ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Riverside Medical Center Medical Office Building
Street Address:	NE Corner of Burns Road and Route 45
City and Zip Code:	Bourbonnais 60914
County: Bourbonnais	Health Service Area: 009 Health Planning Area: 091

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Riverside Medical Center
Street Address:	350 N. Wall Street
City and Zip Code:	Kankakee 60901
Name of Registered Agent:	Phillip M. Kambic
Registered Agent Street Address:	350 N. Wall Street
Registered Agent City and Zip Code:	Kankakee 60901
Name of Chief Executive Officer:	Phillip M. Kambic
CEO Street Address:	350 N. Wall Street
CEO City and Zip Code:	Kankakee 60901
CEO Telephone Number:	815-935-7549

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ 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 they are 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:	Joe Ourth
Title:	Partner
Company Name:	Saul Ewing Arnstein & Lehr LLP
Address:	161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number:	312-876-7815
E-mail Address:	joe.ourth@saul.com
Fax Number:	312-876-6215

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

Name:	Paula M. Jacobi
Title:	Senior Vice President & General Counsel
Company Name:	Riverside Medical Center
Address:	350 N. Wall Street
Telephone Number:	815-936-7362
E-mail Address:	pjacobi@rhc.net
Fax Number:	815-933-0798

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Riverside Medical Center Medical Office Building
Street Address:	NE Corner of Burns Road and Route 45
City and Zip Code:	Bourbonnais 60914
County: Bourbonnais	Health Service Area: 009 Health Planning Area: 091

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Riverside Health System, d/b/a Riverside Healthcare
Street Address:	350 N. Wall Street
City and Zip Code:	Kankakee 60901
Name of Registered Agent:	Phillip M. Kambic
Registered Agent Street Address:	350 N. Wall Street
Registered Agent City and Zip Code:	Kankakee 60901
Name of Chief Executive Officer:	Phillip M. Kambic
CEO Street Address:	350 N. Wall Street
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E-mail Address:	pjacobi@rhc.net
Fax Number:	815-933-0798

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:	Paula M. Jacobi
Title:	Vice President & General Counsel
Company Name:	Riverside Medical Center
Address:	350 N. Wall Street, Kankakee, Illinois 60901
Telephone Number:	815-936-7362
E-mail Address:	pjacobi@rhc.net
Fax Number:	815-933-0798

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Riverside Medical Center
Address of Site Owner:	350 N. Wall Street, Kankakee, Illinois 60901

Street Address or Legal Description of the Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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:	Riverside Medical Center
Address:	350 N. Wall Street, Kankakee, Illinois 60901

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ 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 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 #2006-5 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 #2006-5 **(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 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☐ Substantive

☒ Non-substantive

2. Narrative Description

In the space below, provide 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.

Riverside Medical Center ("Riverside") proposes to construct a three-story 75,000 square foot medical office building in Bourbonnais, Illinois to accommodate physician offices as well as, radiology, physical therapy and occupational therapy suites (the "Project"). In addition, 25,000 s.f. of proposed construction will be shell space to provide for future growth of the Riverside Medical Group and the need for physician office space and related ancillary services. The Applicants verify that it will return to the Review Board for a permit when the third floor shell space is built out for future use.

The building will be constructed on land currently owned by Riverside which is part of its Bourbonnais campus located at the corner of Burns Road and Route 45 in Bourbonnais.

This Project does not establish a new category of service or have an inpatient component. As such, it is classified as a non-substantive project.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation	$198,490	$664,510	$863,000
Off Site Work	$22,080	$73,920	$96,000
New Construction Contracts	$4,632,537	$14,442,458	$19,074,995
Modernization Contracts			
Contingencies	$463,254	$1,444,245	$1,907,499
Architectural/Engineering Fees	$353,616	$1,183,844	$1,537,460
Consulting and Other Fees	$82,971	$277,774	$360,745
Movable or Other Equipment (not in construction contracts)	$656,222	$900,418	$1,556,640
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	$353,107	$1,182,143	$1,535,250
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$6,762,277	$20,169,312	$26,931,589
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$6,762,277**	**$20,169,312**	**$26,931,589**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 $ _____.

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): October 31, 2021

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment 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 [Section 1130.620(c)]

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 **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (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.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**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 the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is 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: Riverside Medical Center		**CITY: Kankakee**			
REPORTING PERIOD DATES:		**From: January 1, 2018**		**to: December 31, 2018**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	163	7,286	30,119	0	163
Obstetrics	30	1,163	2,654	0	30
Pediatrics					
Intensive Care	31	1,208	3,990	0	31
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	64	1,568	14,582	0	64
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify) Rehabilitation	30	805	8,721	0	30
TOTALS:	318	12,030	60,066	0	318

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of Riverside Medical Center*
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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

PHILLIP KAMBIC
PRINTED NAME

PRESIDENT & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of OCTOBER, 2019

Signature of Notary

Seal

OFFICIAL SEAL
PAMELA S. HULL
Notary Public - State of Illinois
My Commission Expires 6/07/2021

SIGNATURE

PAULA JACOBI
PRINTED NAME

SR. V.P. & GENERAL COUNSEL
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of OCTOBER, 2019

Signature of Notary

Seal

OFFICIAL SEAL
PAMELA S. HULL
Notary Public - State of Illinois
My Commission Expires 6/07/2021

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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- 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 is filed on the behalf of Riverside Healthcare*
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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

PHILLIP KAMBIC
PRINTED NAME

PRESIDENT & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of OCTOBER, 2019

Signature of Notary

Seal

OFFICIAL SEAL
PAMELA S. HULL
Notary Public - State of Illinois
My Commission Expires 6/07/2021

SIGNATURE

PAULA JACOBI
PRINTED NAME

SR. V.P. & GENERAL COUNSEL
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of OCTOBER, 2019

Signature of Notary

Seal

OFFICIAL SEAL
PAMELA S. HULL
Notary Public - State of Illinois
My Commission Expires 6/07/2021

*Insert the full legal name of the applicant

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.

1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.
    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. 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.**
5. 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 that the information was 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.

Criterion 1110.110(b) & (d)

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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 Staff 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 1110.120 - 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 and it shall include the basis used for determining the space and the methodology applied.**

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 and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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	MEET 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:

Provide the following information:

1. Total gross square footage (GSF) 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 is 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:

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.

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐		
☐		
☐		

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility

APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

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

VI. 1120.120 - AVAILABILITY OF FUNDS

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]:**

$26,339,056	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;
$26,339,056	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 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 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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.

	Historical 3 Years			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.

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 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.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

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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. 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 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			

	Outpatient			
	Total			

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

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

Section I, Type of Ownership of Applicant/Co-Applicant

Attachment 1

1. **Riverside Medical Center ("Hospital")**: The Hospital is an Illinois not-for-profit organization. A copy of the Hospital's Good Standing Certificate is attached.

2. **Riverside Health System, d/b/a Riverside Healthcare ("System")**: The System is an Illinois not-for-profit organization. A copy of the System's Good Standing Certificate is attached.

ATTACHMENT 1

File Number 3882-598-4

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

RIVERSIDE MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 20, 1959, 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* 4TH *day of* SEPTEMBER *A.D.* 2019 .

Authentication #: 1924703082 verifiable until 09/04/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

#19-052

File Number 5265-328-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

RIVERSIDE HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 19, 1982, 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* 4TH *day of* SEPTEMBER *A.D.* 2019 .

Authentication #: 1924703022 verifiable until 09/04/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

Section I, Site Ownership

Attachment 2

Attached is a copy of the 2019 tax bill for the site, which shows that Hospital owns the site.

#19-052

OPEN M - F 8:30a - 4:30p

CHECK #

CASH

CHANGE

KANKAKEE COUNTY

2018 PAYABLE 2019

DUE DATE 06/20/2019

Parcel Number
17-09-08-100-013

FIRST INSTALLMENT 223,518.24

INTEREST PENALTY PAID

PRIOR YEAR BALANCE

TOTAL 1st INSTALL DUE $0.00

1

RIVERSIDE MEDICAL CENTER
350 N WALL STREET
KANKAKEE IL 60901-2901

PAY TO: COUNTY COLLECTOR, 189 E. Court St, KANKAKEE, IL 60901

RETURN STUB WITH PAYMENT #1

OPEN M - F 8:30a - 4:30p

CHECK #

CASH

CHANGE

KANKAKEE COUNTY

2018 PAYABLE 2019

DUE DATE 09/05/2019

Parcel Number
17-09-08-100-013

SECOND INSTALLMENT 223,518.24

INTEREST PENALTY

TOTAL 2nd INSTALL DUE $223,518.24

TOTAL TAX DUE $223,518.24

2

RIVERSIDE MEDICAL CENTER
350 N WALL STREET
KANKAKEE IL 60901-2901

NO PERSONAL/BUSINESS CHECKS AFTER SEPTEMBER 27th

PAY TO: COUNTY COLLECTOR, 189 E. Court St, KANKAKEE, IL 60901

RETURN STUB WITH PAYMENT #2

Kankakee County Real Estate Tax Bill - Kankakee County Collector
Pay online at KankakeeCountyTreasurer.com (See reverse for fees)
189 E. Court Street Kankakee, IL 60901 815-937-2960

71170

Township: BOURBONNAIS **Tax Code:** 17027
Parcel Number: 17-09-08-100-013 **Prop Class:** 0060
Parcel Address: 100 FITNESS DR
BOURBONNAIS, IL 60914 -9584
200 RIVERSIDE DR
BOURBONNAIS, IL 60914 -4689
300 RIVERSIDE DR
BOURBONNAIS, IL 60914 -4690
400 RIVERSIDE DR
BOURBONNAIS, IL 60914 -5004
85 E 4500 N RD
BOURBONNAIS, IL 60914
85 E BURNS RD
BOURBONNAIS, IL 60914

RIVERSIDE MEDICAL CENTER
RIVERSIDE MEDICAL CENTER
350 N WALL STREET
KANKAKEE IL 60901-2901

Short Legal Description
RIVERSIDE NORTH
SUB
LOT 1 EX N 662'
BAL 55.02AC

Equalized Assessed	5,013,587
Equalized Factor /	0.3333
Market Value	15,042,270
Assessed Value	5,013,587
Home Improve Exemption -	0
Veteran / Disabled Exemption -	0
Returning Veteran Exemption -	0
General Homestead Exemption -	0
Senior Exemption -	0
Senior Freeze Exemption -	0
Vet/Frat Freeze Exemption -	0
Taxable Value	5,013,587
Tax Rate x	8.9165
RE Tax Before Drng & Sp Asmt	447,036.48
Drainage or Special Asmt +	0.00
TOTAL TAX DUE	**447,036.48**

2018 TAXES PAYABLE 2019

TAXING DISTRICTS		CHANGE FROM LAST YEAR	TAXABLE VALUE / 100 x RATE + DRAINAGE = TAX Tax Rate	Tax Amount
KANKAKEE COUNTY		-501.38	0.7883	39,522.08
KANKAKEE COUNTY	Pension	366.00	0.3456	17,326.96
KANKAKEE CC #520		-666.81	0.4798	24,055.18
KANKAKEE CC #520	Pension	75.21	0.0111	556.52
BOURBONNAIS SD #53		-1,148.06	3.2349	162,184.65
BOURBONNAIS SD #53	Pension	-35.15	0.1763	8,838.83
BRADLEY-BOURB. HS #307		-546.52	2.0698	103,771.19
BRADLEY-BOURB. HS #307	Pension	-50.10	0.0306	1,534.19
BOURBONNAIS FIRE		55.15	0.4455	22,335.53
BOURBONNAIS LIBRARY		-30.08	0.1836	9,204.95
BOURBONNAIS TWP. PARK		-491.32	0.3570	17,898.51
BOURBONNAIS TWP. PARK	Pension	180.48	0.0140	701.90
BOURBONNAIS TOWNSHIP ROAD		-60.16	0.2084	10,448.32
BOURBONNAIS TOWNSHIP		-55.14	0.0904	4,532.29
BOURBONNAIS TOWNSHIP	Pension	25.06	0.0129	646.75
VILLAGE OF BOURBONNAIS		-70.18	0.3179	15,938.21
VILLAGE OF BOURBONNAIS	Pension	-40.12	0.1504	7,540.42

PAYMENTS OPTIONS
Visit www.kankakeecountytreasurer.com
and click on CHOICES for more information.

PENALTIES
PENALTY INTEREST OF 1 1/2% PER MONTH ADDED AFTER EACH INSTALLMENT DUE DATE FOR EACH MONTH OR PART OF MONTH

1st INSTALL DUE: **06/20/2019** **$0.00**
2nd INSTALL DUE: **09/05/2019** **$223,518.24**

OPEN M - F 8:30a - 4:30p

ATTACHMENT 2

2018 TAXES PAYABLE 2019				
TAXING DISTRICTS		CHANGE FROM LAST YEAR	TAXABLE VALUE / 100 x RATE + DRAINAGE = TAX	
			Tax Rate	Tax Amount
VILLAGE OF BOURBONNAIS	Pension	-40.12	0.1504	7,540.42
TOTAL CHANGE FROM LAST YEAR		**-2,993.12**		
TOTAL TAX DUE			**8.9165**	**447,036.48**

Section I, Operating Identity/Licensee

Attachment 3

Riverside Medical Center ("RMC") is an Illinois not-for-profit organization. A copy of RMC's Good Standing Certificate is attached.

#19-052

File Number 3882-598-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

RIVERSIDE MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 20, 1959, 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* 4TH *day of* SEPTEMBER *A.D.* 2019 .

Authentication #: 1924703082 verifiable until 09/04/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

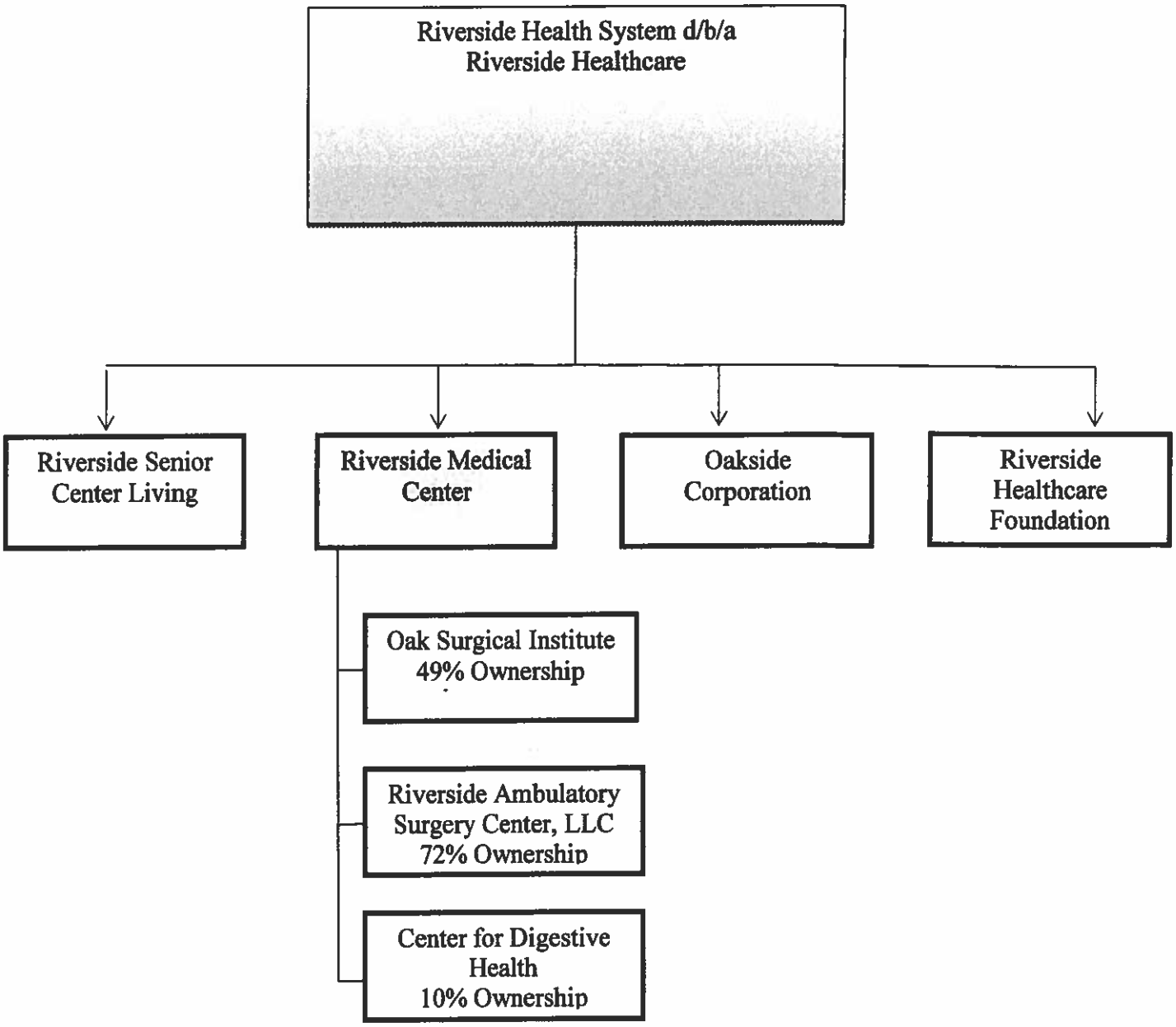
ATTACHMENT 3

Section I, Organizational Relationships

Attachment 4

A copy of Riverside Healthcare's organizational chart is attached.

Organizational Chart



*Shaded entities are the Applicants for this Project.

Section I, Flood Plain Requirement

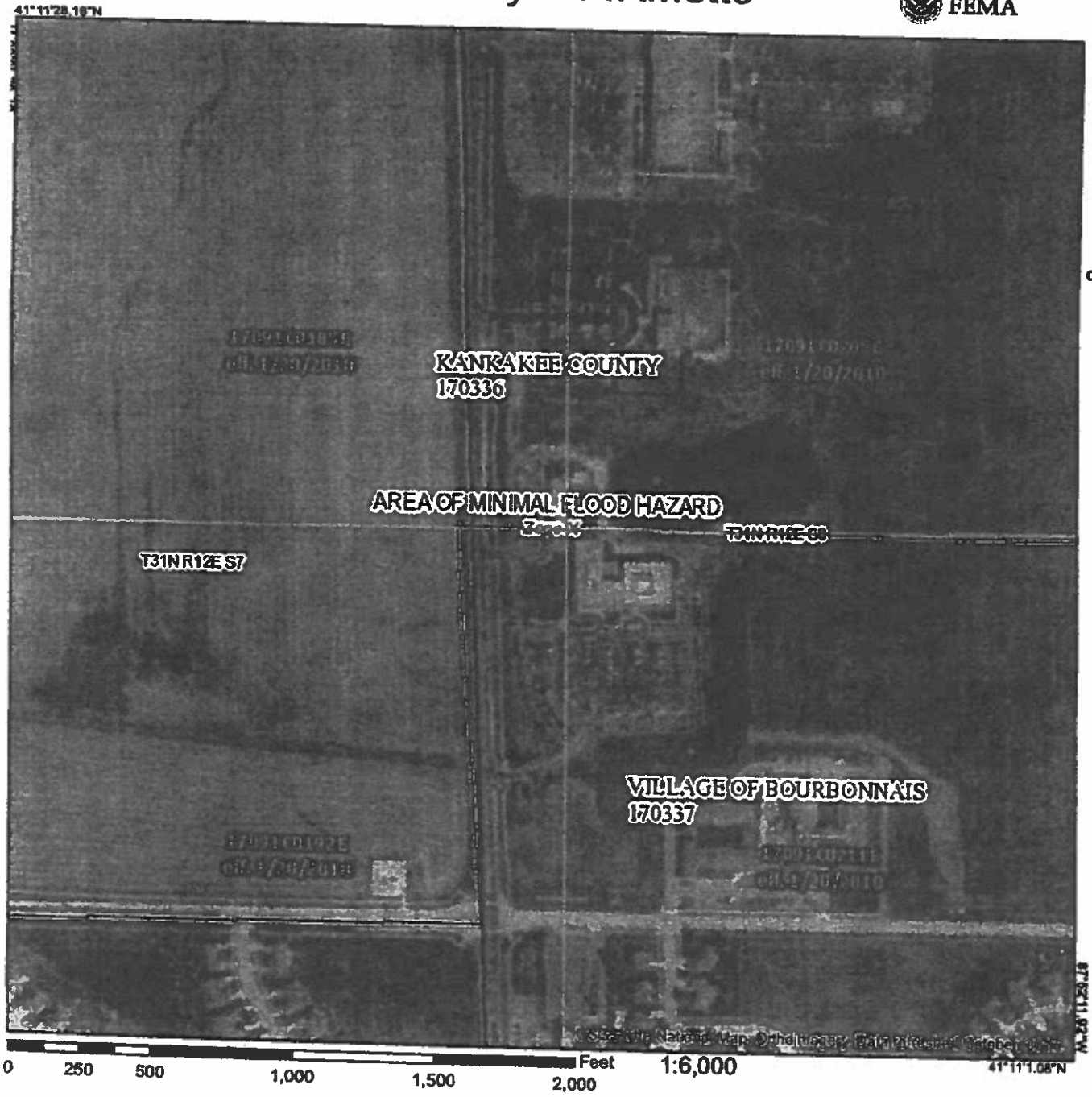
Attachment 5

As shown on the attached FEMA map the site of the Project is not located in a flood plain and that the Project complies with the Flood Plain Rules under Illinois Executive Order #2006-5.

#19-052

ATTACHMENT-5

National Flood Hazard Layer FIRMette



Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE)
- With BFE or Depth
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Area of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
- Future Conditions 1% Annual Chance Flood Hazard Zone X
- Area with Reduced Flood Risk due to Levee. See Notes. Zone X
- Area with Flood Risk due to Levee Zone D

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard Zone X
- Effective LOMRs
- Area of Undetermined Flood Hazard Zone

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 Cross Sections with 1% Annual Chance
- 17.5 Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represe an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 2/12/2019 at 5:25:10 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

Section I, Historic Resources Preservation Act Requirements

Attachment 6

The Project is to construct a medical office building. A letter from the Illinois Department of Natural Resources is hereby attached.

ATTACHMENT 6

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of **Natural Resources**

JB Pritzker, Governor
Colleen Callahan, Director

www.dnr.illinois.gov

Mailing address: State Historic Preservation Office, 1 Old State Capitol Plaza, Springfield, IL 62701

Kankakee County
Bourbonnais
NE of Burns Road & Route 45, Section:8-Township:31N-Range:12E
IHFSRB
New construction, Riverside Medical Center

PLEASE REFER TO: SHPO LOG #002081519

August 29, 2019

Paula M. Jacobi
Riverside Healthcare
350 North Wall Street
Kankakee, IL 60901

Dear Ms. Jacobi:

The Illinois State Historic Preservation Office is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

If further assistance is needed please contact Jeff Kruchten, Chief Archaeologist at 217/785-1279 or Jeffery.kruchten@illinois.gov.

Sincerely,

Robert F. Appleman
Deputy State Historic
Preservation Officer

Section I, Project Costs and Source of Funds

Attachment 7 Section 1120.110, Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**REVIEWABLE**	**NONREVIEWABLE**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation	$198,490	$664,510	$863,000
Off Site Work	$22,080	$73,920	$96,000
New Construction Contracts	$4,632,537	$14,442,458	$19,074,995
Modernization Contracts			
Contingencies	$463,254	$1,444,245	$1,907,499
Architectural/Engineering Fees	$353,616	$1,183,844	$1,537,460
Consulting and Other Fees	$82,971	$277,774	$360,745
Movable and Other Equipment (not in construction contracts)	$656,222	$900,418	$1,556,640
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to be Capitalized	$353,107	$1,182,143	$1,535,250
Acquisition of Building or Other property (excluding land)			
TOTAL USES OF FUNDS	$6,762,277	$20,169,312	$26,931,589
SOURCE OF FUNDS			**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issue (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOUCES OF FUNDS	**$6,762,277**	**$20,169,312**	**$26,931,589**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

ATTACHMENT 7

Riverside Physician Office Building
Bourbonnais Campus
Proposed Cost Detail
Attachment 7

Outlined below is detail regarding Project cost line items:

Site Prep		**$863,000**
Parking Lot		
Storm Sewers		
Off Site Expenses		**$96,000**
Utility Connections		
Water 4" - $11,000		
Water 8" - $15,000 (fire protection)		
Sanitary - $10,000		
Electric - $60,000		
New Construction Contracts		**$19,074,995**
Construction of a three-story 75,000 s.f. facility and includes general conditions, masonry, steel, carpentry, thermal and moisture protection, doors, windows, mechanical, plumbing, HVAC and electrical		
Contingencies		**$1,907,499**
Contingencies are 10% of the new constructions line item		
Architectural and Engineers		**$1,537,460**
Architectural and Engineering fees are budgeted at 7.33% of construction plus contingencies		
Movable or Other Equipment		**$1,556,640**
General Equipment	$545,653	
Clinic Furniture		
Exam Tables		
Stools		
Scale		

ATTACHMENT 7

Wheel Chairs
Cast Removal
Hand Scale
Public Space Furniture
Coffee Bar
Visio TVs
Artwork

IT Equipment $354,765

Elite desks
Keyboards
Phones
LED monitors
Document Scanners
Laser Jet Printers
Label Printers
Signature Pads
Docking Stations for Laptops
HP Elite Books
Fingerprint Readers
Headsets
Pin Pads (credit card processing)
HP Z27s High def monitors
Meraki Wireless Access Points

Imaging Equipment $550,000

2 General Radiology Machines (X-Ray)

PT/OT/Hand Clinic $106,222

Cardio Equipment
SciFit Total Body
SciFit Treadmill
Modality Equipment
E-Stim Tower

Treatment Tables
3 Hi-Low Tables
1 Hi-Low Bariatric Table

Ramp Up Return-to-Sport Rehab Program
Small Turf Area: (12ft by 50ft)

ATTACHMENT 7

Agility/Strength Equipment		
2 Speed Pulleys		
Squat Rack		
Concussion Assessment (ISEN Video Goggles)		
IT Equipment		
4 Laptops with Microsoft		
1 Desktop for Additional Front Desk		
PT Supplies		
Hand Clinic		
BTE		
Hi-Low Table		
Splint Pan		
Additional OT Supplies		
Consulting and Other Fees		**$360,745**
CON Filing Fee	$60,000	
CON Legal Fees	$50,000	
Other Legal and Consulting	$60,000	
Municipal Building Permits (1% of Construction)	$190,745	
Other Costs to be Capitalized		**$1,535,250**
Builders Risk Policy (1% of Construction)	$190,745	
Low Voltage / Security (6% of Construction)	$1,144,499	
Grand Total		**$26,931,589**

ATTACHMENT 7

Section I, Cost Space Requirements

Attachment 9

Cost Space Requirements

Department/Area	Cost	Gross Square Feet Existing	Gross Square Feet Proposed	Amount of Proposed Total BGSF That Is: New Constr.	Modern.	As Is	Vacated Space	Re-assign
Reviewable:								
Imaging	$1,224,158	0	1,033	1,033	0	0	0	
Physical Therapy	$3,838,956	0	13,761	13,761	0	0	0	
Occupational Therapy	$1,699,163	0	2,096	2,096	0	0	0	
Total Reviewable	**$6,762,277**		**16,890**	**16,890**				
Nonreviewable:								
Public	$2,037,664	0	3,478	3,478	0	0	0	
Clinic/Physician Offices	$7,188,925	0	14,492	14,492	0	0	0	
Staff Support	$3,210,356	0	2,444	2,444	0	0	0	
Building Systems	$1,065,085	0	3,333	3,333	0	0	0	
Shell Space	$2,489,270	0	23,810	23,810	0	0	0	
Circulation & Elevators	$4,178,012	0	10,553	10,553	0	0	0	
Total Nonreviewable	**$20,169,312**		**58,110**	**58,110**				
Grand Total	**$26,931,589**		**75,000**	**75,000**				

This Project is to construct a new 75,000 square foot medical office building.

Section III, Background of Applicant

Attachment 11

Section 1110.230, Background, Purpose of the Project and Alternatives

1. **A listing of all health care facilities owned by the applicant, including licensing, and certification if applicable.**

   A copy of Riverside Medical Center's ("Hospital") full general hospital license #0002014, effective January 1, 2019, issued by IDPH, is attached. The Hospital's most recent of accreditation from DNV GL-Healthcare, dated August 25, 2018, is also attached.

   Riverside Healthcare and/or Riverside Medical Center has ownership interest in the following facilities:

FACILITY	LOCATION	LICENSE NO.	ACCREDITATION NUMBER
Riverside Senior Living Center d/b/a Miller Rehabilitation (100%)	1601 Butterfield Trail Kankakee, IL 60901	40659	N/A
Riverside Ambulatory Treatment Center, LLC(72%)	300 Riverside Drive Bourbonnais, IL 60914	HF116574	14D1041895
Center for Digestive Health (10%)	1615 N. Convent Bourbonnais, IL 60814	7002876	AAAHC #65640
OAK Surgical Institute (49%)	403 South Kennedy Drive Bradley, Illinois 60915	7002702	AAAHC# 23419

2. **A certified listing of any adverse action taken against any facility owned and/or operated by applicant during the three years prior to the filing of the application.**

   By their signatures on the Certification pages to this application, each of the Applicants attest that no adverse action has been taken against any facility owned and/or operated by them during the three (3) years prior to the filing of this application.

3. **Authorization permitting HFSRB and DPH access to 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.**

   By their signatures to the Certification pages to this application, each of the Applicants authorize HFSRB and IDPH access to any documents necessary to verify the information submitted, including, but not limited to: (i) official records of IDPH or other State agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of nationally recognized accreditation organizations.

HF116925

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2019		0002014

General Hospital

Effective: 01/01/2019

Riverside Medical Center
350 N Wall Street
Kankakee, IL 60901

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2019

Lic Number 0002014

Date Printed 11/14/2018

Riverside Medical Center

350 N Wall Street
Kankakee, IL 60901

FEE RECEIPT NO.

ATTACHMENT-11

UL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
185706-2018-AHC-USA-NIAHO	8/25/2018	8/25/2021

This is to certify that:

Riverside Medical Center

350 N. Wall Street, Kankakee, IL 60901

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

DNV GL - Healthcare, 400 Techne Center Drive, Suite 100, Milford OH, 45150. Tel: 513-947-8343

www.dnvglhealthcare.com

ATTACHMENT-11

Section III, Purpose of Project

Attachment 12

Section 1110.230(b), Purpose of Project

1. **Document that the project will provide healthcare services that improve the healthcare or well-being of the market area population to be served.**

   The purpose of the Project is to construct a three-story medical office building, which will consist of 50,000 s.f. of physician/provider offices, as well as, radiology, physical and occupational therapy suites. The Project will include one floor of shell space, 25,000 s.f. to accommodate future growth of the Riverside Medical Group for its offices and related ancillary services.

   The Project is proposed to provide improved patient access for primary and specialty care services for patients in the primary service area of Riverside Medical Center ("Riverside"). The Riverside Medical Group ("RMG") is a physician and an advanced practice provider ("APP") group owned by Riverside, which has grown in size from 43 providers in 2009 to a current complement of 174 providers. The Project is intended for occupancy by RMG providers to address a critical shortage of available space for newly recruited physicians and APPs.

2. **Define the planning area or market area, or other, per the applicant's definition.**

   Riverside Medical Center and its medical group serve patients from the following areas:

General Service Area		
ZIP CODE - PATIENT	**PATIENT CITY**	**PERCENT**
60901	Kankakee	20.62%
60914	Bourbonnais	17.24%
60950	Manteno	7.91%
60915	Bradley	6.61%
60481	Wilmington	4.39%
60954	Momence	4.03%
60970	Watseka	3.78%
60964	St. Anne	3.34%
60468	Peotone	2.26%
60416	Coal City	2.21%

60940	Grant Park	1.81%
60408	Braidwood	1.68%
60958	Hopkins Park	1.38%
60922	Chebanse	1.28%
60938	Gilman	1.02%
60927	Clifton	.98%
60449	Monee	.89%
60401	Beecher	.86%
60941	Herscher	.86%
60442	Manhattan	.74%
60966	Sheldon	.74%
60913	Bonfield	.74%
60420	Dwight	.68%
60911	Ashkum	.67%
60423	Frankfort	.59%
60953	Milford	.56%
60935	Essex	.53%
60951	Martinton	.51%
60955	Onarga	.49%
60407	Coal City	.45%
60928	Crescent City	.44%
60450	Channahon	.42%
60930	Danforth	.41%
60424	Gardner	.41%
60931	Donovan	.31%
60417	Crete	.31%
60961	Reddick	.29%
60910	Aroma Park	.28%
60912	Beaverville	.27%
60451	New Lenox	.25%
60477	Tinley Park	.22%
60917	Buckhingham	.21%
OTHER	OTHER	6.34%

3. **Identify the existing problem or issues that need to be addressed, as applicable and appropriate for the project.**

As noted above, the Riverside Medical Group has added 131 new physician and APPs in the past decade. The vast majority of that growth has been experienced in the most recent 5 year period. Riverside Medical Group's current recruitment plan includes opportunities for 14 new physicians and 2 APPs to address the need to improve access to primary and specialty care in our market.

ATTACHMENT 12

Riverside currently owns approximately 204,833 s.f. of office real estate. Of that figure, 181,748 is currently occupied by RMG providers and a small number of independent practitioners. The balance of the space not occupied by physicians houses various hospital programs and services. There is no vacant space in these facilities to accommodate any future growth of the medical group. Additionally, several RMG providers are working within suites that are over-crowded and inadequate to serve the needs of their patients.

4. **Cite the sources of the information provided as documentation.**

   Riverside relied on the inventory of leased and occupied space as provided by McColly Bennett, our physician office property manager. To determine need for additional physician recruitment and the space to accommodate same, Riverside evaluated RMG office visits, admissions and appointment wait time statistics available in EPIC EMR. External data, including CompData and MGMA were also considered in the development of the medical staff recruitment plan.

5. **Detail how the project will address or improve the previously referenced issues or problems.**

   The addition of 50,000 s.f. of new physician office space, including a portion for radiology and PT/OT services, will provide a much-needed option for newly recruited physicians in the coming years. Existing RMG members' practice growth will also be accommodated in the new facility as they outgrow current, temporary quarters.

6. **Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.**

   The goal of the construction of the MOB is to provide quality and easily accessible office space for RMG providers. Upon completion of the Project, that goal as it relates to serving Riverside's primary market will be met.

Section III, Alternatives

Attachment 13

Alternatives

Riverside proposes the construction of a three-story medical office building on currently owned vacant land as the most effective and least costly alternative among those discussed below.

1. **Maintain Status Quo.**

   Maintaining the status quo would do nothing to alleviate the current capacity issues of the Riverside Medical Group. Further, it would not address the growing demand for physician services and need to improve accessibility for the patients in our primary service area. In addition to adversely affecting patient satisfaction, the potential for unnecessary utilization of more expensive ER visits could result as access to physician practices is limited. For the foregoing reasons, maintaining the status quo was rejected as an alternative.

2. **Expand Current MOB Facilities.**

   Riverside currently has physician office buildings located in Kankakee, Bradley and Bourbonnais – its primary service area. An evaluation of these facilities was made to determine if expansion of these locations was feasible. This alternative was rejected as the age and/or structural limitations of the properties prevented adding additional floors or square footage. The cost to address these issues was prohibitive when compared with new construction and for this reason expansion was not considered advisable.

3. **Lease or Purchase Existing Space**

   Riverside sought the input of a commercial realtor to determine if a suitable commercial space was available within our primary service area to lease or possibly acquire. The inventory of facilities that would provide the necessary square footage and be suitable to function as physician office space yielded no viable options. One property with potential to address Riverside's needs was ultimately rejected due to facility size, price and cost of renovation factors.

4. **Joint Venture with Other Providers**

A typical venture for a physician's office building would be to partner with physicians. Riverside is an integrated health system and the physician group, RMG, is already part of Riverside. The Project will be collaborative with RMG physicians, but will not be a joint venture between different entities because RMG is part of Riverside.

Comparison of Alternatives

Alternative – Riverside MOB Orthopedic Specialty	Cost	Pros	Cons
Maintain Status Quo	$0	• No costs.	• Does not address the current issues to accommodate current and future needs of RMG.
Expand Current MOB Facilities	$25+ million construction cost to add additional floors	• No pros over new construction	• Adding floors to an existing building would be more expensive and disruptive to current operations.
Lease or Purchase Existing Building	Est $356/s.f. plus $15/s.f. lease cost for triple net lease	• Could allow faster utilization than construction	• Lack of suitable existing property • Building would not be adjacent to existing hospital buildings on Bourbonnais campus.
Joint Venture Project	• N/A • RMG physicians are already part of Riverside	• N/A	• N/A
Proposed Project	$20 million construction cost	• Address and accommodate the continued growth and demand; • Provide better access to patients; and • Construction related costs and expenses are reasonable. • Building will be adjacent to other Riverside building	• Construction period will mean current space constraints will continue until the Project is complete.

ATTACHMENT 13

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Attachment 14

Project Scope, Utilization and Unfinished/Shell Space

1. **Document that the amount of physical space for the proposed project is necessary and not excessive.**

   As previously discussed, Riverside has grown its employed medical group by 131 providers over the past ten years (from 43 to 174). The recruitment of 16 additional providers is slated for 2019. The need to have available space for our expanding medical group and alleviate overcrowding in existing offices explains the need for this Project. The inclusion of one floor of shell space is prudent to allow for design and construction of the building foundation and exterior walls to accommodate future expansion more cost effectively.

   The growth in RMG's orthopedic practice will necessitate that group's relocation of their offices to the proposed Project. The group currently consists of five surgeons and two physician assistants operating out of a 6,000 s.f. facility. The lack of adequate space for the providers creates difficulty in scheduling and patient through put. Growth of their practices will necessitate the recruitment of additional orthopedic providers which cannot be accommodated in their current space. To take advantage of the specialty overlap with orthopedics and podiatry, these practices will be housed on the second floor of the Project. Podiatry visits have increased by 45.8% between 2016 and 2019. They currently share space with primary care physicians. The patients of both practices (podiatry and primary care) would be better served by segregating them into separate, dedicated spaces.

   The need for diagnostic x-ray for orthopedics and podiatry is self-evident. Patients currently experience wait times in the orthopedic clinic due to the limitations of having one x-ray unit available. With projected 2019 utilization of radiology from the providers who will be housed in the Project at 9,500 procedures the justification for two x-ray units is satisfied. The

foot print for the radiology units are planned at 620 g.s.f each which meets the state standard of 1300 g.s.f. per unit.

Plans for the Project also include approximately 18,235 g.s.f for physical and occupational therapy. The PT/OT space will include an open gym area, semi-private and private treatment rooms and a hand clinic. With the addition of a new orthopedic group and growth in the podiatry practice, PT/OT visits increased by 89% from 2018 to projected 2019. Patient visits for 2019 are projected at 15,480 with an anticipated average growth of 15% annually over the next five year period. The hand clinic will see 3,417 visits this year as a new rehab service offering.

With an allowance for common area and mechanical space, the net available useable space for physician offices and related ancillary services is approximately 37,510 g.s.f. Riverside's experience in constructing physician office space has demonstrated a per physician suite ranging from 1,200 s.f. to 1,500 s.f. This figure was corroborated by independent data published by various sources (e.g. Medical Group Management Association, American Association of Orthopedic Executives, Medscape). With proposed inclusion of PT/OT and general radiology as part of the Project, the net useable square footage for provider offices is 19,275 g.s.f. Given the above described existing need, as well as, additions to RMG in 2019 and beyond, the scope of the Project should be appropriate.

2. SIZE OF PROJECT

Department/Service	Proposed DGSF	State Standard	Difference	Met Standard?
Physician Offices	19,275 dgsf	N/A	N/A	N/A
PT/OT	18,235 dgsf	N/A	N/A	N/A
General Radiology	1,240 dgsf/ (2 units)	1,300 dgsf/unit	-680	Yes

Section IV, Project Services Utilization

Attachment 15

Appendix B, Project Services Utilization

1. **Project Services Utilization – For Areas for Which There are Utilization Standards as Shown in Appendix B.**

General Radiology

Utilization	Department	Historical Utilization	Projected Utilization	State Standard	Meet Standard?	Units
2019	Radiology	9,500		8,000/unit	Yes	1
2020			10,450		Yes	1
2021			11,500		Yes	2
2022			12,650		Yes	2
2023			13,915		Yes	2

The Project proposes to install and operate two general radiology suites for use by the physician occupants of the medical office building. This modality will be used for diagnosis of fractures, soft tissue injury and other diagnostic measures. The proposed Project, including the radiology suites, is expected to be completed and operational by the third quarter of 2021.

The principal user of this radiology equipment will be the orthopedic group of Riverside Medical Center. Their 2019 projected volume of procedures is 8,795. As a newly formed group, a conservative increase year over year of ten percent in procedures is projected. Riverside is currently recruiting for an additional orthopedic surgeon and expects to add an additional hand surgeon within the next three-year period. The growth in the practice of the existing surgeons coupled with the expansion of the group should provide sufficient volume to support the installation of two radiographic units. Over and above the orthopedic utilization in radiology will be the procedures generated by the podiatrists who will locate in

the Project. Their 2019 projected procedure volume is 705. Additional procedures will be generated by the pain specialist also slated to occupy the Project.

For Areas without utilization standards as shown in Appendix B

Physician Offices

Utilization	Department/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?	Units
2019	Physician Offices	17,824		None	N/A	
2020			22,650		N/A	
2021			27,271		N/A	
2022			28,140		N/A	
2023			29,038		N/A	

The Project will initially house Riverside's seven-provider orthopedic group, two podiatrists and a pain management specialist. As noted above, the combined projected volume for these providers for 2019 is 17,824 office visits. The anticipated growth in patient visits over the next two years is 27% and 20% respectively. These estimates are based primarily on the continued growth of the newly established orthopedic group and the addition of a pain management specialist. A more conservative estimate of growth in physician office visits of 3.2% is projected as the providers' practices in this location mature. An additional consideration in the growth projections is the loss of three independent orthopedic surgeons that have left the market served by Riverside's providers since 2018.

Physical Therapy/Occupational Therapy

Utilization	Department/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?	Units
2019	PT/OT	15,480		None	N/A	
2020			20,346		N/A	
2021			24,040		N/A	

ATTACHMENT 15

2022			26,328		N/A	
2023			28,634		N/A	

The PT/OT facility will occupy 18,235 g.s.f and include an open gym area, semi-private and private treatment rooms and a hand clinic.

As with radiology, the principal user of PT/OT services will be the patients treated by the orthopedic group. Similar to the large growth projected for 2020 and 2021 seen in physician office visits, the utilization of rehabilitation services will mirror that increase at 31.4% and 18.2% respectively. Referrals to the hand clinic have been significant as a new service. First year projection for 2019 for the hand clinic are 3,281 visits. Podiatry will also contribute to PT/OT visits, with referrals from their practices.

Section IV Unfinished or Shell Space

Attachment 16

1. The total shell space of the Project is 25,000 g.s.f. which space is earmarked for additional physician offices and a potential for MRI capabilities.

2. The installation of an MRI unit is anticipated to require 975 g.s.f.. As noted above, the balance of the shell space, 24,025 g.s.f will be utilized for physician offices.

3. Riverside currently has no available vacant space to accommodate the continued growth of existing practices or the establishment of new practices as planned. While space available within the first two floors of the Project will be adequate to meet the current and short term needs of our orthopedic group, it is financially prudent to structure the Project to provide a shell space for future expansion of other RMG practices.

4. Riverside has grown its employed medical group by 131 providers over the past ten years. The recruitment of 16 additional providers is slated for 2019. Physician office visits for RMG in the primary service area of Kankakee, Bradley and Bourbonnais have increased by 233% in the most recent five-year period.

Year	2014	2015	2016	2017	2018
Office Visit	60,488	90,112	165,485	177,293	201,672
% Incr.		49.0%	83.6%	7.1%	13.8%

Riverside anticipates build out the shell space to occur within three years following completion of the Project assuming an average annual increase in physician office visits of 11.3% per year.

Section IV Assurances

Attachment 17

The Applicants verify that they will submit to the Review Board 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.

The Applicants anticipate building out the shell space within approximately three years following completion of the Project, assuming an average increase in physician office visits of 11.3%. Riverside would anticipate filing its CON three to five months prior to initiating the build out of the shell space.

Section V, Service Specific Review Criteria

Attachment 30

Clinical Service Area Other Than Categories of Service

1. **Need Determination – Establishment**

   The main purpose of this Project is to increase accessibility for patients in Riverside's primary service area of Kankakee, Bradley and Bourbonnais to physician and APP services. Riverside's primary service area encompasses 75.3% of all RMG provider visits. Constructing the Project in Bourbonnais will allow RMG providers to expand with existing and new practices in a location convenient to the patients they serve.

General Service Area		
ZIP CODE - PATIENT	**PATIENT CITY**	**PERCENT**
60901	Kankakee	20.62%
60914	Bourbonnais	17.24%
60950	Manteno	7.91%
60915	Bradley	6.61%
60481	Wilmington	4.39%
60954	Momence	4.03%
60970	Watseka	3.78%
60964	St. Anne	3.34%
60468	Peotone	2.26%
60416	Coal City	2.21%
60940	Grant Park	1.81%
60408	Braidwood	1.68%
60958	Hopkins Park	1.38%
60922	Chebanse	1.28%
60938	Gilman	1.02%
60927	Clifton	.98%
60449	Monee	.89%
60401	Beecher	.86%
60941	Herscher	.86%
60442	Manhattan	.74%
60966	Sheldon	.74%
60913	Bonfield	.74%
60420	Dwight	.68%
60911	Ashkum	.67%
60423	Frankfort	.59%

ATTACHMENT 30

60953	Milford	.56%
60935	Essex	.53%
60951	Martinton	.51%
60955	Onarga	.49%
60407	Coal City	.45%
60928	Crescent City	.44%
60450	Channahon	.42%
60930	Danforth	.41%
60424	Gardner	.41%
60931	Donovan	.31%
60417	Crete	.31%
60961	Reddick	.29%
60910	Aroma Park	.28%
60912	Beaverville	.27%
60451	New Lenox	.25%
60477	Tinley Park	.22%
60917	Buckhingham	.21%
OTHER	OTHER	6.34%

2. Service Demand

The Project will initially house the orthopedic surgeons, podiatrists and pain management specialist of the Riverside Medical Group. Riverside established a new orthopedic group in the Summer of 2018 with the majority of the seven-provider group arriving late in the third quarter of 2018. The orthopedic specialists have experienced a rapid growth trajectory as evidenced by projected patient visits of 11,440 for 2019. Continued demand for RMG orthopedic services is expected as three orthopedic surgeons unaffiliated with RMG have left the market since the group's inception. The availability of accessible orthopedic care is expected to reduce the outmigration historically experienced in Riverside's service area for orthopedic services. As a result, the growth in patient visits to the RMG orthopedic group is projected at 15% per year over the next five-year period.

In addition to the orthopedic group, Riverside will locate its podiatry practice in the Project. The podiatrists have experience a 45.8% growth in office visits from 2016 through projected 2019. The proximity of the orthopedic and podiatry practices in the Project will take advantage of synergies in these two specialties.

To support the diagnostic and treatment needs of the orthopedic surgeons and podiatrists, the Project includes two general radiographic units and physical and occupational therapy

space. The radiology units will occupy 620 g.s.f each. For 2019 the orthopedic and podiatry groups are expected to generate 9,500 radiology exams. Using the Board's procedure of rounding up for utilization calculations, the historical utilization justifies the need for two units given the state standard of 8,000 procedures/unit.

General Radiology

Utilization	Department	Historical Utilization	Projected Utilization	State Standard	Meet Standard?	Units
2019*	Radiology	9,500		8,000/unit	Yes	1
2020			10,450		Yes	1
2021			11,500		Yes	2
2022			12,650		Yes	2
2023			13,915		Yes	2

*estimated

The PT/OT space is planned at 18,235 g.s.f. The scope of this space was determined after review of current therapy department utilization and comparison to industry standards. PT/OT outpatient referrals have grown by 30% between 2018 and projected 2019 primarily driven by the orthopedic group.

3. **Impact on Other Area Providers**

The proposed Project should have no impact on other area providers. Riverside Medical Center and its employed physician group is part of a fully integrated health system. Currently referrals for physician/APP, radiology, physical and occupational therapy services are made within the Riverside network. The Project will provide a state-of-the-art, convenient facility for patients receiving care and treatment through Riverside's providers.

Section V, Financial Viability Waiver Availability of Funds

Attachment 33

Riverside Health System has a bond rating of A+ from Standard and Poor's rating agency, and A2 from Moody's and this Section should not apply. Evidence of the Bond Ratings are attached.

ATTACHMENT 33

MOODY'S
INVESTORS SERVICE

7 World Trade Center
250 Greenwich Street
New York 10007
www.moodys.com

April 23, 2018

Mr. Bill Douglas
Chief Financial Officer
Riverside Health System
350 North Wall Street
Kankakee, IL 60901

Dear Mr. Douglas:

We wish to inform you that on April 20, 2018, Moody's Investors Service affirmed Riverside Health System's **A2** bond rating. The outlook is **stable**.

Credit ratings issued by Moody's Investors Service, Inc. and its affiliates ("Moody's") are Moody's current opinions of the relative future credit risk of entities, credit commitments, or debt or debt-like securities and are not statements of current or historical fact. Moody's credit ratings address credit risk only and do not address any other risk, including but not limited to: liquidity risk, market value risk, or price volatility.

This letter uses capitalized terms and rating symbols that are defined or referenced either in *Moody's Definitions and Symbols Guide* or *MIS Code of Professional Conduct* as of the date of this letter, both published on www.moodys.com. The Credit Ratings will be publicly disseminated by Moody's through normal print and electronic media as well as in response to verbal requests to Moody's Rating Desk. Moody's related research and analyses will also be published on www.moodys.com and may be further distributed as otherwise agreed in writing with us.

Moody's Credit Ratings or any corresponding outlook, if assigned, will be subject to revision, suspension or withdrawal, or may be placed on review, by Moody's at any time, without notice, in the sole discretion of Moody's. For the most current Credit Rating, please visit www.moodys.com.

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April 23, 2018

Mr. Bill Douglas
Chief Financial Officer
Riverside Health System
350 North Wall Street
Kankakee, IL 60901

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If there is a conflict between the terms of this rating letter and any related Moody's rating application, the terms of the executed rating application will govern and supercede this rating letter.

Should you have any questions regarding the above, please do not hesitate to contact the analyst assigned to this transaction, Rita Sverdlik at 212-553-3908.

Sincerely,
Moody's Investors Service Inc
Moody's Investors Service Inc.

ATTACHMENT-33

S&P Global
Ratings

RatingsDirect®

Illinois Finance Authority
Riverside Health System; Hospital

Primary Credit Analyst:
Wendy A Towber, Centennial (1) 303-721-4230; wendy.towber@spglobal.com

Secondary Contact:
Ashley Henry, Centennial (1) 303-721-4563; Ashley.Henry@spglobal.com

Table Of Contents

ATTACHMENT-33

Illinois Finance Authority
Riverside Health System; Hospital

Credit Profile

Illinois Finance Authority, Illinois
Riverside Hlth Sys, Illinois
Illinois Finance Authority (Riverside Health System)

Long Term Rating	A+/Stable	Affirmed

Rationale

S&P Global Ratings affirmed its 'A+' long-term rating on the Illinois Finance Authority's series 2016, 2013, and 2009 revenue bonds, issued on behalf of Riverside Health System (RHS). The outlook is stable.

We continue to assess RHS' financial profile as very strong and view the enterprise profile as strong. The very strong financial profile reflects our view of RHS' robust financial performance and sound liquidity and financial flexibility. The strong enterprise profile reflects our view of RHS' stable strategy and market position in an evolving competitive landscape and the limited economic fundamentals reflecting the size of the population of the primary service area (PSA). We think these combined credit factors lead to an indicative rating level of 'a+' and a final rating of 'A+'. We anticipate that RHS' financial and enterprise profiles will continue to remain stable in the near term given that we view the fiscal 2018 budget as achievable and in line with historical operating performance and believe that the stable management team will continue to effectively execute its strategic plans to maintain market share.

The rating reflects our view of RHS':

- Longstanding trend of consistently solid operations, which has continued through the first nine months of fiscal 2017 ended Sept. 30;
- Excellent unrestricted reserves as they relate to days' cash on hand; and
- Continued leading market position.

Offsetting the above strengths, in our view, are RHS' higher-than-median leverage, limited size and scale of the revenue base, and market uncertainty related to the changing competitive landscape. Other credit factors include the potential decline of special funding due to changes in Illinois state funding programs.

The 'A+' rating is based on our view of RHS' group credit profile (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP. The debt is secured by RHS' revenue.

Located in Kankakee, about 55 miles south of Chicago, RHS owns and operates a 301-staffed-bed acute-care hospital, outpatient facilities in five counties, a 70,000-square-foot health fitness center in Bourbonnais, an ambulance service, an 18-bed substance abuse program, two ambulatory surgery centers, and a senior living facility. The Kankakee senior living facility is on the 100-acre medical center campus but situated such that natural treeline barriers make it seem as if it were on an independent campus just beyond the medical center.

Outlook

The stable outlook reflects our anticipation that RHS will maintain its solid unrestricted reserves while investing in strategies that help sustain the organization and its market share. We believe the ever-expanding sites of care continue to allow RHS to sustain good cash flow, which have helped to maintain the unrestricted reserves.

Upside scenario

We do not anticipate raising the rating, but would consider doing so if RHS improves its size and scale (revenue base) and its enterprise profile while maintaining all of its other ratios.

Downside scenario

While unlikely, if RHS undergoes a sustained decline in its operations that affects its ability to invest in the organization, or if it issues debt to support future capital plans, we could lower the rating or revise the outlook to negative. Any changes in the competitive landscape that negatively affect market share or utilization volumes could also pressure the rating.

Enterprise Profile

Industry risk

Industry risk addresses our view of the health care sector's overall cyclicality and competitive risk and growth through application of various stress scenarios and evaluation of barriers to entry; the level and trend of industry profit margins; risk from secular change and substitution of products, services, and technologies; and risk in growth trends. We believe the health care services industry represents an intermediate credit risk when compared with other industries and sectors.

Market share and utilization

RHS retains the leading market share, at greater than 65%, and competes primarily against St. Mary's Hospital (part of the Presence Health System). With the acquisition of Presence Health by Ascension Health targeted for early 2018, the competitive landscape is poised to evolve in the near term. While management expects this acquisition will likely have little to no impact on RHS market share, which we view as reasonable, the resulting changes to the competitive landscape remain uncertain. To date, RHS has remained the primary health care provider in the market as the management team continues its focus on high-end clinical service lines, including cancer, heart, orthopedics, and neurosurgery. We believe that this focus, coupled with physician alignments, positions RHS to remain the market leader in the near term.

Inpatient admissions grew slightly in fiscal 2016, although in fiscal 2017 the shift toward outpatient services continues to outpace inpatient volume growth. Physician recruitment continues to be a focus across a variety of specialties, and RHS is pursuing residency and fellowship programs to further support these efforts. The Riverside Medical Group (RMG), the largest multispecialty group in the area, continues to see growth and currently includes 68 physicians and 59 advanced practice professionals. As RMG has grown over the years, leadership has stated that the group has been positive to the system, contributing downstream revenue and growth in referrals.

Also, RHS' Kankakee and Bourbonnais senior living campuses have high occupancy, with independent and assisted living facilities at 82%, and skilled nursing at 75%.

Management

RHS has a stable senior leadership team that continues to implement strategic plans to enhance the system. By evaluating both the services provided and geographic footprint in which it operates, leadership determines how and where to invest to enhance its programs. Evidence of this can be seen in RHS' April 2016 expansion into Frankfort, and the upcoming expansion into immediate care services in Watseka in early 2018, markets that are north and south of RHS' PSA, respectively. The Frankfort facility is a 20,000-square-foot medical complex housing physicians and other diagnostic services. The Watseka facility is a 12,000-square-foot medical complex offering primary and specialty care as well as imaging services. In September 2014, the Medical Center and the employed physician group completed membership participation agreements to join Rush Health. Rush Health consists of a clinically integrated hospital and roughly 1,400 physician and nonphysician network clinicians providing members with managed-care contracting services and technology to support various population health/accountable care initiatives. In mid-2017, RHS terminated its formal affiliation with the Rush University Medical Center (RUMC). While the working partnership with the Medical Center and physician group remains, the Riverside / Rush Corporation (RRC) board has been dissolved and RRC no longer holds reserve powers. Neither RUMC nor RRC was a member of the obligated group, which was not affected by this change. We expect the management team to remain stable in the near term and continue to implement its strategic plans as envisioned.

Financial Profile

Financial policies

The financial policies assessment of "neutral" reflects our opinion that financial reporting and disclosure, investment allocation and liquidity, debt profile, contingent liabilities, and legal structure are appropriate for an organization of this type and size and are not likely to impair the organization's ability to pay debt service.

Financial performance

RHS continues to post healthy operations, a trend we expect to likely be sustained in the near term supported in part by revenue growth from several outpatient services such as cancer treatment, ambulatory infusion, and the cardiac catheterization lab. For the first nine months of fiscal 2017, ended Sept. 30, RHS continued to have healthy operations in line with those of recent years. When comparing the first nine months of 2017 operations to those of fiscal 2016, RHS saw some softness. Management noted that the softer operations were primarily driven by added depreciation related to bringing its Epic platform online. RHS received about $8.6 million in provider tax in fiscal 2017, and management anticipates receiving a similar amount next year. We understand RHS will end the year in line with budget, reflecting an operating margin of roughly 3.7% (as calculated by RHS), which we view as reasonable. RHS' fiscal 2018 budget is in line with recent performance and will likely advance the sustained trend of healthy operations.

Liquidity and financial flexibility

With the continued good operations providing robust cash flow, RHS' balance sheet is expected to remain strong in the near term. Liquidity has modestly improved, growing to above 400 days, which we consider excellent for the rating.

Management noted that the increase is primary a result of the investment markets.

Debt and liability

RHS has direct-placement bonds purchased by JPMorgan Chase Bank N.A., which we have previously reviewed, noting that the covenants call for days' cash to be no less than 70 and maximum annual debt service coverage of no less than 1.1x. If the aforementioned covenants are breached, RHS has a 30-day period in which to cure the covenant violation prior to JPMorgan Chase having the right to accelerate the debt. There are no recent or anticipated covenant violations, and unrestricted reserves that are 10x greater than the contingent liability as of this analysis further mitigate the risk associated with this debt.

RHS is planning to open the newly renovated East Tower of its facility in January 2018, which was completed on time and under budget, according to management. Management expects the tower to provide needed flexibility to absorb additional capacity. The expansion includes a 42-bed unit with all private beds. In addition to routine capital spending, near-term capital plans include implementing the final phases of the Epic install and completing a boiler plant replacement. Virtually the entire fiscal year 2018 capital budget has been approved by the board with spending levels above depreciation in the near term. We expect leverage to remain elevated in the near term, although management has no plans to issue new debt in the outlook period, planning to finance upcoming capital improvements with a mix of cash flow and reserves.

Riverside Health System & Obligated Affiliates, Illinois Financial Statistics

	--Nine months ended Sept. 30--	--Fiscal year ended Dec. 31--			Medians for 'A+' rated stand-alone hospital
	2017	2016	2015	2014	2016
Enterprise profile					
PSA population	N.A.	138,342	139,551	113,449	MNR
PSA market share %	N.A.	67.7	66.8	65.9	MNR
Inpatient admissions	6,730	9,224	8,198	8,115	MNR
Equivalent inpatient admissions	23,912	29,328	27,330	26,071	MNR
Emergency visits	34,873	44,183	43,852	41,048	MNR
Inpatient surgeries	1,681	2,681	2,610	2,464	MNR
Outpatient surgeries	4,526	6,668	6,956	6,263	MNR
Medicare case mix index	1.6300	1.6100	1.7200	1.6400	MNR
FTE employees	2,355	2,293	2,166	1,940	MNR
Active physicians	361	373	336	319	MNR
Based on net/gross revenues	Net	Net	Net	Net	MNR
Medicare %	47.6	47.6	47.3	47.6	MNR
Medicaid %	20.8	21.0	20.3	18.4	MNR
Commercial/Blues %	26.4	26.2	26.7	27.0	MNR
Financial profile					
Financial performance					
Net patient revenue ($000s)	255,927	323,878	312,438	279,002	553,687
Total operating revenue ($000s)	269,315	340,294	327,036	293,306	MNR
Total operating expenses ($000s)	259,037	326,724	311,667	283,034	MNR

Riverside Health System & Obligated Affiliates, Illinois Financial Statistics (cont.)

	--Nine months ended Sept. 30--	--Fiscal year ended Dec. 31--			Medians for 'A+' rated stand-alone hospital
	2017	2016	2015	2014	2016
Operating income ($000s)	10,276	13,570	15,369	10,272	MNR
Operating margin (%)	3.82	3.99	4.70	3.50	3.50
Net nonoperating income ($000s)	14,397	11,301	15,883	14,618	MNR
Excess income ($000s)	24,675	24,871	31,252	24,890	MNR
Excess margin (%)	6.70	7.07	9.11	8.08	6.00
Operating EBIDA margin (%)	13.45	12.78	13.05	13.44	11.00
EBIDA margin (%)	17.84	15.58	17.08	17.55	12.70
Net available for debt service ($000s)	50,620	54,779	58,576	54,031	74,447
Maximum annual debt service ($000s)	12,470	12,470	12,470	12,470	MNR
Maximum annual debt service coverage (x)	5.41	4.39	4.70	4.33	4.60
Operating lease-adjusted coverage (x)	5.41	4.39	4.70	4.33	4.00
Liquidity and financial flexibility					
Unrestricted reserves ($000s)	359,506	321,346	305,642	307,635	423,330
Unrestricted days' cash on hand	413.4	388.3	383.2	428.5	314.40
Unrestricted reserves/total long-term debt (%)	211.6	186.9	188.1	180.9	235.60
Unrestricted reserves/contingent liabilities (%)	1,012.0	819.2	687.8	629.4	671.00
Average age of plant (years)	9.4	10.5	18.1	16.8	10.50
Capital expenditures/depreciation and amortization (%)	95.8	102.1	191.6	179.9	135.00
Debt and liabilities					
Total long-term debt ($000s)	169,906	171,938	162,531	170,012	MNR
Long-term debt/capitalization (%)	27.0	28.6	29.3	30.9	24.00
Contingent liabilities ($000s)	35,525	39,225	44,440	48,875	MNR
Contingent liabilities/total long-term debt (%)	20.9	22.8	27.3	28.7	34.70
Debt burden (%)	3.30	3.55	3.64	4.05	2.70
Defined benefit plan funded status (%)	N/A	N/A	N/A	N/A	74.80

N/A--Not applicable. NA.--Not available. MNR--Median not reported. Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions.

Section VIII, Availability of Funds

Attachment 34

Availability of Funds

Riverside Medical Center's financial statements for the years June 30, 2016, 2017, and 2018 are attached.

ATTACHMENT 34

KPMG

RIVERSIDE MEDICAL CENTER

Consolidated Financial Statements

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 E. Randolph Street
Chicago, IL 60601-6436

Independent Auditors' Report

The Board of Directors
Riverside Medical Center:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Riverside Medical Center (Medical Center), which comprise the consolidated balance sheets as of December 31, 2016 and 2015, and the related consolidated statements of operations, 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 consolidated financial statements in accordance 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Riverside Medical Center as of December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

May 19, 2017

RIVERSIDE MEDICAL CENTER

Consolidated Balance Sheets

December 31, 2016 and 2015

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	31,483,380	35,744,135
Receivables:			
Patient accounts, less allowance for doubtful accounts of approximately $20,500,000 in 2016 and $16,300,000 in 2015		42,837,008	35,927,007
Due from affiliates and other		27,161,644	22,254,866
		69,998,652	58,181,873
Inventory of supplies, at lower of cost (first-in, first-out) or market value		6,910,180	7,061,934
Prepaid expenses		3,821,970	3,421,295
Current portion of estimated insurance recoveries		894,612	1,321,816
Total current assets		113,108,794	105,731,053
Assets whose use is limited or restricted:			
By board of directors for capital improvements and other		236,545,240	218,474,614
Under bond indenture agreements held by trustee		18,173,275	8,401,361
Donor-restricted investments		2,757,322	2,889,947
		257,475,837	229,765,922
Land, buildings, and equipment, net of accumulated depreciation		220,683,026	219,677,618
Due from Riverside HealthCare Foundation, Inc.		5,894,877	5,530,871
Long-term investments		—	3,527,091
Estimated insurance recoveries		3,130,573	4,237,359
Other assets		36,027	36,027
Total assets	$	600,329,134	568,505,941

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets	2016	2015
Current liabilities:		
Current installments of long-term debt	$ 3,943,607	4,566,560
Long-term debt subject to short-term remarketing arrangements	1,855,297	—
Accounts payable	6,179,846	5,953,855
Accrued expenses	22,347,625	23,042,788
Estimated payables under third-party reimbursement programs	26,448,561	29,365,801
Total current liabilities	60,774,936	62,929,004
Long-term debt, excluding current installments, unamortized bond discount and premium, and deferred financing costs	134,208,161	127,177,483
Construction payables	491,085	1,975,224
Estimated insurance liabilities	19,249,509	21,038,709
Other long-term liabilities	2,962,683	2,774,991
Total liabilities	217,686,374	215,895,411
Net assets:		
Unrestricted	379,885,438	349,720,583
Temporarily restricted	2,282,846	2,416,096
Permanently restricted	474,476	473,851
Total net assets	382,642,760	352,610,530
Commitments and contingent liabilities		
Total liabilities and net assets	$ 600,329,134	568,505,941

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Operations

Years ended December 31, 2016 and 2015

	2016	2015
Revenue:		
Net patient service revenue	$ 314,911,803	300,260,501
Provision for uncollectible accounts	(12,130,672)	(8,995,959)
Net patient service revenue less provision for uncollectible accounts	302,781,131	291,264,542
Other revenue	5,754,200	5,382,982
Total revenue	308,535,331	296,647,524
Expenses:		
Salaries and employee benefits	155,990,186	147,382,871
Purchased services and supplies	102,615,343	100,212,995
Depreciation and amortization	20,275,755	17,904,544
Utilities	4,373,053	4,086,290
Professional fees	868,293	655,173
Insurance	5,930,121	6,569,120
Interest	4,992,763	4,814,301
Total expenses	295,045,514	281,625,294
Income from operations	13,489,817	15,022,230
Nonoperating gains (losses):		
Investment income (loss), net	19,245,977	(4,420,495)
Loss on early extinguishment of debt	(3,715,069)	(50,981)
Change in fair value of derivative instruments	(103,126)	778,394
Other, net	94,912	43,687
Net nonoperating gains (losses)	15,522,694	(3,649,395)
Revenue and gains in excess of expenses and losses	29,012,511	11,372,835
Other changes in unrestricted net assets:		
Net assets released from restriction for purchases of land, building, and equipment	1,152,344	1,446,687
Increase in unrestricted net assets	$ 30,164,855	12,819,522

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2016 and 2015

	2016	2015
Unrestricted net assets:		
Revenue and gains in excess of expenses and losses	$ 29,012,511	11,372,835
Other changes in unrestricted net assets:		
Net assets released from restriction for purchases of land, building, and equipment	1,152,344	1,446,687
Increase in unrestricted net assets	30,164,855	12,819,522
Temporarily restricted net assets:		
Contributions for specific purposes	985,651	1,324,056
Investment return earned on temporarily and permanently restricted investments	33,443	6,777
Net assets released from restriction for purchases of land, building, and equipment	(1,152,344)	(1,446,687)
Decrease in temporarily restricted net assets	(133,250)	(115,854)
Change in permanently restricted net assets:		
Change in net unrealized gains and losses on permanently restricted investments	625	(4,960)
Change in net assets	30,032,230	12,698,708
Net assets at beginning of year	352,610,530	339,911,822
Net assets at end of year	$ 382,642,760	352,610,530

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 30,032,230	12,698,708
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	20,275,755	17,904,544
Provision for doubtful accounts	12,130,672	8,995,959
Restricted contributions and investment return	(1,019,719)	(1,325,873)
Net realized and change in unrealized gains and losses on investments	(12,594,698)	10,843,868
Loss on early extinguishment of debt	3,715,069	50,981
Change in fair value of derivative instruments	103,126	(778,394)
Changes in assets and liabilities:		
Patient accounts receivable	(19,040,673)	(8,105,170)
Other receivables	(4,906,778)	(3,198,382)
Inventory of supplies, prepaid expenses, and other assets	(3,963,990)	1,134,892
Accounts payable and accrued expenses	(469,172)	3,982,737
Estimated payables under third-party reimbursement programs	(2,917,240)	1,901,752
Estimated insurance receivables and liabilities	(255,210)	1,358,917
Other long-term liabilities	84,566	72,302
Net cash provided by operating activities	21,173,938	45,536,841
Cash flows from investing activities:		
Sales of assets whose use is limited or restricted	78,824,465	130,049,102
Purchases of assets whose use is limited or restricted	(93,939,682)	(135,758,326)
Net change in long-term investments	3,527,091	(371)
Acquisition of land, buildings, and equipment, net	(21,441,781)	(37,132,198)
Change in construction payables	(1,484,139)	1,352,698
Net cash used in investing activities	(34,514,046)	(41,489,095)
Cash flows from financing activities:		
Repayment of long-term debt	(64,553,223)	(31,229,725)
Proceeds from issuance of debt, including bond premium	73,961,321	27,665,510
Payment of bond issuance costs	(984,458)	(283,089)
Restricted contributions and investment return	1,019,719	1,325,873
Net change in due from Riverside HealthCare Foundation, Inc.	(364,006)	(281,904)
Net cash provided by (used in) financing activities	9,079,353	(2,803,335)
Net change in cash and cash equivalents	(4,260,755)	1,244,411
Cash and cash equivalents at beginning of year	35,744,135	34,499,724
Cash and cash equivalents at end of year	$ 31,483,380	35,744,135
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 5,418,562	6,003,021

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2016 and 2015

(1) Organization and Operations

Riverside Medical Center (Medical Center), a not-for-profit corporation incorporated under the Illinois General Not-for-Profit Corporation Act, operates a short-term general acute care hospital in Kankakee, an off-site substance abuse treatment center, and various community primary and specialty care clinics. The Medical Center provides general healthcare services to residents within its geographic service areas, including inpatient, outpatient, emergency room, physician, and other services. The Medical Center incurs expenses for the provision of healthcare services and related general and administrative activities.

The consolidated financial statements include the accounts of the Medical Center and the accounts of Riverside Ambulatory Surgery Center (RASC), located in Bourbonnais, Illinois.

All significant intercompany balances and transactions have been eliminated in consolidation.

(2) Summary of Significant Accounting Policies

The following accounting policies are utilized in presenting the accompanying consolidated financial statements of the Medical Center:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

(b) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

(c) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations include revenue and gains in excess of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenue and expenses. Transactions incidental to the provision of patient care services are reported as nonoperating gains and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).

(d) Cash and Cash Equivalents

The Medical Center considers demand deposits with banks, repurchase agreements, cash on hand, and all highly liquid debt instruments purchased with terms of three months or less to be cash equivalents, excluding those instruments classified as assets whose use is limited or restricted.

(e) Assets Whose Use Is Limited or Restricted

Assets whose use is limited or restricted include assets set aside by the Medical Center's board of directors (the Board) for future capital improvements and other, over which the Board retains control and may at its discretion subsequently use for other purposes; donor-restricted investments; and assets held by a trustee and limited as to use in accordance with the requirements of bond indenture agreements.

Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, and dividends) is included in revenue and gains in excess of expenses and losses unless the income or loss is restricted by donors, in which case the investment return is recorded directly to temporarily or permanently restricted net assets in accordance with donor intent. The change in net unrealized gains and losses of permanently restricted investments is recorded directly to permanently restricted net assets.

(f) Fair Value

The Medical Center applies the provisions of Accounting Standards Codification (ASC) Subtopic 820-10, *Fair Value Measurement – Overall*, for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Subtopic 820-10 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Subtopic 820-10 also establishes a framework for measuring fair value and expands disclosures about fair value measurements (note 6).

The Medical Center applies the provisions of ASC Subtopic 825-10, *Financial Instruments – Overall*. ASC Subtopic 825-10 gives the Medical Center the irrevocable option to report most financial assets and financial liabilities at fair value on an instrument-by-instrument basis, with changes in fair value reported in earnings. The Medical Center did not elect to measure any additional eligible financial assets or financial liabilities at fair value subsequent to the adoption of ASC Subtopic 825-10.

In May 2015, the Financial Accounting Standards Board issued Accounting Standards Update 2015-07, *Fair Value Measurement (Topic 820), Disclosures for Investment in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*. ASU 2015-07 removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. It also removes the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. The requirements of the standard are effective for reporting periods in fiscal years that begin after December 15, 2016, with early adoption permitted. ASU 2015-07 is to be applied retrospectively. The Medical Center elected to early adopt ASU 2015-07 in 2015. The adoption resulted in the elimination of the disclosure noted above. There was no effect on the Medical Center's consolidated financial statements.

In March 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). ASU 2016-01 eliminates the requirement for not-for-profit organizations to disclose fair value information for financial instruments measured at amortized cost (e.g., debt). The Medical Center has elected to early adopt this part of ASU 2016-01. The remaining

parts of the ASU are effective for the Medical Center for the year ending December 31, 2019. There was no effect on the Medical Center's consolidated financial statements.

(g) Derivative Instruments

The Medical Center accounts for derivatives and hedging activities in accordance with ASC Topic 815, *Derivatives and Hedging*, as amended, which requires that all derivative instruments be recorded in the consolidated balance sheets at their respective fair values.

(h) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost if purchased or at fair value at the date of donation. Depreciation is provided for over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction is capitalized as a component cost of acquiring those assets (note 7).

(i) Inventories

Supplies inventories are stated at the lower of cost or market. Cost is determined on the basis of the most recent purchase price, which approximates the first-in, first-out method.

(j) Gifts, Bequests, and Grants

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restriction. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met within the same year as received are reported directly within the consolidated statements of operations.

(k) Donor-Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. The Medical Center's temporarily restricted net assets are restricted for land, building, and equipment acquisitions at both December 31, 2016 and 2015.

Permanently restricted net assets represent donor-restricted contributions, the principal amount of which may not be expended. Investment income earned on permanently restricted net assets, other than changes in the fair value of permanently restricted net assets, which are recorded directly to permanently restricted net assets, is recorded directly to temporarily restricted net assets and is restricted for land, building, and equipment acquisitions.

ASC Topic 958, *Not-for-Profit Entities*, provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of UPMIFA. ASC Topic 958 also enhances disclosures related to both donor-restricted and board-designated endowment funds.

The Riverside Healthcare Foundation holds certain assets contributed for the Medical Center. Amounts due from the Foundation of $2,269,544 and $2,402,694 at December 31, 2016 and 2015, respectively, are restricted by donors for specified programs and the acquisition of property and equipment. Remaining amounts due from the Foundation at December 31, 2016 and 2015 are unrestricted as to use by the Medical Center.

(l) Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Medical Center follows the provisions of ASU 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost can be identified as direct and indirect costs of providing charity care.

(m) Deferred Financing Costs

Deferred financing costs are amortized using the bonds outstanding method. Bond discount and premium are amortized using the straight-line method over the periods in which the related bonds are outstanding.

In April 2015, the FASB issued ASU 2015-03, *Interest – Imputation of Interest* (ASU 2015-03). ASU 2015-03 amends ASC Topic 835, *Interest*, by requiring debt issuance costs to be presented in the balance sheet as a direct deduction from the carrying amount of the debt liability, consistent with the debt discounts and premiums. The Medical Center adopted this standard retrospectively in 2016. As a result of the adoption, the Medical Center reclassified $1,496,032 from deferred financing costs in 2015 to a direct reduction of long-term debt, excluding current installments, unamortized bond discount and premium, and deferred financing costs.

(n) Long-Lived Assets

The Medical Center evaluates long-lived assets for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset. The Medical Center does not believe that there are any factors or circumstances indicating impairment of its long-lived assets as of December 31, 2016 and 2015.

(o) Income Taxes

The Medical Center accounts for uncertain tax positions in accordance with ASC Subtopic 740-10, *Income Taxes – Overall*. ASC Subtopic 740-10 addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Subtopic 740-10, the Medical Center must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Subtopic 740-10 also provides guidance on derecognition, classification, interest and penalties on income taxes, and accounting in interim periods and requires increased disclosures. As of December 31, 2016 and 2015, the Medical Center does not have a liability for unrecognized tax benefits.

The Medical Center is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

(p) Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program (the Program) provides incentive payments to eligible hospitals and professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. The Medical Center accounts for the Program using the grant model. The Medical Center applies the "ratable recognition" approach, which states that the grant income can be recognized ratably over the entire EHR reporting period based on when the applicable project expenses are incurred and project milestones are achieved. For the years ended December 31, 2016 and 2015, the Medical Center recognized $665,548 and $306,882 as other revenue related to EHR incentives, respectively, which have been received or are expected to be received based on certifications prepared by management under the appropriate guidelines for attestation.

(q) New Accounting Pronouncements

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The requirements of this statement are effective for the Medical Center for the year ending December 31, 2018. The ASU permits the new revenue recognition guidance to be applied using one of two retrospective application methods. The Medical Center has not yet determined which application method it will use or the potential effects on the consolidated financial statements, if any.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* (ASU 2016-14). ASU 2016-14 represents phase 1 of FASB's not-for-profit financial reporting project and reduces the number of net asset classes, requires expense presentation by functional and

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natural classification, requires quantitative and qualitative information in liquidity, retains the option to present the cash flow statement on a direct or indirect method, as well as includes various other additional disclosure requirements. ASU 2016-14 will be effective for the Medical Center for the year ending December 31, 2018 with retrospective application. Early adoption of ASU 2016-14 is permitted. The Medical Center has not evaluated the impact of this statement.

In November 2016, the FASB issued ASU 2016-18, *Restricted Cash* (ASU 2016-18), a consensus of the FASB Emerging Issues Task Force. ASU 2016-18 requires an entity to include amounts generally described as restricted cash and restricted cash equivalents, along with cash and cash equivalents when reconciling beginning and ending balances on the statement of cash flows. ASU 2016-18 will be effective for the Medical Center for the year ending December 31, 2019. Early adoption of ASU 2016-18 is permitted.

In February 2016, the FASB issued ASU 2016-02, *Leases*. ASU 2016-02 requires entities to recognize all leased assets as assets on the balance sheet with a corresponding liability resulting in a gross up of the balance sheet. Entities will also be required to present additional disclosures as the nature and extent of leasing activities. ASU 2016-02 is effective for not-for-profit entities that are conduit bond obligors for the annual reporting period beginning after December 15, 2018. The requirements of this statement are effective for the Medical Center for the year ending December 31, 2019. The Medical Center has not evaluated the impact of this statement.

(3) Net Patient Service Revenue

The Medical Center has agreements with third-party payors, which provide for reimbursement to the Medical Center at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Medical Center's billings at list price and the amounts reimbursed by Medicare, Blue Cross, and certain other third-party payors; the difference between the Medical Center's billings at list price and the allocated cost of services provided to Medicaid patients; and any differences between estimated retroactive third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the basis of reimbursement with major third-party payors is as follows:

(a) Medicare

The Medical Center is paid for inpatient acute care and outpatient services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Medical Center's payment classification of patients under the prospective payment system and the appropriateness of the patients' admissions are subject to validation reviews.

Certain services rendered to Medicare beneficiaries are reimbursed based upon cost-reimbursement methodologies. The Medical Center is reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the Medicare fiscal intermediary. As of December 31, 2016, Medicare reimbursement reports have been audited through December 31, 2011.

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(b) Medicaid

The Medical Center is paid for inpatient acute care service rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge and on a per diem basis for psychiatric and rehabilitation services. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed based upon fee schedules. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment methodologies and rates, based on the amount of funding available to the State of Illinois Medicaid program.

The Medical Center participates in all State of Illinois Hospital Assessment programs. Assessment programs provide hospitals within the State additional Medicaid reimbursement based on funding formulas approved by the Centers for Medicare and Medicaid Services (CMS). The Medical Center has included its reimbursement for the years ended December 31, 2016 and 2015 of $15,195,460 and $15,195,464, within net patient service revenue in the accompanying consolidated statements of operations.

The Medical Center included its related assessment tax payments of $9,098,389 and $9,306,476 for the years ended December 31, 2016 and 2015, respectively, within purchased services and supplies expense in the accompanying consolidated statements of operations.

(c) Affordable Care Act

In March 2010, the federal government passed the Affordable Care Act (ACA), which expanded Medicaid coverage to millions of low-income Americans and made improvements to both the Medicaid and the Children's Health Insurance Program. Beginning in 2014, coverage for newly eligible adults would be funded by the federal government for three years. The Medical Center recognized $2,761,007 and $6,562,497 respectively, of net patient service revenue in 2016 and 2015 under this law.

Beginning in 2016, coverage for newly eligible adults was expanded to include adults covered by an authorized Medicaid managed care organization. The coverage would be funded by the federal government for two years. In 2016, reimbursement under the new law resulted in a net increase of $2,730,438 in operating income, which includes $3,358,878 in Medicaid payments included in net patient service revenue offset by $628,440 in Medicaid provider tax expense. A receivable of $909,840 and $1,139,456 is included in other receivables in the accompanying consolidated balance sheets for amounts yet to be collected under this program as of December 31, 2016 and 2015, respectively.

(d) Blue Cross

The Medical Center participates as a provider of healthcare services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at tentative reimbursement rates and that final reimbursement for these services is determined after the submission of an annual cost report by the Medical Center and a review by Blue Cross. As of December 31, 2016, the Blue Cross cost reports have been reviewed by Blue Cross through December 31, 2015.

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(e) Other

The Medical Center has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the Medical Center and includes discounts from established charges and prospectively determined per diem rates.

A summary of gross and net patient service revenue for the years ended December 31, 2016 and 2015 is as follows:

	2016	2015
Gross patient service revenue	$ 1,032,128,504	971,985,181
Less adjustments for:		
Contractual adjustments under third-party reimbursement programs	(721,110,606)	(673,395,033)
Current year impact of prior period third-party reimbursement settlements and changes in estimates	3,893,905	1,670,353
Net patient service revenue	$ 314,911,803	300,260,501

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of December 31, 2016 and 2015 is as follows:

	2016	2015
Medicare	32%	29%
Medicaid	15	16
Blue Cross	19	18
Managed care/commercial	18	16
Self-pay and other	16	21
	100%	100%

A summary of Medical Center utilization based upon gross patient service revenue for the years ended December 31, 2016 and 2015 is as follows:

	2016	2015
Medicare	52%	51%
Medicaid	16	16
Blue Cross	17	17
Managed care/commercial	11	12
Self-pay and other	4	4
	100%	100%

(Continued)

Patients' accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of patients' accounts receivable, the Medical Center analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Medical Center analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Medical Center records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Medical Center's allowance for uncollectible accounts for self-pay patients and at-risk patients, which includes indigent, contract, worker's compensation, and other decreased from 70% of self-pay and at-risk accounts receivable at December 31, 2015, to 62% of self-pay and at-risk accounts receivable at December 31, 2016. The Medical Center's self-pay write-offs increased $1,300,000 from approximately $3,200,000 for fiscal year 2015 to $4,500,000 for fiscal year 2016. The Medical Center has not changed its charity care or uninsured discount policies during fiscal years 2015 and 2016.

The Medical Center recognizes patient service revenue associated with services provided to 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, the Medical Center recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Medical Center's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Medical Center records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (before the provision for bad debts), is recognized in the period from these major payor sources, as follows:

	2016	2015
Medicare	$ 152,670,158	142,036,387
Medicaid	68,290,778	66,318,217
Blue Cross	49,911,398	47,345,462
Managed care/commercial	32,295,610	33,420,326
Self-pay and other	11,743,859	11,140,109
	$ 314,911,803	300,260,501

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(4) Charity Care

The Medical Center maintains a policy whereby patients in need of medical services are treated without regard to their ability to pay for such services. The Medical Center maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the approximate level of charity care provided at cost in accordance with ASU 2010-23 and the Medical Center's policy in effect during the years ended December 31, 2016 and 2015:

	2016	2015
Costs of charity care provided	$ 2,734,253	3,312,574

The Medical Center provides automatic discounts from charges of 45% to all patients without any form of insurance. In addition, patients may also be eligible for additional discounts from charges based upon certain income criteria.

(5) Investments

A summary of the composition of the Medical Center's investment portfolio at December 31, 2016 and 2015 is as follows:

	2016	2015
Accrued interest	$ 1,003,819	1,006,207
Short-term investments, consisting primarily of money market funds	17,016,775	10,844,069
Common stock	48,894,371	43,173,099
Mutual equity funds	101,391,167	90,493,737
U.S. Treasury and U.S. government agency securities	26,038,702	23,873,643
Corporate bonds and notes	39,831,711	39,687,273
Limited partnerships	23,299,292	24,214,985
	$ 257,475,837	233,293,013

Investments are reported in the accompanying consolidated balance sheets as follows at December 31, 2016 and 2015:

	2016	2015
Assets whose use is limited or restricted:		
By board of directors for capital improvements and other	$ 236,545,240	218,474,614
Under bond indenture agreements held by trustee	18,173,275	8,401,361
Donor-restricted investments	2,757,322	2,889,947
Long-term investments	—	3,527,091
	$ 257,475,837	233,293,013

(Continued)

The composition of investment return on the Medical Center's investment portfolio and Riverside Foundation Trust assets for the years ended December 31, 2016 and 2015 is as follows:

		2016	2015
Interest and dividend income, net of fees and expenses	$	6,845,380	6,565,409
Net realized gains on sale of investments		2,482,798	7,304,762
Change in net unrealized gains and losses during the holding period		10,145,968	(18,150,447)
Investment return	$	19,474,146	(4,280,276)

Investment returns are included in the accompanying consolidated statements of operations and changes in net assets for the years ended December 31, 2016 and 2015 as follows:

		2016	2015
Nonoperating gains (losses):			
Investment income (loss), net	$	19,245,977	(4,420,495)
Other changes in net assets:			
Investment income capitalized on borrowed funds held by trustee		194,101	138,402
Investment return earned on temporarily and permanently restricted investments		33,443	6,777
Change in net unrealized gains and losses on permanently restricted investments		625	(4,960)
Investment return	$	19,474,146	(4,280,276)

(6) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Medical Center in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, accounts payable and accrued expenses, patient accounts receivable, and estimated third-party payor settlements.

  Assets limited as to use and long-term investments: Fair values are estimated based on prices provided by its investment managers, custodian banks, and valuations provided by an independent investment reporting service. Common stocks, quoted mutual funds, and U.S. Treasury obligations are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate bonds, notes, certain American Depository Receipts, and U.S. agency securities are measured using other observable inputs. The carrying value equals fair value.

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The Medical Center has two limited partnership investments for which quoted market prices are not available. The two limited partnership investments are the Barings Core Property Fund, L.P. (formerly known as Cornerstone Patriot Fund, L.P.) and Grosvenor Institutional Partners, L.P. The Medical Center elected to apply the concepts of ASC Subtopic 820-10 to its alternative investments using net asset value as a practical expedient in estimating fair value; however, it is possible that the redemption rights of certain investments may be restricted by the funds in the future in accordance with the underlying fund agreements. Changes in market conditions and the economic environment may impact the net asset value of the funds and consequently the fair value of the Medical Center's interests in the funds. The carrying value equals fair value. The estimated fair value of these investments includes estimates, appraisals, assumptions, and methods provided by external financial advisers and reviewed by the Medical Center.

The investment objective of the Barings Core Property Fund, L.P. is to achieve total returns with reduced risk. This is achieved through a diversified investment fund that primarily comprises stabilized, income-producing equity real estate. There is no additional contractual commitment to fund the Barings Core Property Fund, L.P.

The investment objective of the Grosvenor Institutional Partners, L.P. is to achieve positive returns with low volatility and risk. This is achieved through a multimanager, multistrategy, and diversified investment approach. There is no additional contractual commitment to fund the Grosvenor Institutional Partners, L.P.

- Interest rate swaps: The fair value of interest rate swaps is determined using pricing models developed based on the LIBOR swap rate and other observable market data. The value was determined after considering the potential impact of collateralization and netting agreements, adjusted to reflect nonperformance risk of both the counterparty and the Medical Center. The carrying value equals fair value.

(b) Fair Value Hierarchy

The Medical Center applies ASC Subtopic 820-10 for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis.
ASC Subtopic 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques 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 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Medical Center has the ability to access at the measurement date. Level 1 investments include cash and cash equivalents, common stock, and quoted mutual funds.
- Level 2 inputs are observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 investments include certain money market funds, corporate obligations, and U.S. Treasury and U.S. government agency securities

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- Level 3 inputs to the valuation methodology are unobservable and significant inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between levels for the fiscal years ended December 31, 2016 and 2015.

The following table presents assets and liabilities including accrued interest that are measured at fair value on a recurring basis at December 31, 2016:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 31,483,380	31,483,380	—	—	Daily	One
Total cash and cash equivalents	$ 31,483,380	31,483,380	—	—		
Assets limited as to use excluding accrued interest of $1,003,819:						
Mutual equity funds	$ 101,391,167	101,391,167	—	—	Daily	One
Common stocks	48,894,371	48,894,371	—	—	Daily	One
Money market funds	17,016,775	—	17,016,775	—	Daily	One
U.S. Treasury and U.S. government agency securities	26,038,702	—	26,038,702	—	Daily	One
Corporate bonds and notes	39,831,711	—	39,831,711	—	Daily	One
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	11,458,378	—	—	—	Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	11,840,914	—	—	—	Quarterly	Seventy
Total assets limited as to use	256,472,018	150,285,538	82,887,188	—		
Total assets	$ 287,955,398	181,768,918	82,887,188	—		

(Continued)

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Liabilities:						
Interest rate derivatives	$ 2,265,837	—	—	2,265,837		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

The following table presents assets and liabilities including accrued interest that are measured at fair value on a recurring basis at December 31, 2015:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 35,744,135	35,744,135	—	—	Daily	One
Total cash and cash equivalents	35,744,135	35,744,135	—	—		
Assets limited as to use excluding accrued interest of $1,006,207:						
Mutual equity funds	90,493,737	90,493,737	—	—	Daily	One
Common stocks	43,173,099	43,173,099	—	—	Daily	One
Money market funds	7,316,978	—	7,316,978	—	Daily	One
U.S. Treasury and U.S. government agency securities	23,873,643	—	23,873,643	—	Daily	One
Corporate bonds and notes	39,687,273	—	39,687,273	—	Daily	One

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RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2016 and 2015

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	$ 12,604,310	—	—	—	Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	11,610,675	—	—	—	Quarterly	Seventy
Total assets limited as to use	228,759,715	133,666,836	70,877,894	—		
Long-term investments:						
Money market funds	3,527,091	—	3,527,091	—	Daily	One
Total assets	$ 268,030,941	169,410,971	74,404,985	—		
Liabilities:						
Interest rate derivatives	$ 2,265,837	—	—	2,265,837		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

(7) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at December 31, 2016 and 2015 is as follows:

	2016		2015	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 7,979,046	—	7,979,046	—
Land improvements	2,264,266	778,742	3,894,930	2,820,944
Buildings	229,616,820	102,311,734	235,036,501	117,115,689
Equipment	183,102,219	99,537,403	262,877,020	207,133,207
Construction in progress	348,554	—	36,959,961	—
	$ 423,310,905	202,627,879	546,747,458	327,069,840

The Medical Center is currently engaged in various construction, renovation, and software implementation projects. Outstanding commitments related to these projects approximate $9,700,000 at December 31, 2016.

Interest cost is capitalized as a component cost of significant capital projects. Interest income earned on any project-specific borrowed funds is offset against interest cost capitalized. A summary of interest cost capitalized for the years ended December 31, 2016 and 2015 is as follows:

		2016	2015
Gross interest cost capitalized	$	707,417	1,197,227
Investment income on borrowed funds held by trustee		(194,101)	(138,402)
Net interest cost capitalized	$	513,316	1,058,825

(8) Long-Term Debt

A summary of long-term debt as of December 31, 2016 and 2015 is as follows:

	2016	2015
Variable Rate Demand Revenue Bonds, Series 1994, at variable tax-exempt interest rates (0.51% and 0.08% at December 31, 2016 and 2015, respectively), not to exceed the lesser of 20% per annum or the maximum rate permitted by law, maturing serially through November 2019	$ 2,745,755	3,562,061
Variable Rate Demand Revenue Bonds, Series 1996B, at variable tax-exempt interest rates (0.07% at December 31, 2015), not to exceed the lesser of 20% per annum or the maximum rate permitted by law, matured November 2016	—	515,000
Variable Rate Demand Revenue Bonds, Series 2002B, at variable tax-exempt interest rates (1.45% and 0.06% at December 31, 2016 and 2015, respectively), not to exceed the lesser of 20% per annum or the maximum rate permitted by law, maturing serially November 2005 through November 2017	430,000	1,960,000
Revenue refunding bonds, Series 2006C, at varying effective-interest rates (4.59% at December 31, 2015), depending on date of maturity, advance-refunded in 2016	—	40,256,563
Revenue bonds, Series 2009, at varying fixed effective-interest rates (6.22% at December 31, 2016 and 2015), depending on date of maturity and subject to mandatory annual redemption through 2035, partially advance-refunded in 2016	13,129,870	33,066,899
Revenue bonds, Series 2013, at varying fixed effective-interest rates (4.36% at December 31, 2016 and 2015), depending on date of maturity and subject to annual mandatory redemption through 2042	24,905,600	24,905,600

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2016 and 2015

	2016	2015
Revenue refunding bonds, Series 2015, at variable interest rates determined monthly (2.62% and 0.77% at December 31, 2016 and 2015, respectively), subject to mandatory annual principal redemption through 2029	$ 26,167,185	27,665,510
Revenue bonds, Series 2016, at varying fixed effective-interest rates (from 3.00% to 5.00% at December 31, 2016), depending on date of maturity and subject to annual mandatory redemption through 2045	67,460,524	—
Total long-term debt	134,838,934	131,931,633
Less:		
Current installments of long-term debt	3,943,607	4,566,560
Long-term debt subject to short-term remarketing arrangements	1,855,297	—
Unamortized bond discount	127,729	340,825
Deferred financing costs	2,606,945	1,496,032
Plus:		
Unamortized bond premium	7,902,805	1,649,267
Long-term debt, excluding current installments unamortized bond discount and premium, and deferred financing costs	$ 134,208,161	127,177,483

Riverside Health System (RHS), the Medical Center, Oakside Corporation (Oakside), and Riverside Senior Living Center (RSLC) (note 12) (collectively referred to as the Obligated Group) entered into an amended Master Trust Indenture dated as of November 1, 1996 that has since been supplemented. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit. The Master Trust Indenture also requires Obligated Group members to make payments on notes issued by other members of the Obligated Group if such other members are unable to satisfy their obligations under the Master Trust Indenture. At December 31, 2016 and 2015, members of the Obligated Group, other than the Medical Center, had debt outstanding under the Master Trust Indenture aggregating $35,941,066 and $36,728,367, respectively. The Medical Center has not paid or accrued any amounts related to outstanding debt of other Obligated Group affiliates. The obligations of each member of the Obligated Group are secured by the unrestricted receivables of the Obligated Group.

On September 13, 2016, the Illinois Finance Authority issued revenue bonds, Series 2016, in the principal amount of $79,545,000: $67,460,524 on behalf of the Medical Center, $10,856,302 on behalf of RSLC and $1,228,174 on behalf of Oakside. The loan proceeds of the Series 2016 bonds are secured by direct note obligations issued under the Master Trust Indenture. In addition to the principal amounts issued, RHS received a bond premium of $7,632,173 as part of the proceeds: $6,500,794 on behalf of the Medical Center, $1,010,858 on behalf of RSLC and $120,521 on behalf of Oakside. The proceeds from the sale of the Series 2016 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of

acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities, to pay for certain expenses incurred in connection with the issuance of the Series 2016 bonds, and to refund all of the Series 2006C bonds and a portion of the Series 2009 bonds. As part of the redemption, the unamortized deferred financing costs related to the Series 2006C and Series 2009 Bonds were written off at the time of retirement and are reported as a loss on early extinguishment of debt in the amount of $3,715,069 in the accompanying 2016 consolidated statement of operations.

On October 14, 2015, the Illinois Finance Authority issued revenue refunding bonds, Series 2015, in the principal amount of $37,165,000: $27,665,510 on behalf of the Medical Center, $5,811,090 on behalf of Oakside, and $3,688,400 on behalf of RSLC. The loan proceeds of the Series 2015 bonds are secured by direct note obligations issued under the Master Trust Indenture. Interest on the Series 2015 bonds is variable and determined monthly based on 67% of one-month LIBOR plus 0.60%. The proceeds from the sale of the Series 2015 bonds were used by the Obligated Group to advance-refund the Obligated Group's outstanding principal amounts on the Illinois Finance Authority Revenue Bonds, Series 2006A and Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2004. As part of this redemption, the unamortized deferred financing costs related to the Series 2004 and Series 2006A bonds were written off at the time of retirement and are reported as a loss on early extinguishment of debt in the amount of $50,981 in the accompanying 2015 consolidated statement of operations.

On May 16, 2013, the Illinois Finance Authority issued revenue bonds, Series 2013, in the principal amount of $32,000,000: $24,905,600 on behalf of the Medical Center and $7,094,400 on behalf of RSLC. The loan proceeds of the Series 2013 bonds are secured by direct note obligations issued under the Master Trust Indenture. In addition to the principal amounts issued, RHS received a bond premium of $1,887,767 as part of the proceeds: $1,686,723 on behalf of the Medical Center and $201,044 on behalf of RSLC. The proceeds from the sale of the Series 2013 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities and to pay for certain expenses incurred in connection with the issuance of the Series 2013 bonds.

On August 6, 2009, the Illinois Finance Authority issued revenue bonds, Series 2009, in the principal amount of $66,500,000: $43,636,238 on behalf of the Medical Center and $22,863,762 on behalf of RSLC. The loan proceeds of the Series 2009 bonds are secured by direct note obligations issued under the Master Trust Indenture. The proceeds from the sale of the Series 2009 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities to establish a debt service reserve fund for the Series 2009 bonds; to advance-refund the Obligated Group's total outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2006B; to advance-refund a portion of the Obligated Group's outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2004; and to pay termination costs for a derivative agreement in connection with the Series 2004 bonds. The Obligated Group partially advance-refunded these bonds in September 2016 as part of the 2016 Series financing.

On October 26, 2006, the Illinois Finance Authority issued revenue bonds, Series 2006A, in the principal amount of $15,575,000. The loan of the proceeds of the Series 2006A bonds was secured by direct note obligations issued under the Master Trust Indenture. The proceeds from the sale of the Series 2006A and 2006B bonds were used by the Obligated Group, together with certain other available funds, to finance or reimburse the Medical Center for the costs of certain renovation, remodeling, and equipping of its healthcare facilities; and to pay certain expenses incurred in connection with the issuance of the Series 2006A bonds. Effective January 16, 2008, the Obligated Group exercised its option to convert the

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Series 2006A bonds to a different interest rate mode and reissued Variable Rate Demand Revenue Bonds, Series 2006A, in the amount of $15,275,000 through the Illinois Finance Authority. The Obligated Group advance-refunded these bonds in October 2015 as part of the 2015 Series financing.

On December 6, 2006, the Illinois Finance Authority issued revenue refunding bonds, Series 2006C, in the principal amount of $43,625,000: $41,989,063 on behalf of the Medical Center and $1,635,937 on behalf of RSLC. The loan of the proceeds of the Series 2006C bonds is secured by direct note obligations issued under the Master Trust Indenture. The proceeds from the sale of the Series 2006C bonds were used by the Obligated Group, together with certain other available funds, to advance-refund the Obligated Group's outstanding principal amount of the Illinois Finance Authority Revenue Bonds, Series 2002; and to pay certain expenses incurred in connection with the issuance of the Series 2006C bonds.

On May 28, 2004, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 2004, in the principal amount of $46,450,000: $27,945,000 on behalf of the Medical Center, $7,185,000 on behalf of RSLC, and $11,320,000 on behalf of Oakside. The loan of the proceeds of the Series 2004 bonds was secured by direct note obligations issued under the Master Trust Indenture. Effective February 13, 2008, the Obligated Group exercised its option to convert the Series 2004 bonds to a different interest rate mode and reissued Variable Rate Demand Revenue Bonds, Series 2004 in the amount of $44,975,000. The Obligated Group advance-refunded these bonds in October 2015 as part of the 2015 Series financing.

On November 26, 2002, the Illinois Finance Authority also issued Variable Rate Demand Revenue Bonds, Series 2002B, in the principal amount of $15,000,000 on behalf of the Medical Center. The loan of the proceeds of the Series 2002B bonds is secured by a direct note obligation issued under the Master Trust Indenture. The payment of the debt service on the Series 2002B bonds was also secured by an irrevocable letter-of-credit agreement with a commercial bank through August 2014. This letter of credit was replaced on July 1, 2012 by a new irrevocable letter-of-credit agreement with a commercial bank through November 2017. Such bonds have a put option that allows the holders to redeem the bonds prior to maturity. The Obligated Group has an agreement with a remarketing agent to remarket any bonds redeemed as a result of the exercise of the put options. If the bonds cannot be remarketed, the commercial bank, under the irrevocable letter-of-credit agreement, will purchase the bonds. The interest rate under the former irrevocable letter of credit was the prime rate plus 1%. The interest rate under the former irrevocable letter of credit was the prime rate plus 1%. The interest rate under the new irrevocable letter of credit is the greater of the prime rate or adjusted one-month LIBOR. In the event the bank does not renew the letter of credit and a substitute letter of credit is not secured, the Series 2002B bonds would be subject to acceleration.

On November 1, 1996, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 1996B, in the principal amount of $7,300,000 on behalf of the Medical Center. The loan of the proceeds of the Series 1996B bonds is secured by a note issued under the Master Trust Indenture. The payment of debt service on the Series 1996B bonds was also secured by an irrevocable letter-of-credit agreement with a commercial bank through August 2014. This letter of credit was replaced on July 1, 2012 by a new irrevocable letter-of-credit agreement with a commercial bank through November 2016. The Series 1996B bonds were due in annual serial installments through 2016 with interest payable in accordance with the terms specified for the interest rate mode in which the bonds operated. The Series 1996B bonds were fully redeemed in November 2016.

On December 21, 1994, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 1994, in the aggregate principal amount of $20,000,000 (Series 1994 bonds): $14,848,000 on behalf of the Medical Center and $5,152,000 on behalf of RSLC. The loan of the proceeds of the Series 1994 bonds is secured by notes issued under the Master Trust Indenture. The payment of debt service on the Series 1994 bonds was also secured by an irrevocable letter-of-credit agreement with a commercial bank through August 2014. This letter of credit was replaced on July 1, 2012 by a new irrevocable letter-of-credit agreement with a commercial bank through July 2017. The Series 1994 bonds are due in annual serial installments through 2019 with interest payable in accordance with the terms specified for the interest rate mode in which the bonds are operating. Such bonds have a put option that allows the holders to redeem the bonds prior to maturity. The Obligated Group has an agreement with a remarketing agent to remarket any bonds redeemed as a result of the exercise of the put options. If the bonds cannot be remarketed, the commercial bank, under the irrevocable letter-of-credit agreement, will purchase the bonds. The interest rate under the former irrevocable letter of credit was the prime rate plus 1%. The interest rate under the new irrevocable letter of credit is the greater of the prime rate or adjusted one-month LIBOR. In the event the bank does not renew the letter of credit and a substitute letter of credit is not secured, the Series 1994 bonds would be subject to acceleration. The outstanding Series 1994 principal payments of the Medical Center of $2,745,755 have been shown as a current obligation in the accompanying consolidated balance sheet at December 31, 2016, which comprises a current installment of long-term debt of $890,458 and $1,855,297 of long-term debt subject to short-term remarketing arrangements based on expiration of the letter of credit in July 2017.

Under the terms of the related Series 1994, 1996, 2002, 2009, 2013, and 2015 Bond Indentures, the Medical Center is required to maintain certain reserve, construction, and sinking funds with its Bond Trustee. Such funds are restricted to pay for capital project costs as well as to provide funds for the repayment of principal and interest on outstanding bonds when due.

The Medical Center has variable rate demand notes that have a put option available to the creditor. If the put option is exercised, the bonds are presented to the bank, which in turn draws on the underlying letter of credit. The series and the underlying credit facility terms are described as follows:

Series	Terms
Series 2002B bonds	Installments due on the first business day every third month that is 12 months following tender or expiration date in November 2017
Series 1994 bonds	Installments due on the first business day every third month that is 12 months following tender or expiration date in July 2017

(Continued)

Principal repayments on long-term debt based on the variable rate demand notes being put back to the Medical Center and a corresponding draw being made on the underlying letter-of-credit facility are as follows:

Year ending December 31:	
2017	$ 5,798,904
2018	3,131,301
2019	3,305,974
2020	4,792,336
2021	5,372,282
Thereafter	112,438,137
	$ 134,838,934

Scheduled principal repayments on the long-term debt based on the scheduled redemptions according to the Master Trust Indenture are as follows:

Year ending December 31:	
2017	$ 3,943,607
2018	4,021,783
2019	4,270,753
2020	4,792,467
2021	5,372,084
Thereafter	112,438,240
	$ 134,838,934

(9) Derivative Instruments and Hedging Activities

The Medical Center has interest rate-related derivative instruments to manage its exposure on its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management purposes. That is, the Medical Center does not speculate using derivative instruments.

By using derivative financial instruments to hedge exposures to changes in interest rates, the Medical Center exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the Medical Center, which creates credit risk for Medical Center. When the fair value of a derivative contract is negative, the Medical Center owes the counterparty. The Medical Center minimizes the credit risk in derivative instruments by entering into transactions with high-quality counterparties. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. Medical Center management also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

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On May 28, 2004, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 2004. Effective February 13, 2008, the Series 2004 bonds were converted to a weekly mode, which bore interest at the weekly rate (note 8). This debt exposed the Medical Center to variability in interest payments due to changes in interest rates. Management believed it was prudent to limit the variability of its interest payments and manage fluctuations in cash flows resulting from interest rate risk. To meet this objective, management entered into an interest rate swap agreement in 2004, whereby the Obligated Group received, on a monthly basis, 57% of one-month LIBOR plus 54 basis points. In exchange, the Obligated Group paid an annualized fixed rate of 3.794%.

The 2004 interest rate swap agreement does not meet the criteria to qualify for hedge accounting treatment; accordingly, changes in fair value of the swap are recognized as a component of nonoperating gains (losses) in the accompanying consolidated statements of operations. The change in fair value of the swap for the years ended December 31, 2016 and 2015 of $328,031 and $363,925, respectively, was recognized as a component of nonoperating gains (losses). The fair value of the 2004 interest rate swap agreement of $2,059,598 and $2,387,629 at December 31, 2016 and 2015, respectively, has been included in other long-term liabilities in the accompanying consolidated balance sheets.

During 2009, the Medical Center entered into an interest rate swap agreement (Basis Swap) with a commercial bank. The Basis Swap has a notional amount of $25,000,000, which is subject to adjustment according to the terms of the agreement, whereby the Medical Center will receive, on a quarterly basis, 68% of three-month LIBOR plus 67 basis points and will make quarterly payments equal to the USD-SIMFA Municipal Swap Index rate. The fair value payable (receivable) of the Basis Swap of $206,239 and $(224,918) at December 31, 2016 and 2015, respectively, is included as a component of other long-term liabilities. The change in fair value of $(431,157) and $414,469 for the years ended December 31, 2016 and 2015, respectively, was recorded as a component of nonoperating gains (losses).

A summary of outstanding positions under interest rate swap agreements at December 31, 2016 is as follows:

	Notional amount	Maturity date	Rate received	Rate paid
$	25,000,000	November 15, 2029	57% of one-month LIBOR plus 54 basis points	3.794 %
	26,995,000	November 15, 2035	68% of three-month LIBOR plus 67 basis points	USD-SIFMA Municipal Swap Index

Payments by the Medical Center equal to the differential to be paid or received under the interest rate swap agreements are recognized monthly and amounted to $476,617 and $535,009 included as components of interest expense in the accompanying 2016 and 2015 consolidated statements of operations, respectively.

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(10) Self-Insurance

(a) Professional and General Liability Insurance

The Medical Center participates in the Illinois Provider Trust (Provider Trust), which was established on a pooled-risk basis to provide primary professional and general liability coverage to member hospitals. The Provider Trust provided primary insurance coverage on an occurrence basis through December 31, 2004. Effective January 1, 2005, the Provider Trust began providing primary insurance coverage on a claims-made basis. Excess liability coverage is currently provided through the Trust on a claims-made basis.

Funding of the Provider Trust is determined by annual actuarial valuations based on member hospitals' loss experience. If the actual loss experience of the Provider Trust exceeds the actuarially projected loss experience, additional contributions to the Provider Trust may be required from the Medical Center. No retroactive assessments were assessed in 2016 and 2015. For the 2016 fiscal year, the Provider Trust committed to refund excess contributions to its members, of which the Medical Center will receive $1,183,943. The 2015 fiscal year excess contribution refund was $877,957 and was received in 2016. Total contributions to the Provider Trust amounted to $1,785,840 and $1,087,071 for the years ended December 31, 2016 and 2015, respectively, and have been charged to operating expenses as the Medical Center's best estimate of professional and general liability cost. The Medical Center also recognizes provisions for the estimated incurred-but-not-reported loss exposures under claims-made basis policies as of each balance sheet date. The Medical Center's gross undiscounted incurred-but-not-reported claim liabilities of $14,185,699 and $15,473,376 at December 31, 2016 and 2015, respectively, have been included as components of estimated insurance liabilities in the accompanying consolidated balance sheets. Such estimates were actuarially determined based primarily on the Medical Center's historical claims incurred and reporting experience.

The Provider Trust provided full coverage for primary professional and general liability exposure through December 31, 2006. Beginning January 1, 2007, the Medical Center began retaining the first $250,000 per claim with a $1,500,000 annual aggregate. Beginning January 1, 2013, the annual aggregate increased to $2,000,000. Beginning January 1, 2015, the retention per claim increased to $1,000,000 and the annual aggregate increased to $3,000,000. In connection with their self-insured retention, the Medical Center has engaged the services of a professional consultant for actuarial valuations of self-insured funding requirements and claim liability estimates. The amount included in expenses for professional and general liability insurance for 2016 and 2015 was $2,342,950 and $2,979,362, respectively, and is included in insurance expense in the consolidated statements of operations.

(b) Workers' Compensation

The Medical Center maintains a self-insurance program for workers' compensation coverage. Coverage from commercial insurance carriers is maintained for claims in excess of self-insured retentions. The Medical Center's provision for workers' compensation insurance expense includes undiscounted estimates of the ultimate cost of asserted and unasserted claims, as well as claims incurred but not reported as of fiscal year-end. At December 31, 2016 and 2015, the related estimated insurance liabilities are $2,399,629 and $2,871,142, respectively. The amount included in employee benefits for 2016 and 2015 was $848,684 and $1,237,769, respectively, and is included in insurance expense in the consolidated statements of operations.

(Continued)

(c) Employee Health Insurance

Center maintains a self-insurance program for employee healthcare coverage, combining various levels of self-insured retentions and excess coverage. The Medical Center's provision for employee health insurance expenses includes estimates of known claims as well as claims incurred but not reported as of fiscal year-end. At December 31, 2016 and 2015, related estimated self-insurance liabilities are $2,485,240 and $2,504,389, respectively, and are included as components of estimated insurance liabilities in the accompanying consolidated balance sheets.

(d) Receivable for Insurance Recoveries and Management Estimates

Related to ASU No 2010-24, the Medical Center records separate receivables of $4,025,185 and $5,559,175 from gross estimated insurance liabilities as its estimate of insurance recoveries in the 2016 and 2015 consolidated balance sheets, respectively.

Management believes the estimated self-insurance claims liabilities at December 31, 2016 are adequate to cover the ultimate liabilities; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved.

(11) Pension Plan

The Medical Center sponsors a tax-deferred annuity plan under Section 403(b) of the Code and a defined-contribution plan under Section 401(a) of the Code. Significant provisions of the plans are as follows:

- Contributions – Employees contribute to the 403(b) plan through salary reductions specified in the participant's salary reduction agreement. The Medical Center, at its sole discretion, may make matching contributions to the 401(a) plan equal to a defined percentage of the participant's contributions.
- Qualifications – Employees are eligible to participate in the 403(b) plan on the first day of any pay period following their date of hire.
- Vesting – Medical Center employees are fully and immediately vested in the 403(b) plan and the 401(a) plan. Riverside Senior Living Center and Oakside employees are fully and immediately vested in the 403(b) Plan and are 100% vested in the 401(a) Plan after three years of service.

Pension expense that is funded on a current basis was approximately $4,192,000 and $4,072,000 in 2016 and 2015, respectively, and is included in salaries and employee benefits expense.

(12) Affiliated Corporations

RHS was incorporated during 1982 as a not-for-profit corporation to develop and maintain a comprehensive healthcare delivery system. RHS is the sole corporate member of the Medical Center and also serves as the parent corporation for the following:

- Oakside, a not-for-profit corporation of which RHS is the sole corporate member, provides counseling services and promotes community participation in charitable, educational, and public service programs. Oakside also operates a health and fitness facility. Oakside also serves as parent for the Riverside HealthCare Foundation, Inc. (Foundation), which promotes charitable activities through donation, educational programs, and other human service programs.

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- RSLC, a not-for-profit corporation of which RHS is the sole corporate member, operates a retirement housing community with both independent and assisted living services for senior persons and a skilled nursing facility.

The Medical Center leases certain facilities from Oakside for operation of an off-site substance abuse and therapy program. Rental expense under these leases amounted to $183,000 and $177,000 in 2016 and 2015, respectively. The Medical Center leases space to Oakside for operation of a pharmacy. Rental income under this lease amounted to $56,724 in both 2016 and 2015. The Medical Center also provides accounting and other services to Oakside and RSLC. Revenue recorded for these services amounted to $48,000 in both 2016 and 2015. The Medical Center has also provided advances to Oakside and RSLC in the past for various capital projects. Included in other receivables are net amounts due from affiliates of $24,155,093 and $21,368,648 at December 31, 2016 and 2015, respectively.

(13) Affiliation

The Medical Center is affiliated with Rush University Medical Center (Rush). The Medical Center entered into an affiliation agreement with Rush during July 1996, and finalized the affiliation on November 17, 1998. The board of directors of the Medical Center maintains control over the assets and operations of the Medical Center. Riverside/Rush Corporation, a separately incorporated entity, became the sole member of RHS and was created to enhance and improve the delivery of cost-effective, quality healthcare services.

(14) Commitments and Contingencies

(a) Medicare and Medicaid Reimbursement

For the years ended December 31, 2016 and 2015, the Medical Center recognized approximately $152,670,000 and $142,030,000, respectively, of net patient service revenue from services provided to Medicare beneficiaries. Recently enacted healthcare reform and other Medicare legislation may have an adverse effect on the Medical Center's net patient service revenue. Medicaid-payment methodologies and rates may be subject to modification based on the amount of funding available to the State of Illinois Medicaid Program.

The Medical Center has received notices from the Medicare program requiring that they provide Medicare with documentation for claims to carry out the Recovery Audit Contractors (RAC) Program. The Medical Center is responding to these requests. Review of claims through the RAC Program may result in a liability to the Medicare program and could have an adverse effect on the Medical Center's net patient service revenue.

(b) Legal, Regulatory, and Other Contingencies and Commitments

The laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the Medical Center, and other healthcare organizations. Recently, the federal government has increased its enforcement activity, including audits and investigations related to billing practices, clinical documentation, and related matters. The Medical Center maintains a compliance program designed to educate employees and to detect and correct possible violations.

(Continued)

(c) *Regulatory Investigations*

The U.S. Department of Justice (DOJ) and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The Medical Center is subject to these regulatory efforts. Additionally, the laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the Medical Center and other healthcare organizations. The Medical Center maintains a systemwide compliance program and conducts audits and other activities to identify potential compliance issues, including overpayments to governmental payors. Management is currently unaware of any regulatory matters, which may have a material effect on the Medical Center's financial position or results of operations.

(d) *The Patient Protection and Affordable Care Act and Other Enacted Legislation*

In March 2010, the Patient Protection and Affordable Care Act of 2010 (ACA) was enacted. Some of the provisions of the Affordable Care Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months to 10 years following approval. The Affordable Care Act was designed to make available, or subsidize the premium costs of, healthcare insurance for some of the millions of currently uninsured or underinsured consumers below certain income levels. An increase in utilization of healthcare services by those who are currently avoiding or rationing their healthcare was expected. Although bad debt expenses and/or charity care provided were expected to be reduced, increased utilization would be associated with increased variable and fixed costs of providing healthcare services, which may or may not be offset by increased revenue.

The Affordable Care Act contains more than 32 Sections related to healthcare fraud and abuse and program integrity. The potential for increased legal exposure related to the Affordable Care Act's enhanced compliance and regulatory requirements could increase operating expenses.

The Medical Center continues to analyze the Affordable Care Act, including the potential for repeal or replacement, to assess its effects on current and projected operations, financial performance, and financial condition.

(e) *Tax Exemption for Sales Tax and Property Tax*

Effective June 14, 2012, the Governor of Illinois signed into law, *Public Act 97-0688*, which created an additional method for state sales tax and property tax exemptions to be granted to hospitals in Illinois. The law established new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. This law applies only to those properties, which applied for new property tax exemption after the law's enactment. On January 5, 2016, the Fourth District of Illinois Appellate Court ruled that Public Act 97-0688 was unconstitutional under the Illinois Constitution. The Medical Center expects this case will ultimately be taken by the parties to the Illinois Supreme Court. Meanwhile, the Medical Center's property tax exemptions under the law remain intact. The Medical Center has not accrued any liability for property taxes and maintains the position that its hospital is exempt from property taxes.

(Continued)

(f) Investment Risks and Uncertainties

The Medical Center invests in various investment securities. Investment securities are exposed to various risks such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities and current market conditions, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the accompanying consolidated balance sheets.

(15) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with the recently issued ASC Topic 855, *Subsequent Events*, the Medical Center evaluated subsequent events after the consolidated balance sheet date of December 31, 2016 through May 19, 2017, which was the date the consolidated financial statements were issued, and determined no subsequent events requiring recording or disclosure.

KPMG

RIVERSIDE MEDICAL CENTER

Consolidated Financial Statements

December 31, 2017 and 2016

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 E. Randolph Street
Chicago, IL 60601-6436

Independent Auditors' Report

The Board of Directors
Riverside Medical Center:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Riverside Medical Center, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, 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 Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Riverside Medical Center as of December 31, 2017 and 2016, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

May 17, 2018

RIVERSIDE MEDICAL CENTER

Consolidated Balance Sheets

December 31, 2017 and 2016

Assets	2017	2016
Current assets:		
Cash and cash equivalents	$ 69,760,415	31,483,380
Receivables:		
Patient accounts, less allowance for doubtful accounts of approximately $15,000,000 in 2017 and $20,500,000 in 2016	42,165,183	42,837,008
Due from affiliates and other	15,635,917	27,161,644
	57,801,100	69,998,652
Inventory of supplies	7,070,530	6,910,180
Prepaid expenses	4,781,251	3,821,970
Current portion of estimated insurance recoveries	855,616	894,612
Total current assets	140,268,912	113,108,794
Assets whose use is limited or restricted:		
By board of directors for capital improvements and other	263,045,660	236,545,240
Under bond indenture agreements held by trustee	6,671,959	18,173,275
Donor-restricted investments	4,373,597	2,757,322
	274,091,216	257,475,837
Land, buildings, and equipment, net of accumulated depreciation	224,996,410	220,683,026
Due from Riverside HealthCare Foundation, Inc.	6,512,741	5,894,877
Estimated insurance recoveries	2,903,016	3,130,573
Other assets	36,027	36,027
Total assets	$ 648,808,322	600,329,134

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets	2017	2016
Current liabilities:		
Current installments of long-term debt	$ 3,131,267	3,943,607
Long-term debt subject to short-term remarketing arrangements	—	1,855,297
Accounts payable	8,478,722	6,179,846
Accrued expenses	26,500,380	22,347,625
Estimated payables under third-party reimbursement programs	28,849,343	26,448,561
Total current liabilities	66,959,712	60,774,936
Long-term debt, excluding current installments, unamortized bond discount and premium, and deferred financing costs	131,450,878	134,208,161
Construction payables	105,691	491,085
Estimated insurance liabilities	21,721,329	19,249,509
Other long-term liabilities	2,166,540	2,962,683
Total liabilities	222,404,150	217,686,374
Net assets:		
Unrestricted	422,030,575	379,885,438
Temporarily restricted	3,877,549	2,282,846
Permanently restricted	496,048	474,476
Total net assets	426,404,172	382,642,760
Commitments and contingent liabilities		
Total liabilities and net assets	$ 648,808,322	600,329,134

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Operations

Years ended December 31, 2017 and 2016

	2017	2016
Revenue:		
Net patient service revenue	$ 334,898,408	314,911,803
Provision for uncollectible accounts	(5,930,223)	(12,130,672)
Net patient service revenue less provision for uncollectible accounts	328,968,185	302,781,131
Other revenue	6,395,297	5,754,200
Total revenue	335,363,482	308,535,331
Expenses:		
Salaries and employee benefits	170,022,147	155,990,186
Purchased services and supplies	111,094,840	102,615,343
Depreciation and amortization	23,935,810	20,275,755
Utilities	4,820,078	4,373,053
Professional fees	1,133,423	868,293
Insurance	6,757,845	5,930,121
Interest	5,038,575	4,992,763
Total expenses	322,802,718	295,045,514
Income from operations	12,560,764	13,489,817
Nonoperating gains (losses):		
Investment income, net	28,227,437	19,245,977
Loss on early extinguishment of debt	—	(3,715,069)
Change in fair value of derivative instruments	710,112	(103,126)
Other, net	75,037	94,912
Net nonoperating gains, net	29,012,586	15,522,694
Revenue and gains in excess of expenses and losses	41,573,350	29,012,511
Other changes in unrestricted net assets:		
Net assets released from restriction for purchases of land, building, and equipment	571,787	1,152,344
Increase in unrestricted net assets	$ 42,145,137	30,164,855

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2017 and 2016

	2017	2016
Unrestricted net assets:		
Revenue and gains in excess of expenses and losses	$ 41,573,350	29,012,511
Other changes in unrestricted net assets:		
Net assets released from restriction for purchases of land, building, and equipment	571,787	1,152,344
Increase in unrestricted net assets	42,145,137	30,164,855
Temporarily restricted net assets:		
Contributions for specific purposes	2,130,061	985,651
Investment return earned on temporarily and permanently restricted investments	36,429	33,443
Net assets released from restriction for purchases of land, building, and equipment	(571,787)	(1,152,344)
Increase (decrease) in temporarily restricted net assets	1,594,703	(133,250)
Change in permanently restricted net assets:		
Change in net unrealized gains and losses on permanently restricted investments	21,572	625
Change in net assets	43,761,412	30,032,230
Net assets at beginning of year	382,642,760	352,610,530
Net assets at end of year	$ 426,404,172	382,642,760

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended December 31, 2017 and 2016

	2017	2016
Cash flows from operating activities:		
Change in net assets	$ 43,761,412	30,032,230
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	23,935,810	20,275,755
Provision for doubtful accounts	5,930,223	12,130,672
Restricted contributions and investment return	(2,188,062)	(1,019,719)
Net realized and change in unrealized gains and losses on investments	(20,613,597)	(12,594,698)
Loss on early extinguishment of debt	—	3,715,069
Change in fair value of derivative instruments	(710,112)	103,126
Changes in assets and liabilities:		
Patient accounts receivable	(5,258,398)	(19,040,673)
Other receivables	11,525,727	(4,906,778)
Inventory of supplies and prepaid expenses	(1,119,831)	(3,963,990)
Accounts payable and accrued expenses	6,451,631	(469,172)
Estimated payables under third-party reimbursement programs	2,400,782	(2,917,240)
Estimated insurance receivables and liabilities	2,738,373	(255,210)
Other long-term liabilities	(86,031)	84,566
Net cash provided by operating activities	66,768,127	21,173,938
Cash flows from investing activities:		
Sales of assets whose use is limited or restricted	118,489,648	78,824,465
Purchases of assets whose use is limited or restricted	(114,491,430)	(93,939,682)
Net change in long-term investments	—	3,527,091
Acquisition of land, buildings, and equipment, net	(27,875,210)	(21,441,781)
Change in construction payables	(385,394)	(1,484,139)
Net cash used in investing activities	(24,262,386)	(34,514,046)
Cash flows from financing activities:		
Repayment of long-term debt	(5,798,904)	(64,553,223)
Proceeds from issuance of debt, including bond premium	—	73,961,321
Payment of bond issuance costs	—	(984,458)
Restricted contributions and investment return	2,188,062	1,019,719
Net change in due from Riverside HealthCare Foundation, Inc.	(617,864)	(364,006)
Net cash (used in) provided by financing activities	(4,228,706)	9,079,353
Net change in cash and cash equivalents	38,277,035	(4,260,755)
Cash and cash equivalents at beginning of year	31,483,380	35,744,135
Cash and cash equivalents at end of year	$ 69,760,415	31,483,380
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 5,549,074	5,418,562

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

(1) Organization and Operations

Riverside Medical Center (Medical Center), a not-for-profit corporation incorporated under the Illinois General Not-for-Profit Corporation Act, operates a short-term general acute care hospital in Kankakee, an off-site substance abuse treatment center, and various community primary and specialty care clinics. The Medical Center provides general healthcare services to residents within its geographic service areas, including inpatient, outpatient, emergency room, physician, and other services. The Medical Center incurs expenses for the provision of healthcare services and related general and administrative activities.

The consolidated financial statements include the accounts of the Medical Center and the accounts of Riverside Ambulatory Surgery Center (RASC), located in Bourbonnais, Illinois.

All significant intercompany balances and transactions have been eliminated in consolidation.

(2) Summary of Significant Accounting Policies

The following accounting policies are utilized in presenting the accompanying consolidated financial statements of the Medical Center:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

(b) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

(c) Revenue and Gains In Excess of Expenses and Losses

The consolidated statements of operations include revenue and gains in excess of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenue and expenses. Transactions incidental to the provision of patient care services are reported as nonoperating gains and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).

(d) Cash and Cash Equivalents

The Medical Center considers demand deposits with banks, repurchase agreements, cash on hand, and all highly liquid debt instruments purchased with terms of three months or less to be cash equivalents, excluding those instruments classified as assets whose use is limited or restricted.

(e) *Assets Whose Use Is Limited or Restricted*

Assets whose use is limited or restricted include assets set aside by the Medical Center's board of directors (the Board) for future capital improvements and other, over which the Board retains control and may, at its discretion, subsequently use for other purposes; donor-restricted investments; and assets held by a trustee and limited as to use in accordance with the requirements of bond indenture agreements.

Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, and dividends) is included in revenue and gains in excess of expenses and losses unless the income or loss is restricted by donors, in which case, the investment return is recorded directly to temporarily or permanently restricted net assets in accordance with donor intent. The change in net unrealized gains and losses of permanently restricted investments is recorded directly to permanently restricted net assets.

(f) *Fair Value*

The Medical Center applies the provisions of Accounting Standards Codification (ASC) Subtopic 820-10, *Fair Value Measurement – Overall*, for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Subtopic 820-10 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Subtopic 820-10 also establishes a framework for measuring fair value and expands disclosures about fair value measurements (note 6).

The Medical Center applies the provisions of ASC Subtopic 825-10, *Financial Instruments – Overall*. ASC Subtopic 825-10 gives the Medical Center the irrevocable option to report most financial assets and financial liabilities at fair value on an instrument-by-instrument basis, with changes in fair value reported in earnings. The Medical Center did not elect to measure any additional eligible financial assets or financial liabilities at fair value subsequent to the adoption of ASC Subtopic 825-10.

The Medical Center has disclosed investments for which fair value is measured using net asset value per share as a practical expedient outside the fair value hierarchy in accordance with ASC Subtopic 820-10, *Fair Value Measurement – Overall*.

In March 2016, the Financial Accounting Standards Board (FASB) issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). ASU 2016-01 eliminates the requirement for not-for-profit organizations to disclose fair value information for financial instruments measured at amortized cost (e.g., debt). The Medical Center elected to early adopt this part of ASU 2016-01 in 2016. The remaining parts of the ASU are effective for the Medical Center for the year ending December 31, 2019. There was no effect on the Medical Center's consolidated financial statements.

(g) *Derivative Instruments*

The Medical Center accounts for derivatives and hedging activities in accordance with ASC Topic 815, *Derivatives and Hedging*, as amended, which requires that all derivative instruments be recorded in the consolidated balance sheets at their respective fair values.

(Continued)

(h) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost if purchased or at fair value at the date of donation. Depreciation is provided for over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction is capitalized as a component cost of acquiring those assets (note 7).

(i) Inventories

Supplies inventories are stated at the lower of cost or market. Cost is determined on the basis of the most recent purchase price, which approximates the first-in, first-out method.

(j) Gifts, Bequests, and Grants

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to temporarily restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restriction. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met within the same year as received are reported directly within the consolidated statements of operations.

(k) Donor-Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. The Medical Center's temporarily restricted net assets are restricted for land, building, and equipment acquisitions at both December 31, 2017 and 2016.

Permanently restricted net assets represent donor-restricted contributions, the principal amount of which may not be expended. Investment income earned on permanently restricted net assets, other than changes in the fair value of permanently restricted net assets, which are recorded directly to permanently restricted net assets, is recorded directly to temporarily restricted net assets and is restricted for land, building, and equipment acquisitions.

ASC Topic 958, *Not-for-Profit Entities*, provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of UPMIFA. ASC Topic 958 also enhances disclosures related to both donor-restricted and board-designated endowment funds.

The Riverside Healthcare Foundation (the Foundation) holds certain assets contributed for the Medical Center. Amounts due from the Foundation of $3,864,259 and $2,269,544 at December 31, 2017 and 2016, respectively, are restricted by donors for specified programs and the acquisition of property and equipment. Remaining amounts due from the Foundation at December 31, 2017 and 2016 are unrestricted as to use by the Medical Center.

(Continued)

(l) Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Medical Center follows the provisions in ASC Subtopic 954-605, *Health Care Entities – Revenue Recognition*. ASC Subtopic 954-605 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost can be identified as direct and indirect costs of providing charity care.

(m) Deferred Financing Costs

Deferred financing costs are amortized using the bonds outstanding method. Bond discount and premium are amortized using the straight-line method over the periods in which the related bonds are outstanding.

In April 2015, the FASB issued ASU No. 2015-03, *Interest – Imputation of Interest* (ASU 2015-03). ASU 2015-03 amends ASC Topic 835, *Interest,* by requiring debt issuance costs to be presented in the balance sheet as a direct deduction from the carrying amount of the debt liability, consistent with the debt discounts and premiums. The Medical Center adopted this standard retrospectively in 2016.

(n) Long-Lived Assets

The Medical Center evaluates long-lived assets for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset. The Medical Center does not believe that there are any factors or circumstances indicating impairment of its long-lived assets as of December 31, 2017 or 2016.

(o) Income Taxes

The Medical Center accounts for uncertain tax positions in accordance with ASC Subtopic 740-10, *Income Taxes – Overall*. ASC Subtopic 740-10 addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Subtopic 740-10, the Medical Center must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Subtopic 740-10 also provides guidance on derecognition, classification, interest and penalties on income taxes, and accounting in interim periods and requires increased disclosures. As of December 31, 2017 and 2016, the Medical Center does not have a liability for unrecognized tax benefits.

The Medical Center is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

(p) Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program (the Program) provides incentive payments to eligible hospitals and professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. The Medical Center accounts for the Program using the grant model. The Medical Center applies the "ratable recognition" approach, which states that the grant income can be recognized ratably over the entire EHR reporting period based on when the applicable project expenses are incurred and project milestones are achieved. For the years ended December 31, 2017 and 2016, the Medical Center recognized $1,122,930 and $665,548 as other revenue related to EHR incentives, respectively, which have been received or are expected to be received based on certifications prepared by management under the appropriate guidelines for attestation.

(q) New Accounting Pronouncements

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The requirements of this statement are effective for the Medical Center for the year ending December 31, 2018. The ASU permits the new revenue recognition guidance to be applied using one of two retrospective application methods. The Medical Center expects to record a decrease in net patient service revenue and a corresponding decrease in the provision for uncollectible accounts upon adoption of the standard.

In August 2016, the FASB issued ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* (ASU 2016-14). ASU 2016-14 represents phase 1 of FASB's not-for-profit financial reporting project and reduces the number of net asset classes, requires expense presentation by functional and natural classification, requires quantitative and qualitative information in liquidity, retains the option to present the cash flow statement on a direct or indirect method, as well as includes various other additional disclosure requirements. ASU 2016-14 will be effective for the Medical Center for the year ending December 31, 2018 with retrospective application. Early adoption of ASU 2016-14 is permitted. The Medical Center is in the process of evaluating the impact of this statement.

In November 2016, the FASB issued ASU No. 2016-18, *Restricted Cash* (ASU 2016-18), a consensus of the FASB Emerging Issues Task Force. ASU 2016-18 requires an entity to include amounts generally described as restricted cash and restricted cash equivalents, along with cash and cash equivalents when reconciling beginning and ending balances on the statement of cash flows. ASU 2016-18 will be effective for the Medical Center for the year ending December 31, 2019. Early adoption of ASU 2016-18 is permitted. The Medical Center has not evaluated the impact of this statement.

(Continued)

In February 2016, the FASB issued ASU No. 2016-02, *Leases*. ASU 2016-02 requires entities to recognize all leased assets as assets on the balance sheet with a corresponding liability resulting in a gross-up of the balance sheet. Entities will also be required to present additional disclosures as the nature and extent of leasing activities. ASU No. 2016-02 is effective for not-for-profit entities that are conduit bond obligors for the annual reporting period beginning after December 15, 2018. The requirements of this statement are effective for the Medical Center for the year ending December 31, 2019. The Medical Center has not evaluated the impact of this statement.

(3) Net Patient Service Revenue

The Medical Center has agreements with third-party payors, which provide for reimbursement to the Medical Center at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Medical Center's billings at list price and the amounts reimbursed by Medicare, Blue Cross, and certain other third-party payors; the difference between the Medical Center's billings at list price and the allocated cost of services provided to Medicaid patients; and any differences between estimated retroactive third-party reimbursement settlements for prior years and subsequent final settlements. A summary of the basis of reimbursement with major third-party payors is as follows:

(a) Medicare

The Medical Center is paid for inpatient acute care and outpatient services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Medical Center's payment classification of patients under the prospective payment system and the appropriateness of the patients' admissions are subject to validation reviews.

Certain services rendered to Medicare beneficiaries are reimbursed based upon cost-reimbursement methodologies. The Medical Center is reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the Medicare fiscal intermediary. As of December 31, 2017, Medicare reimbursement reports have been audited through December 31, 2011.

(b) Medicaid

The Medical Center is paid for inpatient acute care service rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge and on a per diem basis for psychiatric and rehabilitation services. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed based upon fee schedules. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment methodologies and rates, based on the amount of funding available to the State of Illinois Medicaid program.

The Medical Center participates in all State of Illinois Hospital Assessment programs. Assessment programs provide hospitals within the State additional Medicaid reimbursement based on funding formulas approved by the Centers for Medicare and Medicaid Services (CMS). The Medical Center has included its reimbursement for the years ended December 31, 2017 and 2016 of $22,128,202 and $21,315,345, respectively, within net patient service revenue in the accompanying consolidated

(Continued)

statements of operations. Included in these amounts is $6,930,706 and $6,119,985, respectively, of additional reimbursement under the Affordable Care Act (ACA) expansion. A receivable of $953,941 and $909,840 is included in other receivables in the accompanying consolidated balance sheets for amounts yet to be collected under this program as of December 31, 2017 and 2016, respectively.

The Medical Center included its related assessment tax payments of $10,715,401 and $9,726,829 for the years ended December 31, 2017 and 2016, respectively, within purchased services and supplies expense in the accompanying consolidated statements of operations. Included in these amounts is $1,617,012 and $628,440, respectively, of incremental Medicaid provider tax expense under the ACA expansion for the years ended December 31, 2017 and 2016.

(c) Other

The Medical Center has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the Medical Center and includes discounts from established charges and prospectively determined per diem rates.

A summary of gross and net patient service revenue for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Gross patient service revenue	$ 1,144,599,499	1,032,128,504
Less adjustments for:		
Contractual adjustments under third-party reimbursement programs	(809,576,750)	(721,110,606)
Current year impact of prior period third-party reimbursement settlements and changes in estimates	(124,341)	3,893,905
Net patient service revenue	$ 334,898,408	314,911,803

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of December 31, 2017 and 2016 is as follows:

	2017	2016
Medicare	38%	32%
Medicaid	15	15
Blue Cross	18	19
Managed care/commercial	17	18
Self-pay and other	12	16
	100%	100%

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

A summary of Medical Center utilization based upon gross patient service revenue for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Medicare	52%	52%
Medicaid	17	16
Blue Cross	16	17
Managed care/commercial	11	11
Self-pay and other	4	4
	100%	100%

Patients' accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of patients' accounts receivable, the Medical Center analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Medical Center analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and co-payments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Medical Center records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Medical Center's allowance for uncollectible accounts for self-pay patients and at-risk patients, which includes indigent, contract, worker's compensation, and other decreased from 62% of self-pay and at-risk accounts receivable at December 31, 2016, to 58% of self-pay and at-risk accounts receivable at December 31, 2017. The Medical Center's self-pay write-offs increased $1,700,000 from approximately $4,500,000 for fiscal year 2016 to $6,200,000 for fiscal year 2017. The Medical Center has not changed its charity care or uninsured discount policies during fiscal years 2016 and 2017.

The Medical Center recognizes patient service revenue associated with services provided to 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, the Medical Center recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Medical Center's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Medical Center records a significant provision for bad debts related to uninsured patients in the period the services are

provided. Patient service revenue, net of contractual allowances and discounts (before the provision for bad debts), is recognized in the period from these major payor sources, as follows:

	2017	2016
Medicare	$ 162,953,278	152,670,158
Medicaid	73,735,285	68,290,778
Blue Cross	50,981,544	49,911,398
Managed care/commercial	33,779,182	32,295,610
Self-pay and other	13,449,119	11,743,859
	$ 334,898,408	314,911,803

(4) Charity Care

The Medical Center maintains a policy whereby patients in need of medical services are treated without regard to their ability to pay for such services. The Medical Center maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the approximate level of charity care provided at cost in accordance with ASC Subtopic 954-605 and the Medical Center's policy in effect during the years ended December 31, 2017 and 2016:

	2017	2016
Costs of charity care provided	$ 3,535,311	2,734,253

The Medical Center provides automatic discounts from charges of 45% to all patients without any form of insurance. In addition, patients may also be eligible for additional discounts from charges based upon certain income criteria.

(5) Investments

A summary of the composition of the Medical Center's investment portfolio at December 31, 2017 and 2016 is as follows:

	2017	2016
Accrued interest	$ 1,082,074	1,003,819
Short-term investments, consisting primarily of money market funds	5,203,975	17,016,775
Common stock	51,799,787	48,894,371
Mutual equity funds	113,996,211	101,391,167
U.S. Treasury and U.S. government agency securities	29,702,081	26,038,702
Corporate bonds and notes	47,506,516	39,831,711
Limited partnerships	24,800,572	23,299,292
	$ 274,091,216	257,475,837

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

Investments are reported in the accompanying consolidated balance sheets as follows at December 31, 2017 and 2016:

	2017	2016
Assets whose use is limited or restricted:		
By board of directors for capital improvements and other	$ 263,045,660	236,545,240
Under bond indenture agreements held by trustee	6,671,959	18,173,275
Donor-restricted investments	4,373,597	2,757,322
	$ 274,091,216	257,475,837

The composition of investment return on the Medical Center's investment portfolio and Riverside Foundation Trust assets for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Interest and dividend income, net of fees and expenses	$ 7,790,186	6,845,380
Net realized gains on sale of investments	12,031,980	2,482,798
Change in net unrealized gains and losses during the holding period	8,639,618	10,145,968
Investment return	$ 28,461,784	19,474,146

Investment returns are included in the accompanying consolidated statements of operations and changes in net assets for the years ended December 31, 2017 and 2016 as follows:

	2017	2016
Nonoperating gains:		
Investment income, net	$ 28,227,437	19,245,977
Other changes in net assets:		
Investment income capitalized on borrowed funds held by trustee	176,346	194,101
Investment return earned on temporarily and permanently restricted investments	36,429	33,443
Change in net unrealized gains and losses on permanently restricted investments	21,572	625
Investment return	$ 28,461,784	19,474,146

(6) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Medical Center in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, accounts payable and accrued expenses, patient accounts receivable, and estimated third-party payor settlements.
- Assets limited as to use and long-term investments: Fair values are estimated based on prices provided by its investment managers, custodian banks, and valuations provided by an independent investment reporting service. Common stocks, quoted mutual funds, and U.S. Treasury obligations are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate bonds, notes, certain American Depository Receipts, and U.S. agency securities are measured using other observable inputs. The carrying value equals fair value.
- The Medical Center has two limited partnership investments for which quoted market prices are not available. The two limited partnership investments are the Barings Core Property Fund, L.P. (formerly known as Cornerstone Patriot Fund, L.P.) and Grosvenor Institutional Partners, L.P. The Medical Center elected to apply the concepts of ASC Subtopic 820-10 to its alternative investments using net asset value as a practical expedient in estimating fair value; however, it is possible that the redemption rights of certain investments may be restricted by the funds in the future in accordance with the underlying fund agreements. Changes in market conditions and the economic environment may impact the net asset value of the funds and, consequently, the fair value of the Medical Center's interests in the funds. The carrying value equals fair value. The estimated fair value of these investments includes estimates, appraisals, assumptions, and methods provided by external financial advisers and reviewed by the Medical Center.

  The investment objective of the Barings Core Property Fund, L.P. is to achieve total returns with reduced risk. This is achieved through a diversified investment fund that primarily comprises stabilized, income-producing equity real estate. There is no additional contractual commitment to fund the Barings Core Property Fund, L.P.

  The investment objective of the Grosvenor Institutional Partners, L.P. is to achieve positive returns with low volatility and risk. This is achieved through a multimanager, multistrategy, and diversified investment approach. There is no additional contractual commitment to fund the Grosvenor Institutional Partners, L.P.

- Interest rate swaps: The fair value of interest rate swaps is determined using pricing models developed based on the LIBOR swap rate and other observable market data. The value was determined after considering the potential impact of collateralization and netting agreements, adjusted to reflect nonperformance risk of both the counterparty and the Medical Center. The carrying value equals fair value.

(Continued)

(b) Fair Value Hierarchy

The Medical Center applies ASC Subtopic 820-10 for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Subtopic 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques 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 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Medical Center has the ability to access at the measurement date. Level 1 investments include cash and cash equivalents, common stock, and quoted mutual funds.
- Level 2 inputs are observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 investments include certain money market funds, corporate obligations, and U.S. Treasury and U.S. government agency securities
- Level 3 inputs to the valuation methodology are unobservable and significant inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between levels for the fiscal years ended December 31, 2017 and 2016.

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

The following table presents assets and liabilities, including accrued interest, that are measured at fair value on a recurring basis at December 31, 2017:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 69,760,415	69,760,415	—	—	Daily	One
Total cash and cash equivalents	$ 69,760,415	69,760,415	—	—		
Assets limited as to use excluding accrued interest of $1,082,074:						
Mutual equity funds	$ 113,996,211	113,996,211	—	—	Daily	One
Common stocks	51,799,787	51,799,787	—	—	Daily	One
Money market funds	5,203,975	—	5,203,975	—	Daily	One
U.S. Treasury and U.S. government agency securities	29,702,081	—	29,702,081	—	Daily	One
Corporate bonds and notes	47,506,516	—	47,506,516	—	Daily	One
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	12,222,613				Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	12,577,959				Quarterly	Seventy
Total assets limited as to use	273,009,142	165,795,998	82,412,572	—		
Total assets	$ 342,769,557	235,556,413	82,412,572	—		
Liabilities:						
Interest rate derivatives	$ 1,555,725	—	1,555,725	—		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

The following table presents assets and liabilities, including accrued interest, that are measured at fair value on a recurring basis at December 31, 2016:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 31,483,380	31,483,380	—	—	Daily	One
Total cash and cash equivalents	$ 31,483,380	31,483,380	—	—		
Assets limited as to use excluding accrued interest of $1,003,819:						
Mutual equity funds	$ 101,391,167	101,391,167	—	—	Daily	One
Common stocks	48,894,371	48,894,371	—	—	Daily	One
Money market funds	17,016,775	—	17,016,775	—	Daily	One
U.S. Treasury and U.S. government agency securities	26,038,702	—	26,038,702	—	Daily	One
Corporate bonds and notes	39,831,711	—	39,831,711	—	Daily	One
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	11,458,378				Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	11,840,914				Quarterly	Seventy
Total assets limited as to use	256,472,018	150,285,538	82,887,188	—		
Total assets	$ 287,955,398	181,768,918	82,887,188	—		
Liabilities:						
Interest rate derivatives	$ 2,265,837	—	2,265,837	—		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

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(7) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at December 31, 2017 and 2016 is as follows:

	2017		2016	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 8,020,853	—	7,979,046	—
Land improvements	3,285,167	1,043,623	2,264,266	778,742
Buildings	234,713,605	109,853,229	229,616,820	102,311,734
Equipment	186,675,783	108,642,258	183,102,219	99,537,403
Construction in progress	11,840,112	—	348,554	—
	$ 444,535,520	219,539,110	423,310,905	202,627,879

The Medical Center is currently engaged in various construction, renovation, and software implementation projects. Outstanding commitments related to these projects approximate $5,800,000 at December 31, 2017.

Interest cost is capitalized as a component cost of significant capital projects. Interest income earned on any project-specific borrowed funds is offset against interest cost capitalized. A summary of interest cost capitalized for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Gross interest cost capitalized	$ 234,539	707,417
Investment income on borrowed funds held by trustee	(176,346)	(194,101)
Net interest cost capitalized	$ 58,193	513,316

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

(8) Long-Term Debt

A summary of long-term debt as of December 31, 2017 and 2016 is as follows:

		2017	2016
Variable Rate Demand Revenue Bonds, Series 1994, at variable tax-exempt interest rates (0.72% and 0.51% at December 31, 2017 and 2016, respectively), not to exceed the lesser of 20% per annum or the maximum rate permitted by law, maturing serially through November 2019	$	—	2,745,755
Variable Rate Demand Revenue Bonds, Series 2002B, at variable tax-exempt interest rates (0.76% and 1.45% at December 31, 2017 and 2016, respectively), not to exceed the lesser of 20% per annum or the maximum rate permitted by law, maturing serially November 2005 through November 2017		—	430,000
Revenue bonds, Series 2009, at varying fixed effective-interest rates (6.30% at December 31, 2017 and 2016), depending on date of maturity and subject to mandatory annual redemption through 2035, partially advance-refunded in 2016		13,129,870	13,129,870
Revenue bonds, Series 2013, at varying fixed effective-interest rates (4.36% at December 31, 2017 and 2016), depending on date of maturity, and subject to annual mandatory redemption through 2042		24,905,600	24,905,600
Revenue refunding bonds, Series 2015, at variable interest rates determined monthly (3.34% and 2.62% at December 31, 2016 and 2015, respectively), subject to mandatory annual principal redemption through 2029		24,455,779	26,167,185
Revenue bonds, Series 2016, at varying fixed effective-interest rates (from 3.00% to 5.00% at December 31, 2017 and 2016), depending on date of maturity, and subject to annual mandatory redemption through 2045		66,548,838	67,460,524
Total long-term debt	$	129,040,087	134,838,934
Less:			
Current installments of long-term debt		3,131,267	3,943,607
Long-term debt subject to short-term remarketing arrangements		—	1,855,297
Unamortized bond discount		121,007	127,729
Deferred financing costs		1,771,101	2,606,945
Plus:			
Unamortized bond premium		7,434,166	7,902,805
Long-term debt, excluding current installments unamortized bond discount and premium, and deferred financing costs	$	131,450,878	134,208,161

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2017 and 2016

Riverside Health System (RHS), the Medical Center, Oakside Corporation (Oakside), and Riverside Senior Living Center (RSLC) (note 12) (collectively referred to as the Obligated Group) entered into an amended Master Trust Indenture dated as of November 1, 1996 that has since been supplemented. The purpose of the Master Trust Indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The Master Trust Indenture requires individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit. The Master Trust Indenture also requires Obligated Group members to make payments on notes issued by other members of the Obligated Group if such other members are unable to satisfy their obligations under the Master Trust Indenture. At December 31, 2017 and 2016, members of the Obligated Group, other than the Medical Center, had debt outstanding under the Master Trust Indenture aggregating $34,229,913 and $35,941,066, respectively. The Medical Center has not paid or accrued any amounts related to outstanding debt of other Obligated Group affiliates. The obligations of each member of the Obligated Group are secured by the unrestricted receivables of the Obligated Group.

On September 13, 2016, the Illinois Finance Authority issued revenue bonds, Series 2016, in the principal amount of $79,545,000: $67,460,524 on behalf of the Medical Center, $10,856,302 on behalf of RSLC, and $1,228,174 on behalf of Oakside. The loan proceeds of the Series 2016 bonds are secured by direct note obligations issued under the Master Trust Indenture. In addition to the principal amounts issued, RHS received a bond premium of $7,632,173 as part of the proceeds: $6,500,794 on behalf of the Medical Center, $1,010,858 on behalf of RSLC, and $120,521 on behalf of Oakside. The proceeds from the sale of the Series 2016 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities, to pay for certain expenses incurred in connection with the issuance of the Series 2016 bonds, and to refund all of the Series 2006C bonds and a portion of the Series 2009 bonds. As part of the redemption, the unamortized deferred financing costs related to the Series 2006C and Series 2009 Bonds were written off at the time of retirement and are reported as a loss on early extinguishment of debt in the amount of $3,715,069 in the accompanying 2016 consolidated statement of operations.

On October 14, 2015, the Illinois Finance Authority issued revenue refunding bonds, Series 2015, in the principal amount of $37,165,000: $27,665,510 on behalf of the Medical Center, $5,811,090 on behalf of Oakside, and $3,688,400 on behalf of RSLC. The loan proceeds of the Series 2015 bonds are secured by direct note obligations issued under the Master Trust Indenture. Interest on the Series 2015 bonds is variable and determined monthly based on 67% of one-month LIBOR plus 0.60%. The proceeds from the sale of the Series 2015 bonds were used by the Obligated Group to advance-refund the Obligated Group's outstanding principal amounts of the Illinois Finance Authority Revenue Bonds, Series 2006A and Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2004.

On May 16, 2013, the Illinois Finance Authority issued revenue bonds, Series 2013, in the principal amount of $32,000,000: $24,905,600 on behalf of the Medical Center and $7,094,400 on behalf of RSLC. The loan proceeds of the Series 2013 bonds are secured by direct note obligations issued under the Master Trust Indenture. In addition to the principal amounts issued, RHS received a bond premium of $1,887,767 as part of the proceeds: $1,686,723 on behalf of the Medical Center and $201,044 on behalf of RSLC. The proceeds from the sale of the Series 2013 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities and to pay for certain expenses incurred in connection with the issuance of the Series 2013 bonds.

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On August 6, 2009, the Illinois Finance Authority issued revenue bonds, Series 2009, in the principal amount of $66,500,000: $43,636,238 on behalf of the Medical Center and $22,863,762 on behalf of RSLC. The loan proceeds of the Series 2009 bonds are secured by direct note obligations issued under the Master Trust Indenture. The proceeds from the sale of the Series 2009 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities; to establish a debt service reserve fund for the Series 2009 bonds; to advance-refund the Obligated Group's total outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2006B; to advance-refund a portion of the Obligated Group's outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2004; and to pay termination costs for a derivative agreement in connection with the Series 2004 bonds. The Obligated Group partially advance-refunded these bonds in September 2016 as part of the 2016 Series financing.

On December 6, 2006, the Illinois Finance Authority issued revenue refunding bonds, Series 2006C, in the principal amount of $43,625,000: $41,989,063 on behalf of the Medical Center and $1,635,937 on behalf of RSLC. The loan of the proceeds of the Series 2006C bonds is secured by direct note obligations issued under the Master Trust Indenture. The proceeds from the sale of the Series 2006C bonds were used by the Obligated Group, together with certain other available funds, to advance-refund the Obligated Group's outstanding principal amount of the Illinois Finance Authority Revenue Bonds, Series 2002; and to pay certain expenses incurred in connection with the issuance of the Series 2006C bonds. The Obligated Group advance-refunded these bonds in September 2016 as part of the 2016 Series financing.

On November 26, 2002, the Illinois Finance Authority also issued Variable Rate Demand Revenue Bonds, Series 2002B, in the principal amount of $15,000,000 on behalf of the Medical Center. The loan of the proceeds of the Series 2002B bonds is secured by a direct note obligation issued under the Master Trust Indenture. The payment of the debt service on the Series 2002B bonds was also secured by an irrevocable letter-of-credit agreement with a commercial bank through August 2014. This letter of credit was replaced on July 1, 2012 by a new irrevocable letter-of-credit agreement with a commercial bank through November 2017, the final maturity date. Such bonds had a put option that allowed the holders to redeem the bonds prior to maturity. The Obligated Group had an agreement with a remarketing agent to remarket any bonds redeemed as a result of the exercise of the put options. If the bonds were not remarketed, the commercial bank, under the irrevocable letter-of-credit agreement, would have purchased the bonds. The interest rate under the former irrevocable letter of credit was the prime rate plus 1%. The interest rate under the new irrevocable letter of credit is the greater of the prime rate or adjusted one-month LIBOR. The Series 2002B bonds were paid off in 2017.

On December 21, 1994, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 1994, in the aggregate principal amount of $20,000,000 (Series 1994 bonds): $14,848,000 on behalf of the Medical Center and $5,152,000 on behalf of RSLC. The loan of the proceeds of the Series 1994 bonds is secured by notes issued under the Master Trust Indenture. The payment of debt service on the Series 1994 bonds was also secured by an irrevocable letter-of-credit agreement with a commercial bank through August 2014. This letter of credit was replaced on July 1, 2012 by a new irrevocable letter-of-credit agreement with a commercial bank through July 2017. The Series 1994 bonds were due in annual serial installments through 2019 with interest payable in accordance with the terms specified for the interest rate mode in which the bonds are operating. Such bonds had a put option that allowed the holders to redeem the bonds prior to maturity. The Obligated Group had an agreement with a remarketing agent to remarket any bonds redeemed as a result of the exercise of the put options. If the bonds were not remarketed, the

commercial bank, under the irrevocable letter-of-credit agreement, would have purchased the bonds. The interest rate under the former irrevocable letter of credit was the prime rate plus 1%. The interest rate under the new irrevocable letter of credit is the greater of the prime rate or adjusted one-month LIBOR. The outstanding Series 1994 principal payments of $2,745,755 have been shown as a current obligation in the accompanying consolidated balance sheet at December 31, 2016, which comprises a current installment of long-term debt of $890,458 and $1,855,297 of long-term debt subject to short-term remarketing arrangements based on expiration of the letter of credit in July 2017. The remaining outstanding amount of $2,745,755 for the Series 1994 bonds was paid in full in June 2017.

Under the terms of the related Series 1994, 1996, 2002, 2009, 2013, and 2015 Bond Indentures, the Medical Center is required to maintain certain reserve, construction, and sinking funds with its Bond Trustee. Such funds are restricted to pay for capital project costs as well as to provide funds for the repayment of principal and interest on outstanding bonds when due.

Scheduled principal repayments on the long-term debt based on the scheduled redemptions according to the Master Trust Indenture are as follows:

Year ending December 31:	
2018	$ 3,131,267
2019	3,306,030
2020	4,792,468
2021	5,372,084
2022	5,580,329
Thereafter	106,857,909
	$ 129,040,087

(9) Derivative Instruments and Hedging Activities

The Medical Center has interest rate-related derivative instruments to manage its exposure on its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management purposes. That is, the Medical Center does not speculate using derivative instruments.

By using derivative financial instruments to hedge exposures to changes in interest rates, the Medical Center exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the Medical Center, which creates credit risk for Medical Center. When the fair value of a derivative contract is negative, the Medical Center owes the counterparty. The Medical Center minimizes the credit risk in derivative instruments by entering into transactions with high-quality counterparties. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The Medical Center's management also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

(Continued)

On May 28, 2004, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 2004. Effective February 13, 2008, the Series 2004 bonds were converted to a weekly mode, which bore interest at a weekly rate (note 8). This debt exposed the Medical Center to variability in interest payments due to changes in interest rates. Management believed it was prudent to limit the variability of its interest payments and manage fluctuations in cash flows resulting from interest rate risk. To meet this objective, management entered into an interest rate swap agreement in 2004, whereby the Obligated Group received, on a monthly basis, 57% of one-month LIBOR plus 54 basis points. In exchange, the Obligated Group paid an annualized fixed rate of 3.794%.

The 2004 interest rate swap agreement does not meet the criteria to qualify for hedge accounting treatment; accordingly, changes in fair value of the swap are recognized as a component of nonoperating gains (losses) in the accompanying consolidated statements of operations. The change in fair value of the swap for the years ended December 31, 2017 and 2016 of $330,694 and $328,031, respectively, was recognized as a component of nonoperating gains (losses). The fair value of the 2004 interest rate swap agreement of $1,728,904 and $2,059,598 at December 31, 2017 and 2016, respectively, has been included in other long-term liabilities in the accompanying consolidated balance sheets.

During 2009, the Medical Center entered into an interest rate swap agreement (Basis Swap) with a commercial bank. The Basis Swap has a notional amount of $25,000,000, which is subject to adjustment according to the terms of the agreement, whereby the Medical Center will receive, on a quarterly basis, 83% of three-month LIBOR and will make quarterly payments equal to the USD-SIMFA Municipal Swap Index rate. The fair value (receivable) payable of the Basis Swap of $(173,179) and $206,239 at December 31, 2017 and 2016, respectively, is included as a component of other long-term liabilities. The change in fair value of $379,418 and $(431,157) for the years ended December 31, 2017 and 2016, respectively, was recorded as a component of nonoperating gains (losses).

A summary of outstanding positions under interest rate swap agreements at December 31, 2017 is as follows:

	Notional amount	Maturity date	Rate received	Rate paid
$	24,070,000	November 15, 2029	57% of one-month LIBOR plus 54 basis points	3.794 %
	25,000,000	November 15, 2035	83% of three-month LIBOR	USD-SIFMA Municipal Swap Index

Payments by the Medical Center equal to the differential to be paid or received under the interest rate swap agreements are recognized monthly and amounted to $494,150 and $476,617 included as components of interest expense in the accompanying 2017 and 2016 consolidated statements of operations, respectively.

(Continued)

(10) Self-Insurance

(a) Professional and General Liability Insurance

The Medical Center participates in the Illinois Provider Trust (Provider Trust), which was established on a pooled-risk basis to provide primary professional and general liability coverage to member hospitals. The Provider Trust provided primary insurance coverage on an occurrence basis through December 31, 2004. Effective January 1, 2005, the Provider Trust began providing primary insurance coverage on a claims-made basis. Excess liability coverage is currently provided through the Trust on a claims-made basis.

Funding of the Provider Trust is determined by annual actuarial valuations based on member hospitals' loss experience. If the actual loss experience of the Provider Trust exceeds the actuarially projected loss experience, additional contributions to the Provider Trust may be required from the Medical Center. No retroactive assessments were assessed in 2016 or 2015. For the 2017 fiscal year, the Provider Trust committed to refund excess contributions to its members, of which the Medical Center will receive $1,646,473. The 2016 fiscal year excess contribution refund was $1,183,943 and was received in 2017. Total contributions to the Provider Trust amounted to $2,299,314 and $1,785,840 for the years ended December 31, 2017 and 2016, respectively, and have been charged to operating expenses as the Medical Center's best estimate of professional and general liability cost. The Medical Center also recognizes provisions for the estimated incurred-but-not-reported loss exposures under claims-made basis policies as of each balance sheet date. The Medical Center's gross undiscounted incurred-but-not-reported claim liabilities of $15,435,799 and $14,185,699 at December 31, 2017 and 2016, respectively, have been included as components of estimated insurance liabilities in the accompanying consolidated balance sheets. Such estimates were actuarially determined based primarily on the Medical Center's historical claims incurred and reporting experience.

The Provider Trust provided full coverage for primary professional and general liability exposure through December 31, 2006. Beginning January 1, 2007, the Medical Center began retaining the first $250,000 per claim with a $1,500,000 annual aggregate. Beginning January 1, 2013, the annual aggregate increased to $2,000,000. Beginning January 1, 2015, the retention per claim increased to $1,000,000 and the annual aggregate increased to $3,000,000. Beginning January 1, 2017, the annual aggregate increased to $4,000,000. In connection with their self-insured retention, the Medical Center has engaged the services of a professional consultant for actuarial valuations of self-insured funding requirements and claim liability estimates. The amount included in expenses for professional and general liability insurance for 2017 and 2016 was $3,506,834 and $2,342,950, respectively, and is included in insurance expense in the consolidated statements of operations.

(b) Workers' Compensation

The Medical Center maintains a self-insurance program for workers' compensation coverage. Coverage from commercial insurance carriers is maintained for claims in excess of self-insured retentions. The Medical Center's provision for workers' compensation insurance expense includes undiscounted estimates of the ultimate cost of asserted and unasserted claims, as well as claims incurred but not reported as of fiscal year-end. At December 31, 2017 and 2016, the related estimated insurance liabilities are $2,523,482 and $2,399,629, respectively. The amount included in employee benefits for 2017 and 2016 was $837,968 and $848,684, respectively, and is included in insurance expense in the consolidated statements of operations.

(Continued)

(c) Employee Health Insurance

The Medical Center maintains a self-insurance program for employee healthcare coverage, combining various levels of self-insured retentions and excess coverage. The Medical Center's provision for employee health insurance expenses includes estimates of known claims as well as claims incurred but not reported as of fiscal year-end. At December 31, 2017 and 2016, related estimated self-insurance liabilities are $3,529,202 and $2,485,240, respectively, and are included as components of estimated insurance liabilities in the accompanying consolidated balance sheets.

(d) Receivable for Insurance Recoveries and Management Estimates

Related to ASU No 2010-24, the Medical Center records separate receivables of $3,758,632 and $4,025,185 from gross estimated insurance liabilities as its estimate of insurance recoveries in the 2017 and 2016 consolidated balance sheets, respectively.

Management believes the estimated self-insurance claims liabilities at December 31, 2017 are adequate to cover the ultimate liabilities; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved.

(11) Pension Plan

The Medical Center sponsors a tax-deferred annuity plan under Section 403(b) of the Code and a defined-contribution plan under Section 401(a) of the Code. Significant provisions of the plans are as follows:

- Contributions – Employees contribute to the 403(b) plan through salary reductions specified in the participant's salary reduction agreement. The Medical Center, at its sole discretion, may make matching contributions to the 401(a) plan equal to a defined percentage of the participant's contributions.
- Qualifications – Employees are eligible to participate in the 403(b) plan on the first day of any pay period following their date of hire.
- Vesting – Medical Center employees are fully and immediately vested in the 403(b) plan and the 401(a) plan. RSLC and Oakside employees are fully and immediately vested in the 403(b) Plan and are 100% vested in the 401(a) Plan after three years of service.

Pension expense that is funded on a current basis was approximately $4,734,600 and $4,192,000 in 2017 and 2016, respectively, and is included in salaries and employee benefits expense.

(12) Affiliated Corporations

RHS was incorporated during 1982 as a not-for-profit corporation to develop and maintain a comprehensive healthcare delivery system. RHS is the sole corporate member of the Medical Center and also serves as the parent corporation for the following:

- Oakside, a not-for-profit corporation of which RHS is the sole corporate member, provides counseling services and promotes community participation in charitable, educational, and public service programs. Oakside also operates a health and fitness facility. Oakside also serves as parent for the Riverside HealthCare Foundation, Inc. (Foundation), which promotes charitable activities through donation, educational programs, and other human service programs.

(Continued)

- RSLC, a not-for-profit corporation of which RHS is the sole corporate member, operates a retirement housing community with both independent and assisted living services for senior persons and a skilled nursing facility.

The Medical Center leases certain facilities from Oakside for operation of an off-site substance abuse and therapy program. Rental expense under these leases amounted to $177,000 and $183,000 in 2017 and 2016, respectively. The Medical Center leases space to Oakside for operation of a pharmacy. Rental income under this lease amounted to $56,724 in both 2017 and 2016. The Medical Center also provides accounting and other services to Oakside and RSLC. Revenue recorded for these services amounted to $48,000 in both 2017 and 2016. The Medical Center has also provided advances to Oakside and RSLC in the past for various capital projects. Included in other receivables are net amounts due from affiliates of $15,142,965 and $24,155,093 at December 31, 2017 and 2016, respectively.

(13) Affiliation

The Medical Center was affiliated with Rush University Medical Center (Rush) through an affiliation during July 1996 and finalized the affiliation on November 17, 1998. During the affiliation, the board of directors of the Medical Center maintained control over the assets and operations of the Medical Center. Riverside/Rush Corporation, a separately incorporated entity, became the sole member of RHS and was created to enhance and improve the delivery of cost-effective, quality healthcare services. On June 29, 2017, the Riverside/Rush Corporation was dissolved by the board of directors.

(14) Commitments and Contingencies

(a) Medicare and Medicaid Reimbursement

For the years ended December 31, 2017 and 2016, the Medical Center recognized approximately $162,950,000 and $152,670,000, respectively, of net patient service revenue from services provided to Medicare beneficiaries. Recently enacted healthcare reform and other Medicare legislation may have an adverse effect on the Medical Center's net patient service revenue. Medicaid-payment methodologies and rates may be subject to modification based on the amount of funding available to the State of Illinois Medicaid Program.

The Medical Center has received notices from the Medicare program requiring that they provide Medicare with documentation for claims to carry out the Recovery Audit Contractors (RAC) Program. The Medical Center is responding to these requests. Review of claims through the RAC Program may result in a liability to the Medicare program and could have an adverse effect on the Medical Center's net patient service revenue.

(b) Litigation

The Medical Center is subject to complaints, claims, and litigation, which have risen in the normal course of business. In addition, the Medical Center is subject to reviews by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. While the outcome of these suits cannot be determined at this time, management, based on advice from legal counsel, believes that any loss, which may arise from these actions, will not have a material adverse effect on the financial position or results of operations of the Medical Center.

(Continued)

(c) *Regulatory Investigations*

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The Medical Center is subject to these regulatory efforts. Additionally, the laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the Medical Center and other healthcare organizations. The Medical Center maintains a systemwide compliance program and conducts audits and other activities to identify potential compliance issues, including overpayments to governmental payors. Management is currently unaware of any regulatory matters, which may have a material effect on the Medical Center's financial position or results of operations.

(d) *Property and Sales Tax Exemption Legislation*

On June 14, 2012, the governor of Illinois signed into law *Public Act 97-0688* (2012 Hospital Exemption Law), which creates new standards for property and sales tax exemptions for hospitals and hospital affiliates in Illinois. The law establishes new eligibility standards for the issuance of such exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals having a value at least equal to the hospital's estimated property tax liability. In early 2016, the Illinois 4th District Appellate Court ruled that the 2012 Hospital Exemption Law is unconstitutional, but that decision was vacated by the Illinois Supreme Court because the appellate court lacked jurisdiction. In September 2017, the Illinois Supreme Court agreed to hear a separate case challenging the 2012 Hospital Exemption Law with a ruling expected before the end of 2018. It is anticipated that the Medical Center and related properties will retain exemptions until then, but if the Supreme Court rules that the 2012 Hospital Exemption Law is unconstitutional, such ruling could threaten the exempt status of the Medical Center and other related properties. The Medical Center has not recorded a liability for related property taxes based upon management's current determination that such hospital entities will remain eligible for property and sales tax exemption based on the amount of qualified services provided.

The Medical Center is exempt from sales tax and property tax based upon their not-for-profit charitable status. Under the 2012 Hospital Exemption Law, the test for both sales tax exemption for hospital corporations and certain affiliated corporations will be the same, as described above. Management believes that the Medical Center qualifies for both property and sales tax exemption under the new law.

(e) *Investment Risks and Uncertainties*

The Medical Center invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities and current market conditions, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the accompanying consolidated balance sheets.

(Continued)

(15) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with the recently issued ASC Topic 855, *Subsequent Events*, the Medical Center evaluated subsequent events after the consolidated balance sheet date of December 31, 2017 through May 17, 2018, which was the date the consolidated financial statements were issued, and determined no subsequent events requiring recording or disclosure.

KPMG

RIVERSIDE MEDICAL CENTER

Consolidated Financial Statements

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

KPMG LLP
Aon Center
Suite 5500
200 E. Randolph Street
Chicago, IL 60601-6436

Independent Auditors' Report

The Board of Directors
Riverside Medical Center:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Riverside Medical Center, which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, 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 Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Riverside Medical Center as of December 31, 2018 and 2017, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 2 to the consolidated financial statements, Riverside Medical Center changed its method of revenue recognition as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2014-009, *Revenue from Contracts with Customers,* effective January 1, 2018 and adopted the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities,* effective December 31, 2018. Our opinion is not modified with respect to these matters.

KPMG LLP

May 9, 2019

RIVERSIDE MEDICAL CENTER

Consolidated Balance Sheets

December 31, 2018 and 2017

Assets	2018	2017
Current assets:		
Cash and cash equivalents	$ 72,464,726	69,760,415
Receivables:		
Patient receivables, less allowance for doubtful accounts of approximately $15,000,000 in 2017	38,827,029	42,165,183
Due from affiliates and other	23,163,403	15,635,917
	61,990,432	57,801,100
Inventory of supplies	7,697,525	7,070,530
Prepaid expenses	5,361,345	4,781,251
Current portion of estimated insurance recoveries	1,057,886	855,616
Total current assets	148,571,914	140,268,912
Assets whose use is limited or restricted:		
By board of directors for capital improvements and other	246,453,480	263,045,660
Under bond indenture agreements held by trustee	3,484,037	6,671,959
Investments related to net assets with donor restrictions	5,211,551	4,373,597
	255,149,068	274,091,216
Land, buildings, and equipment, net of accumulated depreciation	230,808,023	224,996,410
Due from Riverside HealthCare Foundation, Inc.	6,334,471	6,512,741
Estimated insurance recoveries	3,587,382	2,903,016
Other assets	36,027	36,027
Total assets	$ 644,486,885	648,808,322

See accompanying notes to consolidated financial statements.

(Continued)

Liabilities and Net Assets	2018	2017
Current liabilities:		
Current installments of long-term debt	$ 3,306,029	3,131,267
Accounts payable	5,614,872	8,478,722
Accrued expenses	30,913,499	26,500,380
Estimated payables under third-party reimbursement programs	31,684,580	28,849,343
Total current liabilities	71,518,980	66,959,712
Long-term debt, unamortized bond discount and premium, and deferred financing costs, excluding current installments	118,405,575	131,450,878
Construction payables	2,478,511	105,691
Estimated insurance liabilities	24,914,197	21,721,329
Other long-term liabilities	884,634	2,166,540
Total liabilities	218,201,897	222,404,150
Net assets:		
Net assets without donor restrictions	421,073,437	422,030,575
Net assets with donor restrictions	5,211,551	4,373,597
Total net assets	426,284,988	426,404,172
Total liabilities and net assets	$ 644,486,885	648,808,322

(Continued)

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Operations

Years ended December 31, 2018 and 2017

	2018	2017
Revenue:		
Net patient service revenue	$ 351,939,733	334,898,408
Provision for uncollectible accounts	—	(5,930,223)
Net patient service revenue less provision for uncollectible accounts	351,939,733	328,968,185
Other revenue	5,032,349	6,395,297
Total revenue	356,972,082	335,363,482
Expenses:		
Salaries and employee benefits	192,133,569	170,022,147
Purchased services and supplies	107,203,309	111,094,840
Depreciation and amortization	25,519,323	23,935,810
Utilities	5,064,649	4,820,078
Professional fees	1,153,517	1,133,423
Insurance	7,591,482	6,757,845
Interest	4,667,061	5,038,575
Total expenses	343,332,910	322,802,718
Income from operations	13,639,172	12,560,764
Nonoperating gains (losses):		
Investment (loss) income, net	(16,383,130)	28,227,437
Change in fair value of derivative instruments	1,103,571	710,112
Other, net	172,406	75,037
Total nonoperating (losses) gains, net	(15,107,153)	29,012,586
Revenue and gains in (deficient) excess of expenses and losses	(1,467,981)	41,573,350
Other changes in net assets without donor restrictions:		
Net assets released from restriction for purchases of land, building, and equipment	510,843	571,787
(Decrease) increase in net assets without donor restrictions	$ (957,138)	42,145,137

See accompanying notes to consolidated financial statements.

(Continued)

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2018 and 2017

	2018	2017
Net assets without donor restrictions:		
Revenue and gains in (deficient) excess of expenses and losses	$ (1,467,981)	41,573,350
Other changes in net assets without donor restrictions:		
Net assets released from restriction for purchases of land, building, and equipment	510,843	571,787
(Decrease) increase in net assets without donor restrictions	(957,138)	42,145,137
Net assets with donor restrictions:		
Contributions for specific purposes	1,330,991	2,130,061
Investment return earned on net assets with donor restrictions	17,806	58,001
Net assets released from restriction for purchases of land, building, and equipment	(510,843)	(571,787)
Increase in net assets with donor restrictions	837,954	1,616,275
Change in net assets	(119,184)	43,761,412
Net assets at beginning of year	426,404,172	382,642,760
Net assets at end of year	$ 426,284,988	426,404,172

See accompanying notes to consolidated financial statements.

(Continued)

RIVERSIDE MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities:		
Change in net assets	$ (119,184)	43,761,412
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	25,519,323	23,935,810
Provision for doubtful accounts	—	5,930,223
Restricted contributions and investment return	(1,348,797)	(2,188,062)
Net realized and change in unrealized gains and losses on investments	25,299,088	(20,613,597)
Change in fair value of derivative instruments	(1,103,571)	(710,112)
Changes in assets and liabilities:		
Patient accounts receivable	3,338,154	(5,258,398)
Other receivables	(7,527,486)	11,525,727
Inventory of supplies and prepaid expenses	(1,207,089)	(1,119,631)
Accounts payable and accrued expenses	1,549,269	6,451,631
Estimated payables under third-party reimbursement programs	2,835,237	2,400,782
Estimated insurance receivables and liabilities	2,306,232	2,738,373
Other long-term liabilities	(178,335)	(86,031)
Net cash provided by operating activities	49,362,841	66,768,127
Cash flows from investing activities:		
Sales of assets whose use is limited or restricted	105,013,040	118,489,648
Purchases of assets whose use is limited or restricted	(111,369,980)	(114,491,430)
Acquisition of land, buildings, and equipment, net	(31,165,837)	(27,875,210)
Change in construction payables	2,372,820	(385,394)
Net cash used in investing activities	(35,149,957)	(24,262,386)
Cash flows from financing activities:		
Repayment of long-term debt	(13,035,640)	(5,798,904)
Restricted contributions and investment return	1,348,797	2,188,062
Net change in due from Riverside HealthCare Foundation, Inc.	178,270	(617,864)
Net cash used in financing activities	(11,508,573)	(4,228,706)
Net change in cash and cash equivalents	2,704,311	38,277,035
Cash and cash equivalents at beginning of year	69,760,415	31,483,380
Cash and cash equivalents at end of year	$ 72,464,726	69,760,415
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 5,202,995	5,549,074

See accompanying notes to consolidated financial statements.

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2018 and 2017

(1) Organization and Operations

Riverside Medical Center (Medical Center), a not-for-profit corporation incorporated under the Illinois General Not-for-Profit Corporation Act, operates a short-term general acute care hospital in Kankakee, an off-site substance abuse treatment center, and various community primary and specialty care clinics. The Medical Center provides general healthcare services to residents within its geographic service areas, including inpatient, outpatient, emergency room, physician, and other services. The Medical Center incurs expenses for the provision of healthcare services and related general and administrative activities.

The consolidated financial statements include the accounts of the Medical Center and the accounts of Riverside Ambulatory Surgery Center located in Bourbonnais, Illinois.

All significant intercompany balances and transactions have been eliminated in consolidation.

(2) Summary of Significant Accounting Policies

The following accounting policies are utilized in presenting the accompanying consolidated financial statements of the Medical Center:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

(b) Net Patient Service Revenue

Net patient service revenue is reported at the amounts that reflect the consideration to which the Medical Center expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors, and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. The Medical Center has agreements with third-party payors, which provide for reimbursement at amounts different from their established rates. Contractual adjustments under third-party reimbursement programs represent the difference between billings at list price and the amounts reimbursed by Medicare, Blue Cross, and certain other third-party payors; the difference between billings at list price and the allocated cost of services provided to Medicaid patients; and any differences between estimated retroactive third-party reimbursement settlements for prior years and subsequent final settlements.

Performance obligations are determined based on the nature of the services provided by the Medical Center. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Medical Center believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the Medical Center receiving inpatient acute care services or patients receiving outpatient services in the Medical Center. The Medical Center determines the performance obligation as admission into the hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of

(Continued)

discharge or completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to our patients and customers in a retail setting (e.g., pharmaceuticals and medical equipment) and the Medical Center does not believe it is required to provide additional goods or services related to that sale.

The Medical Center determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Medical Center's policy, and implicit price concessions provided to uninsured patients. The Medical Center determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Medical Center determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (i.e., new information becomes available) or as years are settled or are no longer subject to such audits, reviews, and investigations. During 2018 and 2017, changes to prior year variable consideration resulted in a decrease of net patient service revenue of $45,254 and $124,341, respectively due to changes in cost report settlements and other adjustments to prior years.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Medical Center also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Medical Center estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. In evaluating the collectibility of patients' accounts receivable, The Medical Center analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the variable consideration. Management regularly reviews data about these major payor sources of revenue in evaluating the variable consideration. The Medical Center uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The Medical Center believes that revenue recognized using this approach approximates the revenue that would be recognized if an individual contract approach were used. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change.

(c) Revenue and Gains in Excess (Deficient) of Expenses and Losses

The statement of operations includes revenue and gains in excess (deficient) of expenses and losses. Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as revenue and expenses. Transactions incidental to the provision of patient care services are reported as nonoperating gains and losses. Changes in net assets without donor restrictions that are excluded from revenue and gains in excess (deficient) of expenses and losses,

consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).

(d) Cash and Cash Equivalents and Short-Term Investments

The Medical Center considers demand deposits with banks, repurchase agreements, cash on hand, and all highly liquid debt instruments purchased with terms of three months or less to be cash equivalents, excluding those instruments classified as assets whose use is limited or restricted. Short-term investments consist of securities with an original term of one year or less, excluding cash and cash equivalents and amounts limited or restricted as to use.

(e) Assets Whose Use Is Limited or Restricted

Assets whose use is limited or restricted include assets set aside by the Medical Center's board of directors (the Board) for future capital improvements and other, over which the Board retains control and may, at its discretion, subsequently use for other purposes; investments related to net assets with donor restrictions; and assets held by a trustee and limited as to use in accordance with the requirements of bond indenture agreements.

Investment income or loss (including realized gains and losses on investments, changes in unrealized gains and losses on trading securities, interest, and dividends) is included in revenue and gains in excess (deficient) of expenses and losses unless the income or loss is restricted by donors, in which case, the investment return is recorded directly to net assets with donor restrictions in accordance with donor intent.

(f) Fair Value

The Medical Center applies the provisions of Accounting Standards Codification (ASC) Subtopic 820-10, *Fair Value Measurement—Overall*, for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Subtopic 820-10 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction among market participants at the measurement date. ASC Subtopic 820-10 also establishes a framework for measuring fair value and expands disclosures about fair value measurements (note 6).

The Medical Center applies the provisions of ASC Subtopic 825-10, *Financial Instruments—Overall*. ASC Subtopic 825-10 gives the Medical Center the irrevocable option to report most financial assets and financial liabilities at fair value on an instrument-by-instrument basis, with changes in fair value reported in earnings. The Medical Center did not elect to measure any additional eligible financial assets or financial liabilities at fair value subsequent to the adoption of ASC Subtopic 825-10.

The Medical Center has disclosed investments for which fair value is measured using net asset value per share as a practical expedient outside the fair value hierarchy in accordance with ASC Subtopic 820-10.

In March 2016, the Financial Accounting Standards Board (FASB) issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU 2016-01 eliminates

the requirement for not-for-profit organizations to disclose fair value information for financial instruments measured at amortized cost (e.g., debt). The Medical Center elected to early adopt this part of ASU 2016-01 in 2016. The remaining parts of the ASU are effective for the Medical Center for the year ending December 31, 2019. There was no effect on the Medical Center's consolidated financial statements.

(g) Derivative Instruments

The Medical Center accounts for derivatives and hedging activities in accordance with ASC Topic 815, *Derivatives and Hedging*, as amended, which requires that all derivative instruments be recorded in the consolidated balance sheets at their respective fair values.

(h) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost if purchased or at fair value at the date of donation. Depreciation is provided for over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction is capitalized as a component cost of acquiring those assets (note 7).

(i) Inventories

Supplies inventories are stated at the lower of cost or market. Cost is determined on the basis of the most recent purchase price, which approximates the first-in, first-out method.

(j) Gifts, Bequests, and Grants

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by donors. Contributions are reported as direct additions to net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations as net assets released from restriction. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met within the same year as received are reported directly within the consolidated statements of operations.

(k) Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose. The Medical Center's net assets with donor restrictions are restricted for land, building, and equipment acquisitions, and for donor-restricted contributions, the principal amount of which may not be expended, at both December 31, 2018 and 2017.

ASC Topic 958, *Not-for-Profit Entities*, provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of UPMIFA. ASC Topic 958 also enhances disclosures related to both donor-restricted and board-designated endowment funds.

(Continued)

The Riverside Healthcare Foundation (the Foundation) holds certain assets contributed for the Medical Center. Amounts due from the Foundation of $4,702,189 and $3,864,259 at December 31, 2018 and 2017, respectively, are restricted by donors for specified programs and the acquisition of property and equipment. Remaining amounts due from the Foundation at December 31, 2018 and 2017 are not restricted as to use by the Medical Center.

(l) Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Medical Center follows the provisions in ASC Subtopic 954-605, *Health Care Entities—Revenue Recognition*. ASC Subtopic 954-605 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost can be identified as direct and indirect costs of providing charity care.

(m) Deferred Financing Costs

Deferred financing costs are amortized using the bonds outstanding method. Bond discount and premium are amortized using the straight-line method over the periods in which the related bonds are outstanding. Debt issuance costs, discounts, and premiums are presented in the balance sheet as a direct deduction from the carrying amount of the debt liability.

(n) Long-Lived Assets

The Medical Center evaluates long-lived assets for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset. The Medical Center does not believe that there are any factors or circumstances indicating impairment of its long-lived assets as of December 31, 2018 or 2017.

(o) Income Taxes

The Medical Center accounts for uncertain tax positions in accordance with ASC Subtopic 740-10, *Income Taxes—Overall*. ASC Subtopic 740-10 addresses the determination of how tax benefits claimed or expected to be claimed on a tax return should be recorded in the consolidated financial statements. Under ASC Subtopic 740-10, the Medical Center must recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. ASC Subtopic 740-10 also provides guidance on derecognition, classification, interest and penalties on income taxes, and accounting in interim periods and requires increased disclosures. As of December 31, 2018 or 2017, the Medical Center does not have a liability for unrecognized tax benefits.

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The Medical Center is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

(p) Electronic Health Record Incentive Program

The Electronic Health Record (EHR) Incentive Program (the Program) provides incentive payments to eligible hospitals and professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. The Medical Center accounts for the Program using the grant model. The Medical Center applies the "ratable recognition" approach, which states that the grant income can be recognized ratably over the entire EHR reporting period based on when the applicable project expenses are incurred and project milestones are achieved. For the years ended December 31, 2018 and 2017, the Medical Center recognized $450,500 and $1,122,930 as other revenue related to EHR incentives, respectively, which have been received or are expected to be received based on certifications prepared by management under the appropriate guidelines for attestation.

(q) Liquidity and Availability of Resources

Cash and cash equivalents, short-term investments, and patient accounts receivable, net, as reported on the balance sheets at December 31, 2018 and 2017, are the primary liquid resources used by the Medical Center to meet general expenditure needs within the next year. As part of liquidity management, the Medical Center's policy is to structure and manage its financial assets to be available to meet its general expenditure needs. The Medical Center invests cash in excess of daily requirements in short-term investments. To help manage unanticipated liquidity needs, although intended to satisfy long-term obligations, 94% of noncurrent investments at December 31, 2018, could be utilized within the next year if necessary.

(r) Recently Issued Accounting Standards

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The ASU replaces most existing revenue recognition guidance in GAAP. Topic 606 was adopted January 1, 2018. The standard permits the use of either the retrospective or cumulative effect transition method. The Medical Center selected the cumulative effect transition method. The Medical Center has applied the standard to contracts that are not completed at the date of adoption. The adoption of Topic 606 did not have a significant impact on the results of operations. The adoption of ASC Topic 606 resulted in changes to the presentation and disclosure of revenue related to uninsured or underinsured patients. Prior to the adoption of ASC Topic 606, the Medical Center presented a separate provision for bad debts related to self-pay patients, as well as co pays and deductibles owed by patients with insurance. Under ASC Topic 606, the estimated uncollectible amounts due from these patients are generally considered a direct reduction to net patient service revenues and, correspondingly, result in a material reduction in the amounts presented separately as provision for bad debts. Under the new guidance, $11,302,140 of implicit price concessions are presented net within net patient service revenue in 2018. There would not have been a material impact to any financial statement line item in the current period as compared with the guidance that was in effect prior to the change. Disclosures in the *Summary of Significant Accounting Policies – Net Patient Service Revenue* note have been updated as required by the standard.

(Continued)

In February 2016, the FASB issued ASU No. 2016-02, *Leases* (Topic 842). Topic 842 requires entities to recognize all leased assets as assets on the balance sheet with a corresponding liability resulting in a gross-up of the balance sheet. Entities will also be required to present additional disclosures of the nature and extent of leasing activities. Topic 842 is effective for not-for-profit entities that are conduit bond obligors for the annual reporting period beginning after December 15, 2018. The requirements of this statement are effective for the Medical Center on January 1, 2019. In July 2018, the FASB issued an update to its guidance providing companies with the option to adopt the provisions of the standard prospectively without adjusting comparative periods; the Medical Center is electing this option.

The Medical Center is electing certain relief options offered in Topic 842 including the package of transition practical expedients, the option not to separate lease and nonlease components for certain classes of assets, and the option not to recognize right-of-use assets and lease liabilities that arise from short-term leases (i.e., leases with terms of 12 months or less). The Medical Center is not electing the hindsight practical expedient, which allows entities to use hindsight when determining lease term and impairment of right-of-use assets.

The adoption of Topic 842 is not expected to have a significant impact on the special purpose combined balance sheet, results of operations, or cash flows. The Medical Center does not have significant lessor or lessee activity. Management will include new disclosures in 2019 in accordance with Topic 842.

In August 2016, the FASB issued ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* (Topic 958). The amendments in this update make certain improvements that address many of the identified issues about financial reporting for not-for-profits. The new standard was adopted by The Medical Center for the annual period beginning January 1, 2018. The standard requires the use of the retrospective transition method. As such, $496,048 of permanently restricted net assets and $3,877,549 of temporarily restricted net assets were reclassified into net assets without donor restrictions for 2017. Disclosures in the *Functional Expenses* note *(Note 16)* and the *Summary of Significant Accounting Policies—Liquidity and Availability of Resources* note have been added as required by the standard for the classification of expenses and management of liquid resources, respectively.

In November 2016, the FASB issued ASU No. 2016-18, *Restricted Cash*, a consensus of the FASB Emerging Issues Task Force. ASU No. 2016-18 requires an entity to include amounts generally described as restricted cash and restricted cash equivalents, along with cash and cash equivalents when reconciling beginning and ending balances on the statement of cash flows. ASU No. 2016-18 will be effective for The Medical Center for the year ending December 31, 2019. Early adoption of ASU No. 2016-18 is permitted. The Medical Center has not evaluated the impact of this statement.

In June 2018, the FASB issued ASU No. 2018-08 *Not-For-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. The amendments in this update clarify and improve current guidance about whether a transfer of assets is a contribution or an exchange transaction. Additional guidance about when a contribution should be recognized is also included in the amendments. These amendments apply to both resources received by a recipient and given by a resource provider. The new standard is effective for The Medical Center

(Continued)

on January 1, 2019. The adoption of ASU No. 2018-08 is not expected to have a significant impact on the financial statements and related disclosures.

(3) Net Patient Service Revenue

A summary of the basis of reimbursement with major third-party payors is as follows:

(a) Medicare

The Medical Center is paid for inpatient acute care and outpatient services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Medical Center's payment classification of patients under the prospective payment system and the appropriateness of the patients' admissions are subject to validation reviews.

Certain services rendered to Medicare beneficiaries are reimbursed based on cost-reimbursement methodologies. The Medical Center is reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the Medicare fiscal intermediary. As of December 31, 2018, Medicare reimbursement reports have been audited through December 31, 2011.

(b) Medicaid

The Medical Center is paid for inpatient acute care service rendered to Medicaid program beneficiaries under prospectively determined rates-per-discharge and on a per diem basis for psychiatric and rehabilitation services. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed based on fee schedules. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment methodologies and rates, based on the amount of funding available to the State of Illinois Medicaid program.

The Medical Center participates in all State of Illinois Hospital Assessment programs. Assessment programs provide hospitals within the State additional Medicaid reimbursement based on funding formulas approved by the Centers for Medicare and Medicaid Services. The Medical Center has included its reimbursement for the years ended December 31, 2018 and 2017 of $21,654,714 and $22,128,202, respectively, within net patient service revenue in the accompanying consolidated statements of operations. Included in these amounts is $3,116,536 and $6,930,706, respectively, of additional reimbursement under the Affordable Care Act (ACA) expansion. A receivable of $953,941 is included in other receivables in the accompanying consolidated balance sheets for amounts yet to be collected under this program as of December 31, 2017. There is no receivable in 2018 as the Program's final payment was received in October 2018.

The Medical Center included its related assessment tax payments of $12,357,942 and $10,715,401 for the years ended December 31, 2018 and 2017, respectively, within purchased services and supplies expense in the accompanying consolidated statements of operations. Included in these amounts are $966,964 and $1,617,012 of incremental Medicaid provider tax expense under the ACA expansion for the years ended December 31, 2018 and 2017, respectively.

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(c) Other

The Medical Center has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the Medical Center and includes discounts from established charges and prospectively determined per diem rates.

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of December 31, 2018 and 2017 is as follows:

	2018	2017
Medicare	29%	38%
Medicaid	15	15
Blue Cross	23	18
Managed care/commercial	18	17
Self-pay and other	15	12
	100%	100%

A summary of Medical Center utilization based on gross patient service revenue for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Medicare	53%	52%
Medicaid	16	17
Blue Cross	17	16
Managed care/commercial	11	11
Self-pay and other	3	4
	100%	100%

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Medical Center has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (e.g., co-pays and deductibles). The Medical Center records this in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Medical Center expects to collect based on its collection history with those patients.

(Continued)

Patient service revenue, net of contractual allowances and discounts (after the provision for bad debts) is recognized in the period from these major payor sources, as follows:

	2018	2017
Medicare	$ 174,060,206	162,953,278
Medicaid	75,160,887	73,735,285
Blue Cross	54,827,313	50,981,544
Managed care/commercial	35,010,212	33,779,182
Self-pay and other	12,881,115	7,518,896
Net patient service revenue	$ 351,939,733	328,968,185
Other Revenue	5,032,349	6,395,297
Total revenue	356,972,082	335,363,482

Total revenue recognized in the period by type of service is as follows:

	2018	2017
Inpatient	$ 122,164,529	115,175,510
Outpatient/ambulatory	229,775,204	213,792,675
Other	5,032,349	6,395,297
	$ 356,972,082	335,363,482

(4) Charity Care

The Medical Center maintains a policy whereby patients in need of medical services are treated without regard to their ability to pay for such services. The Medical Center maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the approximate level of charity care provided at cost in accordance with ASC Subtopic 954-605 and the Medical Center's policy in effect during the years ended December 31, 2018 and 2017:

	2018	2017
Costs of charity care provided	$ 3,961,009	3,535,311

The Medical Center provides automatic discounts from charges of 45% to all patients without any form of insurance. In addition, patients may also be eligible for additional discounts from charges based on certain income criteria.

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(5) Investments

A summary of the composition of the Medical Center's investment portfolio at December 31, 2018 and 2017 is as follows:

	2018	2017
Accrued interest	$ 1,117,934	1,082,074
Short-term investments, consisting primarily of money market funds	2,718,307	5,203,975
Common stock	45,531,835	51,799,787
Mutual equity funds	103,085,622	113,996,211
U.S. Treasury and U.S. government agency securities	30,937,046	29,702,081
Corporate bonds and notes	46,554,657	47,506,516
Limited partnerships	25,203,667	24,800,572
	$ 255,149,068	274,091,216

Investments are reported in the accompanying consolidated balance sheets as follows at December 31, 2018 and 2017:

	2018	2017
Assets whose use is limited or restricted:		
By board of directors for capital improvements and other	$ 246,453,480	263,045,660
Under bond indenture agreements held by trustee	3,484,037	6,671,959
Investments related to net assets with donor restrictions	5,211,551	4,373,597
	$ 255,149,068	274,091,216

The composition of investment return on the Medical Center's investment portfolio and Riverside Foundation Trust assets for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Interest and dividend income, net of fees and expenses	$ 9,000,444	7,790,186
Net realized gains on sale of investments	3,648,865	12,031,980
Change in net unrealized gains and losses during the holding period	(28,930,147)	8,639,618
Investment return	$ (16,280,838)	28,461,784

(Continued)

Investment returns are included in the accompanying consolidated statements of operations and changes in net assets for the years ended December 31, 2018 and 2017 as follows:

	2018	2017
Nonoperating gains:		
Investment income, net	$ (16,383,130)	28,227,437
Other changes in net assets:		
Investment income capitalized on borrowed funds held by trustee	84,486	176,346
Investment return earned on net assets with donor restrictions	17,806	58,001
Investment return	$ (16,280,838)	28,461,784

(6) Fair Value Measurements

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Medical Center in estimating the fair value of its financial instruments:

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, accounts payable and accrued expenses, patient accounts receivable, and estimated third-party payor settlements.
- Assets limited as to use: Fair values are estimated based on prices provided by its investment managers, custodian banks, and valuations provided by an independent investment reporting service. Common stocks, quoted mutual funds, and U.S. Treasury obligations are measured using quoted market prices at the reporting date multiplied by the quantity held. Corporate bonds, notes, and U.S. agency securities are measured using other observable inputs. The carrying value equals fair value.
- The Medical Center has two limited partnership investments for which quoted market prices are not available. The two limited partnership investments are the Barings Core Property Fund, L.P. and Grosvenor Institutional Partners, L.P. The Medical Center elected to apply the concepts of ASC Subtopic 820-10 to its alternative investments using net asset value as a practical expedient in estimating fair value; however, it is possible that the redemption rights of certain investments may be restricted by the funds in the future in accordance with the underlying fund agreements. Changes in market conditions and the economic environment may impact the net asset value of the funds and, consequently, the fair value of the Medical Center's interests in the funds. The carrying value equals fair value. The estimated fair value of these investments includes estimates, appraisals, assumptions, and methods provided by external financial advisers and reviewed by the Medical Center.

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The investment objective of the Barings Core Property Fund, L.P. is to achieve total returns with reduced risk. This is achieved through a diversified investment fund that primarily comprises stabilized, income-producing equity real estate. There is no additional contractual commitment to fund the Barings Core Property Fund, L.P.

The investment objective of the Grosvenor Institutional Partners, L.P. is to achieve positive returns with low volatility and risk. This is achieved through a multimanager, multistrategy, and diversified investment approach. There is no additional contractual commitment to fund the Grosvenor Institutional Partners, L.P.

- Interest rate swaps: The fair value of interest rate swaps is determined using pricing models developed based on the LIBOR swap rate and other observable market data. The value was determined after considering the potential impact of collateralization and netting agreements, adjusted to reflect nonperformance risk of both the counterparty and the Medical Center. The carrying value equals fair value.

(b) Fair Value Hierarchy

The Medical Center applies ASC Subtopic 820-10 for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis.
ASC Subtopic 820-10 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques 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 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Medical Center has the ability to access at the measurement date. Level 1 investments include cash and cash equivalents, common stock, and quoted mutual funds.
- Level 2 inputs are observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 investments include certain money market funds, corporate obligations, and U.S. Treasury and U.S. government agency securities
- Level 3 inputs to the valuation methodology are unobservable and significant inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between levels for the fiscal year ended December 31, 2018 or 2017.

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RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2018 and 2017

The following table presents assets and liabilities, including accrued interest, that are measured at fair value on a recurring basis at December 31, 2018:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 72,464,726	72,464,726	—	—	Daily	One
Total cash and cash equivalents	$ 72,464,726	72,464,726	—	—		
Assets limited as to use excluding accrued interest of $1,117,934:						
Mutual equity funds	$ 103,085,622	103,085,622	—	—	Daily	One
Common stocks	45,531,835	45,531,835	—	—	Daily	One
Money market funds	2,718,307	—	2,718,307	—	Daily	One
U.S. Treasury and U.S. government agency securities	30,937,046	—	30,937,046	—	Daily	One
Corporate bonds and notes	46,554,657	—	46,554,657	—	Daily	One
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	12,816,264				Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	12,387,403				Quarterly	Seventy
Total assets limited as to use	254,031,134	148,617,457	80,210,010	—		
Total assets	$ 326,495,860	221,082,183	80,210,010	—		
Liabilities:						
Interest rate derivatives	$ 452,154	—	452,154	—		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

(Continued)

RIVERSIDE MEDICAL CENTER

Notes to Consolidated Financial Statements

December 31, 2018 and 2017

The following table presents assets and liabilities, including accrued interest, that are measured at fair value on a recurring basis at December 31, 2017:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Redemption or liquidation	Days notice
Assets:						
Cash and cash equivalents:						
Cash	$ 69,760,415	69,760,415	—	—	Daily	One
Total cash and cash equivalents	$ 69,760,415	69,760,415	—	—		
Assets limited as to use excluding accrued interest of $1,082,074:						
Mutual equity funds	$ 113,996,211	113,996,211	—	—	Daily	One
Common stocks	51,799,787	51,799,787	—	—	Daily	One
Money market funds	5,203,975	—	5,203,975	—	Daily	One
U.S. Treasury and U.S. government agency securities	29,702,081	—	29,702,081	—	Daily	One
Corporate bonds and notes	47,506,516	—	47,506,516	—	Daily	One
Limited partnerships:						
Barings Core Property Fund, L.P. (1)	12,222,613				Quarterly	Thirty
Grosvenor Institutional Partners, L.P. (1)	12,577,959				Quarterly	Seventy
Total assets limited as to use	273,009,142	165,795,998	82,412,572	—		
Total assets	$ 342,769,557	235,556,413	82,412,572	—		
Liabilities:						
Interest rate derivatives	$ 1,555,725	—	1,555,725	—		

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

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(7) Land, Buildings, and Equipment

A summary of land, buildings, and equipment at December 31, 2018 and 2017 is as follows:

	2018		2017	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 8,020,853	—	8,020,853	—
Land improvements	3,400,781	1,352,767	3,285,167	1,043,623
Buildings	252,586,823	118,020,031	234,713,605	109,853,229
Equipment	170,644,895	92,367,582	186,675,783	108,642,258
Construction in progress	7,895,051	—	11,840,112	—
	$ 442,548,403	211,740,380	444,535,520	219,539,110

The Medical Center is currently engaged in various construction, renovation, and software implementation projects. Outstanding commitments related to these projects approximate $20,864,702 at December 31, 2018.

Interest cost is capitalized as a component cost of significant capital projects. Interest income earned on any project-specific borrowed funds is offset against interest cost capitalized. A summary of interest cost capitalized for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Gross interest cost capitalized	$ 392,100	234,539
Investment income on borrowed funds held by trustee	(84,486)	(176,346)
Net interest cost capitalized	$ 307,614	58,193

(Continued)

(8) Long-Term Debt

A summary of long-term debt as of December 31, 2018 and 2017 is as follows:

	2018	2017
Revenue bonds, Series 2009, at varying fixed effective-interest rates (6.30% at December 31, 2018 and 2017), depending on date of maturity and subject to mandatory annual redemption through 2035, partially advance-refunded in 2016	$ 13,129,870	13,129,870
Revenue bonds, Series 2013, at varying fixed effective-interest rates (4.36% at December 31, 2018 and 2017), depending on date of maturity, and subject to annual mandatory redemption through 2042	24,905,600	24,905,600
Revenue refunding bonds, Series 2015, at variable interest rates determined monthly (4.01% and 3.34% at December 31, 2018 and 2017, respectively), subject to mandatory annual principal redemption through 2029	13,194,918	24,455,779
Revenue bonds, Series 2016, at varying fixed effective-interest rates (from 3.00% to 5.00% at December 31, 2018 and 2017), depending on date of maturity, and subject to annual mandatory redemption through 2045	65,230,074	66,548,838
Total long-term debt	$ 116,460,462	129,040,087
Less:		
Current installments of long-term debt	3,306,029	3,131,267
Unamortized bond discount	114,284	121,007
Deferred financing costs	1,606,003	1,771,101
Plus:		
Unamortized bond premium	6,971,429	7,434,166
Long-term debt, unamortized bond discount and premium, and deferred financing costs, excluding current installments	$ 118,405,575	131,450,878

Riverside Health System (RHS), the Medical Center, Oakside Corporation (Oakside), and Riverside Senior Living Center (RSLC) (note 12) (collectively referred to as the Obligated Group) entered into an amended master trust indenture dated as of November 1, 1996 that has since been supplemented. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The master trust indenture requires individual members of the Obligated Group to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Obligated Group members to make payments on notes issued by other members of the Obligated Group if such other members are unable to satisfy their obligations under the master trust indenture. At December 31, 2018 and 2017, members of the Obligated Group, other than the Medical Center, had debt outstanding under the master trust indenture aggregating $27,119,538 and $34,229,913, respectively. The Medical Center has not paid or accrued any amounts related to outstanding debt of other Obligated Group

(Continued)

affiliates. The obligations of each member of the Obligated Group are secured by the unrestricted receivables of the Obligated Group.

On September 13, 2016, the Illinois Finance Authority issued revenue bonds, Series 2016, in the principal amount of $79,545,000: $67,460,524 on behalf of the Medical Center, $10,856,302 on behalf of RSLC, and $1,228,174 on behalf of Oakside. The loan proceeds of the Series 2016 bonds are secured by direct note obligations issued under the master trust indenture. In addition to the principal amounts issued, RHS received a bond premium of $7,632,173 as part of the proceeds: $6,500,794 on behalf of the Medical Center, $1,010,858 on behalf of RSLC, and $120,521 on behalf of Oakside. The proceeds from the sale of the Series 2016 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities; to pay for certain expenses incurred in connection with the issuance of the Series 2016 bonds; and to refund all of the Series 2006C bonds and a portion of the Series 2009 bonds.

On October 14, 2015, the Illinois Finance Authority issued revenue refunding bonds, Series 2015, in the principal amount of $37,165,000: $27,665,510 on behalf of the Medical Center, $5,811,090 on behalf of Oakside, and $3,688,400 on behalf of RSLC. The loan proceeds of the Series 2015 bonds are secured by direct note obligations issued under the master trust indenture. Interest on the Series 2015 bonds is variable and determined monthly based on 79.00% of one-month LIBOR, plus 0.53%. The proceeds from the sale of the Series 2015 bonds were used by the Obligated Group to advance-refund the Obligated Group's outstanding principal amounts of the Illinois Finance Authority Revenue Bonds, Series 2006A and Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2004. In June 2018, RHS retired $15,705,000 of the Series 2015 bonds relating to the principal years 2023 through 2029.

On May 16, 2013, the Illinois Finance Authority issued revenue bonds, Series 2013, in the principal amount of $32,000,000: $24,905,600 on behalf of the Medical Center and $7,094,400 on behalf of RSLC. The loan proceeds of the Series 2013 bonds are secured by direct note obligations issued under the master trust indenture. In addition to the principal amounts issued, RHS received a bond premium of $1,887,767 as part of the proceeds: $1,686,723 on behalf of the Medical Center and $201,044 on behalf of RSLC. The proceeds from the sale of the Series 2013 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities and to pay for certain expenses incurred in connection with the issuance of the Series 2013 bonds.

On August 6, 2009, the Illinois Finance Authority issued revenue bonds, Series 2009, in the principal amount of $66,500,000: $43,636,238 on behalf of the Medical Center and $22,863,762 on behalf of RSLC. The loan proceeds of the Series 2009 bonds are secured by direct note obligations issued under the master trust indenture. The proceeds from the sale of the Series 2009 bonds were used to pay and reimburse the Obligated Group for a portion of the costs of acquiring, constructing, renovating, remodeling, and equipping certain healthcare facilities; to establish a debt service reserve fund for the Series 2009 bonds; to advance-refund the Obligated Group's total outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2006B; to advance-refund a portion of the Obligated Group's outstanding principal amount of the Illinois Finance Authority revenue bonds, Series 2004; and to pay termination costs for a derivative agreement in connection with the Series 2004 bonds. The Obligated Group partially advance-refunded these bonds in September 2016 as part of the 2016 Series financing.

Under the terms of the related Series Bond Indentures, the Medical Center is required to maintain certain reserve, construction, and sinking funds with its bond trustee. Such funds are restricted to pay for capital

(Continued)

project costs as well as to provide funds for the repayment of principal and interest on outstanding bonds when due.

Scheduled principal repayments on the long-term debt based on the scheduled redemptions according to the master trust indenture are as follows:

Year ending December 31:	
2019	$ 3,306,029
2020	4,792,468
2021	5,372,084
2022	5,580,329
2023	3,595,105
Thereafter	93,814,447
	$ 116,460,462

(9) Derivative Instruments and Hedging Activities

The Medical Center has interest rate-related derivative instruments to manage its exposure on its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management purposes. That is, the Medical Center does not speculate using derivative instruments.

By using derivative financial instruments to hedge exposures to changes in interest rates, the Medical Center exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the Medical Center, which creates credit risk for Medical Center. When the fair value of a derivative contract is negative, the Medical Center owes the counterparty. The Medical Center minimizes the credit risk in derivative instruments by entering into transactions with high-quality counterparties. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The Medical Center's management also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

On May 28, 2004, the Illinois Finance Authority issued Variable Rate Demand Revenue Bonds, Series 2004. Effective February 13, 2008, the Series 2004 bonds were converted to a weekly mode, which bore interest at a weekly rate (note 8). This debt exposed the Medical Center to variability in interest payments due to changes in interest rates. Management believed it was prudent to limit the variability of its interest payments and manage fluctuations in cash flows resulting from interest rate risk. To meet this objective, management entered into an interest rate swap agreement in 2004, whereby the Obligated Group received, on a monthly basis, 57.000% of one-month LIBOR plus 54 basis points. In exchange, the Obligated Group paid an annualized fixed rate of 3.794%.

The 2004 interest rate swap agreement does not meet the criteria to qualify for hedge accounting treatment; accordingly, changes in fair value of the swap are recognized as a component of nonoperating gains (losses) in the accompanying consolidated statements of operations. The change in fair value of the

swap for the years ended December 31, 2018 and 2017 of $935,915 and $330,694, respectively, was recognized as a component of nonoperating gains (losses). The fair value of the 2004 interest rate swap agreement of $793,989 and $1,728,904 at December 31, 2018 and 2017, respectively, has been included in other long-term liabilities in the accompanying consolidated balance sheets.

During 2009, the Medical Center entered into an interest rate swap agreement (the Basis Swap) with a commercial bank. The Basis Swap has a notional amount of $25,000,000, which is subject to adjustment according to the terms of the agreement, whereby the Medical Center will receive, on a quarterly basis, 83% of three-month LIBOR and will make quarterly payments equal to the USD-SIMFA Municipal Swap Index rate. The fair value (receivable) payable of the Basis Swap of $(340,835) and $(173,179) at December 31, 2018 and 2017, respectively, is included as a component of other long-term liabilities. The change in fair value of $167,656 and $379,418 for the years ended December 31, 2018 and 2017, respectively, was recorded as a component of nonoperating gains (losses).

A summary of outstanding positions under interest rate swap agreements at December 31, 2018 is as follows:

Notional amount	Maturity date	Rate received	Rate paid
$ 22,520,000	November 15, 2022	57% of one-month LIBOR plus 54 basis points	3.794 %
25,000,000	November 15, 2035	83% of three-month LIBOR	USD-SIFMA Municipal Swap Index

Payments by the Medical Center equal to the differential to be paid or received under the interest rate swap agreements are recognized monthly and amounted to $517,976 and $494,150 included as components of interest expense in the accompanying 2018 and 2017 consolidated statements of operations. On May 4, 2018, RHS terminated $15,705,000 of the fixed payor swap, in conjunction with the partial termination of the Series 2015 Bonds. This advanced the maturity date from November 15, 2029 to November 15, 2022, respectively.

(10) Self-Insurance

(a) Professional and General Liability Insurance

The Medical Center participates in the Illinois Provider Trust (the Provider Trust), which was established on a pooled-risk basis to provide primary professional and general liability coverage to member hospitals. The Provider Trust provided primary insurance coverage on an occurrence basis through December 31, 2004. Effective January 1, 2005, the Provider Trust began providing primary insurance coverage on a claims-made basis. Excess liability coverage is currently provided through the Trust on a claims-made basis.

Funding of the Provider Trust is determined by annual actuarial valuations based on member hospitals' loss experience. If the actual loss experience of the Provider Trust exceeds the actuarially projected loss experience, additional contributions to the Provider Trust may be required from the Medical Center. No retroactive assessments were assessed in 2016 or 2015. For the 2018 fiscal year, the Provider Trust committed to refund excess contributions to its members, of which the Medical Center will receive $1,113,930. For the 2017 fiscal year, the Provider Trust committed to refund excess

(Continued)

contributions to its members, of which the Medical Center will receive $1,646,473. The 2017 fiscal year excess contribution refund was $1,646,473 and was received in 2018. Total contributions to the Provider Trust amounted to $1,385,382 and $2,299,314 for the years ended December 31, 2018 and 2017, respectively, and have been charged to operating expenses as the Medical Center's best estimate of professional and general liability cost. The Medical Center also recognizes provisions for the estimated incurred-but-not-reported loss exposures under claims-made basis policies as of each balance sheet date. The Medical Center's gross undiscounted incurred-but-not-reported claim liabilities of $17,646,223 and $15,435,799 at December 31, 2018 and 2017, respectively, have been included as components of estimated insurance liabilities in the accompanying consolidated balance sheets. Such estimates were actuarially determined based primarily on the Medical Center's historical claims incurred and reporting experience.

The Provider Trust provided full coverage for primary professional and general liability exposure through December 31, 2006. Beginning January 1, 2007, the Medical Center began retaining the first $250,000 per claim with a $1,500,000 annual aggregate. Beginning January 1, 2013, the annual aggregate increased to $2,000,000. Beginning January 1, 2015, the retention per claim increased to $1,000,000 and the annual aggregate increased to $3,000,000. Beginning January 1, 2017, the annual aggregate increased to $4,000,000. In connection with their self-insured retention, the Medical Center has engaged the services of a professional consultant for actuarial valuations of self-insured funding requirements and claim liability estimates. The amount included in expenses for professional and general liability insurance for 2018 and 2017 was $3,039,958 and $3,506,834, respectively, and is included in insurance expense in the consolidated statements of operations.

(b) Workers' Compensation

The Medical Center maintains a self-insurance program for workers' compensation coverage. Coverage from commercial insurance carriers is maintained for claims in excess of self-insured retentions. The Medical Center's provision for workers' compensation insurance expense includes undiscounted estimates of the ultimate cost of asserted and unasserted claims, as well as claims incurred but not reported as of fiscal year-end. At December 31, 2018 and 2017, the related estimated insurance liabilities are $3,221,814 and $2,523,482, respectively. The amount included in employee benefits for 2018 and 2017 was $1,424,999 and $837,968, respectively, and is included in insurance expense in the consolidated statements of operations.

(c) Employee Health Insurance

The Medical Center maintains a self-insurance program for employee healthcare coverage, combining various levels of self-insured retentions and excess coverage. The Medical Center's provision for employee health insurance expenses includes estimates of known claims as well as claims incurred but not reported as of fiscal year-end. At December 31, 2018 and 2017, related estimated self-insurance liabilities are $3,800,813 and $3,529,202, respectively, and are included as components of estimated insurance liabilities in the accompanying consolidated balance sheets.

(d) Receivable for Insurance Recoveries and Management Estimates

Related to ASU No. 2010-24, *Health Care Entities* (Topic 954), the Medical Center records separate receivables of $4,645,268 and $3,758,632 from gross estimated insurance liabilities as its estimate of insurance recoveries in the 2018 and 2017 consolidated balance sheets, respectively.

(Continued)

Management believes the estimated self-insurance claims liabilities at December 31, 2018 are adequate to cover the ultimate liabilities; however, such estimates may be more or less than the amounts ultimately paid when claims are resolved.

(11) Pension Plan

The Medical Center sponsors a tax-deferred annuity plan under Section 403(b) of the Code and a defined-contribution plan under Section 401(a) of the Code. Significant provisions of the plans are as follows:

- Contributions – Employees contribute to the 403(b) plan through salary reductions specified in the participant's salary reduction agreement. The Medical Center, at its sole discretion, may make matching contributions to the 401(a) plan equal to a defined percentage of the participant's contributions.
- Qualifications – Employees are eligible to participate in the 403(b) plan on the first day of any pay period following their date of hire.
- Vesting – Medical Center employees are fully and immediately vested in the 403(b) plan and the 401(a) plan. RSLC and Oakside employees are fully and immediately vested in the 403(b) Plan and are 100% vested in the 401(a) Plan after three years of service.

Pension expense that is funded on a current basis was approximately $5,357,800 and $4,734,600 in 2018 and 2017, respectively, and is included in salaries and employee benefits expense.

(12) Affiliated Corporations

RHS was incorporated during 1982 as a not-for-profit corporation to develop and maintain a comprehensive healthcare delivery system. RHS is the sole corporate member of the Medical Center and also serves as the parent corporation for the following:

- Oakside, a not-for-profit corporation of which RHS is the sole corporate member, provides counseling services and promotes community participation in charitable, educational, and public service programs. Oakside also operates a health and fitness facility. Oakside also serves as parent for the Foundation, which promotes charitable activities through donation, educational programs, and other human service programs.
- RSLC, a not-for-profit corporation of which RHS is the sole corporate member, operates a retirement housing community with both independent and assisted living services for senior persons and a skilled nursing facility.

The Medical Center leases certain facilities from Oakside for operation of an off-site substance abuse and therapy program. Rental expense under these leases amounted to $177,000 in both 2018 and 2017. The Medical Center leases space to Oakside for operation of a pharmacy. Rental income under this lease amounted to $56,724 in both 2018 and 2017. The Medical Center also provides accounting and other services to Oakside and RSLC. Revenue recorded for these services amounted to $48,000 in both 2018 and 2017. The Medical Center has also provided advances to Oakside and RSLC in the past for various capital projects. Included in other receivables are net amounts due from affiliates of $22,711,555 and $15,142,965 at December 31, 2018 and 2017, respectively.

(Continued)

(13) Affiliation

The Medical Center was affiliated with Rush University Medical Center through an affiliation during July 1996 and finalized the affiliation on November 17, 1998. During the affiliation, the board of directors of the Medical Center maintained control over the assets and operations of the Medical Center. Riverside/Rush Corporation, a separately incorporated entity, became the sole member of RHS and was created to enhance and improve the delivery of cost-effective, quality healthcare services. On June 29, 2017, the Riverside/Rush Corporation was dissolved by the board of directors.

(14) Commitments and Contingencies

(a) Medicare and Medicaid Reimbursement

For the years ended December 31, 2018 and 2017, the Medical Center recognized approximately $174,100,000 and $162,950,000, respectively, of net patient service revenue from services provided to Medicare beneficiaries. Recently enacted healthcare reform and other Medicare legislation may have an adverse effect on the Medical Center's net patient service revenue. Medicaid-payment methodologies and rates may be subject to modification based on the amount of funding available to the State of Illinois Medicaid Program.

The Medical Center has received notices from the Medicare program requiring that they provide Medicare with documentation for claims to carry out the Recovery Audit Contractors (RAC) Program. The Medical Center is responding to these requests. Review of claims through the RAC Program may result in a liability to the Medicare program and could have an adverse effect on the Medical Center's net patient service revenue.

(b) Litigation

The Medical Center is subject to complaints, claims, and litigation, which have risen in the normal course of business. In addition, the Medical Center is subject to reviews by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. While the outcome of these suits cannot be determined at this time, management, based on advice from legal counsel, believes that any loss, which may arise from these actions, will not have a material adverse effect on the financial position or results of operations of the Medical Center.

(c) Regulatory Investigations

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The Medical Center is subject to these regulatory efforts. Additionally, the laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the Medical Center and other healthcare organizations. The Medical Center maintains a systemwide compliance program and conducts audits and other activities to identify potential compliance issues, including overpayments to government payors. Management is currently unaware of any regulatory matters, which may have a material effect on the Medical Center's financial position or results of operations.

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(d) Property and Sales Tax Exemption Legislation

On June 14, 2012, the governor of Illinois signed into law *Public Act 97-0688* (2012 Hospital Exemption Law), which creates new standards for property and sales tax exemptions for hospitals and hospital affiliates in Illinois. The law establishes new eligibility standards for the issuance of such exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals having a value at least equal to the hospital's estimated property tax liability. In early 2016, the Illinois 4th District Appellate Court ruled that the 2012 Hospital Exemption Law is unconstitutional, but that decision was vacated by the Illinois Supreme Court because the appellate court lacked jurisdiction. In September 2018, the Illinois Supreme Court agreed to hear a separate case challenging the 2012 Hospital Exemption Law with a ruling expected before the end of 2018. It is anticipated that the Medical Center and related properties will retain exemptions until then, but if the Supreme Court rules that the 2012 Hospital Exemption Law is unconstitutional, such ruling could threaten the exempt status of the Medical Center and other related properties. The Medical Center has not recorded a liability for related property taxes based on management's current determination that such hospital entities will remain eligible for property and sales tax exemption based on the amount of qualified services provided.

The Medical Center is exempt from sales tax and property tax based on their not-for-profit charitable status. Under the 2012 Hospital Exemption Law, the test for both sales tax exemption for hospital corporations and certain affiliated corporations will be the same, as described above. Management believes that the Medical Center qualifies for both property and sales tax exemption under the new law.

(e) Investment Risks and Uncertainties

The Medical Center invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investment securities and current market conditions, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the accompanying consolidated balance sheets.

(15) Functional Expenses

The Medical Center provides healthcare services to residents within its geographic location. Expenses related to providing these services included in the consolidated statements of operations as of December 31, 2018 with 2017 corresponding totals are as follows

(Continued)

		Healthcare services	General and administration	Total
2018				
Salaries and employee benefits	$	180,272,017	11,861,552	192,133,569
Purchased services and supplies		101,169,690	6,033,619	107,203,309
Depreciation and amortization		25,519,323	—	25,519,323
Utilities		4,993,484	71,165	5,064,649
Professional fees		1,153,517	—	1,153,517
Insurance		7,591,482	—	7,591,482
Interest		4,667,061	—	4,667,061
	$	325,366,574	17,966,336	343,332,910
2017	$	304,426,461	18,376,257	322,802,718

Some categories of natural class expenses are attributable to more than one activity and require allocation, applied on a consistent basis. Property costs, including depreciation, are allocated on the basis of square footage. Indirect salaries and benefits are allocated on the basis of budgeted full time equivalent employees. Purchased services and supplies are assigned directly to specific activities as expenditures are made.

(16) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with the recently issued ASC Topic 855, *Subsequent Events*, the Medical Center evaluated subsequent events after the consolidated balance sheet date of December 31, 2018 through May 9, 2019, which was the date the consolidated financial statements were issued, and determined no subsequent events requiring recording or disclosure.

Section IX, Financial Viability

Attachment 35

Financial Viability

Riverside Health System's most recent bond ratings from Standard and Poor's (A+) and Moody's (A2) are included in Attachment 33.

ATTACHMENT 35

Section X, Economic Feasibility

Attachment 36

Economic Feasibility

A. **Reasonableness of Financing Arrangements**.

The Project will be financed through cash on hand and securities.

B. **Conditions of Debt Financing**.

This Project is being paid for through cash and securities and therefore, these criteria do not apply.

C. **Reasonableness of Project and Related Costs**.

The Project should meet all of the Review Board cost standards, with the possible exception of construction costs. To the extent the construction cost exceed the standard Riverside has worked with its architect to identify and quantify construction issues that add to the costs.

	Cost and Gross Square Feet by Department or Service								
Department	A	B	C	D	E	F	G	H	Total
(List Below)	Cost per Square Foot		Gross Square Feet		Gross Square Feet		Const $	Mod $	Costs
	New	Mod.	New	Circ*	Mod.	Circ	A x C	B x E	G + H
Reviewable									
Imaging	$416.80		1,033	20%			$430,559		$430,559
Physical Therapy	$265.00		13,761	15%			$3,646,630		$3,646,630
Occupational Therapy	$265.00		2,096	15%			$555,348		$555,348
Reviewable Subtotal	**$274.28**		**16,890**				**$4,632,537**		**$4,632,537**
Contingency	$27.43						$463,254		$463,254
Non-Reviewable									
Public	$309.72		3,478	15%			$1,077,276		$1,077,276
Clinic/Physician Offices	$309.44		14,492	33%			$4,484,605		$4,484,605
Staff Support	$309.87		2,444	33%			$757,192		$757,192
Building Systems	$306.56		3,333	20%			$1,021,852		$1,021,852
Shell Space	$158.83		23,810	5%			$3,781,630		$3,781,630
Circulation & Elevators	$314.59		10,553	N/A			$3,319,903		$3,319,903
Non-Reviewable Subtotal	**$248.54**		**58,110**				**$14,442,458**		**$14,442,458**
Contingency	$24.85						$1,444,246		$1,444,246
Grand Total			**75,000**				**$20,982,495**		**$20,982,495**

ATTACHMENT 36

Explanation of Construction Cost Issues

Riverside has engaged the architectural firm of Jensen & Halstead, Ltd. for this Project. This firm has experience in construction medical office buildings. Riverside and the architects have calculated additional costs that may not be reflected in RS Means standards.

Site Constraints. The proposed Project is sited at a low elevation and currently is in the path of natural drainage from the surrounding areas. Part of the Project will remedy this situation. During construction of the building, additional costs will be required to keep the site free from water. Additional costs will also need to go into the foundations to ensure proper soil conditions and structural stability of the site.	$300,000
Advanced Infrastructure. The building is to be equipped with a higher level of infrastructure than a typical Medical Office Building with the current services provided. The infrastructure, including electrical and MEP backbones, will be sufficient to account for flexibility of future modalities that will come with the growth of the area and the build-out of the shelled space.	$150,000
Efficient Design. With efficient design, the actual square footage for the imaging department in this Project is significantly less than the state allowable numbers. However, the costs to provide the build-out for these services is equivalent. This results in an increased cost per square foot number	$250,000
Imaging Shielding. In anticipation of future growth and complexity of radiology equipment, the costs of shielding and radiographic protection will be increased in this facility.	$75,000
Emergency Generator. The proposed building will be provided with an Emergency generator, which is not required for a building such as this but is requested for the convenience and safety of the staff and patients. This additional cost is over and above the standard for a building of this type.	$250,000
Natural Lighting. The building façade will include an increased level of vision windows, specifically in the Physical and Occupational Therapy locations. Empirical data shows that natural light provides excellent benefits in the healing process. In a typical office space with physician Exam rooms, windows are less desirable due to the nature of patient privacy. This is not the case for a Therapy space which benefits from a light heating and healing environment.	$125,000
Union Labor. Riverside is committed to constructing this Project using union labor. The difference in cost has not be computed but union labor is often viewed to be an added cost.	Not quantified
Total Premium Costs	**$1,150,000**

ATTACHMENT 36

D. Project Operating Costs.

The criterion is applicable to projects or portions thereof that involve hospital-related clinical departments or services, and this Project does not involve hospital services and thus this is not applicable.

E. Total Effect of Project on Capital Costs.

The criterion is applicable to projects or portions thereof that involve hospital-related clinical departments or services, and this Project does not involve hospital services and thus this is not applicable.

Section XI, Safety Net Impact Statement

Attachment 37

The proposed Project is a non-substantive project and the safety net impact statement should not be applicable.

Section XII, Charity Care Information

Attachment 38

RIVERSIDE MEDICAL CENTER

CHARITY CARE			
	2016	**2017**	**2018**
Net Patient Revenue	$295,481,925	$312,770,233	$351,939,733
Amount of Charity Care (charges)	$2,734,253	$3,535,312	$17,874,267
Cost of Charity Care	$2,734,253	$3,535,312	$3,961,009
Ratio of Charity Care Cost to Net Patient Rev. Medicaid	0.9%	1.1%	1.1%

RIVERSIDE AMBULATORY SURGERY CENTER

CHARITY CARE			
	2016	**2017**	**2018**
Net Patient Revenue	$3,008,050	$3,500,598	$2,992,617
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0
Ratio of Charity Care Cost to Net Patient Revenue	0%	0%	0%
Medicaid	6.0%	9.3%	7.3%

RIVERSIDE SENIOR LIVING CENTER D/B/A MILLER REHABILITATION

CHARITY CARE			
	2016	**2017**	**2018**
Net Patient Revenue	$16,508,158	$15,761,151	$15,505,336
Amount of Charity Care	0	0	0

35770537.8