENTAL HEALTH, AND THE

CHALLENGE OF RETURNING TO SCHOOL.

PARTICIPATING STUDENTS FACED UNPRECEDENTED CHALLENGES DURING THE PANDEMIC,

INCLUDING: LIMITED INTERNET RESOURCES, LOST FAMILY INCOME AND JOBS, HAVING

TO BABYSIT WHILE BEING IN CLASS, LACK OF MOTIVATION AND MENTAL HEALTH

CONCERNS. STUDENTS WERE OFFERED THE SERVICES OF CEDARS-SINAI'S WORK AND

LIFE MATTERS, WHERE THEY WOULD NOT BE EMBARRASSED OR UNCOMFORTABLE TO

DISCUSS WHAT WAS HAPPENING IN THEIR HOUSEHOLDS. SEVERAL STUDENTS

CONTRACTED COVID AND LOST FAMILY MEMBERS DUE TO THE VIRUS.

DURING AUGUST 2020, YED PARTNERED WITH UNITE-LA'S VIRTUAL SOUTH LOS

ANGELES SCHOLARS PROGRAM, A CAREER EXPOSURE PROGRAM FOR UNDERSERVED HIGH

SCHOOL STUDENTS. UNDER THE THEME "LESSONS LEARNED FROM THE FIELD ON

PATIENT CARE DURING COVID-19", CEDARS-SINAI FRONT LINE WORKERS PRESENTED

ON THEIR CAREERS AND DAILY WORK DURING THE PANDEMIC.

HEALTH NEEDS THE HOSPITAL WILL NOT ADDRESS: TAKING EXISTING HOSPITAL AND

COMMUNITY RESOURCES INTO CONSIDERATION, CEDARS-SINAI HAS NOT INCLUDED THE

REMAINING HEALTH NEEDS IDENTIFIED IN THE CHNA IN THE HEALTH FOCUS AREAS

FOR THE 2019-2022 IMPLEMENTATION STRATEGY. THOSE NEEDS ARE: COMMUNITY

SAFETY, DENTAL CARE, ECONOMIC INSECURITY, FOOD INSECURITY, SEXUALLY

TRANSMITTED INFECTIONS, AND SUBSTANCE USE. THE HOSPITAL HAS DETERMINED

THAT THE MOST EFFECTIVE WAYS TO STEWARD COMMUNITY BENEFIT COMMITMENTS IS

THROUGH TARGETED PROGRAMS AND SERVICES IN THE HEALTH FOCUS AREAS. IN SOME

CASES, NEEDS NOT ADDRESSED IN THE HEALTH FOCUS AREAS ARE BEING ADDRESSED

BY TRUSTED PARTNERS AND COMMUNITY-BASED ORGANIZATIONS IN THE REGION.

ADDITIONALLY, CEDARS-SINAI CONTINUES TO PARTICIPATE IN INITIATIVES TO

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.

ADDRESS COMMUNITY HEALTH AND HEALTH-RELATED SOCIAL NEEDS, AND PROVIDE

ASSISTANCE WHERE WE CAN MAKE A MEANINGFUL CONTRIBUTION.

CEDARS-SINAI MEDICAL CENTER

PART V, LINE 16A, FAP WEBSITE:

[HTTPS://WWW.CEDARS-SINAI.ORG/CONTENT/DAM/CEDARS-SINAI/BILLING-INSURANCE/FI](https://www.cedars-sinai.org/content/dam/cedars-sinai/billing-insurance/fi)

[NANCIAL-ASSISTANCE/DOCUMENTS/FAPS/FAP-APPLICATION-ENGLISH-12-1-2020.PDF](#)

CEDARS-SINAI MEDICAL CENTER

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTPS://WWW.CEDARS-SINAI.ORG/CONTENT/DAM/CEDARS-SINAI/BILLING-INSURANCE/FI](https://www.cedars-sinai.org/content/dam/cedars-sinai/billing-insurance/fi)

[NANCIAL-ASSISTANCE/DOCUMENTS/FAPS/FAP-APPLICATION-ENGLISH-4-14-2020.PDF](#)

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTPS://WWW.CEDARS-SINAI.ORG/CONTENT/DAM/CEDARS-SINAI/BILLING-INSURANCE/FI](https://www.cedars-sinai.org/content/dam/cedars-sinai/billing-insurance/fi)

[NANCIAL-ASSISTANCE/DOCUMENTS/PLAIN-LANGUAGE-SUMMARY-ENGLISH-2021.PDF](#)

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? 17

Name and address	Type of Facility (describe)
1 CEDARS-SINAI MEDICAL CENTER 8723 ALDEN DRIVE LOS ANGELES, CA 90048	OUTPATIENT SERVICES-AMBULATORY CARE/ENDOCRINOLOGY/PRIMARY ADULT CARE/LAB
2 CEDARS-SINAI MEDICAL CENTER 8631 W. 3RD STREET LOS ANGELES, CA 90048	OUTPATIENT SERVICES-BLOOD DRAW/CARDIOLOGY/PITUITARY CTR/IMAGING/ETC.
3 CEDARS-SINAI MEDICAL CENTER 8536 WILSHIRE BLVD. BEVERLY HILLS, CA 90211	OUTPATIENT SERVICES-NUCLEAR CARDIAC STRESS
4 CEDARS-SINAI MEDICAL CENTER 444 S SAN VICENTE BLVD. LOS ANGELES, CA 90048	OUTPATIENT SERVICES-GAMMA KNIFE/PAIN CTR/PRENATAL DIAG/REHAB/ETC.
5 CEDARS-SINAI MEDICAL CENTER 8635 W. 3RD STREET BEVERLY HILLS, CA 90211	OUTPATIENT SERVICES-ORGAN TRANSPLANT/UROLOGY/WEIGHT LOSS/VOICE THERAPY
6 CEDARS-SINAI MEDICAL CENTER 9090 WILSHIRE BLVD. BEVERLY HILLS, CA 90211	OUTPATIENT SERVICES-CANCER TREATMENT CENTER
7 CEDARS-SINAI MEDICAL CENTER 127 S SAN VICENTE BLVD. LOS ANGELES, CA 90048	OUTPATIENT SERVICES-NEUROSCIENCES/HEART INST/IMAGING/LAB
8 CEDARS-SINAI MEDICAL CENTER 8900 BEVERLY BLVD. WEST HOLLYWOOD, CA 90048	OUTPATIENT SERVICES-COMPREHENSIVE TRANSPLANT CENTER
9 CEDARS-SINAI MEDICAL CENTER 110 GEORGE BURNS ROAD. LOS ANGELES, CA 90048	OUTPATIENT SERVICES-IMAGING CLINIC
10 90210 SURGERY MEDICAL CENTER, LLC 450 N. ROXBURY SUITE 600 BEVERLY HILLS, CA 90210	OUTPATIENT SERVICES-AMBULATORY SURGERY CENTER-GENERAL SURGERY

Schedule H (Form 990) 2020

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? 17

Name and address	Type of Facility (describe)
11 ENDOSCOPY CTR OF SANTA MONICA, LLC 12400 WILSHIRE BLVD. STE. 100 LOS ANGELES, CA 90025	OUTPATIENT SERVICES-ENDOSCOPY
12 KERLAN-JOBE SURGERY CENTER, LLC 6801 PARK TERRACE STE. 300 LOS ANGELES, CA 90045	OUTPATIENT SERVICES-AMBULATORY SURGERY CENTER-ORTHOPEDIC SURGERY
13 PRECISION AMBULATORY SURGERY CTR, LLC 450 N. ROXBURY SUITE 250 BEVERLY HILLS, CA 90210	OUTPATIENT SERVICES-AMBULATORY SURGERY CENTER-GENERAL SURGERY
14 SANTA MONICA SURGICAL PARTNERS, LLC 2121 WILSHIRE BLVD. SUITE 201 SANTA MONICA, CA 90404	OUTPATIENT SERVICES-AMBULATORY SURGERY CENTER-GENERAL SURGERY
15 SANTA MONICA IMAGING GROUP, LLC 200 N ROBERTSON BLVD STE 101 BEVERLY HILLS, CA 90211	OUTPATIENT SERVICES-IMAGING CLINIC
16 WEST VALLEY IMAGING GROUP, LLC 1510 COTNER AVENUE LOS ANGELES, CA 90025	OUTPATIENT SERVICES-IMAGING CLINIC
17 BEVERLY HILLS TECHNICAL IMAGING, LLC 6500 WILSHIRE BLVD., 9TH FLOOR LOS ANGELES, CA 90048	OUTPATIENT SERVICES-IMAGING CLINIC

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 7:

COSTING METHODOLOGY USED TO CALCULATE AMOUNTS ON LINE 7 WERE DERIVED FROM

COST ACCOUNTING SYSTEM. COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENTS

SEGMENTS - INPATIENT, OUTPATIENT, EMERGENCY ROOM, ETC. AND ALL PAYERS -

PRIVATE INSURANCE, MEDICARE, MEDI-CAL, UNINSURED AND SELF-PAY.

PART I, LINE 7, COLUMN (F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A),

BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN

THIS COLUMN IS \$ 1,187,989.

PART II, COMMUNITY BUILDING ACTIVITIES:

CEDARS-SINAI PROVIDES AN ARRAY OF COMMUNITY SUPPORT TO VULNERABLE AND

NEIGHBORING COMMUNITIES. WITH A HISTORY OF OVER 100 YEARS SERVING THE

COMMUNITY, CEDARS-SINAI PARTICIPATES IN COMMUNITY-BUILDING AND HEALTH

IMPROVEMENT ADVOCACY IN PARTNERSHIP WITH A WIDE ARRAY OF CONSTITUENTS.

DURING FY21, CEDARS-SINAI LEADERS PARTICIPATED IN COMMUNITY ACTIVITIES

FOCUSED ON COMMUNITY HEALTH IMPROVEMENT AND SAFETY, AND CONTINUES TO BE

Part VI Supplemental Information (Continuation)

ENGAGED IN LOCAL, REGIONAL AND STATE EFFORTS AND REGIONAL COLLABORATIVES

THAT SUPPORT ACCESS TO HEALTH CARE, HOUSING AND HOMELESSNESS ISSUES.

EXAMPLES OF COMMUNITY BUILDING PARTNERS INCLUDE: RAND CORPORATION, UCLA

FOUNDATION, AND UNIVERSITY OF SOUTHERN CALIFORNIA (USC).

ADDITIONALLY, CEDARS-SINAI INVESTS STRATEGICALLY IN WORKFORCE DEVELOPMENT

AND MENTORING PROGRAMS AIMED AT HIGH SCHOOL AND MIDDLE SCHOOL-AGED

STUDENTS. WORKFORCE DEVELOPMENT AND MENTORING PROGRAMS ARE IMPLEMENTED

THROUGHOUT THE MEDICAL CENTER, TARGETING LOW INCOME AND UNDERREPRESENTED

STUDENTS, EXPOSING THEM TO CAREERS IN HEALTH, SCIENCES AND HOSPITAL

ADMINISTRATIVE FUNCTIONS. MULTIPLE PROGRAMS ENGAGE STUDENTS IN HANDS-ON

EXPERIENCES, INCLUDING: PRE-HEALTH CARE STUDENT VOLUNTEER PROGRAM FOR

STUDENTS WHO ARE PLANNING TO ATTEND MEDICAL SCHOOL, WITH PRIORITY GIVEN TO

STUDENTS FROM EDUCATIONALLY OR ECONOMICALLY UNDER-RESOURCED COMMUNITIES;

YOUTH EMPLOYMENT DEVELOPMENT HEALTH CAREERS ACADEMY, WHICH IS A TWO-YEAR

PROGRAM IN PARTNERSHIP WITH THE LOS ANGELES UNIFIED SCHOOL DISTRICT THAT

INCLUDES WORKSITE LEARNING AT CEDARS-SINAI, SCHOOL-BASED LEARNING AT

FAIRFAX HIGH SCHOOL AND EMPLOYEE MENTORING; AND YOUTH EMPLOYMENT

DEVELOPMENT HIRE LA YOUTH, A PARTNERSHIP WITH THE LOS ANGELES CHAMBER OF

COMMERCE AND THE MAYOR'S OFFICE WHICH PROVIDED 22 LA YOUTH WITH AN

OPPORTUNITY FOR SUMMER EMPLOYMENT FOR A SPECIFIC NUMBER OF HOURS TO BE

USED OVER THE SUMMER MONTHS. ADDITIONAL WORKFORCE DEVELOPMENT PROGRAMS

INCLUDED EDUCATION CLASSES, SEMINARS, CONFERENCES, DEMONSTRATIONS, TOURS

AND EVENTS WHICH REACHED 89 STUDENTS PROVIDING CAREER EXPOSURE AND

DEVELOPMENT EDUCATION.

PART III, LINE 2:

AS A RESULT OF THE ADOPTION OF ASC 606, THE MEDICAL CENTER IS REPORTING

Part VI Supplemental Information (Continuation)

IMPLICIT PRICE CONCESSIONS, WHICH IS ESTABLISHED BASED ON MANY FACTORS,
INCLUDING PAYER MIX, AGE OF RECEIVABLES, HISTORICAL CASH COLLECTION
EXPERIENCE, AND OTHER RELEVANT INFORMATION, AND BAD DEBT, WHICH IS DUE TO
CREDIT ISSUES NOT ASSESSED AT THE DATE OF SERVICE.

PART III, LINE 4:

AUDITED FINANCIAL STATEMENTS - PAGE 13

PART III, LINE 6 - COSTING METHODOLOGY:

REVENUE AND ALLOWABLE COSTS WERE DERIVED FROM THE MEDICARE COST REPORT
WHICH WAS COMPILED UNDER MEDICARE COSTING RULES AND REGULATIONS AS ISSUED
BY THE HEALTH CARE FINANCING ADMINISTRATION AND ENFORCED BY THE CENTERS
FOR MEDICARE & MEDICAID SERVICES.

PART III, LINE 8:

- RATIONALE FOR MEDICARE SHORTFALL AMOUNT ATTRIBUTABLE TO COMMUNITY

BENEFIT:

IT IS OUR BELIEF THAT ALL OF THE \$216,122,084 SHORTFALL SHOULD BE
CONSIDERED AS COMMUNITY BENEFIT. THE IRS COMMUNITY BENEFIT STANDARD
INCLUDES THE PROVISION OF CARE TO THE ELDERLY AND MEDICARE PATIENTS.
MEDICARE SHORTFALLS MUST BE ABSORBED BY THE MEDICAL CENTER IN ORDER TO
CONTINUE TREATING THE ELDERLY IN OUR COMMUNITY. THE MEDICAL CENTER
PROVIDES CARE REGARDLESS OF THIS SHORTFALL AND THEREBY RELIEVES THE
FEDERAL GOVERNMENT OF THE BURDEN OF PAYING THE FULL COST FOR MEDICARE
BENEFICIARIES. CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED AND
RELIEVES A GOVERNMENT BURDEN AS THESE PATIENTS TYPICALLY HAVE LOW AND/OR
FIXED INCOMES. MEDICARE DOES NOT PROVIDE SUFFICIENT REIMBURSEMENT TO COVER

Part VI Supplemental Information (Continuation)

THE COST OF PROVIDING CARE FOR THESE PATIENTS.

PART III, LINE 9B:

REASONABLE EFFORTS BASED ON BILLING STATEMENT NOTIFICATION AND AMOUNTS NOT

ELIGIBLE:

CEDARS-SINAI NOTIFIES PATIENTS OF ITS FINANCIAL ASSISTANCE PROGRAMS BEFORE

INITIATING ANY EXTRAORDINARY COLLECTION ACTIONS. CEDARS-SINAI REFRAINS

FROM INITIATING EXTRAORDINARY COLLECTION ACTIONS FOR AT LEAST 120 DAYS

FROM THE DATE CEDARS-SINAI BILLS FOR THE CARE IF THE PATIENT HAS NOT

SUBMITTED AN APPLICATION OR CEDARS-SINAI HAS DETERMINED THE PATIENT IS NOT

ELIGIBLE FOR FINANCIAL ASSISTANCE BASED ON THE PATIENT'S APPLICATION.

AT LEAST 30 DAYS BEFORE FIRST INITIATING ANY EXTRAORDINARY COLLECTION

ACTIONS, CEDARS-SINAI PROVIDES THE PATIENT WITH A WRITTEN NOTICE

INDICATING FINANCIAL ASSISTANCE IS AVAILABLE, IDENTIFYING THE

EXTRAORDINARY COLLECTION ACTION THAT CEDARS-SINAI INTENDS TO INITIATE TO

OBTAIN PAYMENT, AND STATING A DEADLINE AFTER WHICH SUCH EXTRAORDINARY

COLLECTION ACTIONS MAY BE INITIATED (WHICH DATE IS NOT EARLIER THAN 30

DAYS AFTER THE DATE THAT THE WRITTEN NOTICE IS PROVIDED). THE NOTICE

INCLUDES A PLAIN LANGUAGE SUMMARY OF CEDARS-SINAI'S FINANCIAL ASSISTANCE

POLICY.

IN ADDITION TO ALL WRITTEN NOTICES, PRIOR TO INITIATING ANY EXTRAORDINARY

COLLECTION ACTIONS, CEDARS-SINAI MAKES A REASONABLE EFFORT TO VERBALLY

NOTIFY THE PATIENT ABOUT CEDARS-SINAI'S FINANCIAL ASSISTANCE POLICY AND

ABOUT HOW THE PATIENT MAY OBTAIN ASSISTANCE THROUGH THE APPLICATION

PROCESS.

PART VI, LINE 2:

A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS CONDUCTED IN FISCAL YEAR

Part VI Supplemental Information (Continuation)

ENDED 6/30/19. SEE NARRATIVE FOR SCHEDULE H, PART V, SECTION B, LINE 3J.

PART VI, LINE 3:

NOTICES, SUMMARIES AND WRITTEN COMMUNICATIONS:

CEDARS-SINAI PROVIDES THE FOLLOWING NOTICES REGARDING FULL AND PARTIAL

FINANCIAL ASSISTANCE FOR QUALIFIED PATIENTS:

A) POSTED SIGNAGE - NOTICE OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN

THE FOLLOWING LOCATIONS: THE EMERGENCY DEPARTMENT, THE ADMITTING

DEPARTMENT, CENTRALIZED AND DECENTRALIZED REGISTRATION AREAS AND OTHER

OUTPATIENT SETTINGS.

B) NOTICES HAND-DELIVERED TO PATIENTS - DURING THE REGISTRATION OR

ADMISSION PROCESS (OR OTHERWISE PRIOR TO DISCHARGE), PATIENTS ARE PROVIDED

A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND

CEDARS-SINAI'S FINANCIAL ASSISTANCE PROGRAMS. PATIENTS ARE ASKED TO

ACKNOWLEDGE RECEIPT OF THIS VIA AN ELECTRONIC SIGNATURE.

C) PATIENT STATEMENT NOTICES - ON THE PATIENT BILLING STATEMENTS,

CEDARS-SINAI PROVIDES A DESCRIPTION OF ITS FINANCIAL ASSISTANCE POLICY AND

PROGRAMS, ALONG WITH INFORMATION ABOUT HOW TO APPLY FOR FINANCIAL

ASSISTANCE.

PUBLICIZING THE POLICY:

CEDARS-SINAI WIDELY PUBLICIZES ITS FINANCIAL ASSISTANCE POLICY AND

PROGRAMS, INCLUDING DISTRIBUTION TO TARGETED COMMUNITY ORGANIZATIONS,

AMONG A VARIETY OF OTHER MEANS, TO ALERT THE CEDARS-SINAI COMMUNITY TO THE

Part VI Supplemental Information (Continuation)

AVAILABILITY OF FINANCIAL ASSISTANCE. THE FINANCIAL ASSISTANCE POLICY, THE

APPLICATION FORM AND THE PLAIN LANGUAGE SUMMARY ARE AVAILABLE ON THE

CEDARS-SINAI WEBSITE AT

WWW.CEDARS-SINAI.ORG/BILLING-INSURANCE/FINANCIAL-ASSISTANCE.HTML

PART VI, LINE 4:

CEDARS-SINAI IS LOCATED AT 8700 BEVERLY BOULEVARD, LOS ANGELES, CALIFORNIA

90048. THE COMMUNITY BENEFIT SERVICE AREA INCLUDES LARGE PORTIONS OF

SERVICE PLANNING AREAS (SPAS) 4 (METRO), 5 (WEST) AND 6 (SOUTH), AND A

SMALLER PORTION OF SPA 8 (SOUTH BAY) IN LOS ANGELES COUNTY. THE COMMUNITY

BENEFIT SERVICE AREA CAN ALSO BE VIEWED BY LOS ANGELES CITY COUNCIL

DISTRICTS, COVERING ALL OR PART OF DISTRICTS 1, 4, 5, 8, 9, 10, 13, 14 AND

15. THE COMMUNITY BENEFIT SERVICE AREA INCLUDES 52 ZIP CODES, REPRESENTING

25 CITIES OR NEIGHBORHOODS. HOWEVER, TWO ZIP CODES (90071 AND 90079 IN

DOWNTOWN LOS ANGELES) HAVE NO RESIDENT POPULATION FROM THE CENSUS AND WILL

NOT BE EXAMINED WITHIN THIS REPORT. TO DETERMINE THE COMMUNITY BENEFIT

SERVICE AREA, CEDARS-SINAI TAKES INTO ACCOUNT THE ZIP CODES OF PATIENTS

DISCHARGED FROM THE HOSPITAL; THE CURRENT UNDERSTANDING OF COMMUNITY NEED

BASED ON THE MOST RECENT CHNA; AND LONG-STANDING COMMUNITY PROGRAMS AND

PARTNERSHIPS. THERE ARE 6 OTHER HOSPITALS SERVING THE COMMUNITIES.

CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA

GEOGRAPHIC AREA	ZIP CODE	SPA	DISTRICT
BALDWIN HILLS	90008	SPA 6	8
BEVERLY HILLS	90210, 90211, 90212	SPA 5	N/A
CENTRAL LA	90013, 90014, 90015, 90017	SPA 4	1,9,14
CENTURY CITY	90067	SPA 5	5

Part VI Supplemental Information (Continuation)

CRENSHAW	90016, 90018	SPA 6	8,10
CULVER CITY	90230, 90232	SPA 5	N/A
DOWNTOWN LA	90010, 90021, 90071, 90079	SPA 4	1,10,14
FAIRFAX/MID-CITY	90019, 90036	SPA 4	4,10
HOLLYWOOD	90028, 90038	SPA 4	4,13
HYDE PARK	90043	SPA 6	8
INGLEWOOD	90301, 90302, 90303, 90305	SPA 8	N/A
L.A./COLISEUM & MLK BLVD	90011	SPA 6	9
L.A./MLK & HOBART	90062	SPA 6	8
LADERA HEIGHTS	90056	SPA 5	N/A
LENNOX	90304	SPA 8	N/A
SOUTH CENTRAL LA	90001, 90002, 90003, 90044, 90047	SPA 6	8,9,15
SOUTH LOS ANGELES	90059	SPA 6	15
UNIVERSITY	90037, 90089	SPA 6	9
USC	90007	SPA 6	1,9
WEST HOLLYWOOD	90046, 90048, 90069	SPA 4	4,5
WEST LA/PALMS	90034	SPA 5	5
WEST LA/RANCHO	90025, 90035, 90064	SPA 5	5
WESTWOOD	90024	SPA 5	5
WILSHIRE	90006, 90057	SPA 4	1,13
WILSHIRE/KOREATOWN	90004, 90005, 90020	SPA 4&6	1,4,13

THE POPULATION OF THE CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA IS 1,814,274. FROM 2011 TO 2016, THE POPULATION INCREASED BY 3.6%, HIGHER THAN THE 2.8% INCREASE IN THE COUNTY POPULATION.

OF THE AREA POPULATION, 49.2% ARE MALE AND 50.8% ARE FEMALE. CHILDREN AND YOUTH, AGES 0-17, MAKE UP 22.0% OF THE POPULATION, 67.6% ARE ADULTS, AGES

Part VI Supplemental Information (Continuation)

18-64; AND 10.3% OF THE POPULATION ARE SENIORS, 65 AND OVER. THE COMMUNITY

BENEFIT SERVICE AREA HAS A HIGHER PERCENTAGE OF CHILDREN, UNDER THE AGE OF

5, AND ADULTS, 18 TO 44, THAN THE COUNTY.

IN THE CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA, 49.1% OF THE

POPULATION IS HISPANIC/LATINO, 19.8% ARE WHITE, 18.4% ARE BLACK/AFRICAN

AMERICAN, 10.1% ARE ASIAN, AND THE REMAINING 2.6% ARE AMERICAN

INDIAN/ALASKAN NATIVE, NATIVE HAWAIIAN/PACIFIC ISLANDER, OTHER

RACE/ETHNICITY, OR MULTIPLE RACES. THERE IS A LOWER PERCENTAGE OF WHITES

AND ASIANS, AND A HIGHER PERCENTAGE OF HISPANIC/LATINOS AND BLACKS/AFRICAN

AMERICANS, IN THE COMMUNITY BENEFIT SERVICE AREA THAN FOUND AT THE COUNTY

LEVEL.

THE LANGUAGES SPOKEN AT HOME BY AREA RESIDENTS MIRROR THE RACIAL/ETHNIC

MAKE-UP OF THE CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA COMMUNITIES.

SPANISH IS SPOKEN IN THE HOME AMONG 45.6% OF THE POPULATION. ENGLISH IS

SPOKEN IN THE HOME AMONG 39.9% OF THE POPULATION, 7.9% OF THE POPULATION

SPEAKS AN ASIAN LANGUAGE, AND 5.3% OF THE POPULATION SPEAKS AN

INDO-EUROPEAN LANGUAGE IN THE HOME.

WHEN EXAMINED AT THE ZIP CODE LEVEL, A NUMBER OF COMMUNITIES HAVE HIGH

PERCENTAGES OF SPANISH SPEAKERS INCLUDING: LA/COLISEUM, SOUTH CENTRAL LOS

ANGELES, AND LENNOX. NEIGHBORHOODS WITH A HIGH PERCENTAGE OF ASIAN

LANGUAGE SPEAKERS INCLUDE: DOWNTOWN LA 90010, UNIVERSITY 90089, CENTURY

CITY, AND THE WILSHIRE AND WILSHIRE/KOREATOWN AREAS. BEVERLY HILLS,

WESTWOOD, WEST HOLLYWOOD AND WEST LOS ANGELES HAVE HIGHER RATES OF

RESIDENTS WHO SPEAK INDO-EUROPEAN LANGUAGES AT HOME.

Part VI Supplemental Information (Continuation)

POVERTY THRESHOLDS ARE USED FOR CALCULATING ALL OFFICIAL POVERTY

POPULATION STATISTICS. THE CENSUS BUREAU ANNUALLY UPDATES OFFICIAL POVERTY

POPULATION STATISTICS. FOR 2016, THE FEDERAL POVERTY LEVEL (FPL) WAS AN

ANNUAL INCOME OF \$11,880 FOR ONE PERSON AND \$24,300 FOR A FAMILY OF FOUR.

AMONG THE RESIDENTS REPRESENTED IN THE AREA SPAS, SPA 6 HAS THE HIGHEST

POVERTY RATES. IN SPA 6, 37.8% ARE AT OR BELOW 100% OF THE FEDERAL POVERTY

LEVEL (FPL) AND 70.3% ARE CONSIDERED LOW-INCOME AT 200% OR BELOW FPL. IN

SPA 4, 31.2% ARE AT OR BELOW 100% FPL AND 55.6% BELOW 200% FPL. IN SPA 5,

5.9% ARE AT OR BELOW 100% FPL AND 17.7% BELOW 200% FPL. RATES OF POVERTY

IN SPA 4 AND SPA 6 ARE HIGHER THAN FOUND IN THE COUNTY.

A VIEW OF CHILDREN IN POVERTY INDICATES THAT 45.4% OF CHILDREN IN SPAS 4

AND 6 LIVE BELOW THE POVERTY LEVEL. IN SPA 6, 75.3% OF CHILDREN ARE

CATEGORIZED AS LOW-INCOME (<200% FPL), 71.6% OF CHILDREN IN SPA 4 AND 4.9%

OF CHILDREN IN SPA 5 ARE LOW-INCOME.

FAMILIES IN POVERTY PAINT AN IMPORTANT PICTURE OF THE POPULATION WITHIN

THE CEDARS-SINAI COMMUNITY BENEFIT SERVICE AREA. OVER ONE-QUARTER (26.3%)

OF FAMILIES LIVE IN POVERTY. WHEN EXAMINED BY ZIP CODE, COMMUNITY POVERTY

RATES ARE HIGH AMONG FAMILIES IN CENTRAL LOS ANGELES, DOWNTOWN LA 90021,

LA/COLISEUM, AND UNIVERSITY AND USC NEIGHBORHOODS.

THE MEDIAN HOUSEHOLD INCOME IN THE COMMUNITY BENEFIT SERVICE AREA IS

\$48,046 AND THE AVERAGE HOUSEHOLD INCOME IS \$72,501. THESE ARE LOWER THAN

COMPARABLE COUNTY INCOMES.

THE PERCENT OF STUDENTS ELIGIBLE FOR THE FREE AND REDUCED PRICE MEAL

Part VI Supplemental Information (Continuation)

PROGRAM IS ONE INDICATOR OF SOCIOECONOMIC STATUS. AMONG LOS ANGELES UNIFIED SCHOOL DISTRICT SCHOOLS, OVER THREE-FOURTHS (78.8%) OF THE STUDENTS ARE ELIGIBLE FOR THE FREE AND REDUCED PRICE MEAL PROGRAM, INDICATING A HIGH LEVEL OF LOW-INCOME FAMILIES. IN THE INGLEWOOD UNIFIED SCHOOL DISTRICT, 80.8% OF STUDENTS QUALIFY FOR THE PROGRAM, AND 93.1% OF LENNOX SCHOOL DISTRICT STUDENTS ARE ELIGIBLE FOR THE FREE AND REDUCED PRICE MEAL PROGRAM.

RESIDENTS IN SPA 6 HAVE HIGHER RATES OF PARTICIPATION IN GOVERNMENT SPONSORED PUBLIC PROGRAMS COMPARED TO RESIDENTS IN SPA 4 AND SPA 5. IN SPA 4, 46.4% OF ADULTS, BELOW 200% OF THE FPL, CANNOT AFFORD FOOD AND 25.5% UTILIZE FOOD STAMPS. IN SPA 6, 49.3% OF RESIDENTS BELOW 200% FPL CANNOT AFFORD FOOD AND 29% UTILIZE FOOD STAMPS. THESE RATES INDICATE A CONSIDERABLE PERCENTAGE OF RESIDENTS WHO MAY QUALIFY FOR FOOD STAMPS BUT DO NOT ACCESS THIS RESOURCE. WIC (WOMEN, INFANTS AND CHILDREN) BENEFITS ARE MORE READILY ACCESSED. AMONG CHILDREN IN SPA 4, 53.6% ACCESS WIC BENEFITS, AND 69.9% IN SPA 6 ACCESS WIC BENEFITS. SPA 5 RESPONDENTS DID NOT REPORT ACCESSING WIC FOR THEIR CHILDREN. AMONG SPA 6 RESIDENTS, 15.8% ARE TANF/CALWORKS RECIPIENTS; 10.7% OF SPA 4 RESIDENTS AND 2.5% OF SPA 5 RESIDENTS ARE TANF/CALWORKS RECIPIENTS.

32.7% OF THE POPULATION IN SPA 4, 10.4% IN SPA 5, AND 48.7% IN SPA 6 HAD MEDI-CAL COVERAGE. IN SPA 4, 30.3% HAD EMPLOYMENT-BASED INSURANCE, WHILE OVER HALF THE POPULATION IN SPA 5 (51.4%) HAD EMPLOYMENT-BASED INSURANCE. IN SPA 6, 22.7% OF THE POPULATION HAD EMPLOYMENT-BASED INSURANCE.

PART VI, LINE 5:

CEDARS-SINAI MEDICAL CENTER IS DRIVEN BY ITS MISSION TO IMPROVE THE HEALTH

Part VI Supplemental Information (Continuation)

STATUS OF THE COMMUNITY AND TO PROVIDE LEADERSHIP AND EXCELLENCE IN
 PATIENT CARE, RESEARCH AND EDUCATION. IN COLLABORATION WITH EXPERT MEDICAL
 STAFF, ADMINISTRATIVE LEADERS AND COMMUNITY PARTNERS, CEDARS-SINAI HAS
 MADE A SIGNIFICANT CONTRIBUTION-BOTH IN QUANTIFIABLE AND NON-QUANTIFIABLE
 TERMS-TO THE BENEFIT OF THE COMMUNITY. CEDARS-SINAI PROVIDES A BREADTH OF
 SERVICES TO MEET IDENTIFIED HEALTH NEEDS IN THE COMMUNITY. MANY
 CEDARS-SINAI PROGRAMS ARE OPERATED AT A FINANCIAL LOSS, BUT CONTINUE TO BE
 OFFERED BECAUSE THEY ARE AN IMPORTANT PART OF THE MEDICAL CENTER'S MISSION
 TO SERVE THE COMMUNITY'S HEALTH NEEDS.

CEDARS-SINAI IS GOVERNED BY A BOARD OF DIRECTORS THAT IS COMPOSED OF
 MEMBERS OF THE COMMUNITY. FURTHERMORE, THE COMMUNITIES ARE SERVED BY AN
 OPEN MEDICAL STAFF. ALSO, ANY SURPLUS FUNDS ARE REINVESTED INTO THE
 ORGANIZATION TO FURTHER SUPPORT THE COMMUNITY.

DURING THE TAX YEAR, CEDARS-SINAI'S COMMUNITY BENEFIT EXPENSES TOTALED
 OVER \$330,000,000 DIVIDED AMONG FIVE MAJOR CATEGORIES. FOR PURPOSES OF
 ESTIMATING CEDARS-SINAI'S FINANCIAL CONTRIBUTION TO COMMUNITY BENEFIT, THE
 FOLLOWING DEFINITIONS ARE USED:

UNREIMBURSED COST OF DIRECT MEDICAL CARE FOR THE POOR AND UNDERSERVED -
 INCLUDES THE UNREIMBURSED COST OF FREE AND DISCOUNTED HEALTHCARE SERVICES
 PROVIDED TO PERSONS WHO MEET THE ORGANIZATION'S CRITERIA FOR FINANCIAL
 ASSISTANCE AND ARE THEREFORE, DEEMED UNABLE TO PAY FOR ALL OR A PORTION OF
 THE SERVICES. IF THERE IS ANY SUBSIDY DONATED FOR THESE SERVICES, THAT
 AMOUNT IS DEDUCTED FROM THE GROSS AMOUNT. TRADITIONAL CHARITY CARE IS
 INCLUDED IN THE INTERNAL REVENUE SERVICE (IRS) FORM 990 SCHEDULE H PART I

LINE 7A.

Part VI Supplemental Information (Continuation)

UNPAID COST OF STATE PROGRAMS - THIS AMOUNT REPRESENTS THE UNPAID COST OF SERVICES PROVIDED TO PATIENTS IN THE MEDI-CAL PROGRAM OR ENROLLED IN HMO AND PPO PLANS UNDER CONTRACT WITH THE MEDI-CAL PROGRAM. THESE COSTS ARE INCLUDED IN THE IRS FORM 990 SCHEDULE H PART I LINE 7B. IN THE STATE OF CALIFORNIA THE MEDICAID PROGRAM IS CALLED MEDI-CAL.

UNREIMBURSED COSTS OF SPECIALTY GOVERNMENT PROGRAMS - ALSO PROVIDES COMMUNITY BENEFIT UNDER SUCH PROGRAMS AS THE VETERANS ADMINISTRATION, LOS ANGELES POLICE DEPARTMENT, SHORT DOYLE, PROPOSITION 99, AND OTHER PROGRAMS TO BENEFIT THE INDIGENT. THIS AMOUNT REPRESENTS THE UNPAID COST OF SERVICES PROVIDED TO PATIENTS IN THESE VARIOUS MEANS-TESTED PROGRAMS. IF THIS COMMUNITY BENEFIT WAS NOT PROVIDED, THE FEDERAL, STATE OR LOCAL GOVERNMENTS WOULD NEED TO FURNISH THESE SERVICES. THESE COSTS ARE INCLUDED IN THE IRS FORM 990 SCHEDULE H PART I LINE 7C.

UNREIMBURSED COST OF DIRECT MEDICAL CARE FOR MEDICARE PATIENTS - PRIMARILY BENEFITS THE ELDERLY. THIS AMOUNT REPRESENTS THE UNPAID COST OF SERVICES PROVIDED TO PATIENTS IN THE MEDICARE PROGRAM AND ENROLLED IN HMO AND PPO PLANS UNDER CONTRACT WITH THE MEDICARE PROGRAM. INCLUDED IN THESE AMOUNTS ARE \$20,003,000 FOR THE YEAR ENDED JUNE 30, 2021 OF UNPAID COSTS OF SERVICES PROVIDED TO PATIENTS IN THE MEDICARE PROGRAM THAT ARE ALSO ELIGIBLE FOR THE MEDI-CAL PROGRAM (DUAL ELIGIBLE BENEFICIARIES). THIS IS SIGNIFICANT IN THAT THESE PATIENTS TEND TO BE MORE COSTLY THAN NON-DUAL ELIGIBLE PATIENTS DUE TO THE COROLLARY SOCIO-ECONOMIC CHALLENGES THEY FACE. THESE PATIENTS OFTEN REQUIRE MORE FREQUENT CARE AND MORE COSTLY CARE WHEN COMPARED TO TRADITIONAL MEDICARE ONLY PATIENTS. THESE COSTS ARE INCLUDED IN THE IRS FORM 990 SCHEDULE H PART III SECTION B.

Part VI Supplemental Information (Continuation)

COMMUNITY BENEFIT PROGRAMS, AS WELL AS EDUCATION AND TRAINING FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS - COST OF SERVICES THAT ARE BENEFICIAL TO THE BROADER COMMUNITY. THIS CATEGORY INCLUDES UNREIMBURSED COSTS OF HEALTH PROFESSIONS EDUCATION, COMMUNITY HEALTH IMPROVEMENT, COMMUNITY BENEFIT OPERATIONS, AND CASH DONATIONS. THESE COSTS ARE INCLUDED IN THE IRS FORM 990 SCHEDULE H PART I LINES 7 E, F, AND I. BELOW ARE SOME EXAMPLES OF COSTS INCLUDED IN THIS CATEGORY OF THE COMMUNITY BENEFIT CONTRIBUTION:

HEALTH PROFESSIONS EDUCATION
 AS AN ACADEMIC MEDICAL CENTER, CEDARS-SINAI OFFERS GRADUATE MEDICAL EDUCATION AND MANY OTHER EDUCATION PROGRAMS FOR A VARIETY OF HEALTH PROFESSIONALS. THEY INCLUDE OFFERING GRADUATE EDUCATION TRAINING PROGRAMS IN NEARLY 100 PHYSICIAN SPECIALTY AND SUBSPECIALTY AREAS; AND OTHER HEALTH PROFESSIONS EDUCATION PROGRAMS INCLUDING DEGREE PROGRAMS AND EXTENSIVE EDUCATIONAL RESOURCES FOR ASPIRING AND CURRENT NURSES, DIETICIANS, PSYCHOLOGISTS, PARAMEDICS, PATHOLOGISTS, RESEARCHERS, REHABILITATION PROFESSIONALS AND CHAPLAINS.

COMMUNITY HEALTH IMPROVEMENT
 * CLINICAL SERVICES ARE PROVIDED TO UNDERSERVED COMMUNITIES DAILY, THROUGH AN ON-SITE PRIMARY ADULT CARE CLINIC; AND THROUGH MOBILE MEDICAL UNITS AND FREE AND COMMUNITY CLINICS THROUGHOUT LOS ANGELES - ALL SERVING UNDERSERVED, UNINSURED AND UNDERINSURED POPULATIONS.

* EACH YEAR, CEDARS-SINAI TAKES PART IN COMMUNITY-BASED ACTIVITIES INCLUDING HEALTH FAIRS, EXERCISE PROGRAMS, AND SCREENING PROGRAMS FOR

Part VI Supplemental Information (Continuation)

CONDITIONS SUCH AS CARDIOVASCULAR DISEASE, DEPRESSION, DIABETES AND
HYPERTENSION, AS WELL IMMUNIZATION PROGRAMS, LECTURES AND WORKSHOPS. ALSO
OFFERED ARE DISEASE-SPECIFIC SUPPORT GROUPS, PATIENT EDUCATION PROGRAMS
AND PROGRAM AFFILIATES.

* CEDARS-SINAI PLANS AND IMPLEMENTS LONG-TERM COMPREHENSIVE STRATEGIES TO
MEET THE HEALTH NEEDS OF UNDERSERVED COMMUNITIES. SIGNATURE COMMUNITY
BENEFIT PROGRAMS SEEK TO IMPROVE HEALTH IN COMMUNITIES BY BUILDING STRONG
PARTNERSHIPS, BUILDING COMMUNITY CAPACITIES AND PROVIDING DIRECT
EDUCATION.

RESEARCH PROGRAMS - CEDARS-SINAI'S CURRENTLY HAS OVER 2,300 ACTIVE
RESEARCH PROJECTS AND HAS MADE SIGNIFICANT CONTRIBUTIONS TO THE
DEVELOPMENT OF NEW MEDICAL TREATMENTS, TECHNOLOGY, MEDICAL KNOWLEDGE AND
PRACTICE. CEDARS-SINAI RANKS AMONG THE NATION'S TOP NON-UNIVERSITY
HOSPITALS IN NATIONAL INSTITUTES OF HEALTH (NIH) RESEARCH FUNDING -
CEDARS-SINAI RECEIVED OVER \$152 MILLION IN RESEARCH FUNDING THIS YEAR.
THESE COSTS ARE INCLUDED IN THE IRS FORM 990 SCHEDULE H PART I LINE 7.

PART VI, LINE 6:

CEDARS-SINAI MEDICAL CENTER, WITH 889 LICENSED BEDS, IS AN AFFILIATE OF
CEDARS-SINAI HEALTH SYSTEM.

CEDARS-SINAI HEALTH SYSTEM INCLUDES THE 133-BED CEDARS-SINAI MARINA DEL
REY HOSPITAL, WHICH HAS A MULTISPECIALTY PHYSICIAN NETWORK AND MANY
PRIMARY CARE, URGENT CARE, AND SPECIALTY CARE CENTERS THROUGHOUT THE LOS
ANGELES REGION. IT IS ALSO A MAJOR RESEARCH AND EDUCATION CENTER.

Part VI Supplemental Information (Continuation)

CEDARS-SINAI HEALTH SYSTEM INCLUDES THE 610-BED TORRANCE MEMORIAL MEDICAL CENTER, A MULTISPECIALTY PHYSICIAN GROUP, AN INDEPENDENT PHYSICIAN ASSOCIATION, AND AN ACCOUNTABLE CARE ORGANIZATION. IT ALSO HAS SEVERAL OUTPATIENT CENTERS LOCATED THROUGHOUT THE SOUTH BAY REGION.

THE AFFILIATION ENABLES EACH INSTITUTION TO CONTINUE THE UNIQUE RELATIONSHIPS EACH HAS WITH THE COMMUNITIES IT SERVES, WHILE PROVIDING A PLATFORM FOR A WIDE VARIETY OF COLLABORATIONS TO BETTER SERVE THE REGION.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CA

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**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

2020

**Open to Public
Inspection**

Name of the organization **CEDARS-SINAI MEDICAL CENTER** Employer identification number **95-1644600**

Part I General Information on Grants and Assistance

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

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
AIRPORT MARINA COUNSELING SERVICE 7891 LA TIJERA BOULEVARD LOS ANGELES, CA 90045	95-2224149	501(C)(3)	40,000.	0.			GENERAL SUPPORT; INCREASED ACCESSIBILITY AND CAPACITY GRANT
THE AMAAD INSTITUTE 10221 COMPTON AVENUE LOS ANGELES, CA 90002	77-0672440	501(C)(3)	15,000.	0.			HPV EDUCATIONAL GRANT
AMERICAN CANCER SOCIETY INC 250 WILLIAMS STREET NW NO 400 ATLANTA, GA 30303	13-1788491	501(C)(3)	40,000.	0.			GENERAL SUPPORT
AMERICAN HEART ASSOCIATION INC 7272 GREENVILLE AVENUE DALLAS, TX 75231	13-5613797	501(C)(3)	40,000.	0.			GENERAL SUPPORT
AMERICAN RED CROSS 431 18TH STREET NW WASHINGTON, DC 20006	53-0196605	501(C)(3)	25,000.	0.			GENERAL SUPPORT; HURRICANE RELIEF GRANT
AMERICAN SOCIETY FOR YAD VASHEM INC - 500 FIFTH AVENUE 42ND FLOOR - NEW YORK, NY 10110	13-3106768	501(C)(3)	50,000.	0.			GENERAL SUPPORT

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 154.

3 Enter total number of other organizations listed in the line 1 table ▶ 7.

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

Schedule I (Form 990) 2020

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ANTELOPE VALLEY PARTNERS FOR HEALTH - 44226 10TH STREET WEST - LANCASTER, CA 93534	47-0957404	501(C)(3)	20,000.	0.			HPV EDUCATIONAL GRANT
APLA HEALTH & WELLNESS 611 S KINGSLEY DR LOS ANGELES, CA 90005	84-1661910	501(C)(3)	75,000.	0.			COVID-19 VACCINE GRANT
ARNOLD GOLD FOUNDATION INC 619 E PALISADES AVENUE ENGLEWOOD CLIFFS, NJ 07632	22-3052098	501(C)(3)	15,000.	0.			GENERAL SUPPORT
ASIAN AMERICANS ADVANCING JUSTICE LOS ANGELES - 1145 WILSHIRE BLVD - LOS ANGELES, CA 90017	95-3854152	501(C)(3)	28,500.	0.			GENERAL SUPPORT; TRAINING AND EDUCATION GRANT
ATERES AVIGAIL 4929 WILSHIRE BLVD LOS ANGELES, CA 90010	95-3120316	501(C)(3)	25,000.	0.			GENERAL SUPPORT
BEIT T'SHUVAH 8831 VENICE BLVD LOS ANGELES, CA 90034	77-0152646	501(C)(3)	15,000.	0.			CAPACITY BUILDING GRANT
BET TZEDEK 3250 WILSHIRE BLVD 13TH FLOOR LOS ANGELES, CA 90010	23-7304205	501(C)(3)	100,000.	0.			GENERAL SUPPORT
BEVERLY HILLS CHAMBER OF COMMERCE AND CIVIC ASSOCIATION - 9400 S SANTA MONICA BLVD 2ND FLOOR - BEVERLY HILLS, CA 90210	95-0548070	501(C)(6)	10,340.	0.			GENERAL SUPPORT
BEVERLY HILLS FIRE CHIEFS FUND 445 N REXFORD DR BEVERLY HILLS, CA 90210	26-4563945	501(C)(3)	45,000.	0.			CIVIC ENGAGEMENT GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BEVERLY HILLS POLICE OFFICERS BENEVOLENT - 9663 SANTA MONICA BLVD NO 786 - BEVERLY HILLS, CA 90210	95-4584633	501(C)(3)	23,500.	0.			GENERAL SUPPORT; HEALTH AND WELLNESS GRANT
BIG SUNDAY 6111 MELROSE AVENUE LOS ANGELES, CA 90038	42-1765317	501(C)(3)	7,500.	0.			GENERAL SUPPORT
BRILLIANT CORNERS 1360 MISSION STREET SUITE 300 SAN FRANCISCO, CA 94103	56-2379862	501(C)(3)	2,575,000.	0.			GENERAL SUPPORT; AFFORDABLE HOUSING FOR SENIORS GRANT
CALIFORNIA COMMUNITY FOUNDATION 221 S FIGUEROA ST SUITE 400 LOS ANGELES, CA 90012	95-3510055	501(C)(3)	5,798,750.	0.			GENERAL SUPPORT; COMMUNITY INITIATIVE GRANT; HEALTH AND WELLNESS GRANT
CALIFORNIA HEALTH COLLABORATIVE PO BOX 25609 FRESNO, CA 93729	94-2862660	501(C)(3)	19,550.	0.			EVERY WOMAN COUNTS GRANT
CALIFORNIA LIFE SCIENCES ASSOCIATION - 9191 TOWNE CENTRE DR SUITE 450 - SAN DIEGO, CA 92122	47-3226523	501(C)(6)	10,000.	0.			GENERAL SUPPORT
CAPITAL LINK INC 40 COURT STREET 10TH FLOOR BOSTON, MA 02108	52-1593251	501(C)(3)	200,000.	0.			TRAINING AND EDUCATION GRANT
THE CENTER AT BLESSED SACRAMENT 6636 SELMA AVENUE HOLLYWOOD, CA 90028	20-3022534	501(C)(3)	100,000.	0.			HOMELESSNESS AND HOUSING GRANT
ECONOMIC DEVELOPMENT CORPORATION OF LOS ANGELES COUNTY - 444 SOUTH FLOWER STREET 37TH FLOOR - LOS ANGELES, CA 90071	95-3643339	501(C)(3)	30,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CENTRAL CITY NEIGHBORHOOD PARTNERS 501 S BIXEL STREET LOS ANGELES, CA 90017	95-4837709	501(C)(3)	20,000.	0.			HEALTH AND WELLNESS GRANT
CHABAD OF LA CIENEGA 1627 S LA CIENEGA BLVD LOS ANGELES, CA 90035	26-0335040	501(C)(3)	6,000.	0.			GENERAL SUPPORT
CHAI LIFELINE INC 151 WEST 30TH STREET NO 7TH FL NEW YORK, NY 10001	11-2940331	501(C)(3)	10,000.	0.			GENERAL SUPPORT
CHARLES R DREW UNIVERSITY 1731 EAST 120TH STREET NO 13 LOS ANGELES, CA 90059	95-6151774	501(C)(3)	100,150.	0.			GENERAL SUPPORT; HEALTH AND WELLNESS GRANT
CHILDREN'S INSTITUTE INC 2121 W TEMPLE STREET LOS ANGELES, CA 90026	95-1641424	501(C)(3)	560,000.	0.			GENERAL SUPPORT; EDUCATION GRANT
CLAREMATRIX 2644 30TH STREET NO 100 SANTA MONICA, CA 90405	23-7076166	501(C)(3)	75,000.	0.			TRAINING AND EDUCATION GRANT
CLINICA MSR OSCAR A ROMERO 2032 MARENGO STREET LOS ANGELES, CA 90033	95-3881333	501(C)(3)	95,000.	0.			GENERAL SUPPORT; BREAST CANCER GRANT
COALITION FOR COMPASSIONATE CARE 2530 RIVER PLAZA DRIVE SACRAMENTO, CA 95833	27-0419836	501(C)(3)	50,000.	0.			GENERAL SUPPORT
COALITION FOR RESPONSIBLE COMMUNITY DEVELOPMENT - 3101 SOUTH GRAND AVENUE - LOS ANGELES, CA 90007	20-2445113	501(C)(3)	100,000.	0.			COMMUNITY BENEFIT GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY - 445 S FIGUEROA ST NO 2100 - LOS ANGELES, CA 90071	95-4576023	501(C)(3)	1,875,000.	0.			HEALTH AND WELLNESS GRANT; CIVIC ENGAGEMENT GRANT
COMMUNITY HEALTH COUNCILS INC 3731 STOCKER STREET LOS ANGELES, CA 90008	95-4487664	501(C)(3)	100,000.	0.			CIVIC ENGAGEMENT GRANT
COMMUNITY PARTNERS 1000 NORTH ALAMEDA STREET NO 240 LOS ANGELES, CA 90012	95-4302067	501(C)(3)	43,500.	0.			GENERAL SUPPORT; TRAINING AND EDUCATION GRANT; HPV EDUCATIONAL GRANT
CONCERN FOUNDATION 11111 OLYMPIC BLVD SUITE 214 LOS ANGELES, CA 90064	23-7002878	501(C)(3)	6,000.	0.			GENERAL SUPPORT
CORPORATION FOR SUPPORTIVE HOUSING 61 BROADWAY NO 2300 NEW YORK, NY 10006	13-3600232	501(C)(3)	75,000.	0.			CIVIC ENGAGEMENT GRANT
CROHN'S & COLITIS FOUNDATION INC 733 THIRD AVENUE SUITE 510 NEW YORK, NY 10017	13-6193105	501(C)(3)	7,500.	0.			GENERAL SUPPORT
CULVER CITY CHAMBER OF COMMERCE 6000 SEPULVEDA BLVD NO 1260 CULVER CITY, CA 90230	95-0662765	501(C)(6)	5,600.	0.			GENERAL SUPPORT
CULVER CITY FIREFIGHTERS FOUNDATION - 9600 CULVER BLVD - CULVER CITY, CA 90232	81-4630130	501(C)(3)	20,000.	0.			HEALTH AND WELLNESS GRANT
CULVER CITY POLICE FOUNDATION 4040 DUQUESNE AVE CULVER CITY, CA 90232	26-4141292	501(C)(3)	15,500.	0.			WELLNESS AND COMMUNITY GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
DIDI HIRSCH COMMUNITY MENTAL HEALTH - 4760 S SEPULVEDA BLVD - CULVER CITY, CA 90230	95-1816023	501(C)(3)	75,000.	0.			HEALTH AND WELLNESS GRANT
DOWNTOWN WOMEN'S CENTER 442 S SAN PEDRO ST LOS ANGELES, CA 90013	31-1597223	501(C)(3)	75,000.	0.			CAPACITY BUILDING GRANT
EISNER HEALTH 1530 SOUTH OLIVE STREET LOS ANGELES, CA 90015	95-1690966	501(C)(3)	165,000.	0.			GENERAL SUPPORT; CAPACITY BUILDING GRANT
EL NIDO FAMILY CENTERS 440 SHATTO PLACE NO 417 LOS ANGELES, CA 90020	95-3186429	501(C)(3)	100,000.	0.			CAPACITY BUILDING GRANT
EXCHANGE CLUB OF CULVER CITY CHARITABLE FOUNDATION INC. - 6017 BRISTOL PARKWAY - CULVER CITY, CA 90230	54-2145774	501(C)(3)	25,000.	0.			FOOD INSECURITY GRANT
FASHION FOOTWEAR CHARITABLE FOUNDATION - 575 5TH AVENUE 14TH FL - NEW YORK, NY 10017	13-4112482	501(C)(3)	5,500.	0.			GENERAL SUPPORT
FILIPINO AMERICAN SERVICE GROUP INC - 135 N PARK VIEW ST - LOS ANGELES, CA 90026	95-3714064	501(C)(3)	20,000.	0.			CANCER AWARENESS GRANT
FOOD FORWARD INC 7412 FULTON AVE NO 3 NORTH HOLLYWOD, CA 91605	90-0678872	501(C)(3)	150,000.	0.			FOOD INSECURITY GRANT
FOUNDATION FOR BIOMEDICAL RESEARCH 1100 VERMONT AVE NW NO 1100 WASHINGTON, DC 20005	04-2746997	501(C)(3)	10,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FUNDERS TOGETHER TO END HOMELESSNESS - 89 SOUTH STREET SUITE 603 - BOSTON, MA 02111	27-3033048	501(C)(3)	10,000.	0.			GENERAL SUPPORT
GRANTMAKERS IN HEALTH 1100 CONNECTICUT AVE NW NO 1100 WASHINGTON, DC 20036	13-3206571	501(C)(3)	15,000.	0.			GENERAL SUPPORT
HOLLYWOOD FOOD COALITION PO BOX 480157 LOS ANGELES, CA 90048	46-4079214	501(C)(3)	50,000.	0.			COVID-19 RELIEF GRANT
HOMEBOY INDUSTRIES 130 W BRUNO STREET LOS ANGELES, CA 90012	95-4800735	501(C)(3)	100,000.	0.			MENTAL HEALTH GRANT
ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI - ONE GUSTAVE L LEVY PLACE - NEW YORK, NY 10029	13-6171197	501(C)(3)	20,000.	0.			GENERAL SUPPORT
IMAGINE LOS ANGELES INC 672 S LAFAYETTE PARK PLACE NO 28 LOS ANGELES, CA 90057	20-4637089	501(C)(3)	25,000.	0.			HOMELESSNESS AND HOUSING GRANT
IMMANUEL PRESBYTERIAN CHURCH 3300 WILSHIRE BLVD LOS ANGELES, CA 90010	95-1643330	501(C)(3)	40,000.	0.			HEALTH AND WELLNESS GRANT
INCLUSIVE ACTION FOR THE CITY 2900 E CESAR E CHAVEZ AVE LOS ANGELES, CA 90033	27-0584116	501(C)(3)	75,000.	0.			GENERAL SUPPORT
INFANT PARENT MENTAL HEALTH FOUNDATION - 11400 W OLYMPIC BLVD NO 590 - LOS ANGELES, CA 90064	26-2055149	501(C)(3)	35,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JEWISH FAMILY SERVICE 330 N FAIRFAX AVE LOS ANGELES, CA 90036	95-1691013	501(C)(3)	35,000.	0.			HEALTH AND WELLNESS GRANT
JEWISH FREE LOAN ASSOC (JFLA) 6505 WILSHIRE BOULEVARD NO 715 LOS ANGELES, CA 90048	95-1691014	501(C)(3)	50,000.	0.			GENERAL SUPPORT
JEWISH JUMPSTART 2801 OCEAN PARK BLVD SANTA MONICA, CA 90405	26-2173175	501(C)(3)	25,000.	0.			RESEARCH STUDY GRANT
JEWISH VOCATIONAL SERVICE (JVS) 6505 WILSHIRE BOULEVARD SUITE 200 LOS ANGELES, CA 90048	95-1691012	501(C)(3)	87,500.	0.			GENERAL SUPPORT
JWCH INSTITUTE INC 5650 JILLSON STREET COMMERCE, CA 90040	95-2289916	501(C)(3)	75,000.	0.			COVID-19 RELIEF GRANT
KARSH FAMILY SOCIAL SERVICE CENTER INC - 3750 WEST 6TH STREET - LOS ANGELES, CA 90020	81-2974850	501(C)(3)	25,000.	0.			FOOD INSECURITY GRANT
KHEIR CENTER 3727 W 6TH STREET NO 210 LOS ANGELES, CA 90020	95-4074660	501(C)(3)	100,000.	0.			GENERAL SUPPORT
KOREAN AMERICAN FAMILY SERVICE CENTER - 3727 WEST 6TH STREET NO 320 - LOS ANGELES, CA 90020	95-3899329	501(C)(3)	83,000.	0.			GENERAL SUPPORT
KORYO HEALTH FOUNDATION 1058 S VERMONT AVE LOS ANGELES, CA 90006	95-2897049	501(C)(3)	20,000.	0.			BREAST CANCER GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LA AFRICAN AMERICAN CHAMBER OF COMMERCE - 5120 GOLDLEAF CIRCLE SUITE 230 - LOS ANGELES, CA 90056	95-4357302	501(C)(6)	15,000.	0.			GENERAL SUPPORT
LA FAMILY HOUSING CORP 7843 LANKERSHIM BLVD NORTH HOLLYWOOD, CA 91605	95-3920560	501(C)(3)	850,000.	0.			HOUSING GRANT
LAX COASTAL AREA CHAMBER OF COMMERCE - 9100 S SEPULVEDA BLVD - WESTCHESTER, CA 90045	95-1806513	501(C)(6)	15,900.	0.			GENERAL SUPPORT
LOS ANGELES BUSINESS COUNCIL 2029 CENTURY PARK EAST SUITE 4380 LOS ANGELES, CA 90067	27-1485429	501(C)(3)	12,500.	0.			GENERAL SUPPORT
LOS ANGELES CHRISTIAN HEALTH CENTERS - 453 S SPRING STREET SUITE 1201 - LOS ANGELES, CA 90013	95-4315734	501(C)(3)	35,000.	0.			GENERAL SUPPORT
LOS ANGELES COUNTY FIRE DEPT FOUNDATION - 1320 N EASTERN AVE - LOS ANGELES, CA 90063	47-5572995	501(C)(3)	60,000.	0.			GENERAL SUPPORT
LOS ANGELES FIRE DEPARTMENT FOUNDATION - 1700 STADIUM WAY ROOM 100 - LOS ANGELES, CA 90012	27-2007326	501(C)(3)	90,000.	0.			GENERAL SUPPORT
LOS ANGELES LGBT CENTER 1118 N MCCADDEN PLACE LOS ANGELES, CA 90038	95-3567895	501(C)(3)	100,000.	0.			GENERAL SUPPORT
LOS ANGELES POLICE FOUNDATION 633 WEST 5TH STREET NO 960 LOS ANGELES, CA 90071	95-4700442	501(C)(3)	25,000.	0.			GENERAL SUPPORT; TRAINING AND EDUCATION GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LOS ANGELES RAMS FOUNDATION 29899 AGOURA RD AGOURA HILLS, CA 91301	81-3467846	501(C)(3)	15,000.	0.			GENERAL SUPPORT
LOS ANGELES TRUST FOR CHILDREN'S HEALTH - 333 S BEAUDRY AVENUE - LOS ANGELES, CA 90017	95-4262448	501(C)(3)	800,000.	0.			HEALTH AND WELLNESS GRANT
LOS ANGELES URBAN LEAGUE 4401 CRENSHAW BLVD SUITE 201 LOS ANGELES, CA 90043	95-1691288	501(C)(3)	75,000.	0.			WORKFORCE DEVELOPMENT GRANT
MAPS CHARITIES 14320 VENTURA BLVD SHERMAN OAKS, CA 91423	27-0749461	501(C)(3)	20,000.	0.			GENERAL SUPPORT
MARCH OF DIMES 1550 CRYSTAL DRIVE SUITE STE 1300 ARLINGTON, VA 22202	13-1846366	501(C)(3)	25,000.	0.			GENERAL SUPPORT
MARINA DEL REY SHERIFF'S SUPPORT UNIT - 15821 VENTURA BLVD 500 - ENCINO, CA 91436	51-0587035	501(C)(3)	10,000.	0.			TRAINING AND EDUCATION GRANT
MAYOR'S FUND FOR LOS ANGELES 200 N SPRING STREET NO 305B LOS ANGELES, CA 90012	47-1084641	501(C)(3)	85,000.	0.			COVID-19 RELIEF GRANT
MEALS ON WHEELS WEST 1823 MICHIGAN AVENUE SUITE A SANTA MONICA, CA 90404	95-4613280	501(C)(3)	25,000.	0.			COVID-19 RELIEF GRANT
MEDICARE RIGHTS CENTER INC 266 WEST 37TH ST 3RD FLOOR NEW YORK, NY 10018	13-3505372	501(C)(3)	6,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

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MEXICAN AMERICAN BAR FOUNDATION (MABF) - PO BOX 862127 - LOS ANGELES, CA 90086	95-4358513	501(C)(3)	15,000.	0.			GENERAL SUPPORT
MF PLACE, INC. POST OFFICE BOX 3867 HOLLYWOOD, CA 90078	95-4834034	501(C)(3)	25,000.	0.			HOUSING FOR THE YOUTH GRANT
MLK JR COMMUNITY HEALTH FOUNDATION 1680 E 120TH STREET LOS ANGELES, CA 90059	45-4433505	501(C)(3)	195,000.	0.			GENERAL SUPPORT; HEALTH AND WELLNESS GRANT
NAMI LAC 3600 WILSHIRE BLVD STE 1804 LOS ANGELES, CA 90010	95-4049720	501(C)(3)	250,000.	0.			HEALTH AND WELLNESS GRANT
NATIONAL ACADEMY OF SCIENCES 2101 CONSTITUTION AVENUE NW WASHINGTON, DC 20418	53-0196932	501(C)(3)	25,000.	0.			GENERAL SUPPORT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) - 1100 13TH ST NW THIRD FLOOR - WASHINGTON, DC 20005	52-1191985	501(C)(3)	5,969.	0.			GENERAL SUPPORT
NATIONAL COUNCIL OF JEWISH WOMEN 5350 WILSHIRE BLVD NO 36849 LOS ANGELES, CA 90036	95-1641433	501(C)(3)	50,000.	0.			GENERAL SUPPORT
NATIONAL MEDICAL FELLOWSHIPS INC PO BOX 3875 NEW YORK, NY 10163	01-0963657	501(C)(3)	10,750.	0.			GENERAL SUPPORT
NATIONAL MULTIPLE SCLEROSIS SOCIETY - 733 THIRD AVENUE - NEW YORK, NY 10017	13-5661935	501(C)(3)	15,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NETWORK FOR EXCELLENCE IN HEALTH (NEHI) - 133 FEDERAL STREET 9TH FLOOR - BOSTON, MA 02110	01-0624865	501(C)(3)	15,000.	0.			GENERAL SUPPORT
NEW DIRECTIONS FOR VETERANS 11303 WILSHIRE BLVD BLDG 116 LOS ANGELES, CA 90073	95-4242745	501(C)(3)	50,000.	0.			MENTAL HEALTH GRANT
NONPROFIT FINANCE FUND 5 HANOVER SQUARE 9TH FL NEW YORK, NY 10004	13-3238657	501(C)(3)	325,000.	0.			GENERAL SUPPORT; FOOD INSECURITY GRANT
NORTHEAST VALLEY HEALTH CORP 1172 NORTH MACLAY AVENUE SAN FERNANDO, CA 91340	23-7120632	501(C)(3)	100,000.	0.			GENERAL SUPPORT
ONEGENERATION 17400 VICTORY BLVD VAN NUYS, CA 91406	95-4066979	501(C)(3)	25,000.	0.			FOOD INSECURITY GRANT
ONELEGACY FOUNDATION 221 SOUTH FIGUEROA STREET NO 500 LOS ANGELES, CA 90012	45-2936915	501(C)(3)	11,000.	0.			GENERAL SUPPORT
OPEN PATHS COUNSELING CENTER 400 CORPORATE POINTE STE 300 CULVER CITY, CA 90230	95-3221061	501(C)(3)	40,000.	0.			MENTAL HEALTH GRANT
OUR HOUSE INC 1663 SAWTELLE BLVD LOS ANGELES, CA 90025	33-0529915	501(C)(3)	25,000.	0.			TRAINING AND EDUCATION GRANT
PACIFIC AREA BOOSTERS ASSOCIATION, INC. - PO BOX 2895 - VENICE, CA 90291	95-3971193	501(C)(3)	20,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PACIFIC COUNCIL ON INTERNATIONAL POLICY - 725 SOUTH FIGUEROA STREET NO 450 - LOS ANGELES, CA 90017	95-4520471	501(C)(3)	125,000.	0.			GENERAL SUPPORT
PACOIMA BEAUTIFUL 13520 VAN NUYS BOULEVARD RM/STE 20 PACOIMA, CA 91331	95-4770745	501(C)(3)	50,000.	0.			GENERAL SUPPORT
PEOPLE ASSISTING THE HOMELESS (PATH) - 340 NORTH MADISON AVENUE - LOS ANGELES, CA 90004	95-3950196	501(C)(3)	50,000.	0.			GENERAL SUPPORT
PLANNED PARENTHOOD LOS ANGELES 400 WEST 30TH STREET LOS ANGELES, CA 90007	95-2408623	501(C)(3)	575,000.	0.			GENERAL SUPPORT; HEALTH AND WELLNESS GRANT
PLANNED PARENTHOOD PASADENA AND SAN GABRIEL VALLEY INC - 2333 N LAKE AVE 2ND FLOOR - ALTADENA, CA 91001	95-1916050	501(C)(3)	100,000.	0.			COMMUNITY INITIATIVE GRANT
PLUNUM HEALTH 1530 S OLIVE STREET LOS ANGELES, CA 90015	83-1653397	501(C)(3)	100,000.	0.			GENERAL SUPPORT
PROJECT ANGEL FOOD 922 VINE ST LOS ANGELES, CA 90038	95-4115863	501(C)(3)	105,000.	0.			GENERAL SUPPORT
RACE TO ERASE MS 1875 CENTURY PARK EAST STE 980 LOS ANGELES, CA 90067	84-1238541	501(C)(3)	10,000.	0.			GENERAL SUPPORT
RAND CORPORATION 1776 MAIN STREET PO BOX 2138 SANTA MONICA, CA 90407	95-1958142	501(C)(3)	30,000.	0.			GENERAL SUPPORT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
READING IS FUNDAMENTAL OF SOUTHERN CALIFORNIA INC - 7250 BANDINI BLVD ROOM 209 - LOS ANGELES, CA 90040	23-7425712	501(C)(3)	10,000.	0.			HEALTH AND WELLNESS GRANT
SABAN COMMUNITY CLINIC 8405 BEVERLY BOULEVARD LOS ANGELES, CA 90048	95-2539105	501(C)(3)	360,000.	0.			GENERAL SUPPORT
SAFE PLACE FOR YOUTH INC 2469 LINCOLN BLVD. VENICE, CA 90291	84-1802637	501(C)(3)	25,000.	0.			TRAINING AND EDUCATION GRANT
SANTA MONICA BAY AREA HUMAN RELATIONS - PO BOX 1307 - SANTA MONICA, CA 90406	61-1486057	501(C)(3)	35,000.	0.			CIVIC ENGAGEMENT GRANT
SANTA MONICA EDUCATION FOUNDATION 1645 16TH ST SANTA MONICA, CA 90404	95-3787674	501(C)(3)	10,000.	0.			GENERAL SUPPORT
SANTA MONICA FIRE FIGHTERS RELIEF FUND - 222 HOLLISTER AVENUE - SANTA MONICA, CA 90405	45-2702863	501(C)(3)	15,000.	0.			HEALTH AND WELLNESS GRANT
SHARSHERET INC 1086 TEANECK ROAD SUITE 2G TEANECK, NJ 07666	13-4198529	501(C)(3)	100,000.	0.			GENERAL SUPPORT
SKID ROW HOUSING TRUST 1317 EAST SEVENTH STREET LOS ANGELES, CA 90021	95-4205316	501(C)(3)	100,000.	0.			HOMELESSNESS AND HOUSING GRANT
SOCIAL VENTURE PARTNERS LOS ANGELES INC - 800 WILSHIRE BLVD NO 200 - LOS ANGELES, CA 90017	51-0563566	501(C)(3)	3,000,000.	0.			HOMELESSNESS AND HOUSING GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SOUTHERN CALIFORNIA COUNSELING CENTER - 5615 W PICO BLVD - LOS ANGELES, CA 90019	95-2430665	501(C)(3)	75,000.	0.			MENTAL HEALTH GRANT
SOUTHERN CALIFORNIA EDUCATION FUND PO BOX 151495 LOS ANGELES, CA 90015	95-3713168	501(C)(3)	50,000.	0.			GENERAL SUPPORT
SOUTHERN CALIFORNIA GRANTMAKERS 1000 NORTH ALAMEDA STREET NO 230 LOS ANGELES, CA 90012	95-2831058	501(C)(3)	13,500.	0.			GENERAL SUPPORT
SOUTHSIDE COALITION OF COMMUNITY HEALTH - 1400 S GRAND AVENUE - LOS ANGELES, CA 90015	20-8892311	501(C)(3)	70,000.	0.			GENERAL SUPPORT; CANCER SUPPORT GRANT
SPECIAL SERVICE FOR GROUPS INC 905 E 8TH STREET LOS ANGELES, CA 90021	95-1716914	501(C)(3)	305,000.	0.			GENERAL SUPPORT; AFFORDABLE HOUSING FOR SENIORS GRANT; FOOD INSECURITY GRANT
ST JOHN'S WELL CHILD & FAMILY CENTER - 808 W 58TH STREET - LOS ANGELES, CA 90037	95-4067758	501(C)(3)	150,000.	0.			HEALTH AND WELLNESS GRANT; COVID-19 RELIEF GRANT
ST JOSEPH CENTER 204 HAMPTON DRIVE VENICE, CA 90291	95-3874381	501(C)(3)	50,000.	0.			FOOD INSECURITY GRANT
SUSAN G KOMEN LOS ANGELES COUNTY AFFL - 13770 NOEL ROAD SUITE 801889 - DALLAS, TX 75380	75-1835298	501(C)(3)	20,000.	0.			GENERAL SUPPORT
SUSTAINABLE ECONOMIC ENTERPRISES OF LOS ANGELES - 1125 WEST 6TH STREET NO 500 - LOS ANGELES, CA 90017	95-4597000	501(C)(3)	150,000.	0.			GENERAL SUPPORT; FOOD INSECURITY GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

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TEEN LINE PO BOX 48750 LOS ANGELES, CA 90048	95-3760982	501(C)(3)	15,000.	0.			GENERAL SUPPORT
THAI COMMUNITY DEVELOPMENT CENTER 6376 YUCCA STREET SUITE B LOS ANGELES, CA 90028	95-4531770	501(C)(3)	75,000.	0.			FOOD INSECURITY GRANT
THE ACHIEVABLE FOUNDATION 5840 UPLANDER WAY NO 101 CULVER CITY, CA 90230	95-4552419	501(C)(3)	20,000.	0.			HEALTH AND WELLNESS GRANT
THE BOYS AND GIRLS CLUBS OF SANTA MONICA INC - 1220 LINCOLN BLVD - SANTA MONICA, CA 90401	95-1890706	501(C)(3)	50,000.	0.			FOOD INSECURITY GRANT; HEALTH AND WELLNESS GRANT
THE CHILDREN'S HEART FOUNDATION 5 REVERE DRIVE NO 200 NORTHBROOK, IL 60062	36-4077528	501(C)(3)	10,000.	0.			GENERAL SUPPORT
THE CHRYSALIS CENTER 522 S MAIN ST LOS ANGELES, CA 90013	95-3972624	501(C)(3)	25,000.	0.			GENERAL SUPPORT
THE HASTINGS CENTER INC 21 MALCOLM GORDON RD GARRISON, NY 10524	13-2662222	501(C)(3)	150,000.	0.			GENERAL SUPPORT
THE CLINIC INC DBA HEALTH AND WELLNESS CENTERS - 3834 SOUTH WESTERN AVE - LOS ANGELES, CA 90062	23-7351622	501(C)(3)	100,000.	0.			COMMUNITY INITIATIVE GRANT
THE MAPLE COUNSELING CENTER (TMCC) 9107 WILSHIRE BLVD LOWER LEVEL BEVERLY HILLS, CA 90210	95-2753118	501(C)(3)	100,000.	0.			COMMUNITY INITIATIVE GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

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THE PEOPLE CONCERN 2116 ARLINGTON AVENUE NO 100 LOS ANGELES, CA 90018	95-6143865	501(C)(3)	230,000.	0.			GENERAL SUPPORT
THE WALL LAS MEMORIAS 5619 MONTE VISTA ST LOS ANGELES, CA 90042	95-4468225	501(C)(3)	20,000.	0.			HPV EDUCATIONAL GRANT
TIDES CENTER PO BOX 29907 SAN FRANCISCO, CA 94129	94-3213100	501(C)(3)	550,000.	0.			GENERAL SUPPORT; HEALTH AND WELLNESS GRANT
TOWER CANCER RESEARCH FOUNDATION 8767 WILSHIRE BLVD NO 401 BEVERLY HILLS, CA 90211	95-4596354	501(C)(3)	7,500.	0.			GENERAL SUPPORT
UCLA FOUNDATION 10889 WILSHIRE BLVD SUITE 1500 LOS ANGELES, CA 90024	95-2250801	501(C)(3)	212,500.	0.			GENERAL SUPPORT
UNIHEALTH FOUNDATION 800 WILSHIRE BLVD SUITE 1300 LOS ANGELES, CA 90017	95-5004033	501(C)(3)	5,000,000.	0.			HEALTH AND WELLNESS GRANT
UNITED STATES OF CARE CAMPAIGN 1110 VERMONT AVENUE NW NO 950 WASHINGTON, DC 20005	82-2860302	501(C)(3)	200,000.	0.			GENERAL SUPPORT
UNIVERSITY OF SOUTHERN CALIFORNIA (USC) - UNIVERSITY GARDENS UGB203 - LOS ANGELES, CA 90089	95-1642394	501(C)(3)	275,000.	0.			GENERAL SUPPORT
VALLEY CARE COMMUNITY CONSORTIUM 7515 VAN NUYS BLVD VAN NUYS, CA 91405	20-5569606	501(C)(3)	50,000.	0.			HEALTH AND WELLNESS GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
VENICE COMMUNITY HOUSING CORP 200 LINCOLN BLVD VENICE, CA 90291	95-4200761	501(C)(3)	350,000.	0.			HOUSING GRANT
VENICE FAMILY CLINIC 604 ROSE AVENUE VENICE, CA 90291	95-2769432	501(C)(3)	80,000.	0.			GENERAL SUPPORT
VIA CARE COMMUNITY HEALTH CENTER INC - 507 S ATLANTIC BLVD - LOS ANGELES, CA 90022	80-0699156	501(C)(3)	95,000.	0.			HEALTH AND WELLNESS GRANT
VILLAGE FOR VETS 149 S BARRINGTON AVE 640 LOS ANGELES, CA 90049	81-1275379	501(C)(3)	50,000.	0.			EQUITY AND INCLUSION GRANT
WEST HOLLYWOOD CHAMBER OF COMMERCE 8272 SANTA MONICA BLVD WEST HOLLYWOOD, CA 90046	95-1359210	501(C)(6)	15,000.	0.			GENERAL SUPPORT
WEST HOLLYWOOD SHERIFF FOUNDATION 780 N SAN VICENTE BLVD WEST HOLLYWOOD, CA 90069	84-4355224	501(C)(3)	20,000.	0.			HOMELESSNESS AND HOUSING GRANT
WESTSIDE FAMILY HEALTH CENTER 3861 SEPULVEDA BOULEVARD CULVER CITY, CA 90230	95-2931931	501(C)(3)	20,000.	0.			GENERAL SUPPORT
WESTSIDE FOOD BANK 1710 22ND STREET SANTA MONICA, CA 90404	95-3685875	501(C)(3)	25,000.	0.			COVID-19 RELIEF GRANT
WESTSIDE JEWISH COMMUNITY CENTER INC - 5870 W OLYMPIC BLVD - LOS ANGELES, CA 90036	95-1691010	501(C)(3)	15,000.	0.			SENIOR WELLNESS GRANT

Schedule I (Form 990)

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

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WESTSIDE PACIFIC VILLAGES PO BOX 90737 LOS ANGELES, CA 90045	80-0348830	501(C)(3)	50,000.	0.			GENERAL SUPPORT
WILSHIRE STATION BOOSTERS INC 4861 VENICE BLVD LOS ANGELES, CA 90019	84-2047956	501(C)(3)	15,000.	0.			WELLNESS AND SAFETY GRANT

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 noncash assistance

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

PART I, LINE 2:

THE ORGANIZATION CONSISTENTLY CONTRIBUTES TO WELL-ESTABLISHED EXEMPT

ORGANIZATIONS AND RELIES ON THE GOVERNING BODY OF EACH OF THESE

ORGANIZATIONS TO ENSURE THAT GRANT FUNDS DONATED TO EACH AND EVERY

ORGANIZATION ARE USED FOR PROPER PURPOSES AND NOT OTHERWISE DIVERTED FROM

THE INTENDED USE.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2020

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.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

CEDARS-SINAI MEDICAL CENTER

Employer identification number

95-1644600

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2020

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 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) THOMAS M. PRISELAC PRESIDENT/CEO	(i)	1,937,823.	1,715,106.	1,124,591.	1,319,754.	25,823.	6,123,097.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) EDUARDO MARBAN, MD DIRECTOR-HEART INSTITUTE	(i)	2,505,782.	426,253.	642,716.	328,485.	35,203.	3,938,439.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) KEITH BLACK, MD CHAIR-NEUROSURGERY	(i)	2,243,843.	449,514.	666,799.	134,694.	29,596.	3,524,446.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) SHLOMO MELMED, MD CHIEF ACADEMIC OFFICER	(i)	1,243,451.	683,479.	692,432.	677,550.	24,931.	3,321,843.	125,000.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) RAJENDRA MAKAR, MD EXEC DIRECTOR-CARDIAC INTERVENTIONAL	(i)	1,314,828.	1,099,286.	409,881.	97,623.	43,541.	2,965,159.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) EDWARD M. PRUNCHUNAS TREASURER	(i)	927,140.	488,327.	900,369.	378,778.	25,965.	2,720,579.	125,000.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOANNA CHIKWE, MD CHAIR, CARDIAC SURGERY	(i)	1,821,110.	351,627.	326,664.	142,740.	24,952.	2,667,093.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) BRUCE GEWERTZ, MD CHAIR-DEPT OF SURGERY	(i)	1,555,690.	370,395.	272,072.	348,193.	25,304.	2,571,654.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) JEFFREY SMITH MD, JD, MMM CHIEF OPERATING OFFICER	(i)	960,710.	494,085.	295,112.	12,775.	44,712.	1,807,394.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) DAVID M. WRIGLEY CHIEF FINANCIAL OFFICER	(i)	721,094.	339,940.	508,793.	188,293.	33,734.	1,791,854.	50,000.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) KIMBERLY GREGORY, MD STAFF PHYS./BOARD MEMBER	(i)	455,190.	81,794.	55,084.	39,900.	36,491.	668,459.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) PEGGY MILES, MD STAFF PHYS./BOARD MEMBER	(i)	322,938.	33,143.	47,654.	62,550.	11,509.	477,794.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(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 I, LINE 1A:

THE ORGANIZATION'S TRAVEL POLICY CONTAINS A PROVISION THAT ALLOWS FLYING

FIRST CLASS FOR ANY ONE-WAY FLIGHT THAT IS LONGER THAN EIGHT HOURS.

EXCEPTIONS REQUIRE SENIOR EXECUTIVE APPROVAL.

THE OFFICERS, DIRECTORS, KEY EMPLOYEES AND HIGHEST-COMPENSATED EMPLOYEES

HAVE, FROM TIME TO TIME, FLOWN FIRST CLASS AS ALLOWED BY THE TRAVEL POLICY.

HOUSING ALLOWANCE WAS PROVIDED TO TWO LISTED PERSONS DURING THE YEAR ENDED

DECEMBER 31, 2020 AND THE BENEFIT WAS TREATED AS TAXABLE COMPENSATION TO

THE EMPLOYEES.

PART I, LINE 4B:

THERE ARE TWO NONQUALIFIED DEFERRED COMPENSATION PLANS IN WHICH ONE OR MORE

OF THE LISTED PERSONS PARTICIPATE.

THE FIRST PLAN IS A DEFERRED COMPENSATION PLAN. THIS IS A "GRANDFATHERED"

TRADITIONAL DEFINED BENEFIT PLAN (NO NEW PARTICIPANTS HAVE BEEN ADDED SINCE

1986). THE BENEFIT FORMULA IS A PERCENTAGE OF THE HIGHEST FIVE YEARS

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.

AVERAGE ANNUAL SALARY TIMES THE NUMBER OF YEARS OF ELIGIBLE SERVICE, WITH A

MAXIMUM CREDITED SERVICE OF 30 YEARS.

THE SECOND PLAN IS A SUPPLEMENTAL RETIREMENT ALLOWANCE THAT IS PAYABLE

DIRECTLY TO THE PARTICIPANTS EACH QUARTER. THE BENEFIT FORMULA FOR THIS

PLAN HAS ANNUAL CONTRIBUTIONS THAT ARE EITHER A PERCENTAGE OF SALARY, OR

ARE DESIGNED TO FUND A PERCENTAGE OF THE ESTIMATED FINAL 5-YEAR AVERAGE

SALARY. CERTAIN INDIVIDUALS ALSO RECEIVED PAYOUTS FROM AMOUNTS ACCRUED IN

PRIOR YEARS.

IN ADDITION, FOUR INDIVIDUALS HAVE RETENTION INCENTIVES WHICH HAD

CLIFF-VESTING DATES IN 2020.

THE FOLLOWING OFFICERS, DIRECTORS, KEY EMPLOYEES AND HIGHEST-COMPENSATED

EMPLOYEES RECEIVED PAYMENTS DURING THE YEAR ENDED DECEMBER 31, 2020 RELATED

TO THE PLANS REFERENCED ABOVE. THESE PAYMENTS ARE INCLUDED IN SCHEDULE J,

PART II AND ARE NOT INCREMENTAL PAYMENTS.

KEITH BLACK, MD

655,993

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.

JOANNA CHIKWE, MD 324,002

BRUCE GEWERTZ, MD 254,104

KIMBERLY GREGORY, MD 53,586

RAJENDRA MAKKAR, MD 359,800

EDUARDO MARBAN, MD 519,736

SHLOMO MELMED, MD 677,564

PEGGY MILES, MD 18,254

THOMAS M. PRISELAC 1,007,563

EDWARD PRUNCHUNAS 815,394

JEFFREY SMITH, MD,JD, MMM 223,747

DAVID M. WRIGLEY 462,984

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.**

Name of the organization <p style="text-align: center;">CEDARS-SINAI MEDICAL CENTER</p>	Employer identification number <p style="text-align: center;">95-1644600</p>
--	---

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 CA HEALTH FACILITIES FINANCING AUTHORITY	52-1643828	13032UKD9	11/09/16	755,157,409.	SEE PART VI, ISSUE A, DESCRIPTION OF PURPOSE		X		X		X
B CA HEALTH FACILITIES FINANCING AUTHORITY	52-1643828	13032UBJ6	11/17/15	438,579,839.	SEE PART VI, ISSUE B, DESCRIPTION OF PURPOSE		X		X		X
C CA HEALTH FACILITIES FINANCING AUTHORITY	52-1643828	13033LVK0	12/21/11	163,357,091.	SEE PART VI, ISSUE C, DESCRIPTION OF PURPOSE		X		X		X
D											

Part II Proceeds									
	A		B		C		D		
1 Amount of bonds retired	24,525,000.		8,720,000.		128,555,000.				
2 Amount of bonds legally defeased									
3 Total proceeds of issue	757,093,777.		438,579,839.		163,357,091.				
4 Gross proceeds in reserve funds									
5 Capitalized interest from proceeds									
6 Proceeds in refunding escrows	435,150,733.								
7 Issuance costs from proceeds	1,932.		4,239.						
8 Credit enhancement from proceeds									
9 Working capital expenditures from proceeds									
10 Capital expenditures from proceeds	321,941,112.								
11 Other spent proceeds			438,575,600.		163,357,091.				
12 Other unspent proceeds									
13 Year of substantial completion	2017		2015		2012				
	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		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		X			
16 Has the final allocation of proceeds been made?	X		X		X				
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X				

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

Schedule K (Form 990) 2020

Part III Private Business Use

	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						
2 Are there any lease arrangements that may result in private business use of bond-financed property?	X							
3a Are there any management or service contracts that may result in private business use of bond-financed property?	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							
c Are there any research agreements that may result in private business use of bond-financed property?	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							
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		%		%		%		%
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		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
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							

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		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?	X			X		X		
b Exception to rebate?		X	X		X			
c No rebate due?	X			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		X		

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
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?	X		X		X			

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

SCHEDULE K, SUPPLEMENTAL INFORMATION:
 ISSUE A, PART I, (F)-DESCRIPTION OF PURPOSE - CAPITAL EXPENDITURE
 REIMBURSEMENT (SERIES 2016A) & ADVANCED REFUND 2009 BONDS (SERIES 2016B -
 ISSUE DATE:10/21/2009).

ISSUE A, PART II, LINE 3: THE TOTAL PROCEEDS REPORTED IS THE SUM OF THE
 ISSUE PRICE REPORTED ON PART I, COLUMN E PLUS THE CUMULATIVE INVESTMENT
 EARNINGS AS OF THE END OF THE TAX YEAR.

ISSUE A, PART III, QUESTION 7: AS PROVIDED IN TREASURY REGULATION SECTION
 1.141-4(C)(2)(I)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT
 UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE
 BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE. ACCORDINGLY, THE
 AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE
 AMOUNT STATED IN PART III, LINE 6. THE ORGANIZATION HAS NOT UNDERTAKEN AN
 ANALYSIS OF THE PRIVATE SECURITY TEST WITH REPECT TO THE BONDS, AS THE
 LEVEL OF PRIVATE USE AND/OR UNRELATED TRADE OR BUSINESS USE REPORTED IN
 PART III, LINE 6 IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF
 THE CODE.

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

ISSUE A, PART IV, QUESTION 2C: THE MOST RECENT REBATE COMPUTATION FOR THE BONDS WAS COMPLETED THROUGH 11/09/2019.

ISSUE B, PART I,(F) - DESCRIPTION OF PURPOSE - REFUND 2005 BONDS AND COI-ISSUE DATE: 8/10/2005.

ISSUE C, PART 1,(F)-DESCRIPTION OF PURPOSE -- REFUND 1997A AND 1997B BONDS - ISSUE DATES:9/15/1997, 10/01/1997.

ISSUE C, PART IV,QUESTION 2C; THE FINAL REBATE COMPUTATION FOR THE BONDS WAS COMPLETED THROUGH 3/21/2014.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2020

Department of the Treasury
Internal Revenue Service

▶ **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.**

Open To Public Inspection

Name of the organization **CEDARS-SINAI MEDICAL CENTER** Employer identification number **95-1644600**

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

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.

(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
G MELMED, MD	SEE PT V	SEE PT V		X	150,000.	30,000.		X	X		X	
J SMITH, MD, JD	KEY EMP	SEE PT V		X	750,000.	675,000.		X	X		X	
SUB CONTRIBUTOR	SEE PT V	SEE PT V		X	250,000.	150,000.		X	X		X	
SUB CONTRIBUTOR	SEE PT V	SEE PT V		X	542,380.	542,380.		X	X		X	
SUB CONTRIBUTOR	SEE PT V	SEE PT V		X	104,640.	104,640.		X	X		X	
VAR INT. PERSON	OFF, BRD	SEE PT V		X	579,930.	579,930.		X	X		X	
Total						▶ \$ 2,081,950.						

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(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

SEE PART V FOR CONTINUATIONS

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
ANGELA HIRAI YANG	PART V NARRATIVE -	177,396.	PART V NARR		X
GIL MELMED, MD	PART V NARRATIVE -	747,048.	PART V NARR		X
MARC EDELSTEIN MD INC.	PART V NARRATIVE -	160,000.	PART V NARR		X
SUBSTANTIAL CONTRIBUTOR	PART V NARRATIVE -	1,130,000.	PART V NARR		X
121 SAN VICENTE LLC	PART V NARRATIVE -	2,982,420.	PART V NARR		X
FIRST PACIFIC ADVISORS LLC	PART V NARRATIVE -	546,984.	PART V NARR		X
SUBSTANTIAL CONTRIBUTOR	PART V NARRATIVE -	2,006,942.	PART V NARR		X
SUBSTANTIAL CONTRIBUTOR	PART V NARRATIVE -	663,995.	PART V NARR		X
SUBSTANTIAL CONTRIBUTOR	PART V NARRATIVE -	960,872.	PART V NARR		X
SUBSTANTIAL CONTRIBUTOR	PART V NARRATIVE -	1,068,184.	PART V NARR		X

Part V Supplemental Information.

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

SCHEDULE L, PART II, LOANS TO AND FROM INTERESTED PERSONS:

(A) NAME OF PERSON: G MELMED, MD

(B) RELATIONSHIP WITH ORGANIZATION: SEE PT V: FAMILY MEMBER OF KEY

EMPLOYEE

(C) PURPOSE OF LOAN: SEE PT V: HOUSING LOAN (EMPLOYEE)

(A) NAME OF PERSON: J SMITH, MD, JD, MMM

(C) PURPOSE OF LOAN: SEE PT V: HOUSING LOAN (EMPLOYEE)

(A) NAME OF PERSON: SUB CONTRIBUTOR

(B) RELATIONSHIP WITH ORGANIZATION: SEE PT V: EMPLOYEE DONOR

(C) PURPOSE OF LOAN: SEE PT V: HOUSING LOAN (EMPLOYEE)

(A) NAME OF PERSON: SUB CONTRIBUTOR

(B) RELATIONSHIP WITH ORGANIZATION: SEE PT V: EMPLOYEE DONOR

(C) PURPOSE OF LOAN: SEE PT V: LIFE INSURANCE PREMIUMS (EMPLOYEE)

(A) NAME OF PERSON: SUB CONTRIBUTOR

(B) RELATIONSHIP WITH ORGANIZATION: SEE PT V: EMPLOYEE DONOR

(C) PURPOSE OF LOAN: SEE PT V: LIFE INSURANCE PREMIUMS (EMPLOYEE)

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(A) NAME OF PERSON: VAR INT. PERSONS

(C) PURPOSE OF LOAN: SEE PT V: LIFE INSURANCE PREMIUMS (EMPLOYEE)

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: ANGELA HIRAI YANG

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - FAMILY MEMBER OF CLEMENT YANG, A BOARD MEMBER

(C) AMOUNT OF TRANSACTION \$ 177,396.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: GIL MELMED, MD

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - FAMILY MEMBER OF DR. SHLOMO MELMED, A KEY EMPLOYEE

(C) AMOUNT OF TRANSACTION \$ 747,048.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: MARC EDELSTEIN MD INC.

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - CORP MORE THAN 35% OWNED BY MARC EDELSTEIN, A BRD MEMBER

(C) AMOUNT OF TRANSACTION \$ 160,000.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 1,130,000.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - SPONSORSHIP AGREEMENT

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: 121 SAN VICENTE LLC

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - LLC MORE THAN 35% OWNED BY MOHAMED AHMAR, A BOARD MEMBER

(C) AMOUNT OF TRANSACTION \$ 2,982,420.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - PROPERTY LEASE

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: FIRST PACIFIC ADVISORS LLC

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - LLC MORE THAN 35% OWNED BY STEVEN ROMICK, A BOARD MEMBER

(C) AMOUNT OF TRANSACTION \$ 546,984.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - INVESTMENT MANAGEMENT

FEES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 2,006,942.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 663,995.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 960,872.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 1,068,184.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 789,394.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 601,100.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 544,561.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 1,966,074.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 1,505,880.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 1,171,977.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 2,236,837.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR

SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

PART V NARRATIVE - SUBSTANTIAL CONTRIBUTOR

(C) AMOUNT OF TRANSACTION \$ 15,458,229.

(D) DESCRIPTION OF TRANSACTION: PART V NARRATIVE - COMPENSATION FOR SERVICES

(E) SHARING OF ORGANIZATION REVENUES? = NO

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization **CEDARS-SINAI MEDICAL CENTER** Employer identification number **95-1644600**

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art	X	46	0.	
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded	X	38	6,262,025.	SEE SCH M, PART II
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ()				
26 Other ()				
27 Other ()				
28 Other ()				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part V, Donee Acknowledgement **29** 6

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

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

Schedule M (Form 990) 2020

Part II

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

SCHEDULE M, PART I, COLUMN (B):

FOR PURPOSES OF SCHEDULE M, PART I, CEDARS-SINAI MEDICAL CENTER IS REPORTING THE NUMBER OF ITEMS RECEIVED FOR LINE 1 WITH RESPECT TO PIECES OF ARTWORK AND THE NUMBER OF INSTANCES OF DONATION OCCURED FOR LINE 9 WITH RESPECT TO PUBLICLY TRADED SECURITIES.

SCHEDULE M, LINE 33:

WORKS OF ART - THE ORGANIZATION HAS ELECTED, AS PERMITTED UNDER ACCOUNTING STANDARDS CODIFICATION 958, NOT TO REPORT ON ITS STATEMENT OF ACTIVITIES AND BALANCE SHEET, WORKS OF ART HELD FOR PUBLIC EXHIBITION.

SCHEDULE M, PART I, LINE 9, COLUMN (D): METHOD OF DETERMINING REVENUE

RELATED TO CONTRIBUTED SECURITIES - CALCULATION IS BASED ON THE MEAN BETWEEN HIGH AND LOW QUOTATIONS ON THE DATE THE SECURITIES PASS UNCONDITIONALLY FROM DONOR CONTROL TO THE ORGANIZATION.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

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.

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

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Inspection

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

EDUCATION AND COMMUNITY BENEFIT PROGRAMS.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

(CONTINUED)

- LEADERSHIP AND EXCELLENCE IN DELIVERING QUALITY HEALTHCARE SERVICES

- EXPANDING THE HORIZONS OF MEDICAL KNOWLEDGE THROUGH BIOMEDICAL

RESEARCH

- EDUCATING AND TRAINING PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS

- STRIVING TO IMPROVE THE HEALTH STATUS OF OUR COMMUNITY

QUALITY PATIENT CARE IS OUR PRIORITY. PROVIDING EXCELLENT CLINICAL AND

SERVICE QUALITY, OFFERING COMPASSIONATE CARE, AND SUPPORTING RESEARCH

AND MEDICAL EDUCATION ARE ESSENTIAL TO OUR MISSION. THIS MISSION IS

FOUNDED IN THE ETHICAL AND CULTURAL PRECEPTS OF THE JUDAIC TRADITION,

WHICH INSPIRES DEVOTION TO THE ART AND SCIENCE OF HEALING, AND TO THE

CARE WE GIVE TO OUR PATIENTS AND STAFF.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

(CONTINUED)

IN FISCAL YEAR 2021, CEDARS-SINAI MEDICAL CENTER REPORTED 270,700

INPATIENT DAYS (APPROXIMATELY 740 PER DAY), AND 886,835 OUTPATIENT

VISITS. THERE WERE 44,882 INPATIENT ADMISSIONS, AND 80,317 EMERGENCY

DEPARTMENT VISITS.

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

Schedule O (Form 990 or 990-EZ) 2020

032211 11-20-20

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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CEDARS-SINAI'S EMERGENCY DEPARTMENT SERVES THE ENTIRE REGION AS ONE OF ONLY FOUR REMAINING LEVEL I TRAUMA CENTERS IN LOS ANGELES COUNTY (AND THE ONLY ONE NOT OPERATED BY THE GOVERNMENT), WITH STAFFING AND TECHNOLOGY TO TREAT THE MOST SEVERELY INJURED ACCIDENT AND NATURAL DISASTER VICTIMS.

AS ONE OF THE LARGEST ACADEMIC MEDICAL CENTERS IN THE WESTERN UNITED STATES, CEDARS-SINAI PROVIDES MANY HIGHLY SPECIALIZED SERVICES THAT ARE NOT AVAILABLE AT MOST OTHER HOSPITALS, AND WHICH REQUIRE A SIGNIFICANT INFRASTRUCTURE OF TECHNOLOGY AND EXPERT STAFFING.

FOR EXAMPLE, IN FISCAL YEAR 2021, CEDARS-SINAI PERFORMED 130 HEART TRANSPLANTS, AMONG THE MOST OF ANY HOSPITAL IN THE WORLD. PATIENTS WITH ADVANCED HEART DISEASE COME TO CEDARS-SINAI BECAUSE OF THE EXPERTISE OF ITS CARDIOLOGISTS AND CARDIAC SURGEONS, AND BECAUSE CEDARS-SINAI HAS THE INFRASTRUCTURE TO OFFER HEART TRANSPLANTS AS WELL AS NEWER TECHNOLOGIES TO TREAT ADVANCED HEART DISEASE.

CEDARS-SINAI'S SERVICES FOR CANCER PATIENTS ARE SIMILARLY BROAD IN SCOPE AND SIZE. IN FISCAL YEAR 2021, CEDARS-SINAI CANCER SERVED 8,103 INPATIENTS AND 368,414 OUTPATIENTS AND DELIVERED 53,011 INFUSIONS.

CEDARS-SINAI IS COMBATING THE COVID-19 PANDEMIC WITH GRIT, EXPERTISE AND COMMITMENT. CEDARS-SINAI'S CLINICIANS, LEADERSHIP, DONORS, PATIENTS AND PARTNERING ORGANIZATIONS BANDED TOGETHER TO CARE FOR THOSE WHO WERE ILL, LEARN MORE ABOUT THE DISEASE AND ITS WIDE-RANGING EFFECTS, AND SERVE THE NEIGHBORS IN NEED.

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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TO ASSIST PATIENTS EXPERIENCING ONGOING COVID-19 SYMPTOMS, CEDARS-SINAI LAUNCHED THE MULTIDISCIPLINARY COVID-19 RECOVERY PROGRAM, WHICH PROVIDES A COMPREHENSIVE EVALUATION OF EACH PATIENT AND CONNECTS THEM TO APPROPRIATE SPECIALTY CARE, INCLUDING CARDIOLOGY, PULMONOLOGY, NEUROLOGY, AND PHYSICAL MEDICINE AND REHABILITATION. THE PROGRAM ALSO OFFERS AN OPPORTUNITY FOR CEDARS-SINAI RESEARCHERS TO LEARN MORE ABOUT PATIENTS WHO SUFFER DEBILITATING EFFECTS FOR MONTHS FOLLOWING THEIR INFECTION. MORE THAN 1,000 PATIENTS RECOVERING FROM COVID-19 HAVE BEEN SERVED SO FAR. THE PROGRAM WAS HONORED AS THE 2021 "BEST NEW PRODUCT OR SERVICE" BY THE LOS ANGELES BUSINESS JOURNAL.

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS:

(CONTINUED)

WHILE SOME OF THESE RESEARCH PROJECTS ARE FUNDED IN PART OR IN WHOLE BY FUNDS FROM THE NATIONAL INSTITUTES OF HEALTH OR OTHER GOVERNMENT AGENCIES, MANY ARE FUNDED BY CEDARS-SINAI, ESPECIALLY SEED GRANTS TO SUPPORT INNOVATIVE NEW RESEARCH. IN FISCAL YEAR 2021, CEDARS-SINAI PROVIDED \$103,307,330 TOWARD RESEARCH PROJECTS, WHILE NIH AND OTHER GRANTS PROVIDED \$152,569,623.

IN CEDARS-SINAI LABORATORIES AND CLINICS, INVESTIGATORS DEVELOP AND TEST NEW IDEAS, EXPLORE THE GENETIC UNDERPINNINGS OF DISEASE, REALIZE THE POTENTIAL OF STEM CELLS, LEVERAGE TECHNOLOGY, AND ASSESS HOW GENDER AND METABOLISM AFFECT HEALTH. CEDARS-SINAI PUSHES FORWARD THE FRONTIERS OF BIOMEDICAL KNOWLEDGE TO PIONEER PRECISION THERAPIES, NOVEL DIAGNOSTIC TOOLS AND SOPHISTICATED NEW SURGICAL TECHNIQUES TO ENHANCE

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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THE LIVES OF MEN, WOMEN AND CHILDREN WORLDWIDE. IN FISCAL YEAR 2021,
 FOR EXAMPLE, CEDARS-SINAI HAD MORE THAN 100 ACTIVE COVID-19 RELATED
 RESEARCH PROJECTS THAT WERE UNDERWAY TO HELP UNDERSTAND THE CORONAVIRUS
 AND FIND EFFECTIVE TREATMENTS.

FORM 990, PART III, LINE 4C, PROGRAM SERVICE ACCOMPLISHMENTS:

(CONTINUED)

619 MEDICAL STUDENTS WERE IN CLINICAL TEACHING ROTATIONS IN NEARLY 100
 SPECIALTY AND SUBSPECIALTY AREAS AT CEDARS-SINAI IN FISCAL YEAR 2021.
 AT ITS NINTH ANNUAL COMMENCEMENT, THE GRADUATE SCHOOL OF BIOMEDICAL
 SCIENCES AWARDED 17 DOCTORAL AND 33 MASTER'S DEGREES.

FORM 990, PART VI, SECTION A, LINE 6:

CEDARS-SINAI HEALTH SYSTEM IS THE SOLE MEMBER OF THE FILING ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

CSMC'S SOLE MEMBER, CEDARS-SINAI HEALTH SYSTEM, HAS THE POWER TO ELECT
 INDIVIDUALS TO THE BOARD OF DIRECTORS OF CEDARS-SINAI MEDICAL CENTER IN
 ACCORDANCE WITH THE NOMINATION AND ELECTION PROCESS SET FORTH IN THE CSMC'S
 BYLAWS.

FORM 990, PART VI, SECTION A, LINE 7B:

CEDARS-SINAI HEALTH SYSTEM'S APPROVAL IS REQUIRED BEFORE CEDARS-SINAI
 MEDICAL CENTER CAN DO ANY OF THE FOLLOWING: CHANGE ITS MISSION, VISION, AND
 VALUES; CHANGE ITS CORPORATE STRUCTURE IN A MANNER THAT WOULD AFFECT
 TAX-EXEMPT STATUS; APPROVE THE COMMUNITY BENEFIT PLAN; VOLUNTARILY
 DISSOLVE; INCUR MATERIAL INDEBTEDNESS; SELL REAL PROPERTY; EXECUTE MATERIAL

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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CONTRACTS NOT ALREADY SET FORTH IN AN APPROVED BUDGET; AND CERTAIN OTHER

MATERIAL CORPORATE ACTIONS.

FORM 990, PART VI, SECTION B, LINE 11B:

THE ORGANIZATION'S FORM 990 UNDERGOES A COMPREHENSIVE REVIEW PROCESS. THE REVIEW INVOLVES VARIOUS MANAGEMENT PERSONNEL, INCLUDING THE GENERAL COUNSEL, AND A BIG FOUR ACCOUNTING FIRM. A MULTI-LEVEL REVIEW IS PERFORMED WITHIN THE FINANCE DEPARTMENT INCLUDING REVIEW BY THE SENIOR VICE-PRESIDENT AND THE CHIEF FINANCIAL OFFICER. ADDITIONALLY, THE COMPENSATION INFORMATION IS REVIEWED BY THE COMPENSATION COMMITTEE. A COMPLETE, UNREDACTED COPY OF THE FORM 990 IS PROVIDED TO ALL MEMBERS OF THE BOARD OF DIRECTORS IN ADVANCE OF A BOARD MEETING WHERE THE FORM 990 IS PRESENTED, ALLOWING THE ENTIRE BOARD THE OPPORTUNITY TO REVIEW AND DISCUSS THE INFORMATION REPORTED BEFORE THE FORM 990 IS FILED.

FORM 990, PART VI, SECTION B, LINE 12C:

THE CEDARS-SINAI MEDICAL CENTER (CSMC) CONFLICT OF INTEREST POLICY IS A BOARD-APPROVED POLICY AND CONFLICT OF INTEREST OVERSIGHT IS THE RESPONSIBILITY OF THE BOARD OF DIRECTORS. CONFLICT REPORTING IS REQUIRED THROUGH THE OFFICE OF THE PRESIDENT/CEO WHO REPORTS TO THE BOARD ON COI-RELATED MATTERS THROUGH THE AUDIT COMMITTEE OF THE BOARD OF DIRECTORS.

MONITORING PRACTICES:

REGULAR AND CONSISTENT MONITORING IS DELEGATED BY THE PRESIDENT/CEO TO THE DIRECTOR OF INTERNAL AUDIT/CONFLICT OF INTEREST (COI) ADMINISTRATOR AND THE CONFLICT OF INTEREST STEERING COMMITTEE. ADDITIONAL MONITORING AND ENFORCEMENT OF CONFLICTS OF INTEREST IS HANDLED THROUGH RESEARCH ADMINISTRATION AND THE INSTITUTIONAL REVIEW BOARDS (IRB) IN SUPPORT OF

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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COMPLIANCE WITH THE CONFLICT OF INTEREST REQUIREMENTS OF THE NATIONAL INSTITUTE OF HEALTH FOR SPECIFIC RESEARCH PROTOCOLS. MECHANISMS ARE IN PLACE TO PROVIDE FOR COLLABORATION BETWEEN COI ADMINISTRATION AND RESEARCH ADMINISTRATION. ADDITIONALLY, HOSPITAL-BASED PHYSICIANS COI MATTERS ARE HANDLED BY THE APPLICABLE HOSPITAL-BASED PHYSICIAN CHAIRMEN AND COORDINATION ALSO OCCURS WHERE NECESSARY (SUCH AS WITH THE MEDICAL STAFF OFFICE FOR PHYSICIANS HOLDING MEDICAL STAFF COMMITTEE APPOINTMENTS). WHERE CONFLICTS ARE IDENTIFIED THAT REQUIRE EITHER FORMAL OR INFORMAL MONITORING, RELATED ROUTINE OR PERIODIC MONITORING IN THESE INSTANCES IS SET AT THE DEPARTMENT CHAIRPERSON OR VICE PRESIDENTIAL LEVEL, WITH ANNUAL OR OTHER FOLLOW-UP BY THE COI STEERING COMMITTEE, IRB, OR COI ADMINISTRATOR AS DEEMED APPLICABLE.

COVERED INDIVIDUALS:
 UNDER THE CONFLICT OF INTEREST POLICY, "COVERED INDIVIDUALS" REQUIRED TO COMPLETE AN ANNUAL CONFLICT OF INTEREST DISCLOSURE QUESTIONNAIRE INCLUDE: MEMBERS OF THE BOARD OF DIRECTORS AND COMMITTEES OF THE BOARD; THE PRESIDENT/CEO; SENIOR EXECUTIVES (DIRECT REPORTS TO THE CEO); MEMBERS OF THE COI STEERING COMMITTEE; MEMBERS OF THE FACULTY; MEMBERS OF THE MEDICAL STAFF WITH ADMINISTRATIVE RESPONSIBILITIES; MEMBERS OF MEDICAL STAFF COMMITTEES; RESEARCH INVESTIGATORS; AND OTHER INDIVIDUALS IDENTIFIED BY THE BOARD OR EXECUTIVE LEADERSHIP. WHILE ALL EMPLOYEES ARE REQUIRED BY POLICY TO DISCLOSE POTENTIAL CONFLICTS TO THEIR SUPERVISORS WHEN THEY ARISE, THE NOTED COVERED INDIVIDUALS ARE REQUIRED TO COMPLETE FORMAL ANNUAL DISCLOSURE USING A PRESCRIBED QUESTIONNAIRE. MORE FREQUENT DISCLOSURE IS REQUIRED AS WARRANTED BY ACTIVITIES UNDERTAKEN BETWEEN ANNUAL DISCLOSURES. THE DISCLOSURE POLICY EXTENDS TO FAMILY MEMBERS OF COVERED INDIVIDUALS AS THEY MAY DIRECTLY OR INDIRECTLY GIVE RISE TO CONFLICTS OF INTEREST.

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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COI, DETERMINATION, AND REVIEW ACTION LEVELS:

ALL CONFLICT OF INTEREST QUESTIONNAIRES ARE ACCUMULATED IN A WEB-BASED DATABASE REFERRED TO AS THE COI SYSTEM. ALL QUESTIONNAIRES ARE ANALYZED AND ALL DISCLOSURES MADE ARE REVIEWED FOR VALIDITY, COMPLETENESS AND THE PRESENCE OF A REAL OR PERCEIVED CONFLICT OF INTEREST.

CONFLICTS OF INTEREST ARE ANALYZED, REVIEWED, MONITORED AND ENFORCED THROUGH WORKFLOWS REPORTING UP TO THE PRESIDENT/CEO. ALL DISCLOSURES ARE REVIEWED FIRST BY COI ADMINISTRATION AND THEN: (1) FOR BOARD, EXECUTIVE AND COI STEERING COMMITTEE MEMBERS, REVIEWED BY GENERAL COUNSEL; AND (2) FOR ALL OTHER INDIVIDUALS REQUIRED TO SUBMIT ANNUAL CONFLICT OF INTEREST DISCLOSURE QUESTIONNAIRES, REVIEWED BY THE COI STEERING COMMITTEE.

THE COI STEERING COMMITTEE IS AN ADVISORY COMMITTEE TO THE PRESIDENT AND CEO ON A VARIETY OF COI MATTERS INCLUDING THE MONITORING AND ENFORCEMENT OF COMPLIANCE WITH THE COI POLICY, COI POLICY DEVELOPMENT AND MAINTENANCE, AND OTHER COI RELATED MATTERS. A SUB-GROUP OF THE COMMITTEE REVIEWS MATTERS IDENTIFIED BY COI ADMINISTRATION AS REQUIRING ADDITIONAL REVIEW AND ACTION. THIS GROUP CLOSSES OR MOVES THE MATTERS UP TO THE COI STEERING COMMITTEE LEVEL FOR REVIEW AND ACTION.

REGARDLESS OF THE MONITORING AND ENFORCEMENT PATH, DISCLOSURES ARE CONCLUDED IN ONE OF THE FOLLOWING MANNERS:

- NO CONFLICT EXISTS;
- MANAGED BY DISCLOSURE;
- MANAGED (BY SOME ACTION);

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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-- MANAGED BY PLAN (FORMAL PLAN WITH FOLLOW-UP);

-- MANAGED BY PLAN: IRB (FORMAL PLAN IS DEVELOPED AND MANAGED BY RESEARCH ADMINISTRATION FOR CLINICAL TRIAL RELATED MATTERS);

-- MANAGED BY SEPARATION (FROM EITHER THEIR APPLICABLE CSMC ROLE OR THE ACTIVITY CREATING THE CONFLICT);

-- CONFLICT (A CONFLICT THAT MUST BE REPORTED FOR CEO/BOARD LEVEL ACTION).

ANYONE IN VIOLATION OF THE POLICY IS SUBJECT TO THE FOLLOWING ADMINISTRATIVE ACTIONS INCLUDING ORAL ADMONISHMENT, WRITTEN REPRIMAND, DISCIPLINE, REASSIGNMENT, DEMOTION, SUSPENSION, REMOVAL, TERMINATION OR SEPARATION. THE MEDICAL CENTER RESERVES THE RIGHT TO PURSUE OTHER ACTIONS AGAINST ANYONE WHO VIOLATES THE COI POLICY TO THE DETRIMENT OF THE MEDICAL CENTER.

FORM 990, PART VI, SECTION B, LINE 15:

THE EXECUTIVE PERSONNEL COMMITTEE (THE COMMITTEE) IS A STANDING COMMITTEE OF THE BOARD OF DIRECTORS. THE COMMITTEE ADDRESSES COMPENSATION AND BENEFITS REGARDING THE MEDICAL CENTER'S EXECUTIVE EMPLOYEES AND CONTRACTUALLY ENGAGED FACULTY (ALL COMPENSATED INDIVIDUALS REPORTED ON PART VII AND SCHEDULE J FALL UNDER ONE OF THESE TWO CATEGORIES), AND IS AUTHORIZED BY THE BOARD OF DIRECTORS TO ACT WITH RESPECT TO SUCH ISSUES, THE COMMITTEE EVALUATES THE PERFORMANCE AND APPROVES THE COMPENSATION AND BENEFITS FOR THE MEDICAL CENTER'S PRESIDENT AND CHIEF EXECUTIVE OFFICER, AND APPROVES THE COMPENSATION AND BENEFIT PLANS FOR EXECUTIVES AND THE MEDICAL CENTER'S CONTRACTUALLY ENGAGED FACULTY. THE COMMITTEE ALSO REVIEWS AND APPROVES THE CEO'S EXECUTION OF THOSE PLANS WITHIN ESTABLISHED PARAMETERS, TAKING INTO CONSIDERATION THE PERFORMANCE OF THE ORGANIZATION AS A WHOLE; AND ADDRESSES SUCH OTHER COMPENSATION ISSUES REGARDING THE

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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MEDICAL CENTER'S EXECUTIVES AND CONTRACTUALLY ENGAGED FACULTY AS REQUESTED

BY THE BOARD OF DIRECTORS.

THE COMMITTEE FOLLOWS A PROCESS THAT ENSURES THAT THE COMPENSATION AND BENEFITS PROVIDED TO THE CEO, OTHER EXECUTIVES AND CONTRACTUALLY ENGAGED FACULTY IS REASONABLE AND IN COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS. THE MEDICAL CENTER'S SVP OF HR PROVIDES STAFF SUPPORT TO THE COMMITTEE. THE COMMITTEE MAY ENGAGE AN INDEPENDENT COMPENSATION AND BENEFITS CONSULTANT, AND ANY OTHER ADVISORS IT DEEMS NECESSARY. THE COMMITTEE MAY ALSO ENGAGE INDEPENDENT COUNSEL. THE MEDICAL CENTER WILL PROVIDE FOR APPROPRIATE FUNDING FOR PAYMENT OF COSTS TO ANY SUCH PERSONS RETAINED BY THE COMMITTEE. AT THE COMMITTEE'S DIRECTION, THE INDEPENDENT COMPENSATION CONSULTANT SHALL PREPARE SUCH REPORTS AS THE COMMITTEE REASONABLY DEEMS NECESSARY. AT A MINIMUM, SUCH REPORTS WILL INCLUDE MARKET SURVEY DATA FROM A PEER GROUP DESIGNATED BY THE COMMITTEE, WHICH SHALL BE CONSIDERED BY THE COMMITTEE PRIOR TO MAKING DECISIONS.

FORM 990, PART VI, LINE 17, LIST OF STATES RECEIVING COPY OF FORM 990:

CA, AL, AK, CO, DC, FL, IL, KY, MD, MA, MI, MN, MS, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, SC, TN
UT, WA, WI

FORM 990, PART VI, SECTION C, LINE 18:

THE ORGANIZATION'S FORMS 990 AND 990-T ARE AVAILABLE UPON REQUEST.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION POSTS ITS CORPORATE INTEGRITY PROGRAM POLICY ON ITS WEBSITE AT [HTTPS://WWW.CEDARS-SINAI.ORG/CONTENT/DAM/CE-
DARS-SINAI/ABOUT-
US/DOCUMENTS/CORPORATE-INTEGRITY-POLICY-2021.PDF](https://www.cedars-sinai.org/content/dam/cedars-sinai/about-us/documents/corporate-integrity-policy-2021.pdf).

Name of the organization CEDARS-SINAI MEDICAL CENTER	Employer identification number 95-1644600
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THE CORPORATE INTEGRITY PROGRAM POLICY OUTLINES THE STANDARDS OF CONDUCT.

ADDITIONALLY, THE ORGANIZATION'S AUDITED CONSOLIDATED FINANCIAL STATEMENTS ARE ATTACHED TO ITS FORM 990. THE CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS ARE NOT AVAILABLE TO THE PUBLIC.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN PENSION LIABILITY	98,591,399.
INVESTMENT IN JOINT VENTURES - PRIOR YEAR	-57,552,591.
TRANSFER TO AFFILIATES	-247,088,486.
INVESTMENT IN JOINT VENTURES - CURRENT YEAR	23,210,793.
ROUNDING	-487.
TOTAL TO FORM 990, PART XI, LINE 9	-182,839,372.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

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Inspection**

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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
PCX SYSTEMS, LLC - 42-1535811 8700 BEVERLY BLVD STE TSB-290 LOS ANGELES, CA 90048	HOSPITAL BILLING	DELAWARE	149,141.	0.	CEDARS-SINAI MEDICAL CENTER
RECS, LLC - 47-2717150 8700 BEVERLY BLVD TSB STE 290 LOS ANGELES, CA 90048	HOLDING COMPANY	DELAWARE	0.	0.	CEDARS-SINAI MEDICAL CENTER
BEVERLY HILLS TECHNICAL IMAGING, LLC - 83-2046634, 6500 WILSHIRE BLVD 9TH FLOOR, LOS ANGELES, CA 90048	HOLDING COMPANY	CALIFORNIA	11,029,839.	16,410,295.	CEDARS-SINAI MEDICAL CENTER
8701-8709 BEVERLY LLC - 46-5022962 6500 WILSHIRE BLVD SUITE 2250 LOS ANGELES, CA 90048	HOLDING COMPANY	CALIFORNIA	594,245.	13,685,860.	CEDARS-SINAI MEDICAL CENTER

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
CEDARS-SINAI MEDICAL CARE FOUNDATION - 95-4457756, 6500 WILSHIRE BLVD., 15TH FLOOR, LOS ANGELES, CA 90048	PROVISION OF MEDICAL CARE, TEACHING, AND RESEARCH	CALIFORNIA	501(C)(3)	LINE 12A, I	CEDARS-SINAI MEDICAL CENTER	X	
CALIFORNIA HEART CENTER FOUNDATION - 95-4772979, 15821 VENTURA BLVD STE 520, ENCINO, CA 91436	PROMOTE, SUPPORT, AND DEVELOP EDUCATIONAL AND SCIENTIFIC RESEARCH	CALIFORNIA	501(C)(3)	LINE 7	CEDARS-SINAI MEDICAL CENTER	X	
KERLAN-JOBE ORTHOPAEDIC FOUNDATION - 95-4707606, 6801 PARK TERRACE STE 500, LOS ANGELES, CA 90045	EDUCATION AND RESEARCH RELATED TO ORTHOPAEDIC MEDICINE	CALIFORNIA	501(C)(3)	LINE 7	CEDARS-SINAI MEDICAL CARE FOUNDATION	X	
SANTA MONICA ORTHOPAEDIC & SPORTS MED RESEARCH FDN - 95-4789926, 2020 SANTA MONICA BLVD 4TH FL, SANTA MONICA, CA 90404	EDUCATION AND RESEARCH RELATED TO ORTHOPAEDIC AND NEUROLOGIC CONDITIONS	CALIFORNIA	501(C)(3)	PF	CEDARS-SINAI MEDICAL CARE FOUNDATION	X	

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

Schedule R (Form 990) 2020

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	
ENDOSCOPY CENTER OF SANTA MONICA, LLC - 11-3652210, 12400 WILSHIRE BLVD STE 100, LOS ANGELES, CA 90025	ENDOSCOPIES AND THE RELATED PROCEDURES	CA	CEDARS-SINAI MEDICAL CENTER	RELATED	218,084.	5,864,599.		X	N/A		X	66.00%
ISS ASC HOLDINGS LLC - 47-1890805, 200 N. ROBERTSON BLVD #101, BEVERLY HILLS, CA 90211	INVESTMENT IN HEALTHCARE SERVICES	CA	CEDARS-SINAI MEDICAL CENTER	RELATED	1,939,718.	24,131,125.		X	N/A		X	83.82%
INTERNATIONAL SPINE & ORTHOPEDIC INSTITUTE, LLC - 26-3738893, 8500 W. 110TH ST, OVERLAND PARK, KS 66210	SPINE AND ORTHOPEDIC INSTITUTE	DE	CEDARS-SINAI MEDICAL CENTER	RELATED	-85,800.	4,200,673.		X	N/A		X	57.16%
SANTA MONICA IMAGING GROUP, LLC - 82-0760657, 200 N. ROBERTSON BLVD #101, BEVERLY HILLS, CA 90211	IMAGING CENTER	CA	CEDARS-SINAI MEDICAL CENTER	RELATED	-2,628,313.	5,866,646.		X	N/A		X	65.00%

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
OPTIMATRIX HEALTH SOLUTIONS, INC - 95-4522779, 6500 WILSHIRE BLVD 9TH FLOOR, LOS ANGELES, CA 90048	INACTIVE	CA	CEDARS-SINAI MEDICAL CENTER	C CORP	0.	0.	100.00%	X	
OTOHARMONICS CORPORATION - 46-1119421 PO BOX 272 WILMINGTON, DE 19899	INACTIVE	DE	CEDARS-SINAI MEDICAL CENTER	C CORP	116,769.	438,278.	91.30%	X	
CENTINELA FREEMAN HOLDINGS, INC. - 59-3811890, 8700 BEVERLY BLVD TSB-290, LOS ANGELES, CA 90048	REAL ESTATE HOLDINGS	CA	CEDARS-SINAI MEDICAL CENTER	C CORP	922,637.	29,255,866.	100.00%	X	
CHARITABLE REMAINDER TRUSTS (CRAT-5, CRUT-3)	TRUST	CA	N/A	TRUST	N/A	N/A	N/A		X
CHARITABLE LEAD TRUSTS (1)	TRUST	CA	N/A	TRUST	N/A	N/A	N/A		X

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
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) CEDARS-SINAI MEDICAL CARE FOUNDATION	B	100,000,000.	FAIR MARKET VALUE
(2) CEDARS-SINAI MEDICAL CARE FOUNDATION	R	908,438,144.	FAIR MARKET VALUE
(3) CEDARS-SINAI MEDICAL CARE FOUNDATION	Q	275,337,155.	FAIR MARKET VALUE
(4) CFHS HOLDINGS INC	L	749,085.	FAIR MARKET VALUE
(5) CFHS HOLDINGS INC	M	4,149,024.	FAIR MARKET VALUE
(6) CFHS HOLDINGS INC	N	5,047,196.	FAIR MARKET VALUE

Part V Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(7) CFHS HOLDINGS INC	O	2,562,080.	FAIR MARKET VALUE
(8) CFHS HOLDINGS INC	P	81,435,560.	FAIR MARKET VALUE
(9) CFHS HOLDINGS INC	Q	65,881,746.	FAIR MARKET VALUE
(10) CFHS HOLDINGS INC	S	8,112,810.	FAIR MARKET VALUE
(11) CENTINELA FREEMAN HOLDINGS INC	P	174,889.	FAIR MARKET VALUE
(12) 90210 ASC VENTURE LLC	A	418,915.	FAIR MARKET VALUE
(13) 90210 ASC VENTURE LLC	P	700,000.	FAIR MARKET VALUE
(14) ENDOSCOPY CENTER OF SANTA MONICA LLC	P	1,632,243.	FAIR MARKET VALUE
(15) ENDOSCOPY CENTER OF SANTA MONICA LLC	Q	1,642,985.	FAIR MARKET VALUE
(16) CEDARS SINAI INTELLECTUAL PROPERTY COMPANY	R	86,435,882.	FAIR MARKET VALUE
(17) TORRANCE MEMORIAL MEDICAL CENTER	A	11,663,995.	FAIR MARKET VALUE
(18) TORRANCE HEALTH ASSOCIATION	M	166,400.	FAIR MARKET VALUE
(19) TORRANCE HEALTH ASSOCIATION	Q	235,252.	FAIR MARKET VALUE
(20) TORRANCE HEALTH ASSOCIATION	R	233,655.	FAIR MARKET VALUE
(21) TORRANCE HEALTH ASSOCIATION	S	10,989,044.	FAIR MARKET VALUE
(22) CALIFORNIA HEART CENTER FOUNDATION	B	1,985,045.	FAIR MARKET VALUE
(23)			
(24)			

Part VII Supplemental Information

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

PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

3565 DEL AMO ASSOCIATES, A CALIFORNIA LIMITED PARTNERSHIP

EIN: 33-0554737

5017 CARMEN STREET

TORRANCE, CA 90503