

ORIGINAL

15-019

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT****RECEIVED****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

APR 17 2015

This Section must be completed for all projects.**Facility/Project Identification****HEALTH FACILITIES &
SERVICES REVIEW BOARD**

Facility Name:	Adventist Bolingbrook Hospital		
Street Address:	500 Remington Blvd		
City and Zip Code:	Bolingbrook, IL 60440		
County:	Will	Health Service Area	IX Health Planning Area: A-13

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Adventist Bolingbrook Hospital
Address:	500 Remington Road Bolingbrook, IL 60440
Name of Registered Agent:	
Name of Chief Executive Officer:	Rick Mace
CEO Address:	500 Remington Road Bolingbrook, IL 60440
Telephone Number:	630/312-6000

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ Other

☐ Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

☐ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact**[Person to receive ALL correspondence or inquiries)**

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7101

Additional Contact**[Person who is also authorized to discuss the application for permit]**

Name:	Rick Mace
Title:	President/CEO
Company Name:	Adventist Bolingbrook Hospital
Address:	500 Remington Blvd Bolingbrook, IL 60440
Telephone Number:	630/312-6000
E-mail Address:	rick.mace@ahss.org
Fax Number:	630/312-6800

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County:	Will	Health Service Area	IX Health Planning Area: A-13

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Adventist Midwest Health.
Address:	900 Hope Way Altamonte Springs, FL 32714
Name of Registered Agent:	
Name of Chief Executive Officer:	Donald L. Jernigan
CEO Address:	900 Hope Way Altamonte Springs, FL 32714
Telephone Number:	407/357-1000

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Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Adventist Health System Sunbelt Healthcare Corporation
Address:	900 Hope Way Altamonte Springs, FL 32714
Name of Registered Agent:	
Name of Chief Executive Officer:	Donald L. Jernigan
CEO Address:	900 Hope Way Altamonte Springs, FL 32714
Telephone Number:	407/357-1000

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Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Alexian Brothers-AHS Midwest Region Health Co.
Address:	3040 West Salt Creek Road Arlington Heights, IL 60005
Name of Registered Agent:	
Name of Chief Executive Officer:	Mark A. Frey
CEO Address:	3040 West Salt Creek Road Arlington Heights, IL 60005
Telephone Number:	847/815-5100

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
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E-mail Address:	rick.mace@ahss.org
Fax Number:	630-312-6800

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name:	Rick Mace
Title:	President/CEO
Company Name:	Adventist Bolingbrook Hospital
Address:	500 Remington Blvd Bolingbrook, IL 60440
Telephone Number:	630/312-6000
E-mail Address:	rick.mace@ahss.org
Fax Number:	630/312-6800

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Adventist Bolingbrook Hospital
Address of Site Owner:	500 Remington Blvd Bolingbrook, IL 60440
Street Address or Legal Description of Site:	500 Remington Blvd Bolingbrook, IL 60440
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name:	Adventist Bolingbrook Hospital		
Address:	500 Remington Blvd Bolingbrook, IL 60440		
☒	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☐	Limited Liability Company	☐	Sole Proprietorship
		☐	Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants propose to establish an acute mental illness (AMI) unit through the renovation of existing space. The clinical focus of the unit will be on adults and older adults in need on inpatient psychiatric care. Child and adolescent psychiatry services are not anticipated to be provided on the proposed AMI unit.

The proposed project is categorized as a "substantive" project because it involves the establishment of a "category of service".

PROJECT COSTS AND SOURCES OF FUNDS

	Clinical/ Reviewable	Non-Clinical/ Non-Reviewable	Total
Project Costs:			
Preplanning Costs	\$16,100	\$8,900	\$25,000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$ 1,753,600	\$ 940,530	\$ 2,694,130
Contingencies	\$ 87,680	\$ 76,790	\$ 164,470
Architectural/Engineering Fees	\$ 154,560	\$ 85,440	\$ 240,000
Consulting and Other Fees	\$ 74,060	\$ 40,940	\$ 115,000
Movable and Other Equipment	\$ 255,200	\$ 44,400	\$ 299,600
Bond Issuance Expense			
Net Interest Expense During Construction			
Fair Mkt Value of Leased Space or Equip			
Other Costs to be Capitalized			
Acquisition of Building or Other Property			
TOTAL COSTS	\$ 2,341,200	\$ 1,197,000	\$ 3,538,200
Sources of Funds:			
Cash and Securities	\$ 2,341,200	\$ 1,197,000	\$ 3,538,200
Pledges			
Gifts and Bequests			
Bond Issues			
Mortgages			
Leases (fair market value)			
Government Appropriations			
Grants			
Other Funds and Sources			
TOTAL FUNDS	\$ 2,341,200	\$ 1,197,000	\$ 3,538,200

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: \$ _____
Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ 26,000.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): March 31, 2016

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM:

State Agency Submittals

Are the following submittals up to date as applicable:

- ☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

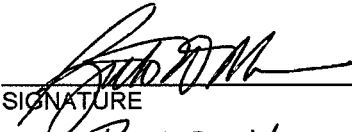
FACILITY NAME: Adventist Bolingbrook Hospital		CITY: Bolingbrook, Illinois			
REPORTING PERIOD DATES: From: January 1, 2014 to: December 31, 2014					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	106	3,669	13,718	-24	82
Obstetrics	20	1,023	2,555	None	20
Pediatrics					
Intensive Care	12	654	2,010	None	12
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	0	0	0	+24	24
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	138	5,346	18,283	0	138

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
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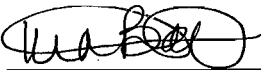
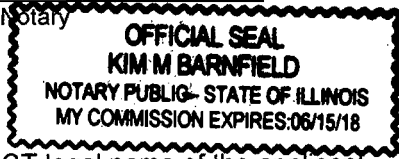
This Application for Permit is filed on the behalf of Adventist Bolingbrook Hospital * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

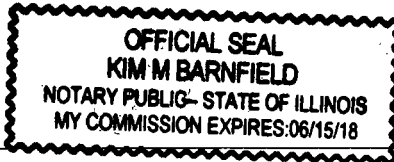

SIGNATURE
Rick D. Mace
PRINTED NAME
CEO
PRINTED TITLE


SIGNATURE
Michael Murrill
PRINTED NAME
CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of April 2015

Notarization:
Subscribed and sworn to before me
this 7th day of April 2015


Signature of Notary
Seal



Signature of Notary
Seal


*Insert EXACT legal name of the applicant

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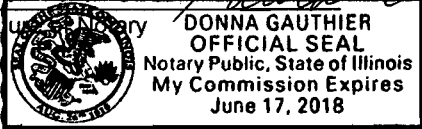
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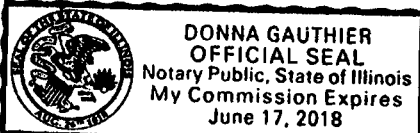
Ronald M. Wehtje
SIGNATURE
Ronald M. Wehtje
PRINTED NAME
Regional CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of April

Donna Gauthier
Signature of Notary
Seal 

Notarization:
Subscribed and sworn to before me
this 14 day of April

Donna Gauthier
Signature of Notary

Seal 

*Insert EXACT legal name of the applicant

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SIGNATURE

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Regional CEO, Midwest Region
PRINTED TITLE

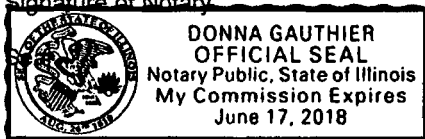
Ronald M. Wehtje
SIGNATURE

Ronald M. Wehtje
PRINTED NAME

Regional CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of April

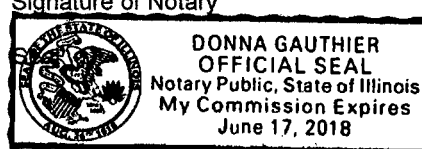
Donna Gauthier
Signature of Notary



*Insert EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 14 day of April

Donna Gauthier
Signature of Notary



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Regional CFO
PRINTED TITLE

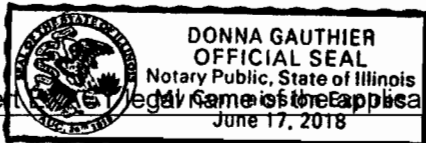
Notarization:

Subscribed and sworn to before me
this 14 day of April

Donna Gauthier
Signature of Notary

Seal

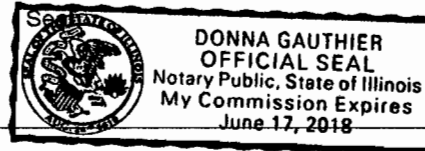
*Insert Seal of Legal Name of Applicant



Notarization:

Subscribed and sworn to before me
this 14 day of April

Donna Gauthier
Signature of Notary

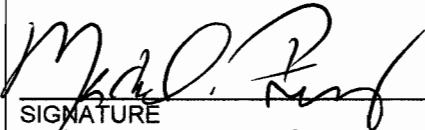


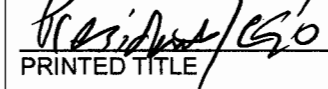
CERTIFICATION

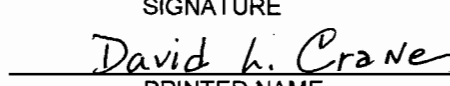
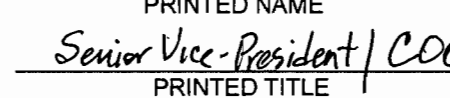
The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Alexian Brothers-AHS Midwest Region Health Co. * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

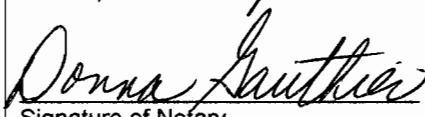

SIGNATURE

PRINTED NAME

PRINTED TITLE


SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 14 day of April


Signature of Notary

Seal

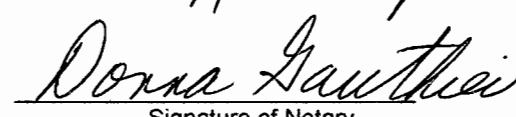


DONNA GAUTHIER
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
June 17, 2018

*Insert EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 14 day of April


Signature of Notary

Seal



DONNA GAUTHIER
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
June 17, 2018

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as **appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:**NOT APPLICABLE, NO SHELL SPACE**

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data are available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**ASSURANCES:****NOT APPLICABLE, NO SHELL SPACE**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17. IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize Acute Mental Illness and Chronic Mental Illness category of service must submit the following information:
2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Acute Mental Illness	0	24
☐ Chronic Mental Illness		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) - Planning Area Need - Service Accessibility	X		
1110.730(c)(1) - Unnecessary Duplication of Services	X		
1110.730(c)(2) - Maldistribution	X		
1110.730(c)(3) - Impact of Project on Other Area Providers	X		
1110.730(d)(1) - Deteriorated Facilities			X
1110.730(d)(2) - Documentation			X
1110.730(d)(3) - Documentation Related to Cited Problems			X
1110.730(d)(4) - Occupancy			X
1110.730(e)(1) - Staffing Availability	X	X	
1110.730(f) - Performance Requirements	X	X	X
1110.730(g) - Assurances	X	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT-22</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

\$3,538,200 _____ _____ _____	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion; b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience. c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts; d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$3,538,200	TOTAL FUNDS AVAILABLE

23

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE, PROJECT TO BE FINANCED WITH CASH

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

NOT APPLICABLE, PROJECT TO BE FINANCED WITH CASH

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2011	2012	2013
Inpatient	281	275	160
Outpatient	1,139	1,273	889
Total	1,420	1,548	1,049
Charity (cost in dollars)			
Inpatient	\$1,510,054	\$1,976,748	\$1,456,514
Outpatient	\$2,134,064	\$2,368,790	\$2,112,199
Total	\$3,644,118	\$4,345,538	\$3,568,713
MEDICAID			
Medicaid (# of patients)	2011	2012	2013
Inpatient	1,232	1,232	1,243
Outpatient	26,634	25,592	22,364
Total	27,866	26,824	23,607
Medicaid (revenue)			
Inpatient	\$6,584,216	\$5,742,006	\$7,548,460
Outpatient	\$3,653,185	\$4,264,707	\$5,309,485
Total	\$10,237,401	\$10,006,713	\$12,857,945

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

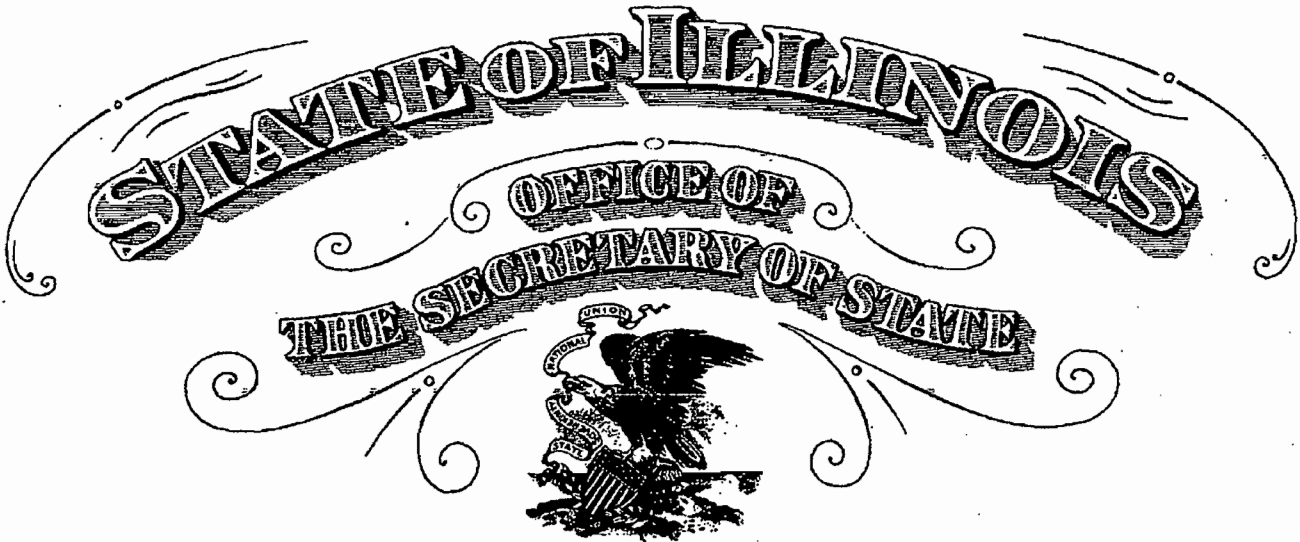
1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2011	2012	2013
Net Patient Revenue	\$116,615,477	\$116,714,846	\$125,224,770
Amount of Charity Care (charges)	\$13,979,626	\$19,412,447	\$17,979,036
Cost of Charity Care	\$3,644,118	\$4,345,538	\$3,568,713

APPEND DOCUMENTATION AS **ATTACHMENT-41**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.



To all to whom these Presents Shall Come, Greeting:

I, Jessé White, Secretary of State of the State of Illinois, do hereby certify that

ADVENTIST BOLINGBROOK HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 25, 2003, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



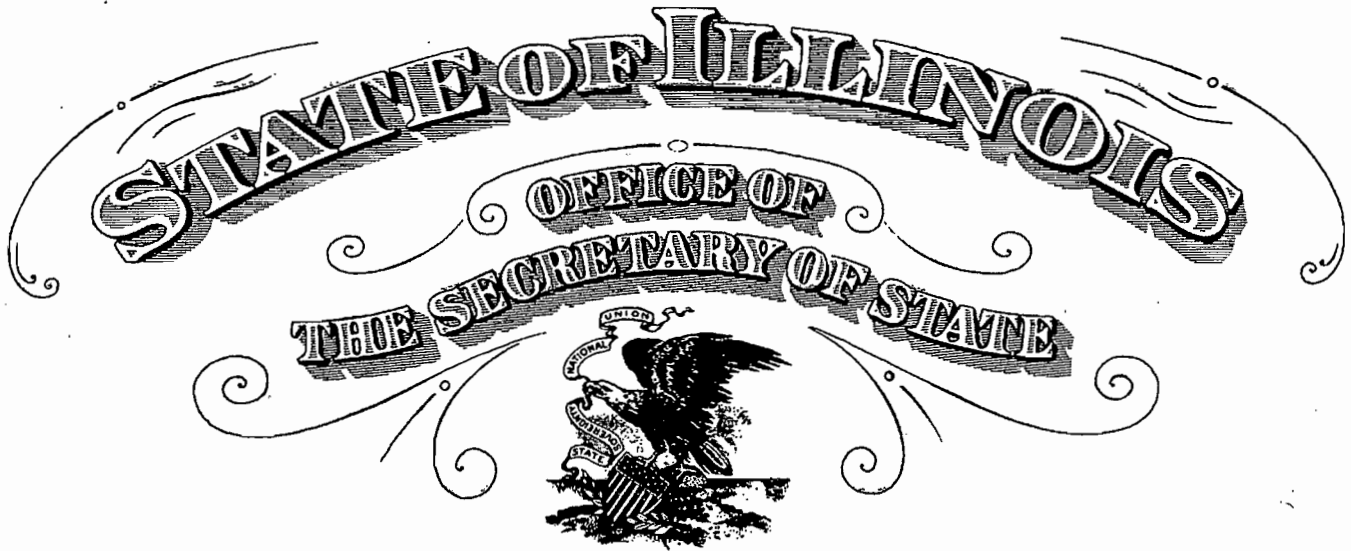
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 1ST day of AUGUST A.D. 2014.

Jesse White

Authentication #: 1421300304

Authenticate at: <http://www.cyberdriveillinois.com>

SECRETARY OF STATE ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVENTIST MIDWEST HEALTH, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 01, 1904, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



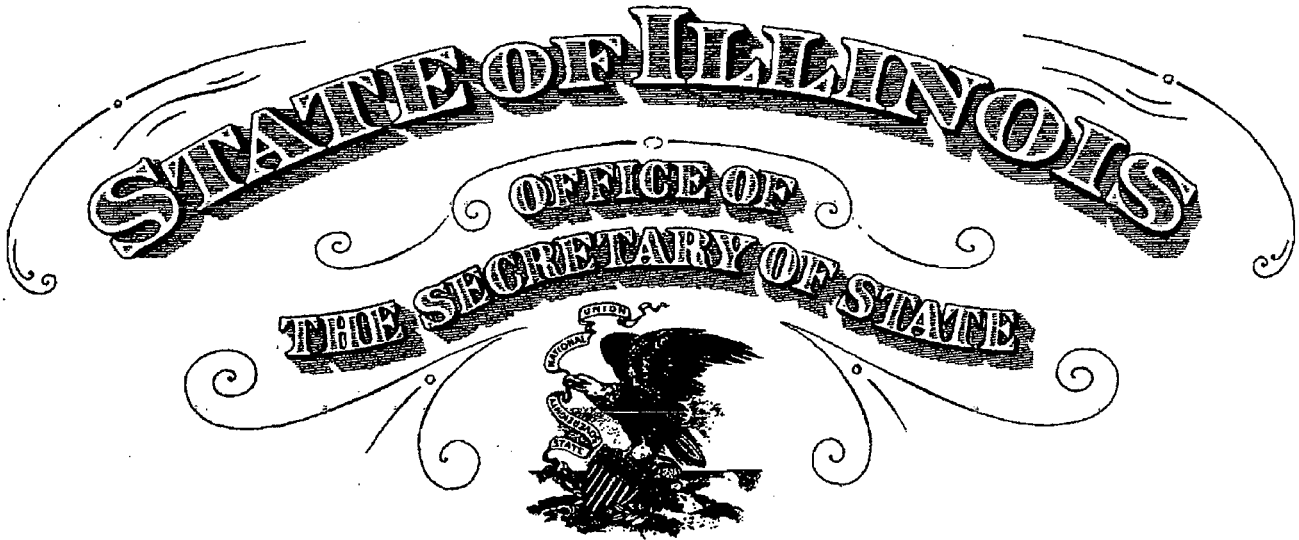
Authentication #: 1506801736

Authenticate at: <http://www.cyberdriveillinois.com>

*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 9TH
day of MARCH A.D. 2015*

Jesse White

SECRETARY OF STATE ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION, INCORPORATED IN FLORIDA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 28, 1997, AND MUST CONDUCT ALL AFFAIRS IN THIS STATE UNDER THE ASSUMED NAME OF ADVENTIST HEALTH SYSTEM, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 26TH day of SEPTEMBER A.D. 2014

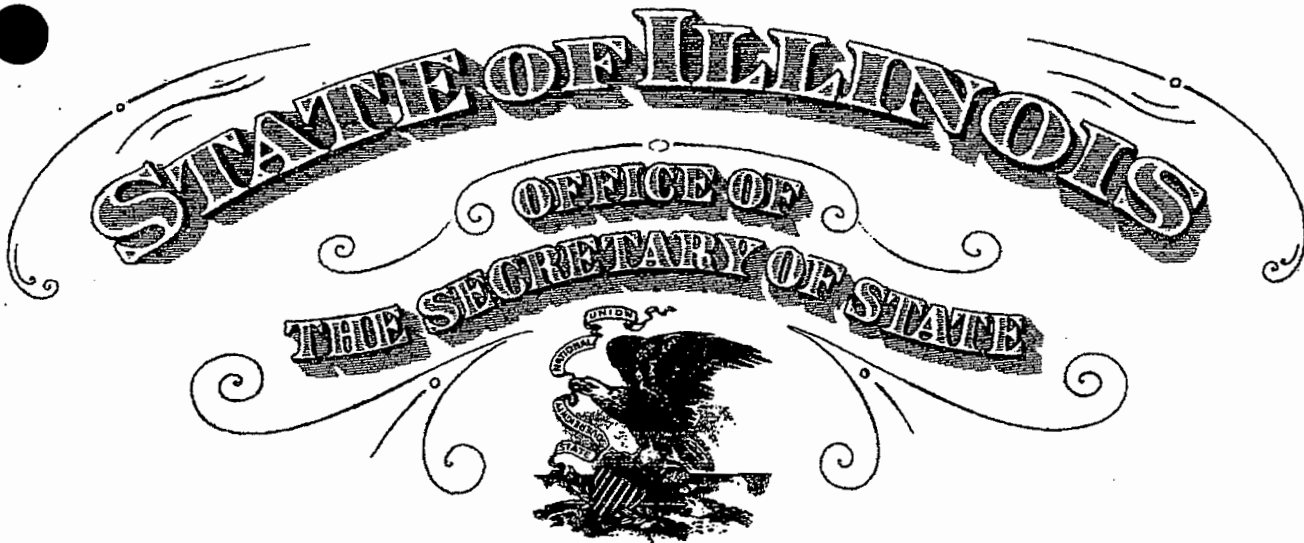
Jesse White

Authentication #: 1426901664

Authenticate at: <http://www.cyberdriveillinois.com>

SECRETARY OF STATE

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

*I, Jesse White, Secretary of State of the State of Illinois, do
hereby certify that*

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 30TH
day of SEPTEMBER A.D. 2014*

Jesse White

SECRETARY OF STATE

Authentication #: 1427301564

Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

*I, Jesse White, Secretary of State of the State of Illinois, do
hereby certify that*

ADVENTIST HEALTH SYSTEM/SUNBELT, INC., INCORPORATED IN FLORIDA AND
LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 28, 1997, APPEARS TO
HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT
CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN
CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE
STATE OF ILLINOIS.



*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 1ST
day of AUGUST A.D. 2014*

Jesse White

SECRETARY OF STATE

Authentication #: 1421300334

Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 1



Adventist
Bolingbrook Hospital
Keeping you well

April 7, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Service Review Board
525 West Jefferson
Springfield, IL 62761

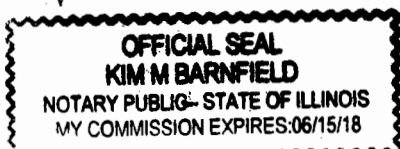
Dear Ms. Avery:

I hereby certify that the owner of the site on which Adventist Bolingbrook Hospital is located is Adventist Bolingbrook Hospital.

Sincerely,

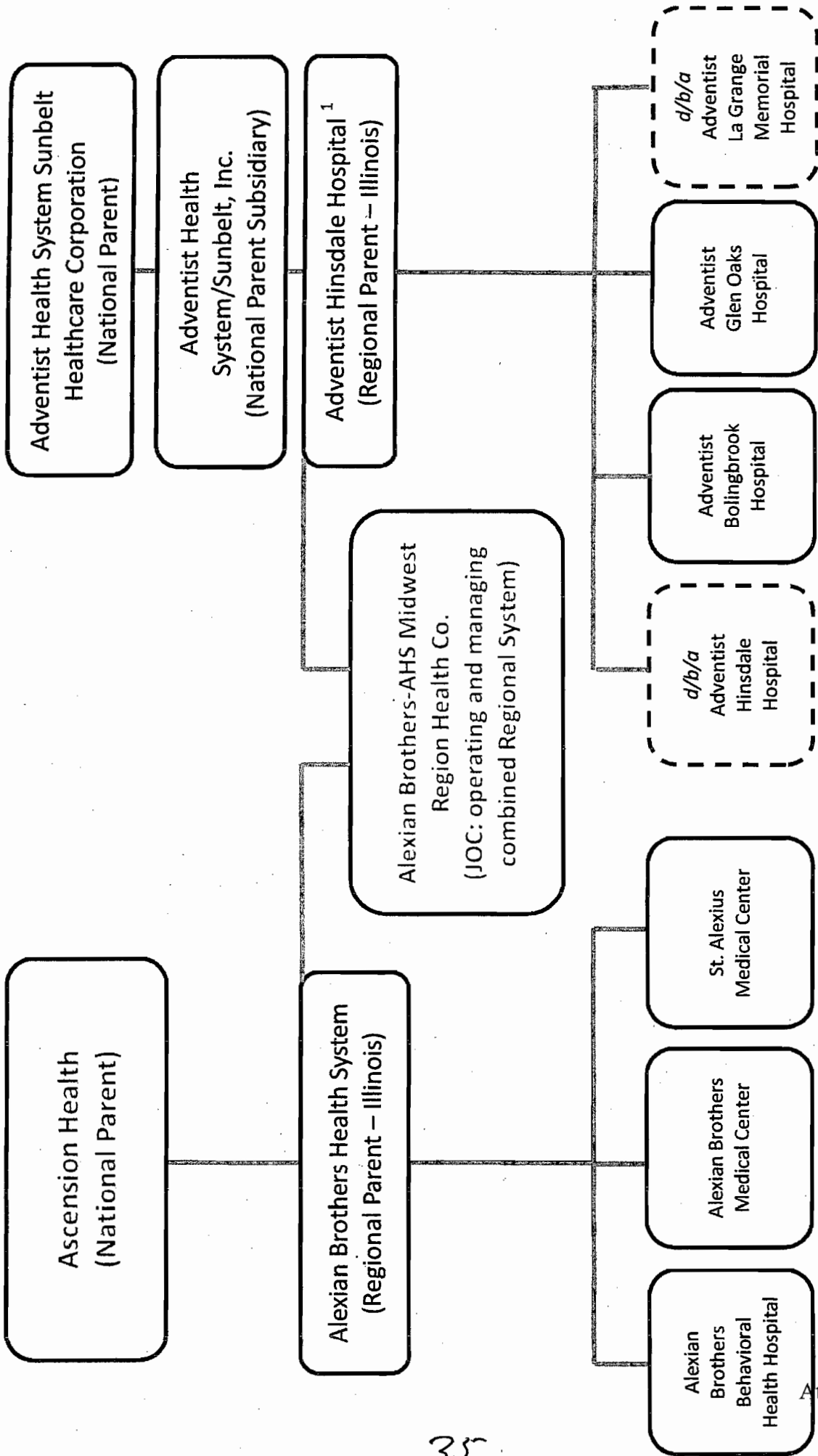

Rick Mace
President/CEO

Notarized:



ATTACHMENT 2

Ascension - Adventist Joint Operating Company



☐ = legal entity
☐ = operating division of legal entity

¹ Once regulatory approval is obtained, the legal entity "Adventist Hinsdale Hospital" will change its name to "Adventist Midwest Health" and will establish "Adventist Hinsdale Hospital" and "Adventist La Grange Memorial Hospital" as d/b/a's for the licensed health care facilities it operates.



Adventist
Bolingbrook Hospital
Keeping you well

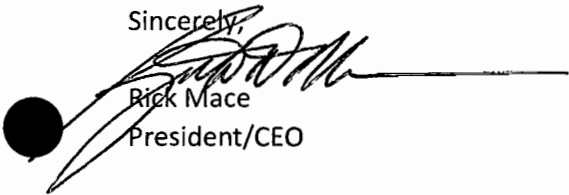
April 7, 2015

Illinois Health Facilities and
Service Review Board
525 West Jefferson
Springfield, IL 62761

To Whom it May Concern:

I hereby certify that the Adventist Bolingbrook Hospital in Bolingbrook, Illinois is not located within a special flood hazard area, and that the project will be developed consistent with the requirements of Illinois Executive Order #2005-5.

Sincerely,

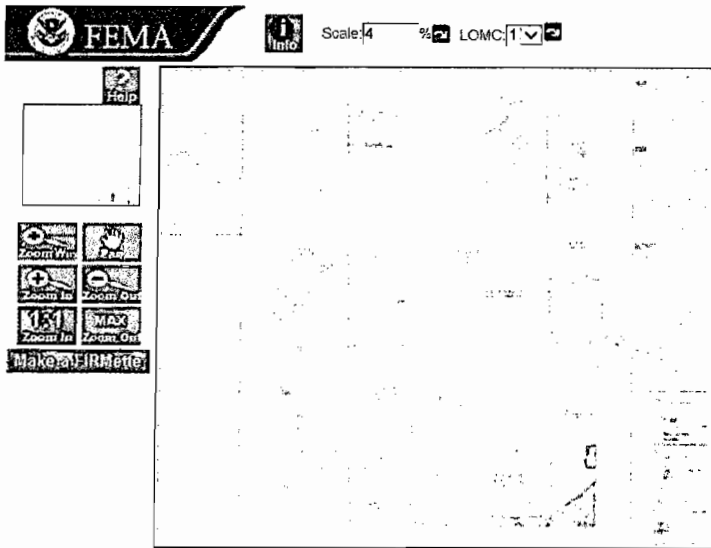


Rick Mace

President/CEO

Date: _____

4/7/2015



ATTACHMENT 5

37



FAX (217) 524-7525

Will County
Bolingbrook

CON - Rehabilitation to Establish an Acute Mental Illness Unit at Adventist Bolingbrook Hospital
500 Remington Road
IHPA Log #013122914

January 15, 2015

Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, IL 60067

Dear Mr. Axel:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

PROJECT COSTS

Preplanning Costs		\$25,000
evaluation of alternatives	\$25,000	
Modernization Contracts		\$2,694,130
renovation of 5-East nursing unit	\$2,694,130	
Contingencies		\$164,470
renovation-related contingency	\$164,470	
Architectural/Engineering Fees		\$240,000
design services	\$190,000	
governmental agency interaction	\$18,000	
inspections/supervision	\$22,000	
misc./other	\$10,000	
Consulting and Other Fees		\$115,000
CON and permit-related	\$85,000	
interiors/furniture selection	\$10,000	
misc./other	\$20,000	
Movable and Other Equipment		\$299,600
patient rooms	\$230,000	
dayroom	\$6,300	
patient support	\$18,900	
family area	\$5,300	
administrative areas/offices	\$23,100	
misc./other	\$16,000	

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
AMI Unit*	\$ 2,341,200	-	8,768	-	8,768	-	-
Support Areas	\$ 398,601	-	1,415	-	1,415	-	-
Circulation	\$ 798,399	-	6,264	-	1,624	-	-
Total	\$ 3,538,200		16,447		11,807		
*all functional areas required by IDPH licensure							

BACKGROUND

On December 16, 2014 the IHFSRB approved Certificate of Exemption applications which joined the four Illinois hospitals controlled by Adventist Health System Sunbelt Healthcare Corporation and the three Illinois hospitals controlled by Ascension Health under a joint operating company, Alexian Brothers-AHS Midwest Region Health Co. That joint operating company has been named as an applicant for the proposed project. The seven hospitals are:

- Adventist Bolingbrook Hospital, Bolingbrook, Illinois
- Adventist GlenOaks Hospital, Glendale Heights, Illinois
- Adventist Hinsdale Hospital, Hinsdale, Illinois
- Adventist La Grange Memorial Hospital, La Grange, Illinois
- Alexian Brothers Behavioral Health Hospital, Hoffman Estates, Illinois
- Alexian Brothers Medical Center, Elk Grove Village, Illinois
- St. Alexius Medical Center, Hoffman Estates, Illinois

DISPLAY THIS PART IN A
CONSPICUOUS PLACE

HF107400

Illinois Department of
PUBLIC HEALTH

LICENSE PERMITS CERTIFICATION, REGISTRATION

The person who is engaged in the above named activity has been certified with the Department of
Public Health and is authorized to engage in the activity as
indicated below.

LaMar Hasbrouck, MD, MPH

Acting Director

Issued under the authority of
the Health Department of
Public Health

01/10/2016

0005496

General Hospital

Effective: 01/11/2015

Exp. Date 01/10/2016

Lic Number 0005496

Date Printed 01/12/2015

Adventist Bolingbrook Hospital
500 Remington Boulevard
Bolingbrook, IL 60440

Adventist Bolingbrook Hospital

500 Remington Boulevard
Bolingbrook, IL 60440

FEE RECEIPT NO.

ATTACHMENT 11



January 15, 2015

Rick Mace
CEO
Adventist Bolingbrook Hospital
500 Remington Boulevard
Bolingbrook, IL 60440

Joint Commission ID #: 454359
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 01/15/2015

Dear Mr. Mace:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning January 31, 2014. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

ATTACHMENT 11



April 7, 2015

Illinois Health Facilities and
Service Review Board
525 West Jefferson
Springfield, IL 62761

RE: Establishment of an Acute Mental Illness Unit at Adventist Bolingbrook Hospital.

To Whom it May Concern:

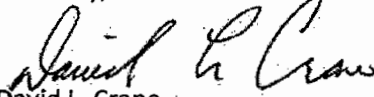
In accordance with Review Criterion 1130.520.b.3, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

Adventist Midwest Health (AMH) has not had any adverse actions against any Illinois health care facility owned or operated by AMH during the three (3) year period prior to the filing of this application.

AMH authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520.b.3 or to obtain any documentation or information which the State Board or Agency finds pertinent to this CON application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call.

Sincerely,

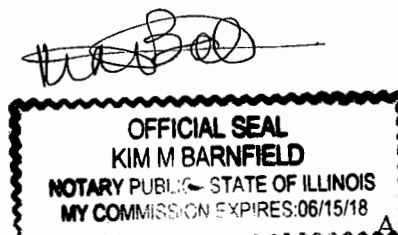


David L. Crane

Executive Vice President/COO

Date: 4/7/15

Notarized:



ATTACHMENT 11

PURPOSE

The proposed project has two primary purposes.

The first purpose is to improve access to acute mental illness ("AMI") inpatient services, particularly for area residents that rely on Adventist Bolingbrook Hospital and the physicians practicing there for their health care services. Historically, these patients, many of which are initially seen in the hospital's Emergency Department, have been referred to another hospital for admission to an AMI unit. The necessity to refer/admit these patients to another hospital compromises the patients' continuity of care.

The second purpose of the proposed project is to address the need for additional AMI beds in Planning Area A-13 (Will and Grundy Counties), as determined by the IHFSRB.

As a result, the proposed establishment of an AMI unit at Adventist Bolingbrook Hospital will improve the health care and well-being of the patient population that has historically looked to Adventist Bolingbrook Hospital for its hospital services.

It is anticipated that the market area for the proposed AMI service will be very similar to that of the hospital in general. Adventist Bolingbrook Hospital is located in extreme northern Will County, with DuPage County being within five minutes of the hospital, to both the north and east. As a result, in addition to serving the residents of Will County, Adventist Bolingbrook Hospital also serves a significantly sized population of DuPage County residents. The table on the following page identifies Adventist Bolingbrook Hospital's patient origin, for the 12-month period ending February 28, 2015.

ZIP Code & Community	%	Cumulative %
60440 BOLINGBROOK*	32.5%	32.5%
60446 ROMEOVILLE*	16.1%	48.7%
60544 PLAINFIELD*	5.5%	54.2%
60490 BOLINGBROOK*	5.5%	59.7%
60517 WOODRIDGE	4.5%	64.2%
60586 PLAINFIELD*	4.5%	68.8%
60435 JOLIET*	2.2%	70.9%
60439 LEMONT	1.9%	72.8%
60403 CREST HILL*	1.7%	74.5%
60441 LOCKPORT*	1.4%	75.9%
60431 JOLIET*	1.3%	77.3%
60585 PLAINFIELD*	1.3%	78.5%
60565 NAPERVILLE	1.0%	79.5%
others, <1.0%	20.5%	100.0%
*Will County		

The goal of the proposed project, which is targeted to be reached within eighteen months, is to reduce the adult AMI transfers from the hospital's ED by 80%+ and to admit those other patients requiring admission to an AMI unit and desiring to receive that care at Adventist Bolingbrook Hospital.

ALTERNATIVES

Adventist Bolingbrook Hospital does not currently provide inpatient acute mental illness (AMI) services. Rather, it relies on other providers as referral sites for patients initially seen in its Emergency Department. In addition, physicians on staff at Adventist Bolingbrook Hospital have had to admit patients requiring AMI services, including those who concurrently require medical care, to other hospitals. The need to transfer/admit patients to other hospitals compromises continuity of care, and often requires that a patient be hospitalized "outside of their community."

The proposed AMI unit will have a clinical focus on the care of adults and older adults, though the alternative of providing AMI services to a broader age group was initially considered. This alternative was dismissed, based on the availability of programs addressing the needs of younger patients in the general area, the belief that the "mixing" of age groups would be clinically inappropriate, and the perceived lack of a sufficiently-sized patient population to support required programming. The capital costs associated with this alternative (above those of the proposed project) were estimated to be negligible, and the operating costs were estimated to be 15-20% greater than those of the proposed project.

The second alternative considered was to continue to fully rely upon other hospitals for the provision of AMI services to those patients to be admitted to the proposed unit at Adventist Bolingbrook Hospital. This alternative, while not having any capital or operating costs, compromises accessibility, as supported by the IHFSRB's calculation of a need for additional AMI beds in the planning area.

SIZE OF PROJECT

The proposed AMI unit will occupy a portion of an existing Medical/Surgical unit, and will be separated from the remainder of the hospital's second floor by secure doorways closing off existing corridors. The space to be used, as identified in the table below, as well as ATTACHMENTS 9 and 39C, is necessary, not excessive, and consistent with IDPH licensure standards.

Three of the 24 private patient rooms will be ADA-compliant, to address the non-AMI needs of selected patients. Existing patient rooms, originally designed for the provision of Medical/Surgical services will be re-used, with renovation appropriate to the provision of AMI services. In addition, a large dining/recreation/occupational therapy space, a nurses station and all other functional areas required to meet licensure standards will be provided on the unit. The table below identifies that 8,768 DGSF will be provided for those functions.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
AMI	8,768	13,440	-4,672	YES

SERVICE DEMAND

The applicants, as a result of the documentation from referral sources provided ATTACHMENT 22c3, anticipate that the proposed acute mental illness (AMI) category of service at Adventist Bolingbrook Hospital will reach the IHFSRB's 85% utilization target during the second year following the project's completion, and will maintain that level. Much of the utilization will, it is anticipated, come through Adventist Bolingbrook Hospital's Emergency Department, which referred over 500 patients to AMI units during the 12-month period ending September 30, 2014. The unit's occupancy rate during the first year of operation is projected to approximate 60%, as a result of the anticipated "ramp-up" period immediately following the unit's opening.

Consistent with IHFSRB requirements, prospective admissions have been documented through letters from referral sources. Specifically, letters are provided from:

- 16 physicians, documenting 521 patients that would have been admitted to ABH during the 12-month period ending September 30, 2014 for AMI services had an AMI unit been available; and
- a letter from ABH's Emergency Department, identifying 447 patients that would have been admitted to HCH for AMI services had an AMI unit been available.

Together, these referral sources identified 968 patients.

The table on the following page, provided consistent with IHFSRB requirements, incorporates a "ramp-up" period during the AMI unit's first year of operation.

Dept./ Service	2013 Historical Utilization (Patient Days) (TREATMENTS) ETC. N/A	PROJECTED UTILIZATION (patient days)		STATE STANDARD	MET STANDARD?
		YEAR 1	YEAR 2		
AMI	N/A	5,256	7,446	7,136+	YES

SERVICE TO PLANNING AREA RESIDENTS

The primary purpose of the proposed project is to provide inpatient acute mental illness (AMI) services to residents of Bolingbrook and the nearby communities. It is anticipated that the patient origin of the proposed AMI unit will be very similar to that experienced by Adventist Bolingbrook Hospital over the past year, with a majority of the patients being Will County residents.

The table below identifies the hospital's historical patient origin, for the 12-month period ending February 28, 2015.

ZIP Code & Community	%	Cumulative %
60440 BOLINGBROOK*	32.5%	32.5%
60446 ROMEOVILLE*	16.1%	48.7%
60544 PLAINFIELD*	5.5%	54.2%
60490 BOLINGBROOK*	5.5%	59.7%
60517 WOODRIDGE	4.5%	64.2%
60586 PLAINFIELD*	4.5%	68.8%
60435 JOLIET*	2.2%	70.9%
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60431 JOLIET*	1.3%	77.3%
60585 PLAINFIELD*	1.3%	78.5%
60565 NAPERVILLE	1.0%	79.5%
others, <1.0%	20.5%	100.0%

*Will County

PLANNING AREA NEED

Adventist Bolingbrook Hospital is located in IDPH-designated Planning Area A-13, for purposes of identifying the Acute Mental Illness ("AMI") bed need. As of the March 2015 IDPH *Inventory*, a need for 31 additional AMI beds exists in Planning Area A-13. Therefore, the project, as proposed, is consistent with the provisions of Section 1110.730.c.1.

SERVICE DEMAND

The proposed project involves the establishment of an Acute Mental Illness ("AMI") category of service, with the scope of the project/number of proposed beds being supported through two sources. First, letters have been provided from sixteen physicians, documenting both the number of AMI patients that they admitted or referred to existing AMI inpatient providers during the 12-month period ending September 30, 2014, as well as the number of patients that they would have admitted to the proposed AMI unit, had it been available. In total, these letters document 521 prospective admissions to the proposed Adventist Bolingbrook Hospital unit. Second, a letter has been provided from Dr. Carlos Martinez, the director of the hospital's Emergency Department, documenting that during the past year, 506 patients were referred by or transferred from the Adventist Bolingbrook Hospital Emergency Department to another hospital for admission to an AMI unit, and that 447 of those patients would have been admitted to Adventist Bolingbrook Hospital's proposed AMI unit, had it been available. Together, these sources document 968 prospective patients to be admitted to the proposed AMI unit.

An average length of stay of 7.5 days, consistent with the anticipated mix of adult and older adult patients, was applied to the 968 admissions, to project 7,260 patient days, and an average daily census of 19.9 patients. The IHFSRB's 85% target occupancy rate was then applied to the average daily census to support the proposed 24 AMI beds.

Copies of the letters referenced above are provided on the following pages.

Name(print): Sumitha Panicker, MD
Specialty: Internal Medicine

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion I110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 10-12 psychiatric patients to the hospitals and identified below:

<u>Adventist Glen Oaks Hospital</u>	<u>10</u> patients
<u>Linden Oaks Hospital</u>	<u>2</u> patients
_____	_____ patients
_____	_____ patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Adventist Glen Oaks Hospital</u>	<u>10</u> Patients to ABH Unit
From Hospital <u>Linden Oaks Hospital</u>	<u>2</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

I estimate that 100 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

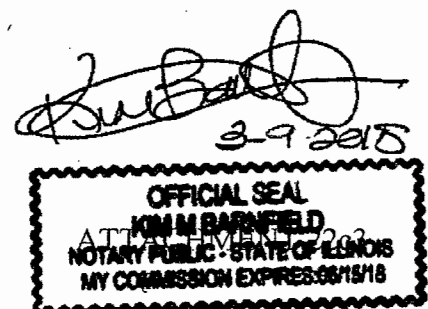
The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,



Signature

Notarized:



Name(print): Zafeer Burki, MD
Specialty: Psychiatry

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 30 psychiatric patients to the hospitals and identified below:

<u>Adventist - Glen Oaks Hospital</u>	<u>30</u> patients
_____	_____ patients
_____	_____ patients
_____	_____ patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Adventist Glen Oaks Hospital</u>	<u>30</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

I estimate that 100 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,


Signature

Notarized:

 3.9.2015



Name(print): Rajeev Kumar, MD
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion I110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 30 psychiatric patients to the hospitals and identified below:

<u>Advocate Good Samaritan Hosp.</u>	<u>10</u> patients
<u>Linden Oaks Hospital</u>	<u>7</u> patients
<u>Adventist Hinsdale Hospital</u>	<u>10</u> patients
<u>Adventist Glen Oaks Hosp.</u>	<u>3</u> patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Advocate Good Samaritan</u>	<u>5</u> Patients to ABH Unit
From Hospital <u>Linden Oaks Hospital</u>	<u>5</u> Patients to ABH Unit
From Hospital <u>Adventist Hinsdale Hosp.</u>	<u>5</u> Patients to ABH Unit
From Hospital <u>Adventist Glen Oaks</u>	<u>3</u> Patients to ABH Unit

I estimate that 90 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

Rajeev Kumar
Signature

Notarized:

[Signature] 3-10-2015





Adventist
Bolingbrook Hospital
Keeping you well

Name(print): Mehrdad Abbassian, M.D.
Specialty: Geriatric Psychiatry

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 22 psychiatric patients to the hospitals and identified below:

<u>Linden Oaks Hospital</u>	<u>10</u> patients
<u>Good Samaritan Hospital</u>	<u>7</u> patients
<u>Palos Community Hospital</u>	<u>5</u> patients
_____	_____ patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Linden Oaks Hospital</u>	<u>10</u> Patients to ABH Unit
From Hospital <u>Good Samaritan Hospital</u>	<u>7</u> Patients to ABH Unit
From Hospital <u>Palos Community Hospital</u>	<u>5</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

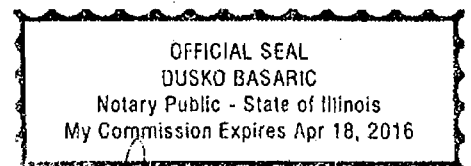
I estimate that 90 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

Mehrdad Abbassian

Signature



Notarized:

Dusko Basaric
ATTACHMENT 22c3
04/04/2015

Name(print): RAMA Davarapalli, MD
Specialty: Internal Medicine

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 25 psychiatric patients to the hospitals and identified below:

<u>Adventist Glen Oaks Hospital</u>	<u>15</u>	patients
<u>Adventist Hinsdale Hospital</u>	<u>1</u>	patients
<u>Linden Oaks</u>	<u>5</u>	patients
<u>Madden</u>	<u>4</u>	patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Adventist Glen Oaks</u>	<u>15</u>	Patients to ABH Unit
From Hospital <u>Adventist Hinsdale</u>	<u>1</u>	Patients to ABH Unit
From Hospital <u>Linden Oaks</u>	<u>5</u>	Patients to ABH Unit
From Hospital <u>Madden</u>	<u>4</u>	Patients to ABH Unit

I estimate that 100% of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

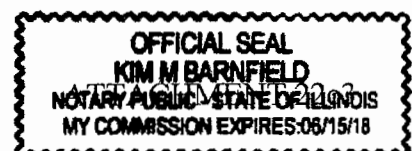
The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

R. Davarapalli MD
Signature

Notarized:

KIM M BARNFIELD 3.11.2015



Name(print): Mohammad Sami, MD
Specialty: Psychiatry

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of _____ psychiatric patients to the hospitals and identified below:

<u>Adventist Glen Oaks Hospital</u>	<u>130</u> patients
<u>Silver Cross Hospital</u>	<u>26</u> patients
_____	_____ patients
_____	_____ patients

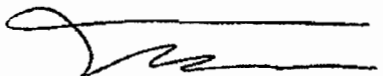
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Adventist Glen Oaks Hospital</u>	<u>130</u> Patients to ABH Unit
From Hospital <u>Silver Cross Hospital</u>	<u>13</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

I estimate that 100 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,



Signature

Notarized:



Name(print): Gregory Adams DO
Specialty: Family Medicine

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion I110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 5 psychiatric patients to the hospitals and identified below:

<u>Adventist Hinsdale Hospital</u>	<u>2</u> patients
<u>Lincoln Oaks</u>	<u>3</u> patients
_____	_____ patients
_____	_____ patients

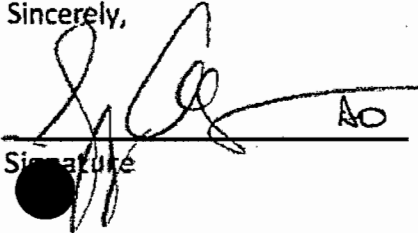
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

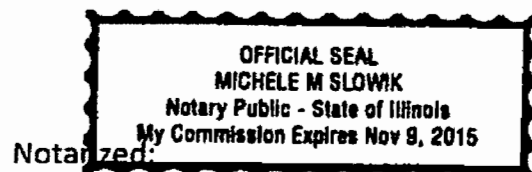
From Hospital <u>Adventist Hinsdale</u>	<u>2</u> Patients to ABH Unit
From Hospital <u>Lincoln Oaks</u>	<u>EA 3</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

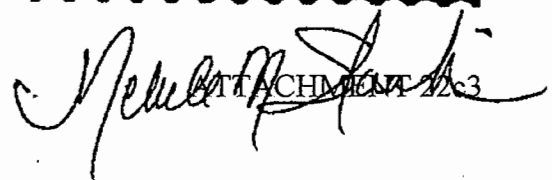
I estimate that 60 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,


Signature




ATTACHMENT 2c3

Name (print): HAZEL KHAN, MD
Specialty: Psychiatry

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 485 psychiatric patients to the hospitals and identified below:

<u>Glen Oaks</u>	<u>375</u> patients
<u>Alexian Brothers Behavioral Health Hosp</u>	<u>40</u> patients
<u>Linden Oaks</u>	<u>30</u> patients
<u>Silver Cross</u>	<u>15</u> patients
<u>MACAL</u>	<u>25</u>

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

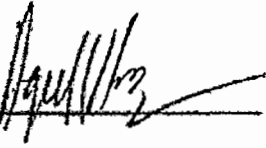
From Hospital: <u>Glen Oaks</u>	<u>140</u> patients to ABH Unit
From Hospital: <u>Alexian Brothers Behavioral Health Hosp</u>	<u>20</u> patients to ABH Unit
From Hospital: <u>Linden Oaks</u>	<u>15</u> patients to ABH Unit
From Hospital: <u>Silver Cross</u>	<u>5</u> patients to ABH Unit
<u>MACAL</u>	<u>10</u>

I estimate that 70% of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

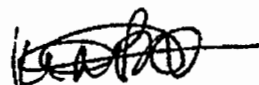
The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

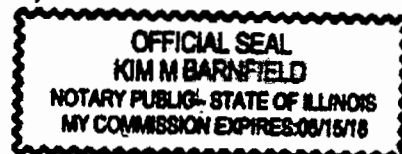
Sincerely,

Signature



Notarized:

 04.10.2015



Name (print): Arthur Pettigrew MD
Specialty: Internal Medicine

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion I110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 10 psychiatric patients to the hospitals and identified below:

<u>STMC</u>	<u>3</u> patients
<u>SCH</u>	<u>3</u> patients
<u>ABH</u>	<u>4</u> patients
_____	_____ patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Silver Cross Hospital</u>	<u>3</u> Patients to ABH Unit
From Hospital <u>AGH</u>	<u>4</u> Patients to ABH Unit
From Hospital <u>St. Joe's Med. Ctr.</u>	<u>3</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

I estimate that 95 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

Signature 

Notarized:




ATTACHMENT 22c3

Name(print): Srilakshmi Vemareddy, M
Specialty: Internal Medicine

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 24 psychiatric patients to the hospitals and identified below:

<u>Glen oaks hospital</u>	<u>15</u> patients
<u>Linden oaks hospital</u>	<u>5</u> patients
<u>Provena St Joseph</u>	<u>2</u> patients
<u>Christ hospital</u>	<u>2</u> patients

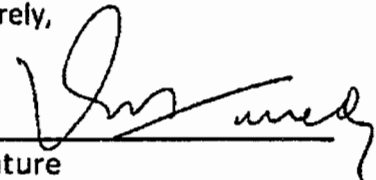
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Glen oaks hospital</u>	<u>15</u> Patients to ABH Unit
From Hospital <u>Linden oaks hospital</u>	<u>3</u> Patients to ABH Unit
From Hospital <u>Provena St Joseph hospital</u>	<u>2</u> Patients to ABH Unit
From Hospital <u>Christ hospital</u>	<u>2</u> Patients to ABH Unit

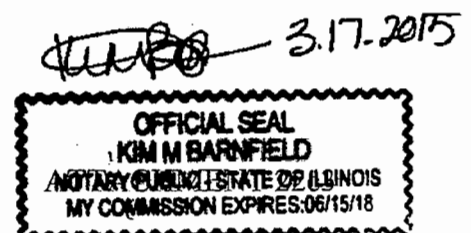
I estimate that 100 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

 3/17/2015
Signature

Notarized:



Name(print): Vyjayanthi Atluri, MD
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 20 psychiatric patients to the hospitals and identified below:

<u>Glen Oaks Hospital</u>	<u>10</u>	patients
<u>Advocate Good Samaritan</u>	<u>10</u>	patients
<u>Linden Oaks</u>	<u>3</u>	patients
_____	_____	patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Glen Oaks</u>	<u>3</u>	Patients to ABH Unit
From Hospital <u>Advocate Good Samaritan</u>	<u>4</u>	Patients to ABH Unit
From Hospital <u>Linden Oaks</u>	<u>2</u>	Patients to ABH Unit
From Hospital _____	_____	Patients to ABH Unit

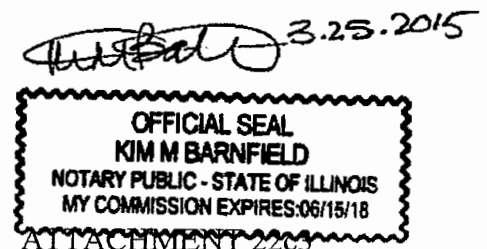
I estimate that _____ % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

V. Atluri 3/13/15.
Signature

Notarized:



Name(print): Arshea Siddiqui MD
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 30 psychiatric patients to the hospitals and identified below:

Good Sam Hospital

30 patients

_____ patients

_____ patients

_____ patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital

Good Sam Hospital

3 Patients to ABH Unit

From Hospital

_____ Patients to ABH Unit

From Hospital

_____ Patients to ABH Unit

From Hospital

_____ Patients to ABH Unit

I estimate that 10 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

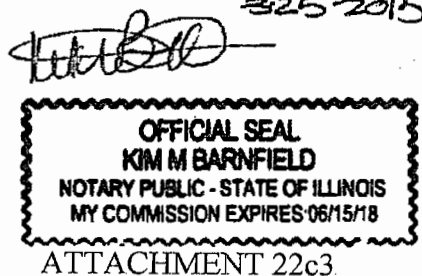
Sincerely,

Signature

Arshea Siddiqui, MD

DR SIDDQUI ARSHEA

Notarized:



Name (print): Rahmawati Sih, MD
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 4 psychiatric patients to the hospitals and identified below:

<u>Good Samaritan</u>	<u>1</u> patients
<u>Glen Oaks</u>	<u>1</u> patients
<u>Rush</u>	<u>1</u> patients
<u>Hrusday</u>	<u>1</u> patients

Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>GS</u>	<u>1</u> Patients to ABH Unit
From Hospital <u>GO</u>	<u>1</u> Patients to ABH Unit
From Hospital <u>Rush</u>	<u>0</u> Patients to ABH Unit
From Hospital <u>HH</u>	<u>1</u> Patients to ABH Unit

I estimate that 99 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

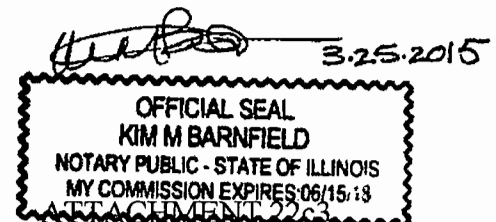
The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

R. Sih

Signature

Notarized:



Name (print): Ahmed Nazimuddin, MD
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 5 psychiatric patients to the hospitals and identified below:

<u>Advocate Good Sam Hospital</u>	<u>4</u> patients
<u>Adventist Glen Oak</u>	<u>1</u> patients
_____	_____ patients
_____	_____ patients

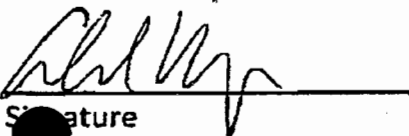
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Good Sam</u>	<u>4</u> Patients to ABH Unit
From Hospital <u>Glen Oak</u>	<u>1</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

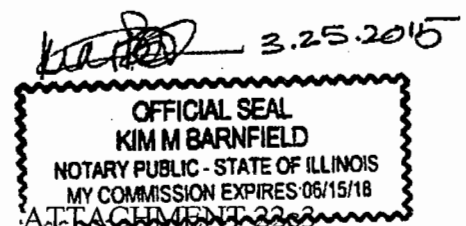
I estimate that 100 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,


Signature

Notarized:



Name(print): Afshan Hafiz
Specialty: Geriatrics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion I110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 13 psychiatric patients to the hospitals and identified below:

<u>Glenn Oaks Hospital</u>	<u>3</u>	patients
<u>Alexian Brothers Medical</u>	<u>5</u>	patients
<u>Good Samaritan Hospital</u>	<u>5</u>	patients
_____	_____	patients

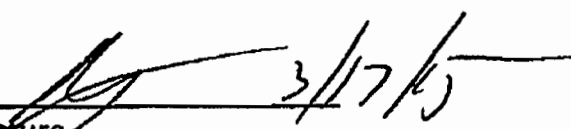
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Good Samaritan</u>	<u>5</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

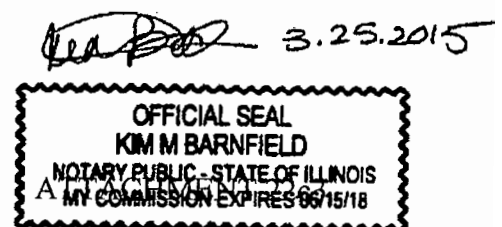
I estimate that _____ % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,


Signature _____ 3/17/15

Notarized:



Name (print): Renato De Los Santos, MD
Specialty: Psychiatry

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed inpatient psychiatry unit to be developed at Adventist Bolingbrook Hospital.

During the 12 month period ending September 30, 2014, I admitted/referred a total of 135 psychiatric patients to the hospitals and identified below:

<u>Alexia Brothers</u>	<u>135</u> patients
<u>Glen Oaks</u>	<u>8</u> patients
<u>Norwich America</u>	<u>6</u> patients
<u>Lutheran General</u>	<u>4</u> patients

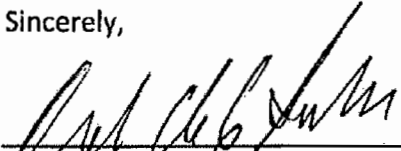
Had the proposed unit been available to me during the 12 month period ended September 30, 2014, I estimate that I would have admitted/referred the following number of psychiatric patients to the proposed Adventist Bolingbrook Hospital (ABH) unit:

From Hospital <u>Glen Oaks</u>	<u>8</u> Patients to ABH Unit
From Hospital <u>Norwich America</u>	<u>4</u> Patients to ABH Unit
From Hospital <u>Lutheran General</u>	<u>4</u> Patients to ABH Unit
From Hospital _____	_____ Patients to ABH Unit

I estimate that 15 % of the patients that I admitted/referred during the 12 month period ended September 30, 2014 and would have admitted/referred to the proposed unit reside in the ZIP Code areas (list attached) located within approximately 30 minutes of Adventist Bolingbrook Hospital.

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,


Signature



Notarized:

 4/9/15
ATTACHMENT 22c3

March 17, 2015

Illinois Health Facilities and
Services Review Board
Springfield, IL 62761

To Whom It May Concern:

I am the Medical Director of Adventist Bolingbrook Hospital's Emergency Department, and am writing this letter in support of the hospital's plans to develop an inpatient psychiatry unit.

During the 12-month period ending December 31, 2014 a total of 506 patients were seen in our Emergency Department, and directly admitted for inpatient psychiatric care at another hospital. Below are listed the hospitals to which those patients were transferred and directly admitted:

Adult Inpatient Psych Hospitals/Hospital Units

Adventist Glen Oaks Hospital	212
Adventist Hinsdale Hospital	24
Linden Oaks Hospital	45
Ingalls Hospital	6
Presence St. Joseph Hospital	21
Alexian Brothers Behavioral Health	12
Riveredge Hospital	39
Hartgrove Hospital	5
Central DuPage Hospital	1
Chicago Lakeshore Hospital	9
Advocate Christ Hospital	5
Garfield Park Behavioral Health	11
Advocate Good Samaritan Hospital	4
Jesse Brown VA Hospital	1
Kindred North Behavioral Health	2
Loretto Hospital	1
Lurie's Childrens Hospital	2
MacNeal Hospital	4
Madden Behavioral Health	32
Presence Mercy Aurora Hospital	6
Methodist Hospital	2
Palos Hospital	1
Riverside Kankakee	3
Silver Cross Hospital	7
St. Elizabeth Hospital	14
St. Mary's Hospital	1

University of Illinois	5
Streamwood Behavioral Health	26
Westlake	4
Rush University	1

Upon the opening of the proposed inpatient psychiatric unit at Adventist Bolingbrook Hospital ("ABH"), the vast majority of patients that would have been transferred to another hospital for admission to a psychiatric unit will be admitted to the ABH unit, assuming a bed is available. Had the proposed ABH unit been available during the 12-month period identified above, I estimate that 447 of those patients would have been directly admitted to that unit after being evaluated in the ABH Emergency Department:

Adult Inpatient Psych Hospitals/Hospital Units

Adventist Glen Oaks Hospital	212
Adventist Hinsdale Hospital	20
Linden Oaks Hospital	20
Ingalls Hospital	6
Presence St. Joseph Hospital	15
Alexian Brothers Behavioral Health	11
Riveredge Hospital	39
Hartgrove Hospital	5
Central DuPage Hospital	1
Chicago Lakeshore Hospital	8
Advocate Christ Hospital	5
Garfield Park Behavioral	11
Advocate Good Samaritan Hospital	4
Jesse Brown VA Hospital	1
Kindred North Behavioral Health	2
Loretto Hospital	1
Lurie's Children Hospital	2
MacNeal Hospital	4
Madden Behavioral Health	32
Presence Mercy Aurora Hospital	6
Methodist Hospital	2
Palos Hospital	1
Riverside Kankakee	3
Silver Cross Hospital	5
St. Elizabeth Hospital	14
St. Mary's Hospital	1
University of Illinois	5
Streamwood Behavioral Health	6
Westlake Hospital	4
Rush University	1



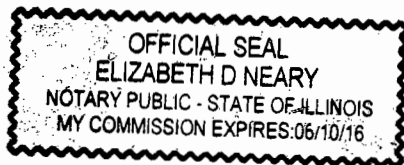
There are great benefits to receiving needed inpatient psychiatric care in a patient's home community or near the patient's home. I estimate that a minimum of 90% of the patients transferred from ABH's Emergency Department to another hospital for inpatient psychiatric care, and which would have been admitted to the ABH inpatient psychiatry program, had it been available, reside within 30 minutes of ABH (list of Zip Codes attached).

The information contained in this letter is true and correct, to the best of my information and belief, and the referenced patients have not been used to support another similar project.

Sincerely,

Carlos Martinez, MD
Medical Director, Emergency Services

Notarized:



Elizabeth D. Neary
3/17/15

ZIP Codes within 30 Minutes
of Adventist Bolingbrook Hospital

60137	60477
60148	60480
60154	60482
60162	60501
60181	60504
60187	60505
60188	60506
60190	60513
60421	60514
60423	60515
60431	60516
60432	60517
60433	60519
60435	60521
60439	60525
60440	60532
60441	60534
60445	60535
60446	60538
60447	60540
60448	60543
60451	60544
60455	60555
60457	60558
60458	60559
60462	60561
60463	60563
60464	60564
60465	60565

UNNECESSARY DUPLICATION

Eight IDPH-approved acute mental illness providers are located within 30 minutes (MapQuest, adjusted) of Adventist Bolingbrook Hospital, with three of those hospitals being located 29 minutes away, as identified below:

Hospital	Location	Minutes*	Miles
Linden Oaks Hospital	Naperville	17	8.71
Silver Cross Hospital	New Lenox	22	16.97
Advocate Good Samaritan	Downers Grove	22	15.75
Adventist Hinsdale Hospital	Hinsdale	24	14.4
Presence St. Joseph Med. Ctr.	Joliet	26	12.78
Palos Community Hospital	Palos Heights	29	19.79
MacNeal Hospital	Berwyn	29	20.47
Adventist GlenOaks Hospital	Glendale Heights	29	21.40

*adjusted per IHFSRB rules
Source: MapQuest, 12/19/14

Below are listed all ZIP Code areas located, in full or in part, within a 30-minute drive of Adventist Bolingbrook Hospital:

60137
60148
60154
60162
60181
60187
60188
60190
60421

60423
60431
60432
60433
60435
60439
60440
60441
60445
60446
60447
60448
60451
60455
60457
60458
60462
60463
60464
60465
60477
60480
60482
60501
60504
60505
60506
60513
60514
60515
60516
60517
60519
60521
60525
60532
60534

ATTACHMENT 22d1

60535
60538
60540
60543
60544
60555
60558
60559
60561
60563
60564
60565

The 2013 population of the 58 ZIP Codes identified above, according to ZIP Code-specific projections developed by Geolytics, is 1,558,313. The State of Illinois does not provide population projections on a ZIP Code-specific basis.



mapquest

Notes

Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

8.71 miles / 15 minutes



Linden Oaks At Edward

852 S West St, Naperville, IL 60540

(630) 305-5500

Download
Free App



1. Start out going **north** on **S West St** toward **Osler Dr.** [Map](#)

0.3 Mi

0.3 Mi Total



2. Turn **right** onto **W Martin Ave.** [Map](#)

0.5 Mi

0.7 Mi Total



3. Turn **right** onto **S Washington St.** [Map](#)

3.7 Mi

4.5 Mi Total



4. Turn **right** to stay on **S Washington St.** [Map](#)

0.7 Mi

5.2 Mi Total



5. **S Washington St** becomes **N Weber Rd.** [Map](#)

1.0 Mi

6.2 Mi Total



6. Turn **left** onto **Veterans Pkwy.** [Map](#)

1.4 Mi

7.6 Mi Total



7. Turn **left** onto **Remington Blvd.** [Map](#)

1.1 Mi

8.7 Mi Total



8. Make a **U-turn** at **S Schmidt Rd** onto **Remington Blvd.** [Map](#)

0.02 Mi

8.7 Mi Total



9. **500 REMINGTON BLVD** is on the **right.** [Map](#)



Adventist Bolingbrook Hospital

500 Remington Blvd, Bolingbrook, IL 60440

(630) 312-5000

Total Travel Estimate: 8.71 miles - about 15 minutes

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Notes

Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

16.97 miles / 19 minutes



Silver Cross Hospital

1900 Silver Cross Blvd., New Lenox, IL 60451

(815) 300-1100

Download
Free App



1. Start out going north on Silver Cross Blvd. [Map](#)

0.1 Mi

0.1 Mi Total



2. Turn right onto Maple Rd / US-6 E. [Map](#)

0.9 Mi

1.0 Mi Total



3. Merge onto I-355 N / Veterans Memorial Tollway N via the ramp on the left toward West Suburbs (Portions toll). [Map](#)

11.9 Mi

12.8 Mi Total



4. Merge onto I-55 S toward St Louis. [Map](#)

2.4 Mi

15.2 Mi Total



5. Take the IL-53 exit, EXIT 267, toward Bolingbrook. [Map](#)

0.3 Mi

15.5 Mi Total



6. Keep right to take the ramp toward Bolingbrook. [Map](#)

0.04 Mi

15.5 Mi Total



7. Turn right onto IL-53 / S Bolingbrook Dr. [Map](#)

0.1 Mi

15.7 Mi Total



8. Turn left onto Remington Blvd. [Map](#)

1.3 Mi

17.0 Mi Total



9. 500 REMINGTON BLVD is on the right. [Map](#)



Adventist Bolingbrook Hospital

500 Remington Blvd, Bolingbrook, IL 60440

(630) 312-5000

Total Travel Estimate: 16.97 miles - about 19 minutes

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Trip to:

Adventist Bolingbrook Hospital **500 Remington Blvd**

Bolingbrook, IL 60440

(630) 312-5000

15.75 miles / 19 minutes

Notes



Advocate Good Samaritan Hospital
 3815 Highland Ave, Downers Grove, IL 60515
 (630) 275-5900

Download
Free App



1. Start out going **north** on **Highland Ave / County Hwy-9** toward **Barneswood Dr.** [Map](#)

1.1 Mi

1.1 Mi Total



2. Merge onto **Butterfield Rd / IL-56** via the ramp on the **left**. [Map](#)

0.5 Mi

1.6 Mi Total



3. Turn **left** onto **Downers Dr.** [Map](#)

0.2 Mi

1.9 Mi Total



4. Merge onto **I-88 W / Chicago-Kansas City Expressway W / Ronald Reagan Memorial Tollway W** (Portions toll). [Map](#)

0.4 Mi

2.3 Mi Total



5. Merge onto **I-355 S / Veterans Memorial Tollway S** toward **Joliet** (Portions toll). [Map](#)

9.5 Mi

11.7 Mi Total



6. Take the exit toward **I-55 S / St Louis.** [Map](#)

0.3 Mi

12.0 Mi Total



7. Keep **left** to take the ramp toward **Joliet Rd S.** [Map](#)

0.4 Mi

12.4 Mi Total



8. Merge onto **I-55 S** via the ramp on the **left** toward **St Louis.** [Map](#)

1.6 Mi

14.0 Mi Total



9. Take the **IL-53** exit, **EXIT 267**, toward **Bolingbrook.** [Map](#)

0.3 Mi

14.3 Mi Total



10. Keep **right** to take the ramp toward **Bolingbrook.** [Map](#)

0.04 Mi

14.3 Mi Total



11. Turn **right** onto **IL-53 / S Bolingbrook Dr.** [Map](#)

0.1 Mi

14.5 Mi Total



12. Turn **left** onto **Remington Blvd.** [Map](#)

1.3 Mi

15.8 Mi Total



13. **500 REMINGTON BLVD** is on the **right.** [Map](#)

ATTACHMENT 22d1

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mapquest

Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

14.40 miles / 21 minutes

Notes



Adventist Hinsdale Hospital
 121 N Elm St, Hinsdale, IL 60521
 (630) 856-9000

Download
Free App



1. Start out going **north** on **N Elm St** toward **E Walnut St.** [Map](#)

0.03 Mi
 0.03 Mi Total



2. Take the **1st right** onto **E Walnut St.** [Map](#)

0.1 Mi
 0.2 Mi Total



3. Take the **1st right** onto **N Oak St.** [Map](#)

0.2 Mi
 0.3 Mi Total



4. Take the **2nd left** onto **E Chicago Ave.** [Map](#)

0.1 Mi
 0.5 Mi Total



5. Take the **1st right** onto **S County Line Rd.** [Map](#)

3.0 Mi
 3.5 Mi Total



6. Merge onto **I-55 S** toward **Joliet.** [Map](#)

9.1 Mi
 12.6 Mi Total



7. Take the **IL-53 exit, EXIT 267**, toward **Bolingbrook.** [Map](#)

0.3 Mi
 12.9 Mi Total



8. Keep **right** to take the ramp toward **Bolingbrook.** [Map](#)

0.04 Mi
 13.0 Mi Total



9. Turn **right** onto **IL-53 / S Bolingbrook Dr.** [Map](#)

0.1 Mi
 13.1 Mi Total



10. Turn **left** onto **Remington Blvd.** [Map](#)

1.3 Mi
 14.4 Mi Total



11. **500 REMINGTON BLVD** is on the **right.** [Map](#)



Adventist Bolingbrook Hospital
 500 Remington Blvd, Bolingbrook, IL 60440
 (630) 312-5000

Total Travel Estimate: 14.40 miles - about 21 minutes

ATTACHMENT 22d1

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Trip to:

500 Remington Blvd

Bolingbrook, IL 60440-4923

12.78 miles / 23 minutes

Notes



Presence Saint Joseph Medical Center

333 Madison St, Joliet, IL 60435

(815) 725-7133

Download
Free App



1. Start out going **north** on **Madison St** toward **Glenwood Ave.** [Map](#)

0.1 Mi

0.1 Mi Total



2. Take the **1st right** onto **Glenwood Ave.** [Map](#)

0.5 Mi

0.6 Mi Total



3. Take the **2nd left** onto **N Larkin Ave / IL-7**. Continue to follow **N Larkin Ave.** [Map](#)

2.0 Mi

2.6 Mi Total



4. **N Larkin Ave** becomes **Weber Rd.** [Map](#)

7.6 Mi

10.2 Mi Total



5. Turn **right** onto **W Remington Blvd.** [Map](#)

1.0 Mi

11.2 Mi Total



6. **W Remington Blvd** becomes **W 115th St.** [Map](#)

0.4 Mi

11.6 Mi Total



7. **W 115th St** becomes **Remington Blvd.** [Map](#)

1.1 Mi

12.7 Mi Total



8. Make a **U-turn** at **S Schmidt Rd** onto **Remington Blvd.** [Map](#)

0.03 Mi

12.8 Mi Total



9. **500 REMINGTON BLVD** is on the **right.** [Map](#)



500 Remington Blvd, Bolingbrook, IL 60440-4923

Total Travel Estimate: 12.78 miles - about 23 minutes

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Notes



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Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

19.79 miles / 25 minutes



Palos Community Hospital

12251 S 80th Ave, Palos Heights, IL 60463

(708) 923-4000

**Download
Free App**



1. Start out going **north** on **S 80th Ave** toward **Brook Ln.** [Map](#)

0.4 Mi

0.4 Mi Total



2. Turn **slight right** onto **IL-7 / Southwest Hwy.** [Map](#)

0.01 Mi

0.5 Mi Total



3. Take the 1st **left** onto **Calumet Sag Rd / IL-83.** Continue to follow **IL-83.** [Map](#)

10.1 Mi

10.6 Mi Total



4. Merge onto **I-55 S** toward **Joliet.** [Map](#)

7.4 Mi

18.0 Mi Total



5. Take the **IL-53** exit, **EXIT 267**, toward **Bolingbrook.** [Map](#)

0.3 Mi

18.3 Mi Total



6. Keep **right** to take the ramp toward **Bolingbrook.** [Map](#)

0.04 Mi

18.4 Mi Total



7. Turn **right** onto **IL-53 / S Bolingbrook Dr.** [Map](#)

0.1 Mi

18.5 Mi Total



8. Turn **left** onto **Remington Blvd.** [Map](#)

1.3 Mi

19.8 Mi Total



9. **500 REMINGTON BLVD** is on the **right.** [Map](#)



Adventist Bolingbrook Hospital

500 Remington Blvd, Bolingbrook, IL 60440

(630) 312-5000

Total Travel Estimate: 19.79 miles - about 25 minutes

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Notes

Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

20.47 miles / 25 minutes



Vanguard MacNeal Hospital

3249 Oak Park Ave, Berwyn, IL 60402

(708) 783-9100

**Download
Free App**



1. Start out going **south** on **Oak Park Ave** toward **Windsor Ave.** [Map](#)

0.4 Mi

0.4 Mi Total



2. Turn **right** onto **Ogden Ave.** [Map](#)

0.6 Mi

1.0 Mi Total



3. Turn **left** onto **Harlem Ave / IL-43.** [Map](#)

1.6 Mi

2.6 Mi Total



4. Turn **right** onto **Canal Bank Rd.** [Map](#)

0.02 Mi

2.7 Mi Total



5. Merge onto **I-55 S.** [Map](#)

16.1 Mi

18.7 Mi Total



6. Take the **IL-53** exit, **EXIT 267**, toward **Bolingbrook.** [Map](#)

0.3 Mi

19.0 Mi Total



7. Keep **right** to take the ramp toward **Bolingbrook.** [Map](#)

0.04 Mi

19.0 Mi Total



8. Turn **right** onto **IL-53 / S Bolingbrook Dr.** [Map](#)

0.1 Mi

19.2 Mi Total



9. Turn **left** onto **Remington Blvd.** [Map](#)

1.3 Mi

20.5 Mi Total



10. **500 REMINGTON BLVD** is on the **right.** [Map](#)



Adventist Bolingbrook Hospital

500 Remington Blvd, Bolingbrook, IL 60440

(630) 312-5000

Total Travel Estimate: 20.47 miles - about 25 minutes

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mapquest

Trip to:

Adventist Bolingbrook Hospital
500 Remington Blvd

Bolingbrook, IL 60440

(630) 312-5000

21.40 miles / 25 minutes

Notes



Adventist GlenOaks Hospital

701 Winthrop Ave, Glendale Heights, IL 60139

(630) 545-8000

Download
Free App



1. Start out going **west** on **Winthrop Ave** toward **Winthrop Ct.** [Map](#)

0.2 Mi

0.2 Mi Total



2. Turn **left** onto **Glen Ellyn Rd.** [Map](#)

0.8 Mi

1.0 Mi Total



3. Turn **left** onto **North Ave / IL-64.** [Map](#)

1.2 Mi

2.2 Mi Total



4. Merge onto **I-355 S / Veterans Memorial Tollway S** toward **Joliet** (Portions toll). [Map](#)

15.2 Mi

17.4 Mi Total



5. Take the exit toward **I-55 S / St Louis.** [Map](#)

0.3 Mi

17.7 Mi Total



6. Keep **left** to take the ramp toward **Joliet Rd S.** [Map](#)

0.4 Mi

18.0 Mi Total



7. Merge onto **I-55 S** via the ramp on the **left** toward **St Louis.** [Map](#)

1.6 Mi

19.6 Mi Total



8. Take the **IL-53** exit, **EXIT 267**, toward **Bolingbrook.** [Map](#)

0.3 Mi

19.9 Mi Total



9. Keep **right** to take the ramp toward **Bolingbrook.** [Map](#)

0.04 Mi

20.0 Mi Total



10. Turn **right** onto **IL-53 / S Bolingbrook Dr.** [Map](#)

0.1 Mi

20.1 Mi Total



11. Turn **left** onto **Remington Blvd.** [Map](#)

1.3 Mi

21.4 Mi Total



12. **500 REMINGTON BLVD** is on the **right.** [Map](#)



Adventist Bolingbrook Hospital

500 Remington Blvd, Bolingbrook, IL 60440

(630) 312-5000

ATTACHMENT 22d1

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MAL-DISTRIBUTION

The proposed project will not result in a mal-distribution of Acute Mental Illness (AMI) beds.

A mal-distribution will not result for two primary reasons: First, Adventist Bolingbrook Hospital is located in AMI Planning Area A-13, which is one of only five AMI Planning areas, state-wide, for which the IHFSRB's AMI bed need methodology has determined there to be a shortage of beds. As reported in the March 2015 *Update* to its bed *Inventory*, a need for 31 additional AMI beds exists in AMI Planning Area A-13. Also as identified in the *Inventory*, there are only two AMI providers in AMI Planning Area A-13. One of those providers operates with a 93% occupancy rate, and the other area provider is located 26 minutes from Adventist Bolingbrook Hospital, bringing into question reasonable accessibility.

Second, there is only one AMI provider, Linden Oaks Hospital, located within 20 minutes of the applicant hospital. As a psychiatric hospital, Linden Oaks Hospital does not have the clinical capability to treat some of the co-morbidity diagnoses often present with older adult AMI patients.

All of the AMI programs in the area are fully matured, and as a result, it is not anticipated that the proposed program will cause any existing program to operate below the IDPH's 85% target utilization rate.

STAFFING

The proposed acute mental illness (AMI) unit will meet or exceed all licensure, JCAHO and industry staffing-related standards.

A Board-Certified psychiatrist will be named to the position of Medical Director. The initial Medical Director will be named approximately three months prior to the unit's opening, and will participate in the process of selecting the unit's staff.

The nursing and therapy staff will include experienced registered nurses and therapists, many of which will have either worked at another hospital affiliated with Adventist Bolingbrook Hospital, or completed an orientation initiated at one of those facilities.

All personnel will undergo a second phase of the orientation process, led by the Medical Director and members of the clinical leadership team.

Positions will initially be made available to Adventist employees, including those from the AMI units at other Adventist hospitals. Subsequent to the initial internal posting of available positions, normal recruitment means, such as advertisements in local newspapers and professional publications will be used to attract and hire qualified staff.

PERFORMANCE REQUIREMENTS

The proposed 24-bed acute mental illness unit is being developed consistent with the minimum size requirements addressed in Section 1110.730(f).



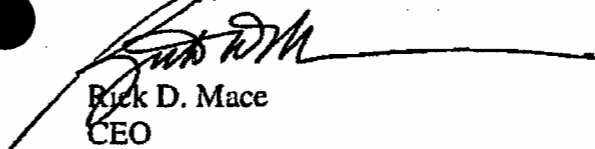
April 9, 2015

Illinois Health Facilities
and Services Review Board
Springfield, IL

To Whom It May Concern:

Please be advised that it is the anticipation of the applicants that the acute mental illness unit proposed to be established at Adventist Bolingbrook Hospital will operate at or above the IHFSRB's target utilization rate by the second year of operation, following the opening of the unit.

Sincerely,



Rick D. Mace
CEO

ATTACHMENT 22g

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**Audited
Consolidated
Financial
Statements**

December 31, 2014

Adventist Health System

ATTACHMENT 37

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Consolidated Balance Sheets

December 31, 2014
and 2013

(dollars in thousands)

ASSETS

Current Assets

Cash and cash equivalents	\$ 1,079,253	\$ 966,141
Investments (including investments pledged under securities lending program of \$0 in 2014 and \$20,154 in 2013)	3,686,458	3,384,068
Current portion of assets whose use is limited	259,166	240,087
Collateral held under securities lending program	—	20,619
Patient accounts receivable, less allowance for uncollectible accounts of \$313,585 in 2014 and \$264,870 in 2013	368,193	345,133
Due from brokers	282,431	378,363
Estimated settlements from third parties	35,663	39,349
Other receivables	435,863	349,098
Inventories	168,346	157,657
Prepaid expenses and other current assets	65,764	78,744
	<u>6,381,137</u>	<u>5,959,259</u>

Property and Equipment

5,092,867 4,872,811

Assets Whose Use is Limited, net of current portion

648,775 605,611

Other Assets

676,624 518,438
\$ 12,799,403 \$ 11,956,119

LIABILITIES AND NET ASSETS

Current Liabilities

Accounts payable and accrued liabilities	\$ 966,735	\$ 771,260
Estimated settlements to third parties	222,854	229,487
Payable under securities lending program	—	20,619
Due to brokers	173,687	247,825
Other current liabilities	275,420	219,304
Short-term financings	106,000	108,324
Current maturities of long-term debt	126,067	75,882
	<u>1,870,763</u>	<u>1,672,701</u>

Long-Term Debt, net of current maturities

3,179,634 3,400,199

Other Noncurrent Liabilities

752,499 562,811
5,802,896 5,635,711

Net Assets

Unrestricted:

Controlling interest	6,776,803	6,105,853
Noncontrolling interests	41,753	39,841
	<u>6,818,556</u>	<u>6,145,694</u>
Temporarily restricted – controlling interest	177,951	174,714
	<u>6,996,507</u>	<u>6,320,408</u>

Commitments and Contingencies

\$ 12,799,403 \$ 11,956,119

Adventist Health System

The accompanying notes are an integral part of these consolidated financial statements.

ATTACHMENT 37

Consolidated Statements of Operations and Changes in Net Assets

For the years ended
December 31, 2014
and 2013

(dollars in thousands)

	2014	2013
Revenue		
Patient service revenue	\$ 8,470,249	\$ 7,666,256
Provision for bad debts	(428,035)	(426,710)
Net patient service revenue	8,042,214	7,239,546
EHR incentive payments	24,797	38,944
Other	316,369	319,309
Total operating revenue	8,383,380	7,597,799
Expenses		
Employee compensation	4,110,670	3,678,015
Supplies	1,429,344	1,334,264
Purchased services	544,745	487,934
Professional fees	470,320	481,061
Other	664,540	550,272
Interest	137,580	132,154
Depreciation and amortization	461,889	433,720
Total operating expenses	7,819,088	7,097,420
Income from Operations	564,292	500,379
Nonoperating Gains (Losses)		
Investment income	53,136	79,781
Loss on extinguishment of debt	(14,362)	(1,919)
Contribution from business combination	9,349	-
Total nonoperating gains, net	48,123	77,862
Excess of revenue and gains over expenses	612,415	578,241
Less: Noncontrolling interests	381	577
Excess of Revenue and Gains over Expenses Attributable to Controlling Interest	612,796	578,818

Consolidated Statements of Operations and Changes in Net Assets (continued)

For the years ended
December 31, 2014
and 2013

(dollars in thousands)

CONTROLLING INTEREST

Unrestricted Net Assets

	2014	2013
Excess of revenue and gains over expenses	\$ 612,796	\$ 578,818
Change in unrealized gains and losses on investments	65,766	(91,423)
Accumulated derivative losses related to terminated cash flow hedges reclassified into loss on extinguishment of debt	703	1,613
Accumulated derivative losses reclassified into excess of revenue and gains over expenses	10,957	11,352
Net assets released from restrictions for purchase of property and equipment	17,065	22,322
Pension-related changes other than net periodic pension cost	(31,882)	24,137
Other	(4,455)	9,166
Increase in unrestricted net assets	670,950	555,985

Temporarily Restricted Net Assets

Investment income	1,654	2,447
Gifts and grants	26,349	36,411
Net assets released from restrictions for purchase of property and equipment or use in operations	(28,517)	(38,107)
Other	3,751	7,685
Increase in temporarily restricted net assets	3,237	8,436

NONCONTROLLING INTERESTS

Unrestricted Net Assets

Deficiency of revenue and gains over expenses	(381)	(577)
Distributions	(768)	(1,613)
Other	3,061	2,270
Increase in noncontrolling interests	1,912	80

Increase in Net Assets

Net assets, beginning of year	676,099	564,501
Net assets, end of year	6,320,408	5,755,907
	<u>\$ 6,996,507</u>	<u>\$ 6,320,408</u>

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Consolidated Statements of Cash Flows

For the years ended
December 31, 2014
and 2013

(dollars in thousands)

	2014	2013
Operating Activities		
Increase in net assets	\$ 676,099	\$ 564,501
Increase in net assets from business combination	(9,349)	—
Provision for bad debts	428,035	426,710
Depreciation	457,999	429,346
Amortization of intangible assets	3,890	4,374
Amortization of deferred financing costs and original issue discounts and premiums	(2,316)	(2,103)
Loss on extinguishment of debt, excluding reclassification of accumulated derivative loss	13,659	306
Change in unrealized gains and losses on investments	(65,766)	91,423
Restricted gifts and grants and investment income	(28,003)	(38,858)
Income from unconsolidated entities	(58,863)	(28,960)
Distributions from unconsolidated entities	12,221	14,178
Pension-related changes other than net periodic pension cost	31,882	(24,137)
Changes in operating assets and liabilities:		
Patient accounts receivable	(449,640)	(460,437)
Other receivables	(86,656)	(16,982)
Other current assets	9,389	1,882
Accounts payable and accrued liabilities	187,145	69,637
Estimated settlements (from) to third parties	(3,304)	47,861
Other current liabilities	50,618	49,424
Other noncurrent liabilities	151,006	25,483
	<u>1,318,046</u>	<u>1,153,648</u>
Investing Activities		
Purchases of property and equipment, net	(666,843)	(652,363)
Cash acquired in business combination	247	—
Sales and maturities of investments	17,630,801	18,327,357
Purchases of investments	(17,867,480)	(18,773,490)
Due from brokers	95,932	290,647
Due to brokers	(74,138)	(158,486)
Sales, maturities and uses of assets whose use is limited	421,245	407,222
Purchases of and additions to assets whose use is limited	(487,968)	(622,696)
Decrease (increase) in collateral held under securities lending program	20,619	(17,559)
Increase in other assets	(117,157)	(11,147)
	<u>(1,044,742)</u>	<u>(1,210,515)</u>
Financing Activities		
Repayments of long-term borrowings	(504,435)	(152,552)
Additional long-term borrowings	341,780	494,676
Repayments of short-term borrowings	(2,324)	(30,700)
Additional short-term borrowings	—	2,079
Payment of deferred financing costs	(2,597)	(1,805)
(Decrease) increase in payable under securities lending program	(20,619)	17,559
Restricted gifts and grants and investment income	28,003	38,858
	<u>(160,192)</u>	<u>368,115</u>
Increase in Cash and Cash Equivalents	<u>113,112</u>	<u>311,248</u>
Cash and cash equivalents at beginning of year	<u>966,141</u>	<u>654,893</u>
Cash and Cash Equivalents at End of Year	<u>\$ 1,079,253</u>	<u>\$ 966,141</u>

Notes to Consolidated Financial Statements

*For the years ended
December 31, 2014
and 2013
(dollars in thousands)*

1. Significant Accounting Policies

Reporting Entity

Adventist Health System Sunbelt Healthcare Corporation d/b/a Adventist Health System (Healthcare Corporation) is a not-for-profit healthcare corporation that operates and controls hospitals, nursing homes and philanthropic foundations (referred to herein collectively as the System). The affiliated hospitals, nursing homes and philanthropic foundations are operated or controlled through their by-laws, governing board appointments or operating agreements by Healthcare Corporation. The System's 42 hospitals, 16 nursing homes and philanthropic foundations operate in 10 states – Colorado, Florida, Georgia, Illinois, Kansas, Kentucky, North Carolina, Tennessee, Texas and Wisconsin.

Healthcare Corporation and the System are collectively controlled by the Lake Union Conference of Seventh-day Adventists, the Mid-America Union Conference of Seventh-day Adventists, the Southern Union Conference of Seventh-day Adventists and the Southwestern Union Conference of Seventh-day Adventists.

SunSystem Development Corporation (Foundation) is a charitable foundation operated by the System for the benefit of the hospitals that are divisions or controlled affiliates of Healthcare Corporation. The board of directors is appointed by the board of directors of the System. The Foundation is involved in philanthropic activities.

Effective January 1, 2014, the System became the sole member of Hospice of the Comforter, a not-for-profit hospice organization in the Orlando, Florida market, which resulted in an inherent, unrestricted contribution of \$9,349 in the accompanying consolidated statements of operations and changes in net assets.

Mission

The System exists solely to improve and enhance the local communities that it serves in harmony with Christ's healing ministry. All financial resources and excess of revenue and gains over expenses are used to benefit the communities in the areas of patient care, research, education, community service and capital reinvestment.

Specifically, the System provides:

Benefit to the underprivileged, by offering services free of charge or deeply discounted to those who cannot pay, and by supplementing the unreimbursed costs of the government's Medicaid assistance program.

Benefit to the elderly, as provided through governmental Medicare funding, by subsidizing the unreimbursed costs associated with this care.

Benefit to the community's overall health and wellness through the cost of providing clinics and primary care services, health education and screenings, in-kind donations, extended education and research.

Benefit to the faith-based and spiritual needs of the community in accordance with its mission of extending the healing ministry of Christ.

Benefit to the community's infrastructure by investing in capital improvements to ensure the facilities and technology provide the best possible care to the community.

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Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Adventist Health System/Sunbelt, Inc. (Sunbelt), the Foundation and other affiliated organizations that are controlled by Healthcare Corporation. Any subsidiary or other operations owned and controlled by divisions or controlled affiliates of Healthcare Corporation are included in these consolidated financial statements. Investments in entities that Healthcare Corporation does not control are recorded under the equity or cost method of accounting depending on the ability to exert significant influence. Income from unconsolidated entities is included in other operating revenue or as a reduction to supplies expense (note 5) in the accompanying consolidated statements of operations and changes in net assets. All significant intercompany accounts and transactions have been eliminated in consolidation.

Change in Accounting Principle

The System has historically accounted for purchases and sales of investments on a settlement-date basis. During the fourth quarter of 2014, the System changed its policy to account for purchases and sales of investments on a trade-date basis, which is a preferable method as it better reflects the timing of the transfer of risk and economic benefits of the related purchase or sale. As a result of this change, the System reclassified \$247,825 as due to broker and \$378,363 as due from broker, which were previously reported within the investment balance of \$3,514,606 as of December 31, 2013. Due from brokers and due to brokers on the consolidated balance sheets represent securities purchased and sold, but not yet settled.

Use of Estimates

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

Recent Accounting Pronouncements

In April 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-08, *Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity*, which amends the definition of a discontinued operation. The new definition elevates the threshold for a disposal transaction to qualify as a discontinued operation. Additional disclosures about discontinued operations and new disclosures about disposal transactions that do not meet the discontinued-operations criteria will be required. This new guidance is being applied prospectively to all disposals that occur in annual periods beginning on or after December 15, 2014 and interim periods within those years.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which outlines a single comprehensive revenue recognition principles-based model that replaces most of the existing revenue recognition guidance, including industry-specific guidance. ASU 2014-09 is effective for annual periods beginning after December 15, 2016, and can be applied retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of the change recognized at the date of the initial application. The System is currently evaluating the potential effects ASU 2014-09 will have on its consolidated financial statements and disclosures.

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Net Patient Service Revenue, Patient Accounts Receivable and Allowance for Uncollectible Accounts

The System's patient acceptance policy is based on its mission statement and its charitable purposes. Accordingly, the System accepts patients in immediate need of care, regardless of their ability to pay. Patient service revenue is reported at estimated net realizable amounts for services rendered. The System recognizes patient service revenue associated with patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, revenue is recognized on the basis of discounted rates in accordance with the System's policy.

Patient service revenue is reduced by the provision for bad debts and accounts receivable are reduced by an allowance for uncollectible accounts. These amounts are based on management's assessment of historical and expected net collections for each major payor source, considering business and economic conditions, trends in healthcare coverage and other collection indicators. Management regularly reviews collections data by major payor sources in evaluating the sufficiency of the allowance for uncollectible accounts. On the basis of historical experience, a significant portion of the System's self-pay patients will be unable to pay for the services provided. Thus, the System records a significant provision for bad debts in the period services are provided related to self-pay patients. The System's allowance for uncollectible accounts for self-pay patients was 97% of self-pay accounts receivable as of December 31, 2014 and 2013. For receivables associated with patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary. Accounts receivable are written off after collection efforts have been followed in accordance with the System's policies.

For all patients other than charity patients, patient service revenue, net of contractual allowances and self-pay discounts and before the provision for bad debts, recognized from major payor sources is as follows:

	Year Ended December 31	
	2014	2013
Third-party payors, net of contractual allowances	\$8,074,102	\$7,240,083
Self-pay patients, net of discounts	396,147	426,173
	<u>\$8,470,249</u>	<u>\$7,666,256</u>

The System has not experienced significant changes in write-off trends and has not changed its self-pay discount or charity care policy for the years ended December 31, 2014 or 2013.

The System has determined, based on an assessment at the reporting-entity level, that services are provided prior to assessing the patient's ability to pay and as such, the entire provision for bad debts is recorded as a deduction from patient service revenue in the accompanying consolidated statements of operations and changes in net assets.

Third-Party Reimbursement Arrangements

Revenue from the Medicare and Medicaid programs represents approximately 30% and 31% of the System's patient service revenue for the years ended December 31, 2014 and 2013, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is a possibility that recorded estimates will change by a material amount in the near term.

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The System is subject to retroactive revenue adjustments due to future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews and investigations. Adjustments to revenue related to prior periods increased patient service revenue by approximately \$41,300 and \$10,600 for the years ended December 31, 2014 and 2013, respectively.

Charity Care

As discussed previously, the System's patient acceptance policy is based on its mission statement and its charitable purposes and as such, the System accepts patients in immediate need of care, regardless of their ability to pay. Patients that qualify for charity are provided services for which no payment is due for all or a portion of the patient's bill. Therefore, charity care is excluded from patient service revenue and the cost of providing such care is recognized within operating expenses.

The System estimates the direct and indirect costs of providing charity care by applying a cost to gross charges ratio to the gross uncompensated charges associated with providing charity care to patients. The System also receives certain funds to offset or subsidize charity services provided. These funds are primarily received from uncompensated care programs sponsored by various states, whereby healthcare providers within the state pay into an uncompensated care fund and the pooled funds are then redistributed based on state-specific criteria. The cost of providing charity care, amounts paid by the System into uncompensated care funds and amounts received by the System to offset or subsidize charity services are as follows:

	Year Ended December 31	
	2014	2013
Cost of providing charity care	\$ 284,752	\$ 293,770
Funds paid into trusts (included in other expenses)	\$ (125,278)	\$ (128,717)
Funds received to offset or subsidize charity services (included in patient service revenue)	108,230	89,481
	<u>\$ (17,048)</u>	<u>\$ (39,236)</u>

EHR Incentive Payments

The American Recovery and Reinvestment Act of 2009 established incentive payments under Medicare and Medicaid programs for certain providers that meaningfully use certified electronic health record (EHR) technology. The System has been eligible for EHR incentive payments and accounts for them as a gain contingency. Income from incentive payments is recognized as revenue after the System has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period and the cost report period that will be used to determine the final incentive payment has ended. Incentive payments totaling \$24,797 and \$38,944 for the years ended December 31, 2014 and 2013, respectively, are included in total operating revenue in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the System's compliance with the meaningful use criteria is subject to audit by the federal government.

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Excess of Revenue and Gains over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue and gains over expenses, which is analogous to net income of a for-profit enterprise. Changes in unrestricted net assets that are excluded from excess of revenue and gains over expenses, consistent with industry practice, may include changes in unrealized gains and losses on certain investments, certain qualifying derivative activity, pension-related changes other than net periodic pension costs and transfers of restricted net assets used for the purpose of acquiring long-lived assets.

Contributed Resources

Resources restricted by donors for specific operating purposes or a specified time period are held as temporarily restricted net assets until expended for the intended purpose or until the specified time restrictions are met, at which time they are reported as other revenue. Resources restricted by donors for additions to property and equipment are held as temporarily restricted net assets until the assets are placed in service, at which time they are reported as transfers to unrestricted net assets. Gifts, grants and bequests not restricted by donors are reported as other revenue. At December 31, 2014 and 2013, the System had \$177,951 and \$174,414, respectively of temporarily restricted net assets that will become available for various programs and capital expenditures at the System's hospitals when time or purpose restrictions are met.

Cash Equivalents

Cash equivalents represent all highly liquid investments, including certificates of deposit and commercial paper with maturities not in excess of three months when purchased. Interest income on cash equivalents is included in investment income.

Functional Expenses

The System does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the System receives substantially all of its resources from providing healthcare services in a manner similar to a business enterprise, other indicators contained in the accompanying consolidated financial statements are considered important in evaluating how well management has discharged its stewardship responsibilities.

Investments

Investment securities, excluding alternative investments accounted for under the equity method, are recorded at fair value. The cost of securities sold is based on the average cost method. Investment income or loss includes realized gains and losses, interest, dividends and certain unrealized gains and losses. The investment income or loss on investments that are restricted by donor or law is recorded as increases or decreases to temporarily restricted net assets.

Management has designated all fixed-income securities as other-than-trading securities and, accordingly, changes in unrealized gains and losses are included in unrestricted net assets. The System also has an equity investment portfolio, which primarily uses exchange-traded funds and futures contracts in domestic and foreign stock exchanges. Management has designated the securities in this portfolio as trading securities and, accordingly, changes in unrealized gains and losses are included in the excess of revenue and gains over expenses. Certain other equity investments, primarily held by the System's foundations, are designated as other than trading and related changes in unrealized gains and losses are included in unrestricted net assets.

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Alternative Investments – Equity Method

As part of its investment strategy, the System invests in alternative investments (primarily hedge funds) through partnership investment trusts. The partnership investment trusts generally contract with managers who have full discretionary authority over the investment decisions. The System accounts for its ownership interest in these alternative investments under the equity method. Accordingly, the System's share of the hedge funds' income or loss, both realized and unrealized, is recognized as investment income or loss, which is a component of excess of revenue and gains over expenses. Alternative investments accounted for using the equity method totaled \$488,849 and \$447,327 at December 31, 2014 and 2013, respectively, and were classified as investments and assets whose use is limited in the accompanying consolidated balance sheets.

Alternative Investments – Fair Value

The System has a wholly-owned subsidiary, AHS-K2 Alternatives Portfolio, Ltd. (Fund) that invests in alternative investments (primarily hedge funds) through partnership investment trusts. The Fund is managed by an external investment manager (Manager) in accordance with the investment guidelines contained within the limited liability company agreement. The Fund has a multi-strategy approach whereby the underlying funds are generally allocated into one of four strategies as follows:

Relative value. The underlying funds utilize non-directional strategies that seek to capture arbitrage opportunities created by price discrepancies between related equity, debt and derivative financial instruments.

Equity long/short. The underlying funds invest both long and short, primarily in common stock, based on the manager's perception of such securities being under or over valued in the market. Some of the managers may specialize in specific sectors or industries.

Directional. The underlying funds anticipate the direction of market movements by taking a net long or net short position in an array of financial instruments.

Event driven. The underlying funds focus on identifying and analyzing securities that may benefit from the occurrence of specific corporate events.

The Fund follows the Financial Services-Investment Companies Topic of the Accounting Standards Codification (ASC) (ASC 946), which requires that the investments in the underlying funds be recorded at fair value. The fair value of the underlying hedge funds is determined in good faith by the Manager in accordance with GAAP and generally represents the Fund's proportionate share of the net assets of the underlying funds as reported by the managers. Unrealized appreciation and depreciation resulting from valuing the underlying funds is recognized as investment income or loss, which is a component of excess of revenue and gains over expenses.

The Fund follows the Fair Value Measurement Topic of the ASC (ASC 820) for estimating the fair value of the underlying funds that have calculated a net asset value (NAV) per share in accordance with ASC 946. Accordingly, the Fund uses NAV as reported by the managers as a practical expedient to determine the fair value of those underlying funds that do not have a readily determinable fair value and either have the attributes of an investment company or prepare their financial statements consistent with the measurement principles of an investment company. As of

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December 31, 2014 and 2013, the fair value of all underlying funds has been determined using the NAV of the underlying funds.

The Manager uses its best judgment in estimating the fair value of these investments. As there are inherent limitations in any estimation technique, the fair value estimates presented herein are not necessarily indicative of an amount that could be realized in an actual transaction and the differences could be material.

Alternative investments accounted for at fair value totaled \$260,996 and \$248,569 as of December 31, 2014 and 2013, respectively, and were classified as investments and assets whose use is limited in the accompanying consolidated balance sheets.

Lock-up Provisions. At December 31, 2014, certain funds cannot currently be redeemed because the funds include restrictions that do not allow for redemption in the first 12 months after investment. These restrictions are referred to as lock-up provisions. Certain underlying funds may charge a withdrawal fee ranging from 2% to 5% if the Fund liquidates its investment prior to the expiration of the lock-up periods. At December 31, 2014, these underlying funds totaling \$25,226 have lock-up provisions that expire through November 30, 2015. The remaining funds totaling \$235,770 have no such restrictions.

Redemption Terms. Upon the expiration of lock-up provisions, the Fund has the ability to liquidate its investments periodically in accordance with the provisions of the respective agreements with the underlying funds. The underlying funds have either monthly, quarterly or annual redemption terms. Certain funds with quarterly redemption terms allow redemptions of up to 25% of the investment each quarter and as such, a period of 12 months would be required to fully redeem these investments.

Certain agreements may also allow the underlying fund to temporarily suspend redemptions or place other temporary restrictions, such as gate provisions or side pockets. Investments that cannot be fully redeemed within 90 days or less due to lock-up provisions and redemption terms totaled \$50,039 and \$65,033 as of December 31, 2014 and 2013, respectively.

Assets Whose Use is Limited

Certain of the System's investments are limited as to use through board resolution, by provisions of contractual arrangements, under the terms of bond indentures or under the terms of other trust agreements. These investments are classified as assets whose use is limited in the accompanying consolidated balance sheets. Interest and dividend income and realized gains and losses on assets whose use is limited are reported as investment income within nonoperating gains, net, in the accompanying consolidated statements of operations and changes in net assets.

Securities Lending Program

The System participated in securities lending transactions with the custodian of its investments, whereby a portion of its investments were loaned to certain brokerage firms in return for cash or similar debt securities from the brokers as collateral for the investments loaned, usually on a short-term basis. The System ended its participation in the securities lending program in September 2014. The fair value of collateral held for loaned securities as of December 31, 2013 was reported as collateral held under securities lending program, with a corresponding obligation reported for repayment of such collateral upon settlement of the lending transaction.

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Adventist Health System

Derivative Financial Instruments

The System accounts for its derivative financial instruments as required by the Derivative and Hedging Topic of the ASC (ASC 815) and the Health Care Entities Derivative and Hedging Topic of the ASC, which requires that not-for-profit healthcare entities apply the provisions of ASC 815 in the same manner as for-profit enterprises.

Sale of Patient Accounts Receivable

The System and certain of its member affiliates maintain a program for the continuous sale of certain patient accounts receivable to the Highlands County, Florida, Health Facilities Authority (Highlands) on a nonrecourse basis. Highlands has partially financed the purchase of the patient accounts receivable through the issuance of tax-exempt, variable-rate bonds (Bonds). The Bonds are private placement, variable-rate bonds with a mandatory tender in February 2017 and a final maturity in November 2027. As of December 31, 2014 and 2013, Highlands had \$409,225 and \$409,600, respectively, of Bonds outstanding.

As of December 31, 2014 and 2013, the estimated net realizable value, as defined in the underlying agreements, of patient accounts receivable sold by the System and removed from the accompanying consolidated balance sheets was \$780,903 and \$700,128, respectively. The patient accounts receivable sold consist primarily of amounts due from government programs and commercial insurers. The proceeds received from Highlands consist of cash from the Bonds, a note on a subordinated basis with the Bonds and a note on a parity basis with the Bonds. The note on a subordinated basis with the Bonds is in an amount to provide the required over-collateralization of the Bonds and was \$102,306 and \$115,528 at December 31, 2014 and 2013, respectively. The note on a parity basis with the Bonds is the excess of eligible accounts receivable sold over the sum of cash received and the subordinated note and was \$269,372 and \$175,000 at December 31, 2014 and 2013, respectively. These notes are included in other receivables (current) in the accompanying consolidated balance sheets. Due to the nature of the patient accounts receivable sold, collectibility of the subordinated and parity notes is not significantly impacted by credit risk.

Inventories

Inventories (primarily pharmaceuticals and medical supplies) are stated at the lower of cost or market using the first-in, first-out method of valuation.

Property and Equipment

Property and equipment are reported on the basis of cost, except for those assets donated, impaired or acquired under a business combination, which are recorded at fair value. Expenditures that materially increase values, change capacities or extend useful lives are capitalized. Depreciation is computed primarily utilizing the straight-line method over the expected useful lives of the assets. Amortization of capitalized leased assets is included in depreciation expense and allowances for depreciation.

Goodwill

Goodwill represents the excess of the purchase price and related costs over the value assigned to the net tangible and identifiable intangible assets of the businesses acquired. These amounts are included in other assets (noncurrent) in the accompanying consolidated balance sheets and are evaluated annually for impairment or when there is an indicator of impairment.

During 2013, the System performed a quantitative assessment of each reporting unit and as a result, no impairment was recognized. During 2014, management elected to

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perform a qualitative assessment of goodwill and determined that the two-step impairment test under the Intangibles-Goodwill and Other Topic of the ASC was not required. As such, no impairment was recognized in 2014.

Deferred Financing Costs

Direct financing costs are included in other assets (noncurrent) and deferred and amortized over the remaining lives of the financings using the effective interest method.

Interest in the Net Assets of Unconsolidated Foundations

Interest in the net assets of unconsolidated foundations represents contributions received on behalf of the System or its member affiliates by independent fund-raising foundations. As the System cannot influence the foundations to the extent that it can determine the timing and amount of distributions, the System's interest in the net assets of the foundations is included in other assets (noncurrent) and changes in that interest are included in temporarily restricted net assets.

Impairment of Long-Lived Assets

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on discounted net cash flows or other estimates of fair value.

Bond Discounts and Premiums

Bonds payable, including related original issue discounts and/or premiums, are included in long-term debt. Discounts and premiums are being amortized over the life of the bonds using the effective interest method.

Income Taxes

Healthcare Corporation and its affiliated organizations, other than North American Health Services, Inc. and its subsidiary (NAHS), are exempt from state and federal income taxes. Accordingly, Healthcare Corporation and its tax-exempt affiliates are not subject to federal, state or local income taxes except for any net unrelated business taxable income.

NAHS is a wholly owned, for-profit subsidiary of Healthcare Corporation. NAHS and its subsidiary are subject to federal and state income taxes. NAHS files a consolidated federal income tax return and, where appropriate, consolidated state income tax returns. All taxable income was fully offset by net operating loss carryforwards for federal income tax purposes; as such, there is no provision for current federal or state income tax for the years ended December 31, 2014 and 2013.

NAHS also has temporary deductible differences of approximately \$63,600 and \$65,000 at December 31, 2014 and 2013, respectively, primarily as a result of net operating loss carryforwards. At December 31, 2014, NAHS had net operating loss carryforwards of approximately \$63,400, expiring beginning in 2020 through 2026. Deferred taxes have been provided for these amounts, resulting in a net deferred tax asset of approximately \$24,200 and \$24,700 at December 31, 2014 and 2013, respectively. A full valuation allowance has been provided at December 31, 2014 and 2013 to offset the deferred tax asset since Healthcare Corporation has determined that it is more likely than not that the benefit of the net operating loss carryforwards will not be realized in future years.

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The Income Taxes Topic of the ASC (ASC 740) prescribes the accounting for uncertainty in income tax positions recognized in financial statements. ASC 740 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken, or expected to be taken, in a tax return. There were no material uncertain tax positions as of December 31, 2014 and 2013.

Reclassifications

Certain reclassifications were made to the 2013 consolidated financial statements to conform to the classifications used in 2014. These reclassifications had no impact on the consolidated excess of revenue and gains over expenses, changes in net assets or cash flows previously reported.

2. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are comprised of the following:

	December 31	
	2014	2013
Other-than-trading portfolio		
Fixed-income instruments:		
U.S. government agencies and sponsored entities	\$ 2,037,493	\$ 2,573,330
Corporate bonds	247,109	213,476
Mortgage backed	426,427	245,717
Other asset backed	70,740	76,415
Short-term investments	67,777	—
Accrued interest	10,800	15,517
	<u>2,860,346</u>	<u>3,124,455</u>
Equity instruments:		
Domestic	19,760	12,147
Foreign	6,129	1,810
	<u>25,889</u>	<u>13,957</u>
Trading portfolio		
Domestic equity index securities	326,044	48,784
Foreign equity index securities	261,219	1,343
	<u>587,263</u>	<u>50,127</u>
Alternative investments – fair value		
Multi-strategy hedge funds	260,996	248,569
Alternative investments – equity method	488,849	447,327
Cash and cash equivalents – assets whose use is limited	<u>371,056</u>	<u>345,331</u>
	4,594,399	4,229,766
Less: assets whose use is limited	<u>(907,941)</u>	<u>(845,698)</u>
Investments	<u>\$ 3,686,458</u>	<u>\$ 3,384,068</u>

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Assets whose use is limited include investments held by bond trustees to fund capital expenditures and debt service, investments held under other trust agreements and investments designated by boards for employee retirement plans and capital expenditures. Amounts to be used for the payment of current liabilities are classified as current assets.

Indenture requirements of tax-exempt financings by the System provide for the establishment and maintenance of various accounts with trustees. These arrangements require the trustee to control the expenditure of debt proceeds, as well as the payment of interest and the repayment of debt to bondholders. Medical malpractice trust funds are set aside to provide funds for settling estimated medical malpractice claims.

A summary of the major limitations as to the use of assets whose use is limited consists of the following:

	December 31	
	2014	2013
Investments held by bond trustees:		
Construction funds	\$ 232,671	\$ 178,876
Required bond funds	9,814	8,938
	<u>242,485</u>	<u>187,814</u>
Malpractice trust funds	412,573	403,716
Employee benefits funds	164,542	161,847
Board-designated funds for capital expenditures	—	18,408
Other	88,341	73,913
	<u>907,941</u>	<u>845,698</u>
Less: amounts to pay current liabilities	<u>(259,166)</u>	<u>(240,087)</u>
	<u>\$ 648,775</u>	<u>\$ 605,611</u>

Investment Income and Unrealized Gains and Losses

Investment income from cash and cash equivalents, investments and assets whose use is limited amounted to \$53,136 and \$79,781 for the years ended December 31, 2014 and 2013, respectively, and consisted of the following:

	Year Ended December 31	
	2014	2013
Interest and dividend income	\$ 42,203	\$ 43,663
Net realized and unrealized (losses) gains	(245)	26,834
The System's share of income from alternative investments – equity method	11,178	9,284
	<u>\$ 53,136</u>	<u>\$ 79,781</u>

Changes in unrealized gains and losses that are included as an increase to (reduction of) unrestricted net assets in the accompanying consolidated statements of operations and changes in net assets totaled \$65,766 and \$(91,423) for 2014 and 2013, respectively.

At December 31, 2014 and 2013, the total fair value of investments and assets whose use is limited, excluding alternative investments, amounted to \$3,833,754 and \$3,518,353, respectively. The net unrealized losses associated with these holdings were \$1,135 at December 31, 2014, which is comprised of gross unrealized gains of

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\$32,930 and gross unrealized losses of \$34,065. The net unrealized losses associated with these holdings were \$68,744 at December 31, 2013, which is comprised of gross unrealized gains of \$20,663 and gross unrealized losses of \$89,407.

The following tables summarize the unrealized losses on investments and assets whose use is limited:

December 31, 2014				
Unrealized Losses				Fair Value of Loss Holdings
Greater than 12 Months	Less than 12 Months	Total		
Fixed-income instruments				
U.S. government agencies and sponsored entities	\$ 17,369	\$ 8,326	\$ 25,695	\$ 874,200
Corporate bonds	258	487	745	108,959
Mortgage backed	5,086	1,598	6,684	270,297
Other asset backed	—	31	31	25,463
	22,713	10,442	33,155	1,278,919
Equity instruments				
Domestic	353	407	760	3,725
Foreign	4	146	150	1,524
	357	553	910	5,249
	\$ 23,070	\$ 10,995	\$ 34,065	\$1,284,168

December 31, 2013				
Unrealized Losses				Fair Value of Loss Holdings
Greater than 12 Months	Less than 12 Months	Total		
Fixed-income instruments				
U.S. government agencies and sponsored entities	\$ 17,788	\$ 64,235	\$ 82,023	\$1,870,118
Corporate bonds	404	1,349	1,753	106,118
Mortgage backed	1,473	3,940	5,413	180,560
Other asset backed	—	29	29	9,188
	19,665	69,553	89,218	2,165,984
Equity instruments				
Domestic	138	47	185	2,275
Foreign	3	1	4	80
	141	48	189	2,355
	\$ 19,806	\$ 69,601	\$ 89,407	\$2,168,339

Management has evaluated the investments with unrealized losses and has concluded that none of the above losses should be considered other than temporary as of December 31, 2014 and 2013. Management does not intend to sell the investments and it is not more likely than not that the System will be required to sell the investments before recovery of their amortized cost. Factors considered in this evaluation included credit rating information, discussions with external advisors and duration of the investments.

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3. Unrestricted Cash and Investments

The System's unrestricted cash and cash equivalents, investments and board-designated funds for capital expenditures consist of the following:

	December 31	
	2014	2013
Cash and cash equivalents	\$ 1,079,253	\$ 966,141
Investments	3,686,458	3,384,068
Due from brokers, net	108,744	130,538
Board-designated funds for capital expenditures	—	18,408
	<u>\$ 4,874,455</u>	<u>\$ 4,499,155</u>
Days cash and investments on hand	<u>242</u>	<u>245</u>

Days cash and investments on hand is calculated as unrestricted cash and cash equivalents, investments, due from brokers, net and certain board-designated funds divided by daily operating expenses (excluding depreciation and amortization). The annualized operating expenses of a newly constructed facility are included in the 2013 calculation.

4. Property and Equipment

Property and equipment consists of the following:

	December 31	
	2014	2013
Land and improvements	\$ 693,442	\$ 654,033
Buildings and improvements	4,429,582	4,196,324
Equipment	3,927,768	3,619,591
	<u>9,050,792</u>	<u>8,469,948</u>
Less allowances for depreciation	<u>(4,215,983)</u>	<u>(3,897,246)</u>
	4,834,809	4,572,702
Construction in progress	258,058	300,109
	<u>\$ 5,092,867</u>	<u>\$ 4,872,811</u>

Certain hospitals have entered into construction contracts or other commitments for which costs have been incurred and included in construction in progress. These and other committed projects will be financed through operations and existing construction funds held by trustees (note 2). The estimated costs to complete these projects approximated \$174,100 at December 31, 2014.

During periods of construction, interest costs are capitalized to the respective property accounts. Interest capitalized approximated \$7,700 and \$6,700 for the years ended December 31, 2014 and 2013, respectively.

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The System capitalizes the cost of acquired software for internal use. Any internal costs incurred in the process of developing and implementing software are expensed or capitalized depending primarily on whether they are incurred in the preliminary project stage, application development stage or post-implementation stage. Capitalized software costs and estimated amortization expense in the table below exclude software in progress of approximately \$5,800 and \$43,000 at December 31, 2014 and 2013, respectively. Capitalized software costs and accumulated amortization expense, which are included in property and equipment on the accompanying consolidated balance sheets, are as follows:

	December 31	
	2014	2013
Capitalized software costs	\$ 286,525	\$ 203,110
Less: accumulated amortization	(141,957)	(134,006)
Capitalized software costs, net	<u>\$ 144,568</u>	<u>\$ 69,104</u>

Estimated amortization expense related to capitalized software costs for the next five years and thereafter is as follows:

2015	\$ 15,568
2016	13,340
2017	11,513
2018	9,803
2019	9,377
Thereafter	84,967

5. Other Assets

Other assets consist of the following:

	December 31	
	2014	2013
Goodwill	\$ 171,966	\$ 171,078
Deferred financing costs	19,828	21,620
Notes and other receivables	147,667	69,802
Interests in net assets of unconsolidated foundations	68,534	63,429
Investments in unconsolidated entities	180,818	122,115
Other noncurrent assets	87,811	70,394
	<u>\$ 676,624</u>	<u>\$ 518,438</u>

The System's ownership interest and carrying amounts of investments in unconsolidated entities consist of the following:

	Ownership Interest	December 31	
		2014	2013
Texas Health Huguley, Inc.	49%	\$ 60,329	\$ 49,290
Centura Health Corporation	35%	45,750	37,867
Premier Healthcare Alliance, LP	3%	40,311	6,411
Other	5% - 50%	34,428	28,547
		<u>\$ 180,818</u>	<u>\$ 122,115</u>

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Income from unconsolidated entities of \$31,321 and \$28,960 for 2014 and 2013, respectively, is included in other operating revenue in the accompanying consolidated statements of operations and changes in net assets.

The System holds membership units in Premier Healthcare Alliance, LP (Premier LP), which is a group purchasing organization (GPO). In 2013, the general partner, Premier, Inc., restructured from a privately held to a publicly traded company in an initial public offering. In connection with the restructuring, the System's membership units in Premier LP have vesting rights over a seven-year period and upon vesting become eligible for exchange into the common stock of Premier, Inc. The increase in estimated value of the membership units as they vest is considered a vendor incentive under GAAP, which increases the System's investment in Premier LP and reduces supplies expense over the vesting period. The System recognized a vendor incentive for the stock vesting of \$18,450 for the year ended December 31, 2014. Additionally, under a right of first refusal among the limited partners, the System was able to purchase additional membership units in Premier LP for \$8,544 during the year ended December 31, 2014. This purchase did not significantly increase the System's ownership percentage in Premier LP.

6. Long-Term Debt

Long-term debt consists of the following:

	December 31	
	2014	2013
Fixed-rate hospital revenue bonds, interest rates from 1.06% to 7.25%, payable through 2039	\$ 2,944,067	\$ 3,095,305
Variable-rate hospital revenue bonds, payable through 2035	285,010	300,410
Capitalized leases payable	30,826	34,317
Other indebtedness	1,333	1,361
Unamortized original issue premium, net	44,465	44,688
	<u>3,305,701</u>	<u>3,476,081</u>
Less current maturities	<u>(126,067)</u>	<u>(75,882)</u>
	<u>\$ 3,179,634</u>	<u>\$ 3,400,199</u>

Master Trust Indenture

Long-term debt has been issued primarily on a tax-exempt basis. Substantially all bonds are secured under a Master Trust Indenture (MTI), which provides for, among other things, the deposit of revenue with the master trustee in the event of certain defaults, pledges of accounts receivable, pledges not to encumber property and limitations on additional borrowings. In addition, the MTI requires certain covenants and reporting requirements to be met by the System.

Variable-Rate Bonds and Sources of Liquidity

Certain variable-rate bonds may be put to the System at the option of the bondholder. The variable-rate bond indentures generally provide the System the option to remarket the obligations at the then prevailing market rates for periods ranging from one day to the maturity dates. The obligations have been primarily marketed for seven-day periods during 2014, with annual interest rates ranging from 0.01% to 0.20%. Additionally, the System paid fees, such as remarketing fees, on variable-rate bonds during 2014.

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The System has various sources of liquidity, including a revolving credit agreement (Revolving Note) with a syndicate of banks (Syndicate) and a commercial paper program (CP Program). In the event any variable-rate bonds are put and not remarketed, the Revolving Note is available for liquidity and the System's obligation to the banks would be payable in accordance with the variable-rate bond's original maturities with the remaining amounts due upon expiration of the Revolving Note. The Revolving Note is also available for letters of credit, liquidity facilities and general corporate needs, including working capital, capital expenditures and acquisitions and has certain prime rate and LIBOR-based pricing options. During 2014, the System reduced the Revolving Note from an aggregate amount of \$1,000,000 to \$500,000 and extended the maturity date from November 2015 to December 2019. No amounts were outstanding under the Revolving Note as of December 31, 2014 and 2013, respectively.

The System implemented the CP Program in September 2014, which allows for up to \$500,000 of taxable, commercial paper notes to be issued for general corporate purposes at an interest rate to be determined at the time of issuance. As of December 31, 2014, no amounts were outstanding on the commercial paper program. During the year ended December 31, 2014, \$25,000 of notes were issued and repaid under the CP Program.

2014 Debt Transactions

In July 2014, the System issued fixed-rate bonds at par with amounts totaling \$190,000, maturity dates ranging from 2028 to 2029 and interest rates ranging from 2.34% to 2.59%. The System also issued fixed-rate bonds at a premium with par amounts totaling \$75,000, maturity dates ranging from 2024 to 2039, stated interest rates ranging from 4.00% to 5.00% and effective interest rates ranging from 2.76% to 4.07%. With the proceeds, the System financed or refinanced certain costs of the acquisition, construction and equipping of certain facilities.

During 2014, the System prepaid approximately \$114,000 of existing fixed-rate bonds prior to their stated maturity. In addition to certain fees and accrued interest, the System recognized a loss on extinguishment of debt of \$7,310 related to these prepayments. In December 2014, the System deposited approximately \$220,000 into an irrevocable trust for the advanced repayment of approximately \$210,000 of existing fixed-rate bonds (Defeasance). In accordance with GAAP, these bonds, along with the related trust assets, are excluded from the System's accompanying consolidated balance sheet as of December 31, 2014. The System recognized a loss of \$7,052 related to the Defeasance, which is included in loss on extinguishment of debt in the accompanying consolidated statement of operations and changes in net assets.

2013 Debt Transactions

During 2013, the System issued fixed-rate bonds with par amounts totaling \$485,000 and maturity dates ranging from 2025 to 2032. The interest rates range from 2.36% to 3.72% through 2029. Beginning in 2030, the interest rate for the remaining balance of \$73,350 increases to 7.25% through the maturity date in 2032. With the proceeds, the System financed or refinanced certain costs of the acquisition, construction, renovations and equipping of certain facilities.

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Debt Maturities

The following represents the maturities of long-term debt for the next five years and thereafter:

2015	\$ 126,067
2016	101,990
2017	111,068
2018	124,441
2019	94,078
Thereafter	2,703,592

Cash paid for interest, net of amounts capitalized, approximated \$131,000 and \$121,000 during the years ended December 31, 2014 and 2013, respectively.

7. Derivative Financial Instruments

Derivatives Designated as Hedging Instruments

Prior to 2012, the System had interest rate swaps associated with its fixed-rate and variable-rate borrowings that were designated and qualified as cash flow hedges for accounting purposes. In connection with an overall debt restructuring plan during 2012, the System terminated and cash settled all of its interest rate swap agreements. The effective portion of the net derivative losses is reported as a component of unrestricted net assets and reclassified into earnings in the same line item (interest expense) associated with the forecasted transaction and in the same time periods during which the original cash flow hedge affects excess of revenue and gains over expenses.

The changes in the accumulated net derivative losses included in unrestricted net assets associated with the System's terminated cash flow hedges are as follows:

	Year Ended December 31	
	2014	2013
Accumulated net derivative losses included in unrestricted net assets at beginning of year	\$ (39,992)	\$ (52,957)
Net reclassifications into excess of revenue and gains over expenses	11,660	12,965
Accumulated net derivative losses included in unrestricted net assets at end of year	\$ (28,332)	\$ (39,992)

The System expects that the amount of net losses existing in unrestricted net assets to be reclassified into excess of revenue and gains over expenses within the next 12 months will be approximately \$10,700. None of the System's outstanding variable-rate debt had its interest payments designated as a hedged forecasted transaction at December 31, 2014 or 2013.

Investment Derivatives

In the execution of the System's investment strategies, various exchange-traded derivative instruments may be entered into for trading purposes, including futures and options contracts. These instruments are used to gain broad market exposure, to gain additional exposure to certain equity markets and to generate investment returns. As of December 31, 2014, the total notional amount of commodity futures held in a short and long position was \$763 and \$763, respectively. As of December 31, 2013, the total notional amount of equity futures held in a short and long position was \$0 and \$9,206, respectively.

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Additionally, domestic interest-rate futures contracts are used to adjust the fixed-income portfolio duration. As of December 31, 2014, the total notional amount of domestic interest-rate futures held in a short and long position was approximately \$242,000 and \$0, respectively. As of December 31, 2013, the total notional amount of domestic interest-rate futures held in a short and long position was \$113,142 and \$369, respectively.

These derivative instruments are not designated as hedging instruments under ASC 815 (non-qualifying hedges). As such, both the realized and unrealized gains and losses are included in investment income in the period that they occur. The System's investment derivatives are traded on established exchanges that offer high liquidity, transparent pricing, daily cash settlement and collateralization through margin requirements. The System posted collateral totaling \$9,208 and \$1,402 as of December 31, 2014 and 2013, respectively. Collateral is included in cash and cash equivalents in the accompanying consolidated balance sheets.

8. Retirement Plans

Defined Contribution Plans

The System participates with other Seventh-day Adventist healthcare entities in a defined contribution retirement plan (Plan) that covers substantially all full-time employees who are at least 18 years of age. The Plan is exempt from the Employee Retirement Income Security Act of 1974 (ERISA). The Plan provides, among other things, that the employer contribute 2.6% of wages, plus additional amounts for very highly paid employees. Additionally, the Plan provides that the employer match 50% of an employee's contributions up to 4% of the contributing employee's wages, resulting in a maximum available match of 2% of the contributing employee's wages each year.

Contributions for the Plan are included in employee compensation in the accompanying consolidated statements of operations and changes in net assets in the amount of \$95,995 and \$89,503 for the years ended December 31, 2014 and 2013, respectively.

Defined Benefit Plan – Multiemployer Plan

Prior to January 1, 1992, certain of the System's entities participated in a multiemployer, noncontributory, defined benefit retirement plan, the Seventh-day Adventist Hospital Retirement Plan Trust (Old Plan) administered by the General Conference of Seventh-day Adventists that is exempt from ERISA. The risks of participating in multiemployer plans are different from single-employer plans in the following aspects:

Assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers.

If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.

If an entity chooses to stop participating in the multiemployer plan, it may be required to pay the plan an amount based on the underfunded status of the plan, referred to as withdrawal liability.

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During 1992, the Old Plan was suspended and the Plan was established. The System, along with the other participants in the Old Plan, may be required to make future contributions to the Old Plan to fund any difference between the present value of the Old Plan benefits and the fair value of the Old Plan assets. Future funding amounts and the funding time periods have not been determined by the Old Plan administrators; however, management believes the impact of any such future decisions will not have a material adverse effect on the System's consolidated financial statements.

The plan assets and benefit obligation data for the Old Plan as of December 31, 2013 is as follows:

Total plan assets	\$ 867,091
Actuarial present value of accumulated plan benefits	789,498
Funded status	109.8%

The System did not make contributions to the Old Plan for the years ended December 31, 2014 or 2013.

Defined Benefit Plan – Frozen Pension Plans

Certain of the System's entities sponsored noncontributory, defined benefit pension plans (Pension Plans) that have been frozen such that no new benefits accrue. The following table sets forth the remaining combined projected and accumulated benefit obligations and the assets of the Pension Plans at December 31, 2014 and 2013, the components of net periodic benefit costs for the years then ended and a reconciliation of the amounts recognized in the accompanying consolidated financial statements:

	Year Ended December 31	
	2014	2013
Accumulated benefit obligation, end of year	<u>\$ 177,145</u>	<u>\$ 176,979</u>
Change in projected benefit obligation:		
Projected benefit obligation, beginning of year	\$ 176,979	\$ 199,672
Interest cost	8,535	8,183
Benefits paid	(6,683)	(6,105)
Actuarial losses (gains)	33,352	(24,771)
Settlements	(35,038)	—
Projected benefit obligation, end of year	<u>177,145</u>	<u>176,979</u>
Change in plan assets:		
Fair value of plan assets, beginning of year	154,965	150,164
Actual return on plan assets	4,487	7,406
Employer contributions	7,900	3,500
Benefits paid	(6,683)	(6,105)
Settlements	(35,038)	—
Fair value of plan assets, end of year	<u>125,631</u>	<u>154,965</u>
Deficiency of fair value of plan assets over projected benefit obligation, included in other noncurrent liabilities	<u>\$ (51,514)</u>	<u>\$ (22,014)</u>

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No plan assets are expected to be returned to the System during the fiscal year ending December 31, 2014.

Included in unrestricted net assets at December 31, 2014 and 2013 are unrecognized actuarial losses (gains) of \$29,143 and \$(2,739), respectively, which have not yet been recognized in net periodic pension expense. Net actuarial losses increased during 2014 primarily resulting from a decrease in the weighted-average discount rate from 5.06% as of December 31, 2013 to 4.12% as of December 31, 2014 and the use of updated mortality assumptions during 2014, which increased the projected benefit obligation. None of the actuarial losses included in unrestricted net assets are expected to be recognized in net periodic pension cost during the year ending December 31, 2015.

Changes in plan assets and benefit obligations recognized in unrestricted net assets include:

	Year Ended December 31	
	2014	2013
Net actuarial losses (gains)	\$ 36,879	\$ (24,081)
Settlement loss	(4,959)	-
Amortization of net actuarial losses	(38)	(56)
Total decrease (increase) recognized in unrestricted net assets	<u>\$ 31,882</u>	<u>\$ (24,137)</u>

The components of net periodic pension cost were as follows:

	Year Ended December 31	
	2014	2013
Interest cost	\$ 8,535	\$ 8,183
Expected return on plan assets	(8,014)	(8,096)
Settlement loss	4,959	-
Recognized net actuarial losses	38	56
Net periodic pension cost	<u>\$ 5,518</u>	<u>\$ 143</u>

The assumptions used to determine the benefit obligation and net periodic pension cost for the Pension Plans are set forth below:

	Year Ended December 31	
	2014	2013
Used to determine projected benefit obligation		
Weighted-average discount rate	4.12%	5.06%
Used to determine pension cost		
Weighted-average discount rate	4.93%	4.16%
Weighted-average expected long-term rate of return on plan assets	5.50%	5.50%

The Pension Plans' assets are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. The Pension Plans' assets are managed solely in the interest of the participants and

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their beneficiaries. Diversification is achieved by allocating funds to various asset classes and investment styles and by retaining multiple investment managers with complementary styles, philosophies and approaches.

The expected long-term rate of return on the Pension Plans' assets is based on historical and projected rates of return for current and planned asset categories and the target allocation in the investment portfolio. The target investment allocation during 2014 for the Pension Plans was 40% fixed-income and 60% equity securities. In 2013, this allocation was 50% fixed-income and 50% equity securities. As of December 31, 2014, the Pension Plans' assets were in the process of being reallocated among asset classes and as a result, had more cash holdings than usual.

The following table presents the Pension Plans' financial instruments as of December 31, 2014, measured at fair value on a recurring basis by the valuation hierarchy defined in note 11.

	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 71,974	\$ 71,974	\$ —	\$ —
Debt securities				
U.S. government agencies and sponsored entities	16,376	2,807	13,569	—
Corporate bonds	22,564	—	22,564	—
Mortgage backed	2,468	—	2,468	—
Other asset backed	2,620	—	2,620	—
Equity securities				
Domestic equities	5,837	4,981	856	—
Foreign equities	3,792	3,792	—	—
Total plan assets	<u>\$ 125,631</u>	<u>\$ 83,554</u>	<u>\$ 42,077</u>	<u>\$ —</u>

The following table presents the Pension Plans' financial instruments as of December 31, 2013, measured at fair value on a recurring basis by the valuation hierarchy defined in note 11.

	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 7,612	\$ 7,612	\$ —	\$ —
Debt securities				
U.S. government agencies and sponsored entities	19,938	1,919	18,019	—
Corporate bonds	45,165	—	45,165	—
Mortgage backed	2,772	—	2,772	—
Other asset backed	11,120	—	11,120	—
Equity securities				
Domestic equities	7,605	7,605	—	—
Foreign equities	4,308	4,308	—	—
Alternative investments				
Multi-strategy hedge funds	56,445	—	47,177	9,268
Total plan assets	<u>\$ 154,965</u>	<u>\$ 21,444</u>	<u>\$ 124,253</u>	<u>\$ 9,268</u>

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Fair value methodologies for Levels 1, 2 and 3 are consistent with the inputs described in note 11.

The changes in financial assets classified as Level 3 during the years ended December 31, 2014 and 2013 related to alternative investments and were as follows:

	December 31	
	2014	2013
Beginning balance	\$ 9,268	\$ 10,588
Gross purchases	—	1,440
Gross sales	(1,657)	(2,595)
Transfers out	(8,461)	—
Realized gains	23	113
Realized losses	—	(103)
Unrealized gains	827	180
Unrealized losses	—	(355)
Ending balance	<u>\$ —</u>	<u>\$ 9,268</u>

The following represents the expected benefit plan payments for the next five years and the five years thereafter:

Year ending December 31:	
2015	\$ 6,930
2016	7,149
2017	7,386
2018	7,784
2019	8,168
2020-2024	46,359

9. Medical Malpractice

The System established a self-insured revocable trust (Trust) that covers the System's subsidiaries and their respective employees for claims within a specified level (Self-Insured Retention). Claims above the Self-Insured Retention are insured by claims-made coverage that is placed with Adhealth Limited (Adhealth), a Bermuda company. Adhealth has purchased reinsurance through commercial insurers for the excess limits of coverage. A Self-Insured Retention of \$2,000 was established for the year ended December 31, 2001. The Self-Insured Retention was increased to \$7,500 and \$15,000 effective January 1, 2002 and 2003, respectively, and has remained at \$15,000 through December 31, 2014.

The Trust funds are recorded in the accompanying consolidated balance sheets as assets whose use is limited in the amount of \$412,573 and \$403,716 at December 31, 2014 and 2013, respectively. The related accrued malpractice claims are recorded in the accompanying consolidated balance sheets as other current liabilities in the amount of \$85,905 and \$83,125 and as other noncurrent liabilities in the amount of \$295,083 and \$292,540 at December 31, 2014 and 2013, respectively. The related estimated insurance recoveries are recorded as other assets in the amount of \$12,720 and \$11,251 in the accompanying consolidated balance sheets at December 31, 2014 and 2013, respectively.

Management, with the assistance of consulting actuaries, estimated claim liabilities at the present value of future claim payments using a discount rate of 3.75% at December 31, 2014 and 2013.

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10. Commitments and Contingencies

Operating Leases

The System leases certain property and equipment under operating leases. Lease and rental expense was approximately \$110,200 and \$97,600 for the years ended December 31, 2014 and 2013, respectively, and is included in other expenses in the accompanying consolidated statements of operations and changes in net assets.

The following represents the net future minimum lease payments under noncancelable operating leases for the next five years and thereafter:

Year ending December 31:	
2015	\$ 44,488
2016	40,158
2017	30,111
2018	17,696
2019	11,168
Thereafter	20,627

Compliance with Laws and Regulations

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Compliance with such laws and regulations can be subject to future review and interpretation, as well as regulatory actions unknown or unasserted at this time. Management assesses the probable outcome of unresolved litigation and investigations and records contingent liabilities reflecting estimated liability exposure.

As a part of its compliance activities, the System determined that relationships with certain physicians were not in full technical compliance with the Stark Law and elected to make voluntary self-disclosures to the federal government in 2013. The System is engaged in discussions and is fully cooperating with the Department of Justice on this matter. Based on information available to date, management believes that the System has adequately provided for the most likely outcome of the self-disclosure. However, as more information becomes known, it is possible that the estimate could change. As such, assurance cannot be given that the resolution of these matters will not affect the financial condition or operations of the System, taken as a whole.

The System is involved in litigation regarding certain related professional liability claims. Based on the information available to date, management believes that the System has adequately provided for the most likely outcome of this professional liability matter after considering applicable insurance coverage. However, as more information becomes known, it is possible that the estimate could change. As such, assurance cannot be given that the resolution of these matters will not affect the consolidated financial condition or operations of the System taken as a whole.

In addition, certain of the System's affiliated organizations are involved in litigation and other regulatory investigations arising in the ordinary course of business. In the opinion of management, after consultation with legal counsel, these matters will be resolved without material adverse effect to the System's consolidated financial statements, taken as a whole.

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11. Fair Value Measurements

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value, on a recurring basis, into a three-tier fair value hierarchy. Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement, which should be determined based on assumptions that would be made by market participants. The three-tier hierarchy prioritizes the inputs used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement). Level inputs are defined as follows.

Level 1 – based on unadjusted quoted prices for identical assets or liabilities in an active market that the System has the ability to access.

Level 2 – based on pricing inputs that are either directly observable or that can be derived or supported from observable data as of the reporting date. Level 2 inputs may include quoted prices for similar assets or liabilities in nonactive markets or pricing models whose inputs are observable for substantially the full term of the asset or liability.

Level 3 – based on prices or valuation techniques that require inputs that are both significant to the fair value of the financial asset or liability and are generally less observable from objective sources. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

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Recurring Fair Value Measurements

The fair value of financial assets measured at fair value on a recurring basis at December 31, 2014 was as follows:

	Total	Level 1	Level 2	Level 3
ASSETS				
<i>CASH AND CASH EQUIVALENTS</i>	\$ 1,079,253	\$1,078,646	\$ 607	\$ —
<i>INVESTMENTS AND ASSETS WHOSE USE IS LIMITED</i>				
Cash and cash equivalents	371,056	371,056	—	—
Debt securities				
U.S. government agencies and sponsored entities	2,037,493	—	2,037,493	—
Corporate bonds	247,109	—	247,109	—
Mortgage backed	426,427	—	426,427	—
Other asset backed	70,740	—	70,740	—
Short-term investments	67,777	—	67,777	—
Equity securities				
Domestic equities	19,760	19,760	—	—
Foreign equities	6,129	6,129	—	—
Domestic equity index securities	326,044	326,044	—	—
Foreign equity index securities	261,219	261,219	—	—
Alternative investments				
Multi-strategy hedge funds	260,996	—	210,957	50,039
	<u>4,094,750</u>	<u>984,208</u>	<u>3,060,503</u>	<u>50,039</u>
Total assets at fair value	<u>\$ 5,174,003</u>	<u>\$2,062,854</u>	<u>\$3,061,110</u>	<u>\$ 50,039</u>

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The fair value of financial assets measured at fair value on a recurring basis at December 31, 2013 was as follows:

	Total	Level 1	Level 2	Level 3
ASSETS				
<i>CASH AND CASH EQUIVALENTS</i>	\$ 966,141	\$ 935,335	\$ 30,806	\$ —
<i>INVESTMENTS AND ASSETS WHOSE USE IS LIMITED</i>				
Cash and cash equivalents	345,331	345,331	—	—
Debt securities				
U.S. government agencies and sponsored entities	2,573,330	10,645	2,562,685	—
Corporate bonds	213,476	—	213,476	—
Mortgage backed	245,717	—	245,717	—
Other asset backed	76,415	—	76,415	—
Equity securities				
Domestic equities	12,147	12,147	—	—
Foreign equities	1,810	1,810	—	—
Domestic equity index securities	48,784	48,784	—	—
Foreign equity index securities	1,343	1,343	—	—
Alternative investments				
Multi-strategy hedge funds	248,569	—	183,536	65,033
	3,766,922	420,060	3,281,829	65,033
Collateral held under securities lending program	20,619	—	20,619	—
Total assets at fair value	\$ 4,753,682	\$ 1,355,395	\$ 3,333,254	\$ 65,033

The changes in financial assets classified as Level 3 during the years ended December 31, 2014 and 2013 related to alternative investments and were as follows:

	December 31	
	2014	2013
Beginning balance	\$ 65,033	\$ 70,299
Gross purchases	—	10,500
Gross sales	(11,474)	(18,405)
Transfers out	(12,453)	—
Realized gains	3,207	796
Realized losses	(2)	(400)
Unrealized gains	5,728	3,051
Unrealized losses	—	(808)
Ending balance	<u>\$ 50,039</u>	<u>\$ 65,033</u>

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Notes to Consolidated Financial Statements

For the years ended
December 31, 2014
and 2013
(dollars in thousands)

Transfers between levels are determined as of the beginning of the period, which assumes the investment would be transferred at fair value at the beginning of the reporting period. Transfers from Level 3 to Level 2 occurred as a result of liquidity restrictions expiring during the period.

The following tables represent a reconciliation of financial instruments at fair value to the accompanying consolidated balance sheets as follows:

	December 31	
	2014	2013
Investments and assets whose use is limited measured at fair value	\$ 4,094,750	\$ 3,766,922
Alternative investments accounted for under the equity method	488,849	447,327
Accrued interest	10,800	15,517
Total	<u>\$ 4,594,399</u>	<u>\$ 4,229,766</u>
Investments	\$ 3,686,458	\$ 3,384,068
Assets whose use is limited:		
Current	259,166	240,087
Noncurrent	648,775	605,611
Total	<u>\$ 4,594,399</u>	<u>\$ 4,229,766</u>

The fair values of the securities included in Level 1 were determined through quoted market prices. The fair values of Levels 2 and 3 financial assets were determined as follows:

Cash equivalents, U.S. government agencies and sponsored entities, corporate bonds, mortgage backed, other asset backed and short-term investments – These Level 2 securities were valued through the use of third-party pricing services that use evaluated bid prices adjusted for specific bond characteristics and market sentiment.

Alternative investments – These underlying funds are valued using the NAV as a practical expedient to determine fair value. Several factors are considered in appropriately classifying the underlying funds in the fair value hierarchy. An underlying fund is generally classified as Level 2 if the System has the ability to withdraw its investment with the underlying fund at NAV at the measurement date or within the near term. An underlying fund is generally classified as Level 3 if the System does not have the ability to redeem its investment with the underlying fund at NAV within the near term.

Collateral held under securities lending program – The System participated in securities lending transactions with the custodian of its investments during 2013 and ended its participation in 2014. Any cash collateral was invested by the System in a securities lending quality trust (SLQT), the fair value of which was determined by considering its NAV and actual issuances and redemptions of interests in the SLQT.

Notes to Consolidated Financial Statements

*For the years ended
December 31, 2014
and 2013
(dollars in thousands)*

Other Fair Value Disclosures

The carrying values of accounts receivable, accounts payable, accrued liabilities and payable under the securities lending program are reasonable estimates of their fair values due to the short-term nature of these financial instruments.

The fair values of the System's fixed-rate bonds are estimated using Level 2 inputs based on quoted market prices for those or similar instruments. The estimated fair value of the fixed-rate bonds was approximately \$3,224,000 and \$3,219,000 as of December 31, 2014 and 2013, respectively. The carrying value of the fixed-rate bonds was approximately \$2,944,000 and \$3,095,000 as of December 31, 2014 and 2013, respectively. The carrying amount approximates fair value for all other long-term debt (note 6).

12. Subsequent Events

The System entered into an Affiliation Agreement (Affiliation) with Ascension Health (Ascension) to create a joint operating company, which will allow for an integrated healthcare delivery system with Ascension and the System's existing facilities and related operations in the greater Chicago market, while maintaining separate ownership of assets by each party. The Affiliation, which is effective February 1, 2015, allows both organizations to preserve their respective religious identities and mission priorities.

The System evaluated events and transactions occurring subsequent to December 31, 2014 through February 27, 2015, the date the accompanying consolidated financial statements were issued. During this period, there were no subsequent events that required recognition in the accompanying consolidated financial statements. There were no additional nonrecognized subsequent events that required disclosure.

Notes to Consolidated Financial Statements

For the years ended
December 31, 2014
and 2013
(dollars in thousands)

13. Fourth Quarter Results of Operations (Unaudited)

The System's operating results for the three months ended December 31, 2014 are presented below:

Revenue	
Patient service revenue	\$ 2,221,694
Provision for bad debts	(107,675)
Net patient service revenue	2,114,019
EHR incentive payments	15,802
Other	84,129
Total operating revenue	2,213,950
Expenses	
Employee compensation	1,071,709
Supplies	387,764
Purchased services	149,157
Professional fees	123,422
Other	218,367
Interest	34,839
Depreciation and amortization	118,882
Total operating expenses	2,104,140
Income from Operations	109,810
Nonoperating Gains (Losses)	
Investment income	1,171
Loss on extinguishment of debt	(10,333)
Total nonoperating losses, net	(9,162)
Excess of revenue over expenses and losses	100,648
Less: Noncontrolling interests	(317)
Excess of Revenue over Expenses and Losses Attributable to Controlling Interests	100,331
Other changes in unrestricted net assets, net	(7,231)
Decrease in temporarily restricted net assets, net	(2,095)
Increase in Net Assets	\$ 91,005

Report of Independent Certified Public Accountants

The Board of Directors
Adventist Health System Sunbelt Healthcare Corporation
d/b/a Adventist Health System

We have audited the accompanying consolidated financial statements of Adventist Health System Sunbelt Healthcare Corporation and Subsidiaries (the System), which comprise the consolidated balance sheets as of December 31, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the System at December 31, 2014 and 2013, and the consolidated results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

Orlando, Florida
February 27, 2015

Adventist Health System

ATTACHMENT 37



**Adventist
Midwest Health**

A Member of Adventist Health System

April 7, 2015

Illinois Health Facilities and
Service Review Board
525 West Jefferson
Springfield, IL 62761

RE: Establishment of an Acute Mental Illness Service at Adventist Bolingbrook Hospital.

To Whom it May Concern:

I hereby attest that:

- The proposed establishment of an acute mental illness service at Adventist Bolingbrook Hospital will be funded through cash, and that no debt financing is to be used; and
- Applicant Adventist Health System maintains sufficient cash and short-term securities to fund this project.

Sincerely,

BY:

David L. Crane

Title: Executive Vice President/COO

Notarized:



ATTACHMENT 39

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	A	B		C		D		E		F		G	H	Total
		Cost/Sq. Foot		Gross Sq. Ft.		Gross Sq. Ft.		Gross Sq. Ft.		Gross Sq. Ft.		Const. \$	Mod. \$	Costs
	New		Mod.	New	Circ.		Circ.	Mod.	Circ.		Circ.	(A x C)	(B x E)	(G + H)
AMI Unit*		\$	200.00					8,768					\$ 1,753,600	\$ 1,753,600
Support areas		\$	222.00					1,415					\$ 314,130	\$ 314,130
Circulation		\$	100.00					6,264					\$ 626,400	\$ 626,400
Contingency		\$	10.00										\$ 164,470	\$ 164,470
TOTAL		\$	173.81					16,447					\$ 2,858,600	\$ 2,858,600
* all functional areas required by IDPH licensure														

**AMI**

\$

Hospital

\$

\$

\$

327.72

\$

\$

1,185.28

\$

180.22

SAFETY NET IMPACT STATEMENT

The establishment of an inpatient acute mental illness ("AMI") program at Adventist Bolingbrook Hospital (ABH"), consistent with the IHFSRB's determination that additional AMI beds are needed to serve the area population, will address the provision of safety net services by the hospital in a material way.

As well documented, the need and demand for mental health programming in all modalities (outpatient, partial hospitalization and inpatient) continues to grow. The absence of this service at Adventist Bolingbrook Hospital has resulted in limited access to inpatient psychiatric care, and the direct referral or transfer of over 500 patients from ABH's Emergency Department out of the community to other hospitals for admission to an AMI unit during the past year. The proposed AMI unit will 1) improve access to AMI services, 2) eliminate the need to transfer many of these patients outside of their home community, and 3) improve continuity of care by allowing physicians who routinely admit medical patients to ABH to follow their patients while they receive inpatient psychiatric care.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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