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: AdventHealth Hinsdale f/k/a Adventist Hinsdale Hospital	specialty nursery replacement
Street Address: 120 North Oak Street	
City and Zip Code: Hinsdale, IL 60521	
County: Cook Health Service Area: VII	Health Planning Area: A-05

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

Exact Legal Name:	Adventist Midwest Health d/b/a AdventHealth Hinsdale
Street Address:	120 North Oak Street
City and Zip Code:	Hinsdale, IL 60521
Name of Registered Agent:	CT Corporation
Registered Agent Street Address:	208 South LaSalle Street Suite 814 Chicago, IL 60604
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Adam Maycock
CEO Street Address:	120 North Oak Street
CEO City and Zip Code:	Hinsdale, IL 60521
CEO Telephone Number:	630/856-9000

Type of Ownership of Applicants

- [X] 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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Street Address: 120 North Oak Street		
City and Zip Code: Hinsdale, IL 60521		
County: Cook	Health Service Area: VII	Health Planning Area: A-05

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

Exact Legal Name:	Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth
Street Address:	900 Hope Way
City and Zip Code:	Altamonte, FL 32714
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	280 South La Salle Street Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Terry Shaw
CEO Street Address:	900 Hope Way
CEO City and Zip Code:	Altamonte, FL 32714
CEO Telephone Number:	407/357-1000

Type of Ownership of Applicants

- [X] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
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E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

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:	Adam Maycock
Title:	President & CEO
Company Name:	AdventHealth Hinsdale
Address:	120 North Oak Street Hinsdale, IL 60521
Telephone Number:	630/956-9000
E-mail Address:	adam.maycock@AdventHealth.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Adventist Midwest Health
Address of Site Owner:	120 North Oak Street Hinsdale, IL 60521

Street Address or Legal Description of the Site: 120 North Oak Street Hinsdale, IL 60521

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:	Adventist Midwest Health
Address:	120 North Oak Street Hinsdale, IL 60521

- [X] 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**). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

X 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.

The applicants propose to replace, through the renovation of existing space, AdventHealth Hinsdale's special care nursery, which includes Level III (NICU), and Level II stations. No other clinical areas of the hospital will be impacted by this project.

The project is classified a "non-substantive" because it does not address the establishment or discontinuation of a category of service. A Certificate of Need Permit is required because the anticipated project cost exceeds the current review threshold.

PROJECT COST AND SOURCES OF FUNDS

	Clinical	Non-Clinical	Total
Project Cost:			
Preplanning Costs	$ 220,000	$ 30,000	$ 250,000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$ 11,189,024	$ 1,525,776	$ 12,714,800
Contingencies	$ 588,896	$ 80,304	$ 669,200
Architectural/Engineering Fees	$ 771,760	$ 105,240	$ 877,000
Consulting and Other Fees	$ 561,968	$ 76,632	$ 638,600
Movable and Other Equipment (not in construction contracts)	$ 5,372,488	$ 732,612	$ 6,105,100
Net Interest Expense During Construction Period			
Fair Market Value of Leased Space			
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized-Phasing @ 10%			
Acquisition of Building or Other Property			
TOTAL USES OF FUNDS	**$ 18,704,136**	**$ 2,550,564**	**$ 21,254,700**
Sources of Funds:			
Cash and Securities	$ 18,704,136	$ 2,550,564	$ 21,254,700
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 18,704,136**	**$ 2,550,564**	**$ 21,254,700**

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 X No

Purchase Price: $_____

Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service

☐ Yes X 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

X Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): September 1, 2024

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

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.**

Not Reviewable Space [i.e. non-clinical]: *means an area for the benefit of the patients, visitors, staff or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

		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: AdventHealth Hinsdale		**CITY: Hinsdale**			
REPORTING PERIOD DATES:		**From: January 1, 2020**	**to: December 31, 2020**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	131	5,225	20,496	-13	118
Obstetrics	37	2,540	6,607	-2	35
Pediatrics	18	166	455	None	18
Intensive Care	44	942	8,477	None	44
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	17	662	4,077	None	17
Neonatal Intensive Care	14	237	2,001	None	14
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	261	9,772	42,113	-15	246

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 _Adventist Midwest Health d/b/a AdventHealth Hinsdale__* 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.

Lynn C. Aoois

SIGNATURE

LYNN C. AOOISCOTT

PRINTED NAME

ASSISTANT SECRETARY

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5th day of October

Martha A Miller

Signature of Notary

Seal

MARTHA A MILLER
Notary Public - State of Florida
Commission # HH 285012
My Comm. Expires Jul 7, 2026
Bonded through National Notary Assn.

Michael E. Saunders

SIGNATURE

Michael E. Saunders

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5th day of October

Martha A Miller

Signature of Notary

Seal

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*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 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 ___Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth__* 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.

Lynn C. Adamcott
SIGNATURE

LYNN C. ADDISCOTT
PRINTED NAME

ASSISTANT SECRETARY
PRINTED TITLE

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Subscribed and sworn to before me
this 5TH day of October

Signature of Notary

Seal

MARTHA A MILLER
Notary Public - State of Florida
Commission # HH 285012
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Bonded through National Notary Assn.

Michael E. Saunders
SIGNATURE

Michael F. Saunders
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5TH day of October

Signature of Notary

Seal

MARTHA A MILLER
Notary Public - State of Florida
Commission # HH 285012
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Bonded through National Notary Assn.

*Insert the EXACT 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 can 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** 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:

not applicable, project does not include 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:

not applicable, project does not include shell space

Submit the following:

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

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

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)**

proof of bond rating provided as ATTACHMENT 34

VII. 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]:**

_____	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 timetable 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 timetable of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
		1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
		2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
		3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
		4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;

	5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 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 the project's 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 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

proof of bond rating provided as ATTACHMENT 34

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

proof of bond rating provided as ATTACHMENT 34

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 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

proof of bond rating provided as ATTACHMENT 34

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 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

not applicable, non-substantive project

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

1. The project's material impact, if any, on essential safety net services in the community, ***including the impact on racial and health care disparities 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 37.

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 38, 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			
	FY 2019	FY 2020	FY 2021
Net Patient Revenue	**$335,135,281**	**$267,053,500**	**$295,073,396**
Amount of Charity Care (charges)	$7,140,054	$6,005,228	$12,896,179
Cost of Charity Care	$1,828,575	$1,449,572	$3,010,678

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

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: please see page 1 of application

2. Project Location: please see page 1 of application

You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go To NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA:

Yes___ No _X__

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? no

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

_____

Name of Official:_____Title: _____

_____

Business/Agency:_____Address:

_____

(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date:

_____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

File Number 0940-715-4

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* DECEMBER *A.D.* 2021 .

Authentication #: 2134902654 verifiable until 12/15/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

25

File Number 5938-890-8

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* DECEMBER *A.D.* 2021 .

Authentication #: 2134902666 verifiable until 12/15/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

SITE OWNERSHIP

With the signatures provided on the Certification pages of this Certificate of Need ("CON") application, the applicants attest that the AdventHealth Hinsdale site, that being 120 North Oak Street in Hinsdale, Illinois, is owned by Adventist Midwest Health.

ATTACHMENT 2

File Number 0940-715-4

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

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

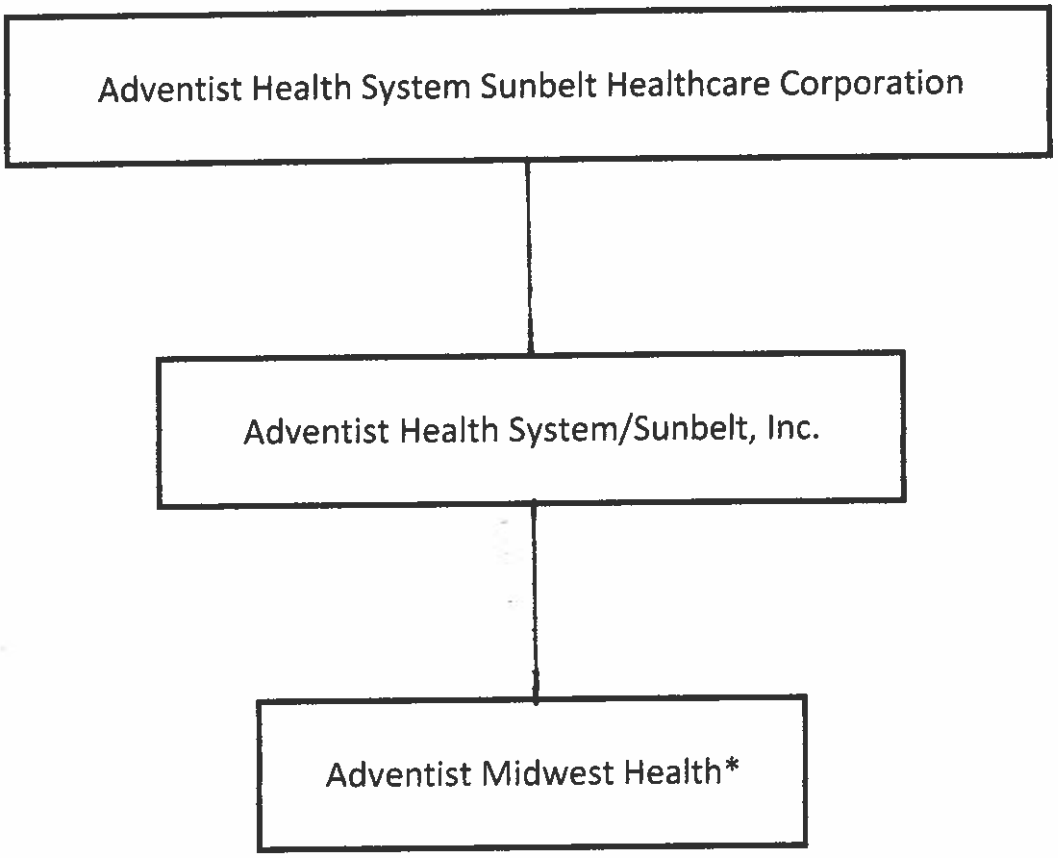
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* DECEMBER *A.D.* 2021 .

Authentication #: 2134902654 verifiable until 12/15/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 3

ORGANIZATIONAL CHART



*conducts business as both *AdventHealth Hinsdale and AdventHealth La Grange*

ATTACHMENT 4

FLOOD PLAIN REQUIREMENTS

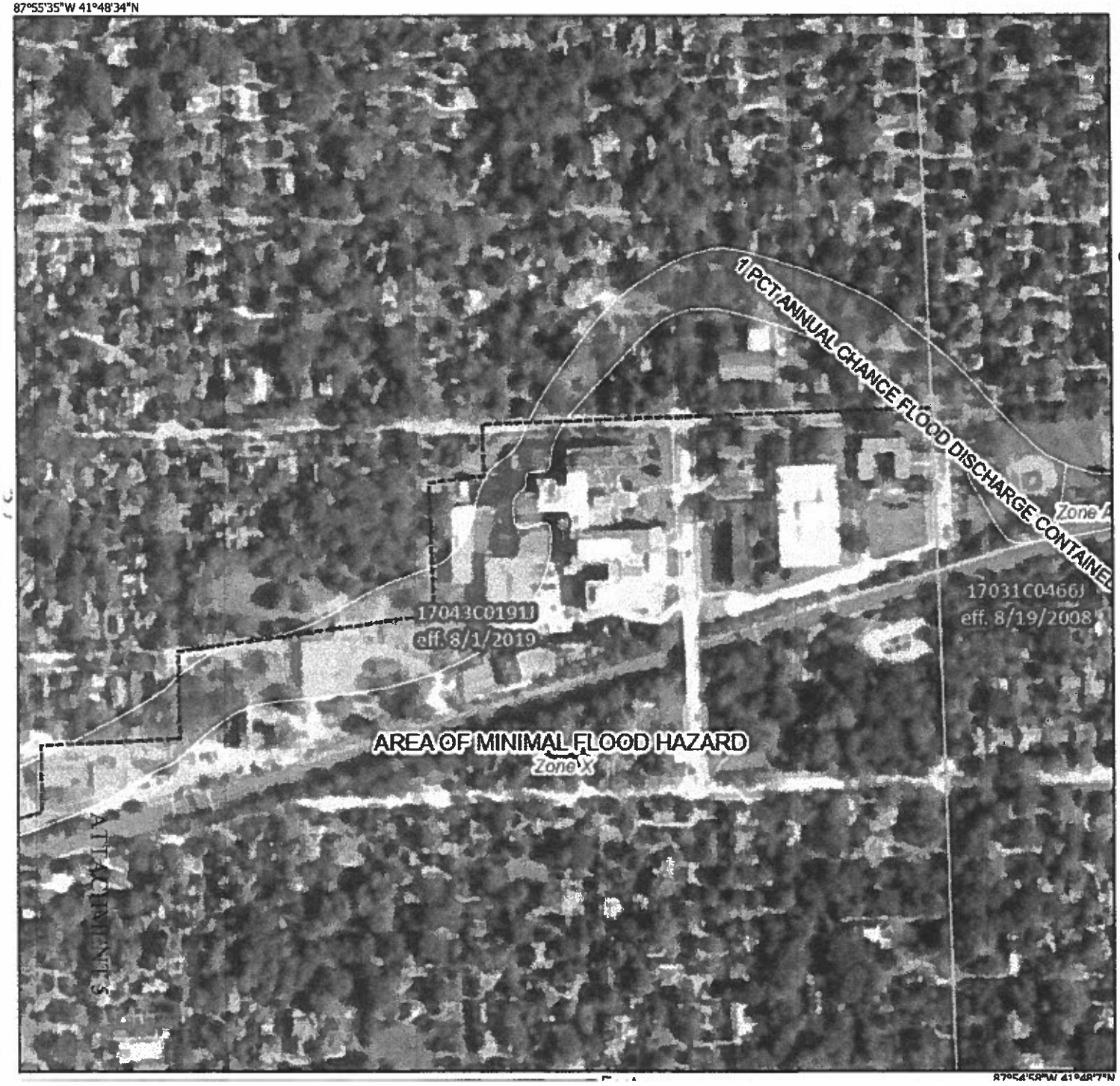
With the signatures provided on the Certification pages of this Certificate of Need application, the applicants confirm that the project addressed through this Certificate of Need application, and located at 120 Oak Street in Hinsdale, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA is attached.

ATTACHMENT 5

National Flood Hazard Layer FIRMette

FEMA

87°55'35"W 41°48'34"N



Legend

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

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) Zone A, V, A99
- With BFE or Depth Zone AE, AO, AH, VE, AR
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas 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 D

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 represer 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 4/25/2022 at 4:41 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

#22-033

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

May 20, 2022

Illinois Dept. of Natural Resources
Illinois State Historic Preservation Office
ATTN: Review and Compliance/Old State Capitol
1 Old State Capitol Plaza
Springfield, IL 62701

RE: Proposed Internal Renovation
AdventHealth Hinsdale

To Whom It May Concern:

I am in the process of developing a Certificate of Need application, to be filed with the Illinois Health Facilities Services and Review Board, and I am in need of a determination of applicability from your agency.

The project involves the renovation of a portion of the fourth floor of AdventHealth Hinsdale (formerly known as Hinsdale Hospital) that appears to have been constructed in the 1990s, there do not appear to be any structures of historical significance near the site, the exterior of the buildings will not be altered, and the project will have no impact on surrounding buildings.

I have enclosed a map of the site, and pictures of the hospital, as well as surrounding buildings.

A letter from your office, confirming that the Preservation Act is not applicable to this project would be greatly appreciated.

Should you have any questions, I may be reached at the phone number below.

Sincerely,

Jacob M. Axel
President

enclosures

ATTACHMENT 6

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101

PROJECT COSTS and
SOURCES OF FUNDS

PROJECT COSTS

Preplanning Costs			
Evaluation of Alternatives	$	50,000	
Pre-Arch. Functional Plan.	$	75,000	
Internal Approval Process	$	50,000	
Misc./Other	$	75,000	
			$ 250,000
Modernization Contracts			$ 12,714,800
*please see note at end of this ATTACHMENT			
Contingencies (Modernization)			$ 669,200
Architectural and Engineering			
Design	$	720,000	
Document Preparation	$	30,000	
Interface with Agencies	$	20,000	
Project Monitoring	$	42,000	
Misc./Other	$	65,000	
			$ 877,000
Consulting and Other Fees			
Zoning and Local Approvals	$	20,000	
CON-Related	$	80,000	
Project Management	$	380,000	
Interior Design	$	23,600	
Equipment Planning	$	85,000	
Misc./Other	$	50,000	
			$ 638,600
Movable Equipment			
Level III & Level II Stations	$	5,860,100	
Nursing Suite	$	30,000	
OB Triage & Observation	$	120,000	
Elevator Lobby	$	10,000	
Prayer Room	$	15,000	
Administrative Office	$	15,000	
Neonatologists' Office	$	20,000	
Staff Areas	$	15,000	
Family Area	$	20,000	
			$ 6,105,100

ATTACHMENT 7

PROJECT COSTS and
SOURCES OF FUNDS

TOTAL USES OF FUNDS		$ 21,254,700
SOURCES OF FUNDS		
Cash from AdventHealth	$ 21,254,700	
TOTAL SOURCES OF FUNDS		$ 21,254,700

ATTACHMENT 7

NOTE ON ANTICIPATED MODERNIZATION COST

The estimated modernization cost for this project was developed by Jacobs Engineering Group, Inc, ("Jacobs") one of the nation's largest engineering and construction management firms, with health care projects comprising a major portion of its portfolio. Jacobs developed early-stage project cost estimates shortly after planning for the project was initiated in November 2021. Since that time, and as a result to significant changes in the global economy caused by such issues as supply chain delays, rapidly increasing costs for construction materials, rising salaries within the construction industry, and the impact of the Covid-19 pandemic; the applicants have seen their modernization cost estimates increase significantly over the past nine months. This, as the Board is aware, is an issue that has plagued numerous applicants over the past year. The modernization cost estimates, as detailed in ATTACHMENT 36C were developed by Jacobs in July of this year.

In addition to the issues identified above, the estimated modernization cost incorporates two factors that, while not unique to this project, cannot necessarily be considered commonplace to all hospital modernization projects, with both of which contributing to the overall modernization cost. Those factors are: 1) the need to maintain an "operational" specialty care nursery during the entirety of the project, eliminating/limiting disruptions to patient care to the greatest extent possible, and 2) the need to "phase" the project over a longer period of time that would be normally required for a project addressing 16,000 DGSF of modernization. These two factors, alone, have increased the estimated modernization cost by approximately 15% or $119 per DGSF.

ATTACHMENT 7

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet			
				That is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
Levels II & III Stations	$ 15,524,433		11,350		11,350	0	
Nursing Suite	$ 1,309,290		1,145		1,145	0	
Triage and Observation	$ 1,870,414		1,585		1,585	0	
	$ 18,704,136		14,080		14,080	0	
Non-Reviewable							
Elevator Lobby	$ 714,158		538		538	0	
Prayer Room	$ 204,045		160		160	0	
Administrative	$ 408,090		320		320	0	
Neonatologist's Office	$ 459,102		360		360	0	
Staff Areas	$ 377,483		290		290	0	
Family Area	$ 387,686		300		300	0	
	$ 2,550,564		1,968		1,968	0	
TOTAL	$ 21,254,700		16,048		16,048	0	

ATTACHMENT 9

#22-033

BACKGROUND OF THE APPLICANT

Applicant Adventist Health System Sunbelt Healthcare Corporation (d/b/a AdventHealth) maintains "ultimate control" of four hospitals in Illinois:

- Adventist Bolingbrook Hospital, d/b/a AdventHealth Bolingbrook
- Adventist GlenOaks Hospital, d/b/a AdventHealth GlenOaks
- Adventist Midwest Health d/b/a AdventHealth Hinsdale
- Adventist Midwest Health d/b/a AdventHealth La Grange

In addition, AdventHealth also maintains "ultimate control" over approximately fifty hospitals in eight other states.

In accordance with Review Criterion 1130.520.b.3, Background of the Applicant, and with the signatures placed on the Certification pages of this Certificate of Need application, the applicants assure the Illinois Health Facilities and Services Review Board that either of the applicants nor any subsidiary entity has had any adverse actions against it during the three (3) year period prior to the filing of this application. In addition, the applicants authorize the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520.b.3 or to obtain any documentation or information which the State Board or Agency finds pertinent to this Certificate of Need application.

ATTACHMENT 11

PURPOSE OF THE PROJECT

The proposed project is limited in scope to address the replacement on of the hospital's special care nursery, consisting of it's Level II and Level III nurseries. The replacement will be accomplished through the reconfiguration and renovation of the existing special care nursery and a limited amount of adjacent vacant space on the hospital's fourth floor; and will greatly improve patient/family privacy and staff flow. As such, the project will improve the healthcare and well being of the market area population traditionally looking to the hospital for obstetrics/newborn care.

The proposed project does not involve the addition of any HFSRB-designated Level III (NICU) stations.

The applicant hospital is located in DuPage County, and therefore, per the HFSRB's definition of geographic service areas, the geographic service area for the proposed project consists of those ZIP Code areas located within ten miles of the hospital, and identified in the table on the following page. The population of this area, which consists of sixty-three ZIP Codes, is estimated by SearchBug to be 1,332,480.

ATTACHMENT 12

ZIP CODE	City
60558	WESTERN SPRINGS
60521	HINSDALE
60522	HINSDALE
60526	LA GRANGE PARK
60514	CLARENDON HILLS
60154	WESTCHESTER
60513	BROOKFIELD
60523	OAK BROOK
60525	LA GRANGE
60559	WESTMONT
60162	HILLSIDE
60155	BROADVIEW
60534	LYONS
60546	RIVERSIDE
60501	SUMMIT ARGO
60527	WILLOWBROOK
60141	HINES
60104	BELLWOOD
60458	JUSTICE
60163	BERKELEY
60153	MAYWOOD
60126	ELMHURST
60682	CHICAGO
60402	BERWYN
60130	FOREST PARK
60181	VILLA PARK
60480	WILLOW SPRINGS
60561	DARIEN

ATTACHMENT 12

60515	DOWNERS GROVE
60165	STONE PARK
60161	MELROSE PARK
60638	CHICAGO
60160	MELROSE PARK
60457	HICKORY HILLS
60455	BRIDGEVIEW
60516	DOWNERS GROVE
60305	RIVER FOREST
60304	OAK PARK
60599	FOX VALLEY
60164	MELROSE PARK
60148	LOMBARD
60301	OAK PARK
60804	CICERO
60303	OAK PARK
60459	BURBANK
60302	OAK PARK
60465	PALOS HILLS
60171	RIVER GROVE
60131	FRANKLIN PARK
60137	GLEN ELLYN
60517	WOODRIDGE
60644	CHICAGO
60707	ELMWOOD PARK
60532	LISLE
60415	CHICAGO RIDGE
60439	LEMONT
60138	GLEN ELLYN

ATTACHMENT 12

60499	BEDFORD PARK
60454	OAK LAWN
60632	CHICAGO
60464	PALOS PARK
60623	CHICAGO
60482	WORTH

Historically, the hospital's NICU patients have come from a broad area, with no more than 6.11% of its admissions coming from any one ZIP Code area during the 2019-2021 sample period, and as identified in the patient origin table on the following page. During the three-year sample period, newborns having mothers residing in a total of 155 ZIP Code areas were admitted to the NICU, with 28 of the ZIP Code areas cumulatively accounting for 60.25% of the babies, and 127 of the ZIP Code areas accounting for less than 1.00% of the admissions, each.

ZIP Code	Community	2019-2021 Admissions	%	Cumulative %
60525	La Grange	53	6.11%	6.11%
60440	Bolingbrook	34	3.92%	10.02%
60559	Westmont	32	3.69%	13.71%
60638	Bedford Park	29	3.34%	17.05%
60521	Hinsdale	27	3.11%	20.16%
60517	Woodridge	26	3.00%	23.16%
60446	Romeoville	22	2.53%	25.69%
60516	Downers Grove	22	2.53%	28.23%
60513	Brookfield	22	2.53%	30.76%
60527	Willowbrook	21	2.42%	33.18%
60435	Joliet	19	2.19%	35.37%
60181	Villa Park	17	1.96%	37.33%
60558	Western Springs	16	1.84%	39.17%
60561	Darien	16	1.84%	41.01%
60439	Lemont	15	1.73%	42.74%
60526	La Grange Park	14	1.61%	44.35%
60515	Downers Grove	14	1.61%	45.97%
60458	Justice	14	1.61%	47.58%
60402	Berwyn	13	1.50%	49.08%
60532	Lisle	13	1.50%	50.58%
60586	Plainfield	13	1.50%	52.07%
60491	Homer Glen	11	1.27%	53.34%
60514	Clarendon Hills	11	1.27%	54.61%
60154	Westchester	11	1.27%	55.88%
60534	Lyons	10	1.15%	57.03%
60501	Summit Argo	10	1.15%	58.18%
60540	Naperville	9	1.04%	59.22%
60441	Lockport	9	1.04%	60.25%
	other, <1%	345	39.75%	100.00%

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ALTERNATIVES

Given the limited scope of the proposed project, aside from the alternative of "doing nothing", only one alternative holds potential. That alternative is to relocate the entire special care nursery to another location in the hospital. The sole advantage of doing so, if an appropriate location could be identified, would be the elimination of the "phasing" costs (estimated at approximately $1.0M) resulting from the need to keep the special care nursery operational during the proposed modernization. This alternative is deemed inferior to the proposed project because it would not provide the desired proximity relationship with the other obstetrics and newborn services afforded by the current/proposed location.

Had the alternative identified above been selected, accessibility, quality of care and operational costs would be similar to that of the proposed project, while renovation-related capital costs could differ, depending on the site to be used.

SIZE

As discussed in ATTACHMENT 15, and consistent with the contemporary delivery of specialty care nursery services, the hospital's stations traditionally viewed as Level II or Level III stations will operate functionally interchangeably, negating the need to physically relocate babies as their required level of care either increases or decreases. Per the HFSRB's *Inventory,* the hospital is currently approved to operate fourteen Level III stations, and for the purposes of the assessment of the proposed project's consistency with the HFSRB's space standard (568 DGSF per station), it is assumed that the *Inventory* will continue to identify fourteen Level III stations as being provided at the hospital.

The HFSRB does not have a "need" methodology for Level II stations, making the number of Level II stations (which, as noted above, will function interchangeably with the HFSRB-designated Level III stations) irrelevant. Rather, the HFSRB's "size" standard is 160 DGSF per obstetrics bed.

The table below confirms the proposed project's consistency with the HFSRB's size standards currently in place per Section 1110 APPENDIX B.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Level III Nursery (14)	6,924	7,952	(1,028)	YES
Level II Nursery (9)	4,426	5,600	(1,174)	YES

UTILIZATION

As discussed throughout this application, it is the applicants' intent to operate a contemporary special care nursery.

Approximately twenty years ago the HFSRB very significantly altered the manner in which it reviews the establishment or modernization of Level III nurseries. Specifically, with the adopted change, establishment or modernization projects could and have been addressed through the Certificate of Exemption ("COE") process, with no requirement that utilization, or the ability to "support" the proposed number of stations, be addressed. And, as a COE application, that HFSRB approval is assured, as long as the required (minimal) information is provided. The HFSRB's NICU-specific information required through the COE process is limited to:1) an identification of the NICU's location within the hospital, 2) an identification of the number of "beds" to be provided, 3) verification that a final cost report will be filed with the HFSRB, and 4) verification that completion of the project within 24 months will invalidate the COE. There is no requirement that the proposed number of stations be "justified".

The proposed project is required to be addressed through the CON process (as opposed to the COE process) solely because the projected project cost exceeds the current review threshold; and it is the applicant's understanding that the last CON project addressing the establishment or modernization of a NICU was project 15-039, which addressed the establishment of a new hospital.

Contemporary special care nurseries, providing Level III and Level II/II+ do so with a seamless delivery of care between the levels, with a fully cross-trained staff, and with as little

disruption as possible to the patient and his/her parents. The American Academy of Pediatrics and the American Academy of Obstetricians and Gynecologists has defined both the various levels of neonatal care and the required clinical capabilities to be present in each setting. Separate billing codes have been established for each level of care, with clinical conditions that must be present for a patient to meet the various care classifications and reimbursement qualifications. Each patient is evaluated every midnight, with the patient's classification (Level II, Level III, etc.) often changing from day-to day, either up or down. Through this type of delivery of system, the need to physically move a patient as its care classification level changes (either up or down), is eliminated, maximized continuity in staffing is maintained, and the important relationship that is developed between the care team and that parents remains in place. As a result, the process of changing a patient's level of care/reimbursement level is transformed from one of physically relocating the patient (and parents) from one location to another, to a simple "paperwork" process. The overall focus shifts from the type of station (with most equipment now being portable), to one that is based on clinical factors. Further, recent discussions with the State Perinatal Network have revealed that when the Network evaluates a "need" for stations, they combine the utilization of existing Levell II, Level II+, and Level III stations.

Please refer to the attached article for a more detailed discussion of the delivery system addressed above.

The proposed project is scheduled to be completed in late 2024, with the second full year following completion being 2026. The table below identifies the hospital's historical (Level II and Level III) utilization, in terms oof average daily census ("ADC").

2018:	16.95
2019:	15.69
2020:	13.86
average:	15.50

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As noted above, the HFSRB does not (and has not) have/had a target utilization level for Level II stations. It's target utilization level for Level III stations, per Section 1110 APPENDIX B, is 75%. For planning purposes, and anticipating no significant changes to local obstetricians' practice patterns or the area's demographics impacting birth volume, the special care nursery's average daily census is projected to remain constant at the 15.50 patients identified in the table above.

PacificSource

Neonatal Levels of Care and Inpatient Management

State(s):					LOB(s):		
☒ Idaho	☒ Montana	☒ Oregon	☒ Washington	☐ Other:	☒ Commercial	☒ Medicare	☒ Medicaid

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

The American Academy of Pediatrics (AAP) and American College of Obstetricians, and Gynecologists (ACOG) has defined both the levels of neonatal care (Level I Newborn Observation Unit to Level IV Regional Neonatal Intensive Care Unit) and capabilities required of facilities to provide each level of care. Facilities offering neonatal intensive care must meet healthcare standards through federal/state licensing or certification. It is the hospital's responsibility to know their NICU level certification. The American Hospital Association has delineated 4 billing codes that correspond to varying degrees of intensity of clinical care provided to neonates at each level. These 4 codes are widely accepted as billing designations and focus on the quantity and intensity of medical care and services the newborn needs on a given day.

Criteria

Commercial

PacificSource considers admission to and continued stay in appropriate neonatal levels of care medically necessary for appropriate care of the neonatal (up to 28 days old) member.

- PacificSource considers neonates to be a newborn up to 28 days old.
- Newly admitted infants over 28 days old may not qualify for NICU level of care.
- NICU billing levels may be reviewed daily and are based on the infant's intensity of care needs at 2400 hours on the day being reviewed.
- Approved codes may fluctuate during the NICU admission.
- Transition periods between levels, defined as 4 hours or fewer in the NICU, will be approved for the lowest appropriate level care regardless of interventions completed during the transition time.

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- Facilities will be reimbursed based on their NICU level credentialing only (i.e., facility must be credentialed to provide NICU level 3 care to be reimbursed NICU level 3).
- Revenue code 0171 (NICU level 1) is the lowest accepted billing level for NICU.
- Revenue code 0179 is not an accepted billing level.

Facilities with a Level I and Level II Nursery only: Revenue Code 0173 or 0174 may be used when:

- Providing mechanical ventilation for brief duration (<24 hours) or Nasal/Mask CPAP;
- Stabilizing infants born before 32 weeks gestation and weighing less than 1500 grams until a transfer to a Level III or IV NICU.

NICU Level I: Revenue Code 0171

This level of care is for infants who are physiologically stable, receiving routine evaluation, care, and observation in the immediate post-partum period. This billing code can be utilized by facilities approved to provide Level I, II, III and IV care. PacificSource considers the coverage of infants for Level I medically necessary when **ONE** of the following conditions is met:

- Oral (nipple) feedings for asymptomatic hypoglycemia not requiring subsequent Intravenous (IV) therapy;
- Routine tests, examples include, but are not limited to, bilirubin, blood glucose, blood type and Coombs, direct antiglobulin test (DAT), complete blood count (CBC) or oximetry;
- Diagnostic work-up/surveillance, on an otherwise stable neonate where no therapy is initiated;
- Hyperbilirubinemia requiring phototherapy (single bank only) or bili blanket;
- Infants transferred from a higher level of care who are physiologically stable, breathing room air, in an open crib, and taking either no medications or on a stable or declining dose of oral medications and requiring observation to document successful nipple feeding;
- Initial sepsis evaluation (CBC, blood culture for an asymptomatic neonate) until transfer to higher level of care;
- Services rendered to growing premature infant without supplemental oxygen or IV fluid needs or environmental control needs (other than blankets, cap, swaddling, etc.);
- Services to improve poor breast or bottle feeding that is advancing to full volume feeds;
- Temperature instability surveillance requiring use of isolette or warmer until transfer to higher level of care.

NICU Level II: Revenue Code: 0172

This billing code can be utilized by Level II, III and IV facilities. PacificSource considers the coverage of infants for NICU Level II medically necessary when **ONE** of the following conditions is met:

- Apnea/Bradycardia episode requiring mild stimulation;
- Oral pharmacologic treatment for apnea and/or bradycardic episodes;
- Evaluation of apnea of prematurity;

- Feeding via an orally or nasally inserted tube, for example nasogastric, nasojejunal, or gastrostomy tube;
- Services rendered for Neonatal Abstinence Syndrome (withdrawal) scores less than 8;
- Hyperbilirubinemia requiring phototherapy more than single bank or bili blanket;
- Documented need for environmental control via an incubator/warmer for thermoregulation in an otherwise physiologically stable infant;
- Physiologically stable infants in the process of being weaned from an incubator/warmer to an open crib;
- Initial medical or surgical sub-specialty consultation;
- IV fluids, IV medications or IV treatment of hypoglycemia;
- High-flow nasal cannula (HFNC) with flow less than or equal to 3 liters per minute;
- Supplemental oxygen via oxygen hood or low flow nasal cannula;
- Vapotherm up to 8L/min;
- Initial sepsis evaluation (CBC, blood culture, and other blood tests or cultures) for an asymptomatic neonate and antibiotic treatment pending laboratory and/or culture results;
- Sepsis suspected or documented with treatment (IV/IM therapies) beyond the initial 48 hours of treatment;
- Evaluation of temperature instability requiring isolette or warmer to maintain body temperature;

NICU Level III: Revenue Code: 0173

This level of care is directed at those neonates that require invasive therapies and/or are critically ill with respiratory, circulatory, metabolic or hematologic instabilities and/or require surgical intervention with general anesthesia. This billing code can be utilized by Level III and IV facilities. PacificSource considers the coverage of infants for NICU Level III medically necessary when **ONE** of the following conditions is met:

- Infants less than 32 weeks gestational age or less than 1500 grams;
- IV pharmacologic treatment for apnea and/or bradycardic episodes;
- Blood or blood product transfusion;
- Services rendered for Neonatal Abstinence Syndrome (NAS) when the score is greater than or equal to 8;
- Chest tube;
- Exchange transfusion, partial or complete and up to 48 hours after exchange transfusion;
- Inborn error of metabolism requiring IV therapy (e.g., blood glucose less than 30 mg/dl at least twice within 12 hour period);
- IV therapy for severe physiologic/metabolic instability (including blood thinners);
- Metabolic acidosis, alkalosis, or electrolyte imbalance requiring IV therapy;
- Seizures requiring IV therapy;

- Short bowel or "dumping" syndrome requiring total parenteral nutrition (TPN) at 50 or greater ml/kg/day;
- High-flow nasal cannula (HFNC) with flow greater than 3 liters per minute;
- CPAP providing regulated and measured pressure via mask, nasal or bubble devices;
- Positive pressure ventilator assistance with intubation and 24 hours post-ventilator care;
- Conditions requiring invasive intervention for airway protection (i.e., repogle);
- Surgical conditions requiring general anesthesia up to two days post-op;
- Surgical intervention or therapies for retinopathy of prematurity (ROP);
- Umbilical Artery Catheters (UACs), Peripheral Artery Catheters (PACs), Umbilical Vein Catheters (UVCs) and/or Central Vein Catheters (CVCs);
- Peritoneal Dialysis;
- Withdrawal of life support; end of life care; palliative care.

Note: Immediate post-delivery intubation in the delivery room [DR] (when the endotracheal tube is removed prior to leaving the DR), brief intubation for administration of surfactant, or deep tracheal suctioning does not meet level III criteria for intubation.

NICU Level IV: Revenue Code: 0174

This level of care covers critically ill neonates with respiratory, circulatory, metabolic or hemolytic instabilities as well as conditions that require surgical intervention. This billing code can be utilized by Level IV facilities only. PacificSource considers the coverage of infants for NICU Level IV medically necessary when **ONE** of the following conditions is met:

- Invasive hemodynamic monitoring and CNS pressure monitoring;
- High Frequency Ventilation: oscillator or jet;
- Extracorporeal Membrane Oxygenation (ECMO) / Nitric Oxide (NO);
- Hypothermia therapy for anoxic damage, including selective head cooling;
- Hemodialysis;
- Encephalopathy, coma, or other acute neurologic abnormality;
- Pre- and post-surgical care for severe congenital malformations or acquired conditions (e.g., gastroschisis, ventricular septal defect (VSD) or bowel perforation, that require the use of advanced technology and support); May move to lower level post-op day 1-2;
- CPR in the last 24 hours;
- Continuous IV infusion or IV medication requiring close monitoring or dose adjustment including **one (1) or more** of the following:
    - Antiarrhythmic agents;
    - Neuromuscular blocking agents (e.g., pancuronium, vecuronium);
    - Beta-blockers;
    - Calcium channel blocking agents;
    - Inotropic or chronotropic drugs;

ATTACHMENT 15

- IV prostaglandin therapy.

Medicaid

PacificSource Community Solutions follows Oregon Administrative Rules (OAR) 410-125-0000 to 2080 and MCG Care Guidelines 26th edition for coverage of Neonatal Levels of Care and Inpatient Management.

Medicare

PacificSource Medicare follows this policy for coverage of Neonatal Levels of Care and Inpatient Management.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

0170 Room and Board Nursery

0171 Newborn Level I

0172 Newborn Level II

0173 Newborn Level III

0174 Newborn Level IV

Definitions

Apnea of Prematurity (AOP) - A condition in which premature infants stop breathing for 15 to 20 seconds during sleep and apnea spells require medical management such as Aminophylline, theophylline, or caffeine.

Bubble CPAP - A CPAP that uses nasal prongs or a nasal mask as the delivery device and creates positive pressure by immersing the expiratory limb of the circuit into a fluid column to the desired depth (cmH2O) to achieve the desired end-expiratory pressure.

Continuous Positive Airway Pressure (CPAP) - A treatment modality used to maintain continuous positive pressure during both inspiratory and expiratory phases when the infant is breathing spontaneously.

Exchange Transfusion - A potentially life-saving procedure that is done to counteract the effects of serious jaundice or changes in the blood due to diseases such as sickle cell anemia or Hemolytic Disease of the Newborn (HDN). The procedure involves slowly removing the patient's blood and replacing it with fresh donor blood or plasma. In most cases, this involves placing one or more thin tubes, called catheters, into a blood vessel.

(ECMO) Extracorporeal membrane oxygenation - A treatment that uses a pump to circulate blood through an artificial lung back into the bloodstream of a very ill baby. This system provides heart-lung bypass support outside of the baby's body. The purpose of ECMO is to provide enough oxygen to the baby while allowing time for the lungs and heart to rest or heal.

Gastroschisis - A herniation (displacement) of the intestines through an abdominal wall defect, usually on the right side of the umbilical cord.

Neonatal Abstinence Syndrome - group of problems that occur when a pregnant woman takes addictive illicit or prescription drugs such as: Amphetamines, Barbiturates, Benzodiazepines (diazepam, clonazepam), Cocaine, Marijuana, Opiates/Narcotics (heroin, methadone, and codeine). These and other substances pass through the placenta to the baby during pregnancy. The placenta is the organ that connects the baby to its mother in the womb. The baby becomes addicted along with the mother. At birth, the baby is still dependent on the drug. Because the baby is no longer getting the drug after birth, symptoms of withdrawal may occur.

Respiratory Distress Syndrome (RDS) - The disease is mainly caused by a lack of a slippery substance in the lungs called surfactant. This substance helps the lungs fill with air and keeps the air sacs from deflating. Surfactant is present when the lungs are fully developed. Neonatal RDS can also be due to genetic problems with lung development. Most cases of RDS occur in babies born before 37 weeks. The less the lungs are developed, the higher the chance of RDS after birth. The problem is uncommon in babies born full-term (at 40 weeks).

Transition Period - A stay of four hours or less in the NICU.

Related Policies

Enteral Nutrition and Pumps

References

American Academy of Pediatrics (AAP). Committee on Fetus and Newborn, Levels of neonatal care. Pediatrics 2012; 130(3): 587-597. Accessed on January 16, 2014, August 25, 2017, May 23, 2018, August 15, 2019, June 23, 2020. http://pediatrics.aappublications.org/content/130/3/587.full.pdf

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Specification Manual for Joint Commission National Quality Measures (v2019A), Admission to NICU, 2019, Accessed June 23, 2020 https://manual.jointcommission.org/releases/TJC2019A/DataElem0275.html

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Appendix

Policy Number:

Effective: 8/1/2020 **Next review:** 8/1/2022

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s):

Commercial OPs: 6/2022

Government OPs: 6/2022

ATTACHMENT 15

NEONATAL INTENSIVE CARE

The proposed project seeks to replace AdventHealth Hinsdale's special care nursery, which includes Level III and Level II stations. Upon the project's completion, a total of 23 stations will be provided, 14 of which will be designated as Level III by the HFSRB.

The special care nursery is located on the fourth floor of the hospital, with the project including the renovation of the nursery's existing location, and expanding into adjacent currently vacant space.

With the signatures on this Certificate of Need application, the applicants verify that: 1) the project's final cost report will be submitted to the HFSRB within ninety days of the project's completion date; and 2) failure to complete the proposed project within 24 months of the Board's approval of the proposed project will invalidate the project's Permit.

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project includes two clinical services areas that are not HFSRB-designated categories of service: a nursing suite, and an obstetrics triage and observation area.

The HFSRB does not have utilization or space standards for either the proposed triage/observation area or the nursing suite, each of which will consist of four stations.

ATTACHMENT 31

S&P Global
Ratings

RatingsDirect®

AdventHealth, Florida; System

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Rating Action

Stable Outlook

Related Research

AdventHealth, Florida; System

Credit Profile		
US$400.0 mil taxable hosp rev bnds ser 2021E due 11/15/2051		
Long Term Rating	AA/Stable	New

Rating Action

S&P Global Ratings assigned its 'AA' long-term rating to AdventHealth Obligated Group, Fla.'s (AdventHealth) $400 million series 2021E taxable hospital revenue bonds. The outlook is stable.

Proceeds from the series 2021E taxable bonds will be used for the long-term financing of the purchase of Redmond Regional Medical Center, located in Rome, Ga. Securing the bonds is a pledge of gross revenues from the obligated group, which includes a majority of the system's hospitals.

In our recent rating review dated June 2, 2021, we incorporated into our analysis the signed definitive agreement between AdventHealth and HCA Healthcare (HCA) and likely acquisition of HCA's 230-bed Redmond Regional Medical Center (RRMC). On Oct. 1, 2021, AdventHealth completed the purchase of RRMC from HCA Healthcare for approximately $637 million. The purchase agreement includes the 230-bed hospital, as well as its related businesses, physician clinic operations, outpatient services and all issued and outstanding equity interests. RRMC serves as a regional referral center for all of northwest Georgia and parts of Alabama. It is the only hospital in northwest Georgia with an open-heart surgery program and Level I Emergency Cardiac Care Center designation.

The cost of acquisition was financed with $400 million of additional debt (initially through a drawdown of CP to be refinanced with the series 2021E long-term debt), and $237 million from an equity contribution. We factored in the acquisition, additional debt and equity contribution into our prior analysis and key metrics, and AdventHealth's performance through June 30, 2021, has remained in line with expectations. According to management, RRMC's operating performance is favorable, with strong cash flow of about 15%. We expect the impact to the income statement will be generally accretive to AdventHealth's operating metrics, while the additional carrying charges and expense base will be slightly dilutive to some key balance sheet metrics. Overall, the acquisition is considered neutral from a credit rating perspective.

Credit overview

The rating reflects AdventHealth's broad geographic coverage and differentiated markets in nine states, many of which are exhibiting strong growth and demographic characteristics. The rating is further supported by AdventHealth's continued solid operating performance and cash flow despite the pandemic-related challenges, strong operating and financial dispersion, and maintenance of a strong balance sheet, highlighted by a conservative investment allocation and good liquidity. Furthermore, we believe the historically positive operating trend reflects the system's strong management team, the benefits of conservative investment strategies, and sound financial planning. Management's efforts over the past decade to significantly lower leverage ratios have created additional debt capacity at the current rating level to allow for continued expansion through acquisition or organic growth. System expansion has historically

- Moderately high but declining contingent liabilities partially offset by sufficient unrestricted reserves and a

conservative investment policy.

The stable outlook reflects disciplined management, revenue diversity, and benefits of operating in regions with strong demographics, all of which have produced robust earnings and cash flow as well as a stronger balance sheet that supports the rating even in light of pandemic-related challenges. The stable outlook also recognizes AdventHealth has some debt capacity at the current rating level assuming a commensurate growth in unrestricted reserves, and we expect management will continue to take a measured and balanced approach to any future merger and acquisition activity. Management's stated intention of maintaining capital spending within its capital allocation model also supports the outlook.

Environmental, social, and governance (ESG) factors

We view AdventHealth's social risk as lower than sector peers as the system operates in several markets that have high population growth and favorable payer characteristics that have led to healthy earnings and cash flow. That said, we believe AdventHealth, like other hospitals, is exposed to heightened risks related to COVID#?19. The core mission of health care facilities is to protect the health and safety of communities, which is further evidenced by responsibilities to serve the demand of patients ill with COVID#?19 as well as maintain adequate capacity and supplies for those patients and others. This is especially challenging given the uneven vaccination rates in some markets and ensuing COVID#?19 hospitalization surges due to the Delta variant. We believe this exposes AdventHealth and its peers to additional social risks that continue to present financial pressure, especially given increased staffing and labor challenges, though we believe the system as weathered this pressure well to#?date. We view AdventHealth's overall environmental risks as elevated relative to those of industry peers given its location in markets that are historically prone to severe weather-related events, particularly hurricanes. However, in our view, the diversified location of AdventHealth's facilities help dampen this risk as it is highly unlikely that the entire system would be affected simultaneously. Governance risk is in line with sector standards.

Stable Outlook

Downside scenario

We consider a negative outlook or downgrade to be unlikely during our two-year outlook period given the historical stability of financial performance and the strength of the enterprise profile. However, we could consider a negative outlook if the financial and economic repercussions from the pandemic are too significant to absorb at the current rating level, or if there is any sustained deterioration in market position, operating performance, or balance sheet metrics.

Upside scenario

In our opinion, AdventHealth has the enterprise profile to support a higher rating. However, with pandemic related challenges and ongoing recovery, coupled with continued growth through acquisition that includes increasing debt levels, it is unlikely we would consider a positive outlook until operating performance and cash flow are sustained at historical levels, while balance sheet metrics improve to levels more consistent with a higher rating.

For a more detailed analysis, please see the full report published June 2, 2021 on RatingsDirect.

focused on Florida, where it has a robust presence, or in markets adjacent to existing system members in its remaining eight states; we do not anticipate any change in this strategy.

AdventHealth's financial performance weakened in fiscal 2020 due to the government-mandated mid-March shutdown of all elective services and expenses incurred to prepare to treat patients with COVID-19. However, AdventHealth entered the pandemic ahead of budget, managed through the crisis with strong system oversight, and benefitted from governmental support by recognizing $539 million of federal Coronavirus Aid, Relief, and Economic Security (CARES) Act stimulus funds in fiscal 2020. In addition, AdventHealth received $446 million of Medicare advance payments and obtained a $250 million term loan to bolster liquidity. Management used internal funds to pay off the term loan and issued a similar $250 million for capital purposes as part of the prior series 2021 bond issue.

Admissions and surgeries have rebounded nicely when compared with prior-year levels while outpatient metrics and emergency department visits have rebounded more slowly. AdventHealth expects continued steady improvement in metrics through fiscal 2021, although actual results will be influenced by the pace of vaccination rates in its core markets, the increasing surge from the Delta variant, the willingness of patients to continue to seek care, and investment market performance. In addition to lingering effects from the pandemic, the 2021 budget has additional expenses associated with an information technology implementation that could limit margin growth through 2022.

The rating reflects our view of AdventHealth's:

- Broad geographic and financial dispersion, with many facilities in high-growth markets including Florida that generates over half of the system's operating revenue;
- Extremely stable, predictable, and well-above median operating and cash flow margins, with generally consistent performance in fiscal 2020 when factoring in the CARES funding;
- Deep and broad presence in Florida with leadership positions in many markets;
- Extremely low average age of plant and a structured capital spending allocation process;
- Modest leverage, even considering $400 million of additional debt to partially finance the Redmond transaction, leading to sound coverage of pro forma maximum annual debt service;
- Healthy defined-benefit pension funding levels; and
- Disciplined financial and strategic planning including a focus on cost control that in a normal environment consistently delivers results in line with or above budgeted expectations.

In our opinion, offsetting factors include:

- Stable, but lower-than-median unrestricted reserves relative to operating expenses and pro forma debt;
- High capital requirements in many of its growth markets, which constrains unrestricted reserve growth;
- Competitive pressures in several regions, while the elimination of the certificate of need law in Florida has led to increased capital spending for many;
- Traditionally weak financial performance in the Chicago region even with broader affiliations that have brought together 19 hospitals in the market through its minority investment in AMITA Health; and

Table 1

AdventHealth, Florida Enterprise Statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		
	2021	2020	2019	2018
PSA population	N.A.	3,570,839	3,250,904	2,188,268
PSA market share (%)	N.A.	45.3	44.6	44.4
Inpatient admissions	189,836	362,768	378,411	364,628
Equivalent inpatient admissions	398,187	742,146	808,775	761,735
Emergency visits	846,195	1,513,334	1,775,790	1,760,037
Inpatient surgeries	58,231	110,348	123,526	108,303
Outpatient surgeries	111,760	190,980	212,764	163,968
Medicare case mix index	1.9020	1.8430	1.7450	1.7520
FTE employees	65,935	63,180	59,191	57,628
Active physicians	N.A.	17,207	14,110	16,824
Based on net/gross revenues	Net	Net	Net	Net
Medicare (%)	34.0	35.0	34.0	33.0
Medicaid (%)	8.0	8.0	9.0	10.0
Commercial/Blues (%)	53.0	52.0	52.0	51.0

N.A.--Not available. Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions.

Table 2

AdventHealth, Florida Financial Statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		Medians for 'AA' rated health care systems
	2021	2020	2019	2020
Financial performance				
Net patient revenue ($000s)	6,754,403	11,572,183	11,435,650	3,978,564
Total operating revenue ($000s)	7,001,191	12,557,199	11,829,970	4,949,023
Total operating expenses ($000s)	6,561,552	11,933,432	11,065,080	MNR
Operating income ($000s)	439,639	623,767	764,890	MNR
Operating margin (%)	6.28	4.97	6.47	3.20
Net nonoperating income ($000s)	198,101	99,106	263,727	MNR
Excess income ($000s)	637,740	722,873	1,028,617	MNR
Excess margin (%)	8.86	5.71	8.51	5.80
Operating EBIDA margin (%)	11.71	11.09	12.45	8.30
EBIDA margin (%)	14.14	11.79	14.36	10.70
Net available for debt service ($000s)	1,017,779	1,492,190	1,736,648	577,381
Maximum annual debt service ($000s)	237,879	237,879	237,879	MNR
Maximum annual debt service coverage (x)	8.56	6.27	7.30	5.80
Operating lease-adjusted coverage (x)	6.02	4.62	5.51	4.80
Liquidity and financial flexibility				
Unrestricted reserves ($000s)	8,204,295	7,976,797	7,273,948	4,447,015
Unrestricted days' cash on hand	241.0	259.0	254.2	344.90
Unrestricted reserves/total long-term debt (%)	245.0	236.5	239.8	300.70

Table 2

AdventHealth, Florida Financial Statistics (cont.)

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		Medians for 'AA' rated health care systems
	2021	2020	2019	2020
Unrestricted reserves/contingent liabilities (%)	454.7	505.7	457.6	880.80
Average age of plant (years)	9.9	9.5	9.6	10.80
Capital expenditures/depreciation and amortization (%)	174.5	186.3	189.9	137.60
Debt and liabilities				
Total long-term debt ($000s)	3,348,722	3,372,720	3,033,315	MNR
Long-term debt/capitalization (%)	20.1	21.2	20.7	22.20
Contingent liabilities ($000s)	1,804,347	1,577,347	1,589,673	MNR
Contingent liabilities/total long-term debt (%)	53.9	46.8	52.4	44.70
Debt burden (%)	1.65	1.88	1.97	1.80
Defined-benefit plan funded status (%)	N.A.	88.24	85.49	81.70
Pro forma ratios				
Unrestricted reserves ($000s)	7,967,295	N/A	N/A	MNR
Total long-term debt ($000s)	4,016,722	N/A	N/A	MNR
Unrestricted days' cash on hand	234.0	N/A	N/A	MNR
Unrestricted reserves/total long-term debt (%)	198.4	N/A	N/A	MNR
Long-term debt/capitalization (%)	23.2	N/A	N/A	MNR
Miscellaneous				
Medicare advance payments ($000s)*	410,739	446,000	N/A	MNR
Short-term borrowings ($000s)*	0	0	0	MNR
CARES Act grants recognized ($000s)	5,000	539,000	N/A	MNR
Risk based capital ratio (%)	N/A	N/A	N/A	MNR
Total net special funding ($000s)	8,603	49,938	62,597	MNR

*Excluded from unrestricted reserves, long-term debt, and contingent liabilities. N.A.--Not available. N/A--Not applicable. MNR--Median not reported. Pro forma ratios include $400 million of new debt from the series 2021E bond issue and $268 million in debt outstanding from the July 2021 financing. In addition, pro forma unrestricted reserves are reduced by $237 million for an equity contribution towards the acquisition of Redmond Regional Medical Center.

Related Research

Through The ESG Lens 2.0: A Deeper Dive Into U.S. Public Finance Credit Factors, April 28, 2020

U.S. PUBLIC FINANCE

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CREDIT OPINION
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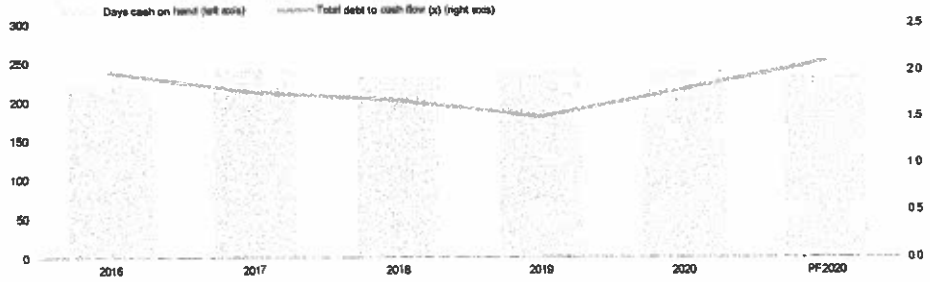
AdventHealth Obligated Group (formerly Adventist Health System/Sunbelt Obligated

Update to credit analysis

Summary

AdventHealth (AH, Aa2 stable) will benefit from consistently strong operating cash flow (OCF) margins, large scale and still relatively low, albeit higher operating leverage following a rise in debt. This will help offset days cash that will remain solid but below peers. Following over a 30% increase in absolute debt since 2019 associated with several initiatives, including the acquisition of Redmond Regional Medical Center (Redmond), cash to debt and debt to cash flow metrics will be less favorable than historical levels. However, these metrics will likely improve as management focuses on deleveraging. Atypical of multistate systems, revenues and cash flow will continue to be heavily concentrated in Florida. These highly competitive markets will be a key ongoing challenge, exacerbated by recent elimination of CON regulation in Florida. The Redmond transaction brings some risk as AH attempts to increase its presence in Georgia where it currently has very minimal assets. Sector-wide challenges include shifts to outpatient services as well as an unanticipated further rise in labor costs. However, absent temporary costs (through 2023) associated with a new clinical and revenue cycle IT system, OCF margins will likely remain around 13%. AH's highly centralized management model will help mitigate risk of potential IT-related operating disruption. This well tenured management team will also continue to address margin constraints with cost cutting initiatives. Strong daily liquidity will support AH's VMIG 1 and P-1 ratings.

Exhibit 1
Relatively low, albeit higher debt to cash flow, helps offset below average days cash



Fiscal 2020 days cash excludes Medicare Accelerated Payments of $446 million and deferred payroll taxes of $164 million. Pro-forma fiscal 2020 adds $509 million of new par debt, excludes $237 million of cash for Redmond transaction.
Source: Moody's Investors Service

Credit strengths

» Consistently strong operating cash flow margins will be sustained despite higher labor expenses, but will likely moderate somewhat because of temporary IT expenses

» Operating leverage, as measured by debt to cash flow, will rise somewhat with new debt but will likely return to historically low levels aided by strong cash flow generation

» Cash to debt will decline with added debt but improve to more favorable levels as absolute cash levels rise; days cash will be solid but below similarly rated peers

» Market position in Orlando, as well as several other high growth markets will remain favorable

» Management will remain focused on cost-cutting and disciplined capital spending especially as it focuses on absorbing additional debt

Credit challenges

» Debt related to acquisition of Redmond Regional will limit capacity for further leverage at the current rating level

» AH will derive a very high level of revenue and cash flow from Florida, and in particular, Orlando, which is atypical of most national multistate systems

» AH will face strong competition, particularly in high growth Florida, Texas and Denver markets; elimination of CON in Florida will increase challenges

» Softer inpatient volume trends due to a sector-wide shift to outpatient services and further wage pressure, will weigh on margins

» System wide install of new IT system will present some uncertainty

Rating outlook

The stable outlook reflects our view that despite higher labor costs, AH will at least achieve forecasted OCF margins through 2023 while it incurs temporary IT conversion costs, but will return to 13% OCF margins thereafter. The outlook also reflects our expectation that management will focus on deleveraging (including increasing cash to debt and reducing debt to cash flow) following the addition of debt.

Factors that could lead to an upgrade

» Greater diversification of cash flow generation

» Materially improved balance sheet measures

» Short-term ratings (VMIG 1 and P-1): not applicable

Factors that could lead to a downgrade

» Operating cash flow margins, excluding one-time IT related expenses, do not return to around 13%

» Leverage (as measured by cash to debt and debt to cash flow) does not decline

» Decline in absolute cash or days cash on hand

» Additional growth initiatives that dilute operating or balance sheet measures beyond current expectations

» Short-term ratings (VMIG 1 and P-1): material decline in daily liquidity or overall credit quality

Key indicators

AdventHealth, FL

	2016	2017	2018	2019	2020	PF2020
Operating Revenue ($'000)	9,651,689	10,083,125	10,974,124	11,892,267	12,623,222	12,623,222
3 Year Operating Revenue CAGR (%)	8.3	6.3	6.4	7.2	7.8	7.8
Operating Cash Flow Margin (%)	13.2	13.4	13.2	12.9	11.6	11.6
PM: Medicare (%)	46.0	47.1	47.5	47.9	47.9	47.9
PM: Medicaid (%)	13.9	14.1	13.5	13.1	13.2	13.2
Days Cash on Hand	220	240	232	238	259	232
Unrestricted Cash and Investments to Total Debt (%)	168.9	198.2	206.6	240.7	241.6	187.1
Total Debt to Cash Flow (x)	2.0	1.8	1.7	1.5	1.8	2.1

Based on audited financial statements for AdventHealth for fiscal year ended December 31
Fiscal 2020 includes Medicare Accelerated Payments of $446 million and deferred payroll taxes of $164 million. Excluding these items, days cash on hand and unrestricted cash and investments to total debt would be about 239 days and 223%, respectively. Pro-forma fiscal 2020 adds $509 million of new par debt, excludes $237 million of cash for Redmond transaction.
Source: Moody's Investors Service

Profile

AdventHealth (AH) is a multi-state health system, headquartered in Altamonte Springs, FL. AH operates 45 acute care hospitals and other health care services in nine states – Colorado, Florida, Georgia, Illinois, Kansas, Kentucky, North Carolina, Texas and Wisconsin. AH acquired Redmond Regional Medical Center in Rome, Georgia on October 1, 2021.

Detailed credit consideration

Market position: large scale with heavy reliance on FL, limiting diversification; generally good positioning but competition will rise with elimination of FL CON

AH will benefit from its position as a large multi-state system, operating in nine-states with about $12.6 billion in fiscal 2020 revenues. That said, AH will be highly concentrated in one state, which is atypical of multi-state systems.

AH will remain heavily reliant on Florida, which accounted for about 71% of 2020 revenues but almost 76% of operating cash flow (excluding corporate overhead) with margins in excess of the overall system. The system's reliance on Florida will continue to increase following four in-state acquisitions (adding close to 900 beds in South Central FL and West FL) from CHS/Community Health System (B3 stable) in 2018 and 2019. AH will continue to integrate and improve operations at these underperforming facilities. Also in 2019, AH acquired minority ownership of Health First, a four-hospital Florida system in Brevard County, helping it to broaden its regional network. Each of these recent acquisitions will provide a presence in attractive, but highly competitive growth markets. While AH reports about 42.8% inpatient share in its key Orlando market, it faces strong competition from Orlando Health (A2 stable), with 36.9% share. The presence of numerous systems in other markets, including west Florida (Tampa) and east Florida (Daytona) will also provide challenges. The elimination of CON regulation in Florida (in July 2019) will continue to raise competitive pressures.

Beyond Florida, other markets with the strongest operating performance will be the Rocky Mountain Region (Colorado) accounting for about 10.3% of revenues and 12.1% of AH's operating cash flow in fiscal 2020, and Mid-America (Kansas and Wisconsin) with about 4.9% of system revenues but about 5.7% of system operating cash flow in 2020. The Midwest (AMITA, a joint operating company (JOC), which AH operates with Ascension Health Alliance's (Aa2 stable) Chicago area hospitals) is still among AH's weakest performers.

AH's $637 million acquisition of 230-bed Redmond Regional Medical Center in Rome, Georgia from HCA will expand its presence in a state where it currently has two small hospitals (accounting for about 1% of OCF and less than 2% of revenues). Despite benefits from an enhanced presence in GA, the dominance of several large regional players will potentially present challenges.

Volume trends continue to show recovery following a third and peak surge in COVID cases in the August 2021 timeframe. Same store admissions are back to pre-COVID 2019 levels but surgeries are still below, in part because of the need to limit overnight stay surgeries

to accommodate COVID cases. Separate from COVID, however, overall inpatient volume trends will remain softer as AH experiences sector-wide shifts to outpatient care.

Operating performance, balance sheet and capital plans: favorable OCF margins but solid days cash offset by rising, albeit still low operating leverage

Management anticipates that operating cash flow (OCF) margins will improve in fiscal 2021 to the mid-12% range compared to fiscal 2020 levels of 11.6% despite higher staffing costs associated with lingering disruption from the pandemic. During fiscal 2022-2023, OCF margins will moderate because of temporary IT-related expenses, but will likely return to the 13% range thereafter. Management will continue to focus on cost reductions, which will help to offset headwinds including softer volume trends, heightened salary and wage pressures and rising supply costs.

The system-wide conversion of AH's IT billing and clinical systems has been delayed somewhat due to the pandemic and will carry risk of potential uncertainty associated with operational disruptions. This conversion will aid operating efficiencies as physician and home health divisions have been on different IT platforms than AH's hospitals. Operations are highly centralized, including managed care contracting. AH will continue to increase exposure to risk sharing contracts (including full risk taking for certain exchange lives) but the majority of AH's commercial payer contracts will likely remain fee-for-service over the coming year.

Over the next few years, management's capital spending levels will be funded through operating cash flow and will likely rise to about 82% of operating EBIDA compared to its average of 75%. Recent major projects that are outside of its typical capital plan such as (the previously unplanned) IT conversion, the Health First and the Redmond Regional transactions, have required debt financing. Management will reevaluate levels of capital spending if operating performance falls below expectations and impedes deleveraging.

Liquidity

Days cash levels will be solid but well-below similarly rated peers, with about 230 days cash on hand based on pro-forma fiscal 2020 excluding $237 million of cash used to fund Redmond (versus the 2019 Aa2 median of 373 days). This figure would be somewhat lower after including Redmond's expense base. Pro-forma for the Redmond transaction, fiscal 2020 cash to debt (ex-Medicare advance, FICA funds) would be about 187% (compared to 223% prior to adding new debt); this metric would fall to about 175% including AR debt. While still favorable, these measures are below the 2019 median of about 254% for similarly rated systems. Moody's computation includes the net amount of "due from/due to brokers".

AH's investment allocation will remain relatively conservative with about 67% in fixed income (heavily weighted toward government bonds) and cash, 21% in equities and the balance in alternative investments in fiscal 2020. AHS also has a $500 million multi-bank revolver (expires December 2023) and a $500 million commercial paper program (the latter of which is backed by AH's own liquidity and discussed further below), providing ample liquidity for working capital, operating and routine capital needs.

Debt structure and legal covenants: conservative debt structure

Following several years of steady to declining absolute debt levels, AH's debt will be materially higher, rising by about 30% (or $900 million) between fiscal 2019 and fiscal 2021. Debt to cash flow rose from 1.5 times in fiscal 2019 to about 2.1 times based on fiscal 2020, proforma for the Redmond transaction. This metric will likely decline as absolute operating cash flow and cash levels increase. Maintenance of the ratings and outlook would reflect an expectation that management will refrain from additional acquisitions while focusing on deleveraging.

AH will continue to maintain a program which sells receivables to Highlands County, Florida, Health Facilities Authority on a non-recourse basis. Related to financing this program, Highlands County currently has about $250 million in debt outstanding (which, if included, would raise AH's total debt by about 6.6%).

The system will have ample headroom under its MTI and bank loan financial covenants. MTI covenants include a 1.15 times rate covenant in the most recent fiscal year measured annually, based on the annual debt service requirement. Per management, bank covenants on its private placement debt include the following: 1.15 times rate covenant; 75 days cash on hand; no more than 65% debt to capitalization.

Legal security
The system's outstanding debt is secured by a joint and several gross revenue pledge of the obligated group, which includes nearly all of the system hospitals. As of December 31, 2020, this represented about 96% of system revenues and operating income. No mortgage is pledged.

AH will add four new members to the Obligated Group on November 1, 2021. These include AdventHealth Ottawa (acquired May 2019), Redmond Regional Medical Center, AdventHealth South Overland Park (newly opened on October 2021) and AdventHealth Riverview (under construction, expected to be completed in 2023).

Debt structure
AH will maintain a relatively conservative debt structure following this transaction with about 66% of fixed rate debt, 20% in fixed rate intermediate-term puttable debt, and 14% in variable rate debt, which will include self-liquidity backed weekly VRDBs (see below).

The system will continue to maintain its long-standing internal liquidity program, which supports AH's general obligation to make payments on tendered bonds that are not remarketed or rolled over. As of September 30, 2021, AH had approximately $3.7 billion of investments with same-day liquidity, which incorporates Moody's discounted assumptions and includes US treasuries and Aaa-rated agencies. AH will have weekly VRDBs backed by its own liquidity of about $524 million. It also has borrowed about $400 million in commercial paper (CP) to initially finance its Redmond facility. Management will refinance this CP with bond proceeds related to the Redmond acquisition and expects no additional draws over the coming year.

Debt-related derivatives
No derivatives present.

Pensions and OPEB
AH will have very limited exposure to pension liabilities, with a small defined benefit plan that is fully frozen and was inherited with an earlier acquisition.

ESG considerations

Environmental
Although AH is a multi-state system, it has material concentration in Florida, in particular in Orlando, located in Orange County. According to Moody's affiliate, Four Twenty Seven, Orange County is exposed to extremely high risk of hurricanes and typhoons as well as high risk of heat stress.

Social
The pandemic will continue to present a key social consideration. AH will see ongoing volume recovery following its most recent peak COVID case surge in the July through August time frame. Another key social issue will be salary and wage pressures, already an issue prior to the pandemic, which will be exacerbated by pandemic related staffing challenges. These include clinician burnout, higher expenses associated with retention and recruitment as well as agency personnel.

Governance
AH will benefit from an executive leadership team that is highly seasoned with a strong sense of financial discipline and accountability. The CEO's 12-member cabinet will continue to meet weekly to ensure that AH focuses on its new Vision 2030 goals; this will be aided by a highly centralized management structure. AH will likely continue to achieve good operating performance, and meet or exceed conservative budgets. This will be more critical as AH focuses on deleveraging following several debt-financed strategic investments.

REPORT NUMBER 1302970

Audited Consolidated Financial Statements

December 31, 2021

AdventHealth

ATTACHMENT 34

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Consolidated Balance Sheets

December 31, 2021 and 2020

(dollars in thousands)	2021	2020
ASSETS		
Current Assets		
Cash and cash equivalents	$ 506,777	$ 1,210,037
Investments	7,716,423	6,951,313
Current portion of assets whose use is limited	438,224	433,910
Patient accounts receivable	1,123,267	905,103
Due from brokers	125,744	898,168
Estimated settlements from third parties	251,606	90,576
Other receivables	792,446	597,536
Inventories	327,697	357,367
Prepaid expenses and other current assets	148,682	107,580
	11,430,866	11,551,590
Property and Equipment	8,536,375	7,798,166
Operating Lease Assets	302,051	324,218
Assets Whose Use is Limited, net of current portion	452,973	444,529
Other Assets	1,705,906	1,121,486
	$ 22,428,171	$ 21,239,989
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable and accrued liabilities	$ 1,953,148	$ 1,572,650
Estimated settlements to third parties	162,081	174,106
Due to brokers	124,724	1,083,015
Other current liabilities	829,305	1,129,744
Short-term financings	520,310	324,285
Current maturities of long-term debt	58,102	65,011
	3,647,670	4,348,811
Long-Term Debt, net of current maturities	3,432,468	3,048,435
Operating Lease Liabilities, net of current portion	248,221	258,450
Other Noncurrent Liabilities	762,750	821,824
	8,091,109	8,477,520
Net Assets		
Net assets without donor restrictions	14,062,347	12,521,994
Net assets with donor restrictions	221,319	195,078
	14,283,666	12,717,072
Noncontrolling interests	53,396	45,397
	14,337,062	12,762,469
Commitments and Contingencies		
	$ 22,428,171	$ 21,239,989

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

Consolidated Statements of Operations and Changes in Net Assets

For the years ended December 31, 2021 and 2020

(dollars in thousands)	2021	2020
Revenue		
Net patient service revenue	$ 14,177,120	$ 11,572,183
Other	705,594	1,051,039
Total operating revenue	14,882,714	12,623,222
Expenses		
Employee compensation	7,430,730	6,164,642
Supplies	2,479,704	2,213,856
Purchased services	1,134,839	1,127,396
Professional fees	857,800	783,097
Other	1,181,712	870,872
Interest	73,279	78,663
Depreciation and amortization	730,033	690,654
Total operating expenses	13,888,097	11,929,180
Income from Operations	994,617	694,042
Nonoperating Gains (Losses)		
Investment return	524,945	225,030
Loss on extinguishment of debt	(6,043)	–
Other	(1,231)	–
Total nonoperating gains, net	517,671	225,030
Excess of revenue and gains over expenses	1,512,288	919,072
Noncontrolling interests	(6,817)	(4,252)
Excess of Revenue and Gains over Expenses Attributable to Controlling Interest	1,505,471	914,820

Continued on following page.

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

For the years ended December 31, 2021 and 2020

(dollars in thousands)	2021	2020
CONTROLLING INTEREST		
Net Assets Without Donor Restrictions		
Excess of revenue and gains over expenses	$ 1,505,471	$ 914,820
Net assets released from restrictions for purchase of property and equipment	17,041	11,147
Other	17,841	12,020
Increase in net assets without donor restrictions	1,540,353	937,987
Net Assets With Donor Restrictions		
Gifts and grants	32,377	28,164
Net assets released from restrictions for purchase of property and equipment or use in operations	(28,076)	(26,892)
Investment return	2,774	2,285
Other	19,166	3,679
Increase in net assets with donor restrictions	26,241	7,236
NONCONTROLLING INTERESTS		
Net Assets Without Donor Restrictions		
Excess of revenue and gains over expenses	7,380	4,252
Distributions	(4,934)	(481)
Other	5,553	2,399
Increase in noncontrolling interests	7,999	6,170
Increase in Net Assets	1,574,593	951,393
Net assets, beginning of year	12,762,469	11,811,076
Net assets, end of year	$ 14,337,062	$ 12,762,469

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

Consolidated Statements of Cash Flows

For the years ended December 31, 2021 and 2020

(dollars in thousands)	2021	2020
Operating Activities		
Increase in net assets	$ 1,574,593	$ 951,393
Depreciation and amortization	730,033	690,654
Amortization of deferred financing costs and original issue discounts and premiums	(22,927)	(16,570)
Loss on extinguishment of debt	6,043	–
Net realized and unrealized gains on investments	(344,255)	(133,793)
Restricted gifts and grants and investment return	35,151	(30,449)
Income from unconsolidated entities	(81,038)	(74,398)
Distributions from unconsolidated entities	10,675	18,038
Changes in operating assets and liabilities:		
Patient accounts receivable	(1,443,205)	(1,129,201)
Other receivables	(65,859)	(30,671)
Other current assets	(514)	(68,905)
Accounts payable and accrued liabilities	400,170	146,955
Estimated settlements to third parties, net	(173,055)	(3,580)
Other current liabilities	(175,574)	540,979
Other noncurrent assets and liabilities	(46,034)	154,258
Net cash provided by operating activities	404,204	1,014,710
Investing Activities		
Purchases of property and equipment, net	(1,335,739)	(1,286,743)
Cash paid for acquisitions, net of cash received	(646,052)	–
Sales and maturities of investments	5,163,486	5,638,026
Purchases of investments	(5,582,291)	(5,331,954)
Due from brokers	772,424	(636,208)
Due to brokers	(958,291)	449,937
Sales, maturities, and uses of assets whose use is limited	129,081	519,464
Purchases of and additions to assets whose use is limited	(116,872)	(531,790)
Consideration paid to acquire noncontrolling interest	(125,000)	(125,000)
Cash receipts on sold patient accounts receivable	1,096,635	1,000,607
Increase in other assets	(32,711)	(44,462)
Net cash used in investing activities	(1,635,330)	(348,123)
Financing Activities		
Repayments of long-term borrowings	(1,100,387)	(62,791)
Additional long-term borrowings	1,494,395	429,871
Repayments of short-term borrowings	(3,975)	(305,305)
Additional short-term borrowings	200,000	303,500
Restricted gifts and grants and investment return	(35,151)	30,449
Net cash provided by financing activities	554,882	395,724
(Decrease) Increase in Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents	(676,244)	1,062,311
Cash, cash equivalents, restricted cash, and restricted cash equivalents at beginning of year	1,565,376	503,065
Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents at End of Year	$ 889,132	$ 1,565,376
Noncash Investing Activity		
Beneficial interest obtained in exchange for patient accounts receivable	$ (1,225,686)	$ (817,725)
Consideration payable to acquire noncontrolling interest	–	225,000

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

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 20 (dollars in thousands)

1. Significant Accounting Policies

Reporting Entity

Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth (Healthcare Corporation) is a not-for-profit healthcare corporation that owns and/or operates hospitals, nursing homes, physician offices, urgent care centers and other healthcare facilities, and a philanthropic foundation with various informal divisions (collectively referred to herein as the System). The System's affiliated healthcare facilities are operated or controlled through their by-laws, governing board appointments, or operating agreements. The System's 48 hospitals, 10 nursing homes, and philanthropic foundations operate in 9 states – Colorado, Florida, Georgia, Illinois, Kansas, Kentucky, North Carolina, Texas, and Wisconsin.

SunSystem Development Corporation (Foundation) is a charitable foundation operated by Healthcare Corporation for the benefit of many of the hospitals that are divisions or controlled affiliates. Healthcare Corporation is the Foundation's member and appoints its board of managers. The Foundation engages in philanthropic activities.

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

Mission

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

Specifically, the System provides:

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

Benefit to the elderly, by subsidizing the unreimbursed costs associated with providing care to those receiving governmental Medicare funding.

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

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

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

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of affiliated organizations that are controlled by Healthcare Corporation. Any subsidiary or other operations owned and controlled by divisions or controlled affiliates of Healthcare Corporation are included in these consolidated financial statements. Investments in entities that Healthcare Corporation does not control are recorded under the equity or cost method of accounting, depending on the ability to exert significant influence. Income from unconsolidated entities is included in other operating revenue or as a reduction to supplies expense (Note 6) in the accompanying consolidated statements of operations and changes in net assets. All significant intercompany accounts and transactions have been eliminated in consolidation. Partial ownership by another entity in the net assets and results of operations of a consolidated subsidiary is reflected as noncontrolling interests in the accompanying consolidated financial statements.

Use of Estimates

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

Recently Adopted Accounting Guidance

In August 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract.* This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The System adopted the standard effective January 1, 2021, on a prospective basis. This standard did not have a material impact on the System's accompanying consolidated financial statements.

Recent Accounting Guidance Not Yet Adopted

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* This ASU requires earlier recognition of credit losses on financing receivables and other financial assets in scope. For trade receivables, loans, and held-to-maturity debt securities, entities will be required to estimate lifetime expected credit losses, resulting in earlier recognition of credit losses. For available-for-sale debt securities, entities will be required to recognize an allowance for credit losses rather than a reduction to the carrying value of the asset. In addition, entities will have to make more disclosures, including disclosures by year of origination for certain financing receivables. Management is currently evaluating the potential impact of this guidance, which will be effective for the System beginning in 2023.

In September 2020, the FASB issued ASU 2020-07, Not-for-Profit Entities (Topic 958): *Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets.* This ASU changes the presentation and disclosure requirements for not-for-profit entities to increase transparency about contributed nonfinancial assets. Management is currently evaluating the potential impact of this guidance, which will be effective for the System beginning in 2022.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Net Patient Service Revenue

Net patient service revenue is reported at the amount that reflects the consideration the System expects to be due from patients and third-party payors in exchange for providing patient care. Providing patient care services is considered a single performance obligation, satisfied over time, in both the inpatient and outpatient setting. Generally, the System bills the patients and third-party payors several days after services are performed or the patient is discharged from the facility.

Revenue for inpatient acute care services is recognized based on actual charges incurred in relation to total expected, or actual, charges. The System measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge.

As all the System's performance obligations relate to contracts with a duration of less than one year, the System is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially satisfied at the end of the reporting period, which are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

For patients covered by third-party payors, the System determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to those third-party payors. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. The System is subject to retroactive revenue adjustments due to future audits, reviews, and investigations. Additionally, the System participates in certain state programs that provide supplemental Medicaid funding to partially offset unreimbursed Medicaid costs. These programs include a combination of intergovernmental transfers and federal matching dollars. They are typically approved by governmental agencies on an annual basis and as such, funding for future years is not certain and subject to change. Contracts the System has with commercial payors also provide for retroactive audit and review of claims. Settlements with third-party payors for retroactive adjustments 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 with the payor, and the System's historical settlement activity, attempting to ensure that a significant revenue reversal will not occur when the final amounts are subsequently determined. Estimated settlements are adjusted in future periods as new information becomes available, or as years are settled or are no longer subject to such audits, reviews, and investigations. Net adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, resulted in increases to revenue of approximately $34,000 and $37,000 for the years ended December 31, 2021 and 2020, respectively.

Generally, patients covered by third-party payors are responsible for related deductibles and coinsurance, which is referred to as the patient portion. The System also provides services to uninsured patients and offers those uninsured patients a discount from standard charges in accordance with its policies.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. Therefore, the System has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances such as copay and deductibles. The difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients is recorded as implicit price concessions, or as a direct reduction to net patient service revenue. Subsequent adjustments that are determined to be the result of an adverse change in the patient's or payor's ability to pay are recognized as bad debt expense. Bad debt expense for the years ended December 31, 2021 and 2020 was not material for the System, and is included within other expense in the accompanying consolidated statements of operations and changes in net assets, rather than as a deduction to arrive at revenue.

The System estimates the transaction price for the patient portion and uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions.

The composition of net patient service revenue by primary payor is as follows:

	Year Ended December 31,			
	2021		2020	
	Amount	%	Amount	%
Managed Care	$ 7,518,396	53%	$ 6,014,295	52%
Medicare	2,404,793	17	2,308,713	20
Managed Medicare	2,214,713	15	1,759,956	15
Medicaid	528,947	4	478,240	4
Managed Medicaid	802,751	6	501,338	4
Self-pay	113,715	1	79,028	1
Other	593,805	4	430,613	4
	$14,177,120	100%	$11,572,183	100%

Charity Care

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

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

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

The cost of providing charity care services, amounts paid by the System into uncompensated care funds, and amounts received by the System to offset or subsidize charity care services are as follows:

	Year Ended December 31, 2021	2020
Charity Care Cost		
Cost of providing charity care services	$ 378,686	$ 403,072
Charity Care Funding		
Funds received to offset or subsidize charity care services (included in patient service revenue)	$ 304,613	$ 283,593
Funds paid into trusts (included in other expenses)	(261,757)	(253,417)
Net charity care funding received	$ 42,856	$ 30,176

Excess of Revenue and Gains over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue and gains over expenses as the performance indicator, which is analogous to net income of a for-profit enterprise. Changes in net assets without donor restrictions that are excluded from the performance indicator may include transfers of net assets released from restrictions for the purpose of acquiring long-lived assets, and other changes in net assets.

Contributed Resources

Resources restricted by donors for specific operating purposes or a specified time period are held as net assets with donor restrictions until expended for the intended purpose or until the specified time restrictions are met, at which time they are reported as other revenue. Resources restricted by donors for additions to property and equipment are held as net assets with donor restrictions until the assets are placed in service, at which time they are reported as transfers to net assets without donor restrictions. Gifts, grants, and bequests not restricted by donors are reported as other revenue.

Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents

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

The following table provides a reconciliation of cash, cash equivalents, restricted cash, and restricted cash equivalents reported within the statement of financial position that sum to the total of the same such amounts shown in the statements of cash flows. Restricted cash and cash equivalents consist of funds included in assets whose use is limited.

	December 31, 2021	2020
Cash and cash equivalents	$ 506,777	$ 1,210,037
Restricted cash and restricted cash equivalents included in assets whose use is limited	382,355	355,339
Total cash, cash equivalents, restricted cash, and restricted cash equivalents shown in the statement of cash flows	$ 889,132	$ 1,565,376

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Investments

Investments include marketable securities and other investments. Investments in debt and equity securities with readily determinable fair values are reported at fair value, based on quoted market prices and are primarily designated as trading securities. The cost of securities sold is based on the average cost method.

Other investments include alternative investments, which are primarily hedge funds, commingled funds, and private equity funds, which determine fair value using net asset values (NAV). The value of such investments is estimated, and those estimates may change in the near term. The financial statements and internal controls of the funds are audited annually by independent auditors. The System's risk is limited to its investment in the fund. In September 2020, the System submitted redemption notices for approximately $529,000 of its hedge funds, of which approximately $352,000 were redeemed as of December 31, 2020, and the remaining amount was redeemed in January 2021. Private equity funds generally require capital commitments over an initial period of time and capital is returned as monetization events occur. Unfunded commitments related to private equity funds were approximately $114,000 and $43,000 as of December 31, 2021 and 2020, respectively. Commingled funds are used to obtain the desired exposure targets within the investment portfolio and have daily redemption terms.

Other investments may also include exchange-traded and over-the-counter derivative instruments that are held for trading purposes and to act as economic hedges to manage the risk of the investment portfolio. These instruments, which primarily include futures, options, and swaps, are used to gain broad market exposure and additional exposure to equity markets, adjust the fixed-income portfolio duration, provide an economic hedge against fluctuations in foreign exchange rates, and generate investment returns. These derivative instruments are not designated as hedging instruments.

Investment return includes realized gains and losses, interest, dividends, and net change in unrealized gains and losses. The investment return on investments restricted by donor or law is recorded as increases or decreases to net assets with donor restrictions. Investment return earned on the System's self-insurance trust funds and employee benefits funds is recorded in other operating revenue.

Assets Whose Use is Limited

Certain of the System's investments are limited as to use through the terms of trust agreements, internal designation, under the terms of bond indentures, or the provisions of other contractual arrangements. These investments are classified as assets whose use is limited in the accompanying consolidated balance sheets.

Sale of Patient Accounts Receivable

The System and certain of its member affiliates maintain a program for the continuous sale of certain patient accounts receivable to the Highlands County, Florida, Health Facilities Authority (Highlands) on a nonrecourse basis. Highlands has partially financed the purchase of the patient accounts receivable through the issuance of private placement, tax-exempt, variable-rate bonds (Bonds). Highlands had Bonds outstanding of $240,000 and $280,000 as of December 31, 2021 and 2020, respectively. The Bonds have a put date of December 2022 and a final maturity date of November 2027. On February 1, 2022, the put date of the Bonds was extended to the final maturity date of November 2027. The System is the servicer of the receivables under this arrangement and is responsible for performing all accounts receivable administrative functions.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

As of December 31, 2021 and 2020, the estimated net realizable value, as defined in the underlying agreements, of patient accounts receivable sold by the System and removed from the accompanying consolidated balance sheets was $849,526 and $760,475, respectively. The patient accounts receivable sold consist primarily of amounts due from government programs and commercial insurers. The proceeds received from Highlands consist of cash from the Bonds, a note on a subordinated basis with the Bonds, and a note on a parity basis with the Bonds. The note on a subordinated basis with the Bonds is in an amount to provide the required over-collateralization of the Bonds and was $60,000 and $70,000 at December 31, 2021 and 2020, respectively. The note on a parity basis with the Bonds is the excess of eligible accounts receivable sold over the sum of cash received and the subordinated note and was $549,526 and $410,475 at December 31, 2021 and 2020, respectively. These notes are included in other receivables in the accompanying consolidated balance sheets. Due to the nature of the patient accounts receivable sold, collectability of the subordinated and parity notes is not significantly impacted by credit risk.

The notes on a parity and subordinated basis represent the System's beneficial interest in the receivables subsequent to the sale. Cash received at the time of sale is recognized within the consolidated statement of cash flows as part of operating activities. Any subsequent cash received on the beneficial interest is recognized within the consolidated statement of cash flows as part of investing activities.

Inventories

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

Property and Equipment

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

Goodwill

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

	December 31, 2021	December 31, 2020
Goodwill	$ 745,612	$ 225,058
Less: accumulated amortization	(59,085)	(23,452)
Goodwill, net	$ 686,527	$ 201,606

Goodwill increased in 2021 as a result of a business combination (Note 2). Goodwill is amortized over a period of ten years. Amortization expense for goodwill was $35,633 and $23,542 for the years ended December 31, 2021 and 2020, respectively, and is included in depreciation and amortization in the accompanying consolidated statement of operations and changes in net assets.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Interest in the Net Assets of Unconsolidated Foundations

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

Impairment of Long-Lived Assets

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

Deferred Financing Costs

Direct financing costs are included as a reduction to the carrying amount of the related debt liability and are deferred and amortized over the remaining lives of the financings using the effective interest method.

Bond Discounts and Premiums

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

Income Taxes

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

NAHS is a wholly owned, for-profit subsidiary of Healthcare Corporation. NAHS and its subsidiary are subject to federal and state income taxes. NAHS files a consolidated federal income tax return and, where appropriate, consolidated state income tax returns. All taxable income was fully offset by net operating loss carryforwards for federal income tax purposes; as such, there is no provision for current federal or state income tax for the years ended December 31, 2021 and 2020.

NAHS also has temporary deductible differences of approximately $33,000 and $41,800 at December 31, 2021 and 2020, respectively, primarily as a result of net operating loss carryforwards. At December 31, 2021, NAHS had net operating loss carryforwards of approximately $34,000, expiring beginning in 2022 through 2026. Deferred taxes have been provided for these amounts, resulting in a net deferred tax asset of approximately $8,100 and $10,200 at December 31, 2021 and 2020, respectively. NAHS remeasured its deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally 21%. A full valuation allowance has been provided at December 31, 2021 and 2020 to offset the deferred tax asset since Healthcare Corporation has determined that it is more likely than not that the benefit of the net operating loss carryforwards will not be realized in future years.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

The Income Taxes Topic of the Accounting Standards Codification (ASC) (ASC 740) prescribes the accounting for uncertainty in income tax positions recognized in financial statements. ASC 740 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken, or expected to be taken, in a tax return. There were no material uncertain tax positions as of December 31, 2021 and 2020.

Reclassifications

Certain reclassifications were made to the 2020 consolidated financial statements to conform to the classifications used in 2021. These reclassifications had no impact on the consolidated excess of revenue and gains over expenses, changes in net assets, or cash flows previously reported.

2. Organizational Changes

Business Combinations

The System accounts for transactions that represent business combinations in accordance with the Not-for-Profit Entities, Business Combinations Topic of the ASC (ASC 958-805), where the assets acquired and liabilities assumed are recognized and measured at their fair values on the acquisition date. Fair values that are not finalized are estimated and reported as provisional amounts.

On October 1, 2021, the System purchased Redmond Regional Medical Center, which was renamed AdventHealth Redmond (AH Redmond) and includes a 230-bed hospital in Rome, Georgia, as well as its related businesses, physician clinics, outpatient services, and all issued and outstanding equity interests.

The assets acquired and liabilities assumed were recorded based on their acquisition date fair values. Cash consideration was $646,063, which primarily represented the payment for the real and personal property and goodwill. The System issued fixed-rate, taxable bonds totaling $400,000 to finance a portion of the acquisition price (Note 8). The amounts recognized as of the acquisition date for each major class of assets acquired and liabilities assumed are as follows:

Assets	
Cash and cash equivalents	$ 11
Patient accounts receivable	646
Inventories	10,029
Prepaid expenses and other current assets	889
Property and equipment	117,702
Operating lease assets	1,549
Other assets	521,453
	652,279
Liabilities	
Accounts payable and accrued liabilities	$ 4,532
Other current liabilities	135
Operating lease liabilities, net of current portion	1,549
	6,216
Fair Value of Net Assets Acquired	$ 646,063

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

The goodwill acquired represents the excess of the purchase price and related costs over the value assigned to the net tangible and identifiable intangible assets of the business acquired. Goodwill, totaling approximately $520,000, is included in other assets (noncurrent) in the accompanying consolidated balance sheets.

The results of operations and changes in net assets for AH Redmond was included in the System's consolidated financial statements beginning October 1, 2021. AH Redmond had total operating revenue of $67,915 and a deficiency of revenue and gains over expenses of $15,060 for the period from October 1, 2021 through December 31, 2021.

The following pro forma combined results of operations present the acquisition as if it had occurred on January 1, 2020 and, as such, reflects the impact of amortizing the fair value adjustments to property and equipment, amortizing goodwill acquired, and recognizing interest expense on the issued debt as of January 1, 2020. The pro forma combined results of operations do not necessarily represent the System's consolidated results of operations had the acquisition occurred on the date assumed, nor are these results necessarily indicative of the System's future consolidated results of operations. AH Redmond serves as a regional referral center for all of northwest Georgia and parts of Alabama. It is the only hospital in northwest Georgia with an open-heart surgery program and Level 1 emergency Cardiac Care Center designation. The System expects to realize certain benefits from integrating AH Redmond into the System's other services provided in the Georgia market and to incur certain one-time integration costs. The pro forma combined results of operations do not reflect these benefits or costs.

	Year Ended December 31, 2021	2020
Pro forma revenue	$ 15,102,923	$ 12,892,160
Pro forma excess of revenue and gains over expenses	1,486,179	892,631
Pro forma change in net assets without donor restrictions	1,510,821	908,877

Other Changes

On April 1, 2020, the System sold substantially all of the assets of Central Texas Medical Center together with certain other affiliated assets (CTMC) to CHRISTUS Santa Rosa Healthcare (CHRISTUS), a faith-based health system headquartered in Irving, Texas. CTMC provides healthcare services to the San Marcos, Texas community and surrounding areas. The System received proceeds of approximately $32,500 from the sale.

In October 2021, the System and Ascension decided to unwind their AMITA Health partnership, the joint operating company serving the healthcare needs of residents of the greater Chicago area. Following the transition, the System will operate its individual hospitals and related healthcare facilities in the Chicagoland area and the System's four hospitals and related healthcare facilities will continue to be controlled and consolidated by the System. The change will not have a material impact on the System's accompanying consolidated financial statements.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

3. Investments and Assets Whose Use is Limited

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

	December 31, 2021	2020
Debt securities		
U.S. government agencies and sponsored entities	$ 3,311,876	$ 3,475,149
Foreign government agencies and sponsored entities	299,462	2,154
Corporate bonds	83,288	294,329
Mortgage backed	38,280	27,991
Other asset backed	26,253	20,805
Short-term investments	5,377	179,571
Accrued interest	13,583	9,909
	3,778,119	4,009,908
Domestic equity securities	131,818	128,341
Exchange traded and mutual funds		
Domestic equity	1,314,482	928,408
Foreign equity	667,974	426,361
Fixed income	977,468	735,294
	2,959,924	2,090,063
Investments at NAV		
Hedge funds and private equity funds	1,014,704	872,397
Commingled funds	340,700	373,704
	1,355,404	1,246,101
Cash and cash equivalents – assets whose use is limited	382,355	355,339
	8,607,620	7,829,752
Less: assets whose use is limited	(891,197)	(878,439)
Investments	$ 7,716,423	$ 6,951,313

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Investment Derivatives

The fair value of investment derivative instruments and the associated notional amounts, presented gross, were as follows:

	December 31, 2021			
	Notional		Fair Value	
	Long	Short	Assets	Liabilities
Equity options	$ –	$ (207)	$ –	$ (207)
Interest rate swaps	5,020	(4,126)	5,020	(4,126)
Futures	1,409,255	(237,690)	–	–
Foreign currency exchange contracts	214,255	(497,757)	2,110	(3,457)
Total derivative instruments, gross	$ 1,628,530	$ (739,780)	$ 7,130	$ (7,790)

	December 31, 2020			
	Notional		Fair Value	
	Long	Short	Assets	Liabilities
Equity options	$ –	$ (3)	$ –	$ (3)
Interest rate swaps	18	(2)	18	(2)
Futures	397,014	(148,689)	–	–
Total derivative instruments, gross	$ 397,032	$ (148,694)	$ 18	$ (5)

The System posted collateral related to investment derivative instruments totaling $47,607 and $19,114 as of December 31, 2021 and 2020, respectively. Collateral is included in either cash and cash equivalents or investments in the accompanying consolidated balance sheets, depending on the type of collateral posted. The System had investment return related to investment derivative instruments of $93,286 and $(63,021) for the years ended December 31, 2021 and 2020, respectively.

Assets Whose Use is Limited

Assets whose use is limited includes investments held under trust agreements for settling payments under the professional and general liability program, and internally designated investments for employee retirement plans. Amounts to be used for the payment of current liabilities are classified as current assets.

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

	December 31,	
	2021	2020
Self-insurance trust funds	$ 459,497	$ 446,294
Employee benefits funds	272,136	254,441
Other	159,564	177,704
	891,197	878,439
Less: amounts to pay current liabilities	(438,224)	(433,910)
	$ 452,973	$ 444,529

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Investment Return and Unrealized Gains and Losses

Investment return from cash and cash equivalents, investments, and assets whose use is limited in the accompanying consolidated statements of operations and changes in net assets consisted of the following:

	Year Ended December 31, 2021	2020
Interest and dividend income	$ 178,641	$ 93,730
Net realized gains (losses)	202,092	(4,287)
Net change in unrealized gains and losses	144,212	135,587
	$ 524,945	$ 225,030

4. Liquidity and Available Resources

The System's primary cash requirements are paying operating expenses, servicing debt, incurring capital expenditures related to the expansion and renovation of existing facilities, and acquisitions. Cash in excess of near-term working capital needs is invested as described in Notes 1 and 3. Primary cash sources are cash flows from operating and investing activities. Additionally, the System has access to public and private debt markets and maintains a revolving credit agreement and commercial paper program, as described in Note 8.

The System had 228 and 260 days cash on hand at December 31, 2021 and 2020, respectively. As described in Note 14, the System repaid approximately $181,000 of Medicare accelerated payments during 2021. Days cash on hand is calculated as unrestricted cash and cash equivalents, investments, and due to brokers, net, divided by daily operating expenses (excluding depreciation and amortization expense). Unrestricted cash and cash equivalents, investments, and due to brokers, net consist of the following:

	December 31, 2021	2020
Cash and cash equivalents	$ 506,777	$ 1,210,037
Investments	7,716,423	6,951,313
Due from (to) brokers, net	1,020	(184,847)
	$ 8,224,220	$ 7,976,503
Unrestricted days cash and investments on hand	228	260

The System's financial assets also consist of patient accounts receivable totaling $1,123,267 and $905,103 as of December 31, 2021 and 2020, respectively. Other receivables, totaling $792,446 and $597,536 as of December 31, 2021 and 2020, are primarily comprised of the notes associated with the System's sale of patient accounts receivable, which is more fully described in Note 1. The System's financial assets are available as its general expenditures, liabilities, and other obligations come due.

Certain assets whose use is limited are to be used for current liabilities for self-insured programs and employee benefit funds and are more fully described in Note 3.

For the years ended December 31, 2021 and 2020 (dollars in thousands)

5. Property and Equipment

Property and equipment consist of the following:

	December 31, 2021	2020
Land and improvements	$ 1,097,939	$ 971,759
Buildings and improvements	7,389,680	6,666,483
Equipment	6,406,298	5,860,423
	14,893,917	13,498,665
Less: allowances for depreciation	(7,200,916)	(6,565,025)
	7,693,001	6,933,640
Construction in progress	843,374	864,526
	$ 8,536,375	$ 7,798,166

Certain hospitals have entered into construction contracts or other commitments for which costs have been incurred and included in construction in progress. These and other committed projects will be financed through operations and proceeds of borrowings. The estimated costs to complete these projects approximated $173,000 at December 31, 2021.

The System capitalizes the cost of acquired software for internal use. Any internal costs incurred in the process of developing and implementing software are expensed or capitalized, depending primarily on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage. Capitalized software costs and estimated amortization expense in the table below exclude software in progress of approximately $369,000 and $168,000 at December 31, 2021 and 2020, respectively. Capitalized software costs and accumulated amortization expense, which are included in property and equipment in the accompanying consolidated balance sheets, were as follows:

	December 31, 2021	2020
Capitalized software costs	$ 380,291	$ 360,975
Less: accumulated amortization	(293,101)	(247,843)
Capitalized software costs, net	$ 87,190	$ 113,132

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

2022	$ 38,712
2023	13,092
2024	7,076
2025	5,601
2026	5,515
Thereafter	17,194

During periods of construction and periods of developing software, interest costs are capitalized to the respective property accounts. Interest capitalized approximated $16,800 and $13,100 for the years ended December 31, 2021 and 2020, respectively.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

6. Other Assets

Other assets consist of the following:

	December 31, 2021	2020
Investments in unconsolidated entities	$ 827,559	$ 733,265
Goodwill	686,527	201,606
Interests in net assets of unconsolidated foundations	87,769	72,832
Notes and other receivables	58,570	65,075
Other noncurrent assets	45,481	48,708
	$ 1,705,906	$ 1,121,486

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

	Ownership Interest	December 31, 2021	2020
Health First, Inc.	27%	$ 407,901	$ 374,461
Texas Health Huguley, Inc.	49%	209,669	188,668
Centura Health Corporation	35%	100,047	96,518
Other	5% – 50%	109,942	73,618
		$ 827,559	$ 733,265

Income from unconsolidated entities totaled $81,038 and $74,398 for 2021 and 2020, respectively, and is included in other operating revenue in the accompanying consolidated statements of operations and changes in net assets.

On January 3, 2020, the System acquired a noncontrolling interest in Health First, Inc. (Health First). Health First is a community based not-for-profit healthcare system located in Brevard County, Florida and includes hospitals, insurance plans, a multi-specialty medical group, and outpatient and wellness services. The total consideration for the 27% noncontrolling interest acquired was $350,000. The System paid $125,000 at closing and a second payment of $125,000 was made in June 2021. The remaining $100,000 is payable on June 30, 2023 and is included in other noncurrent liabilities in the accompanying consolidated balance sheets.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

7. Leases

The System's leases primarily consist of real estate and medical equipment. The System determines if an arrangement is a lease at contract inception. Lease assets and lease liabilities are recognized based on the present value of the lease payments over the lease term at the commencement date. Because most of the System's leases do not provide an implicit rate of return, the System uses a risk-free rate based on the daily treasury yield curve at lease commencement in determining the present value of lease payments. Lease assets exclude lease incentives received.

Most leases include one or more options to renew, with renewal terms that can extend the lease term from one month to thirty years. The exercise of such lease renewal options is at the System's sole discretion. For purposes of calculating lease liabilities, lease terms include options to extend or terminate the lease when it is reasonably certain that the System will exercise that option. Certain leases also include options to purchase the leased asset. The depreciable life of assets and leasehold improvements is limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise.

The System does not separate lease and non-lease components except for certain medical equipment leases. Leases with a lease term of 12 months or less at commencement are not recorded on the consolidated balance sheets. Lease expense for these arrangements is recognized on a straight-line basis over the lease term.

Operating and finance leases consist of the following:

	December 31, 2021	2020
Operating Leases		
Operating lease assets	$ 302,051	$ 324,218
Other current liabilities	$ 82,439	$ 86,786
Operating lease liabilities, net of current portion	248,221	258,450
Total operating lease liabilities	$ 330,660	$ 345,236
Finance Leases		
Property and equipment	$ 30,401	$ 42,090
Current maturities of long-term debt	$ 9,096	$ 6,624
Long-term debt, net of current maturities	19,889	34,639
Total finance lease liabilities	$ 28,985	$ 41,263

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Lease expense for lease payments is recognized on a straight-line basis over the lease term. The components of lease expense were as follows:

	December 31, 2021	2020
Operating lease expense	$ 106,306	$ 108,635
Variable lease expense	48,155	34,117
Short-term lease expense	28,454	27,990
Finance lease expense		
Amortization of lease assets	7,840	7,220
Interest on lease liabilities	1,679	3,069
Total lease expense	$ 192,434	$ 181,031

Lease term and discount rate were as follows:

	December 31, 2021	2020
Weighted-average remaining lease term:		
Operating leases	8.2 years	8.1 years
Finance leases	11.6 years	11.5 years
Weighted-average discount rate:		
Operating leases	2.1%	2.0%
Finance leases	2.0%	5.7%

The following table summarizes the maturity of lease liabilities under finance and operating leases for the next five years and the years thereafter, as of December 31, 2021:

	Operating Leases	Finance Leases	Total
2022	$ 87,627	$ 9,532	$ 97,159
2023	65,456	8,131	73,587
2024	44,636	7,224	51,860
2025	32,448	436	32,884
2026	23,332	436	23,768
Thereafter	115,754	6,676	122,430
Total lease payments	369,253	32,435	$ 401,688
Less: imputed interest	38,593	3,450	
Total lease liabilities	$ 330,660	$ 28,985	

Supplemental cash flow information related to leases was as follows:

	December 31, 2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 128,294	$ 110,771
Operating cash flows from finance leases	1,305	2,628
Financing cash flows from finance leases	8,529	7,006
Lease assets obtained in exchange for new operating lease liabilities	38,367	90,721
Lease assets obtained in exchange for new finance lease liabilities	2,502	2,073

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

8. Debt Obligations

Long-term debt consisted of the following:

	December 31, 2021	2020
Fixed-rate hospital revenue bonds, interest rates from 1.90% to 5.00%, payable through 2051	$ 3,188,495	$ 2,303,612
Variable-rate hospital revenue bonds payable through 2039	–	207,000
Other notes payable	6,349	425,088
Finance leases payable	28,985	41,263
Unamortized original issue premium, net	288,770	153,426
Deferred financing costs	(22,029)	(16,943)
	3,490,570	3,113,446
Less: current maturities	(58,102)	(65,011)
	$ 3,432,468	$ 3,048,435

Master Trust Indenture

Long-term debt has been issued primarily on a tax-exempt basis. Substantially all bonds are secured under a Master Trust Indenture (MTI), which provides for, among other things, the deposit of revenue with the master trustee in the event of certain defaults, pledges of accounts receivable, pledges not to encumber property, and limitations on additional borrowings. Certain affiliates controlled by Healthcare Corporation comprise the AdventHealth Obligated Group (Obligated Group). Members of the Obligated Group are jointly and severally liable under the MTI to make all payments required with respect to obligations under the MTI. The MTI requires certain covenants and reporting requirements be met by the System and the Obligated Group. At December 31, 2021 and 2020, the Obligated Group had total net assets of approximately $13,493,000 and $11,568,000, respectively.

Variable-Rate Bonds and Sources of Liquidity

Certain variable-rate bonds, including $520,310 and $324,285 as of December 31, 2021 and 2020, respectively, classified as short-term financings in the accompanying consolidated balance sheets, may be put to the System at the option of the bondholder. The variable-rate bond indentures generally provide the System the option to remarket the obligations at the then prevailing market rates for periods ranging from one day to the maturity dates. The obligations have been primarily marketed for seven-day periods during 2021, with annual interest rates ranging from 0.01% to 0.13%. Additionally, the System paid fees, such as remarketing fees, on variable-rate bonds during 2021.

The System has various sources of liquidity, including a $500,000 revolving credit agreement (Revolving Note) with a syndicate of banks and a $500,000 commercial paper program (CP Program). The Revolving Note, which expires in December 2023, is available for letters of credit, liquidity facilities, and general corporate needs, including working capital, capital expenditures, and acquisitions and has certain prime rate and LIBOR-based pricing options. At December 31, 2021 and 2020, the System had approximately $500 and $1,100 committed to letters of credit under the Revolving Note. The System's CP Program allows for up to $500,000 of taxable, commercial paper notes (CP Notes) to be issued for general corporate purposes at an interest rate to be determined at the time of issuance. No amounts were outstanding under the CP Program as of December 31, 2021 and 2020.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

2021 Debt Transactions

During the third quarter of 2021, the System issued fixed-rate, variable-rate and put bonds with total proceeds of $1,079,996, including premiums of $159,551.The fixed-rate bonds have par amounts totaling $491,785, maturity dates ranging from 2037 to 2051, stated interest rates ranging from 3.00% to 5.00%, and effective interest rates ranging from 1.40% to 2.19% through the call date of 2031. The put bonds have par amounts totaling $228,660, a stated interest rate of 5.00% with mandatory redemptions ranging from 2026 to 2031 and final maturities ranging from 2052 to 2054. The effective interest rates on these put bonds range from 0.56% to 1.17% through the mandatory redemption date. The variable-rate bonds have par amounts totaling $200,000, mandatory redemption dates ranging from 2054 to 2056, and final maturity dates ranging from 2055 to 2056. These variable-rate bonds provide the System the option to remarket the obligations at the then prevailing market rates for periods ranging from one day to the maturity dates. The obligations have been primarily marketed for seven-day periods during 2021 with annual interest rates ranging from 0.01% to 0.13% and are included in short-term financings in the accompanying consolidated balance sheet. The System used bond proceeds of $227,000 for repayment of CP Notes, approximately $348,000 for the repayment of existing bonds, and $250,000 for repayment of a fixed-rate loan. The System will use the remaining bond proceeds to finance or refinance certain costs of the acquisition, construction and equipping of certain facilities.

During the fourth quarter of 2021, the System issued fixed-rate, taxable bonds totaling $400,000, with a maturity date of 2051, and interest rate of 2.80%. The System used the bond proceeds as long-term financing of the AH Redmond acquisition (Note 2). During 2020 and 2021, the System made short-term draws under the Revolver and the CP Program. These draws were repaid as described within and no amounts are outstanding as of December 31, 2021 under either program.

2020 Debt Transactions

In response to the COVID-19 pandemic, as more fully discussed in Note 14, actions were taken during 2020 to increase liquidity and mitigate the pandemic's disruption to the System's business. In March 2020 the System drew $478,500 from its Revolving Note and as a result, certain variable-rate bonds totaling $221,670 that had been classified as long-term debt, supported by the Revolving Note, were reclassified to short-term debt. As the volatility in operations and financial markets gradually improved, the System repaid $303,500 of the Revolving Note in August 2020. As of December 31, 2020, $175,000 was outstanding under the Revolving Note and in 2021 was refinanced as long-term debt.

Additionally, in May 2020, the System borrowed $250,000 on a 1.73% fixed-rate loan, which was refinanced as long-term debt in 2021. Additional lines of credit were secured in 2020, totaling $425,000, and were subsequently cancelled in December 2020.

For the years ended December 31, 2021 and 2020 (dollars in thousands)

Debt Maturities

The following represents the maturities of long-term debt, excluding finance leases disclosed in Note 7, for the next five years and the years thereafter:

2022	$ 48,252
2023	53,137
2024	68,327
2025	60,252
2026	256,947
Thereafter	2,707,929

Cash paid for interest, net of amounts capitalized, approximated $92,000 and $96,000 during the years ended December 31, 2021 and 2020, respectively.

9. Retirement Plans

Defined Contribution Plans

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

Contributions to the Plan are included in employee compensation in the accompanying consolidated statements of operations and changes in net assets in the amount of $202,815 and $179,243 for the years ended December 31, 2021 and 2020, respectively.

Defined Benefit Plan – Multiemployer Plan

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

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

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

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

Notes to Consolidated Financial Statements

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

The most recent available plan asset and benefit obligation data for the Old Plan is as of December 31, 2020 and is as follows:

Total plan assets	$ 538,689
Actuarial present value of accumulated plan benefits	537,158
Funded status	100.3%

The System did not make contributions to the Old Plan for the years ended December 31, 2021 or 2020.

Defined Benefit Plan – Frozen Pension Plans

Certain of the System's entities sponsored noncontributory, defined benefit pension plans (Pension Plans) that have been frozen such that no new benefits accrue. The following table sets forth the remaining combined projected and accumulated benefit obligations and the assets of the Pension Plans at December 31, 2021 and 2020, the components of net periodic pension cost for the years then ended, and a reconciliation of the amounts recognized in the accompanying consolidated financial statements:

	Year Ended December 31, 2021	2020
Accumulated benefit obligation, end of year	$ 142,168	$ 160,186
Change in projected benefit obligation:		
Projected benefit obligation, beginning of year	$ 160,186	$ 154,354
Interest cost	4,170	4,959
Benefits paid	(15,445)	(9,027)
Actuarial (gains)/losses	(6,743)	9,900
Projected benefit obligation, end of year	142,168	160,186
Change in plan assets:		
Fair value of plan assets, beginning of year	141,342	131,953
Actual return on plan assets	4,070	18,416
Benefits paid	(15,445)	(9,027)
Fair value of plan assets, end of year	129,967	141,342
Deficiency of fair value of plan assets over projected benefit obligation, included in other noncurrent liabilities	$ (12,201)	$ (18,844)

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

No plan assets are expected to be returned to the System during the fiscal year ending December 31, 2022.

Included in net assets without donor restrictions at December 31, 2021 and 2020 are unrecognized actuarial losses of $17,705 and $23,093, respectively, which have not yet been recognized in net periodic pension cost.

Changes in plan assets and benefit obligations recognized in net assets without donor restrictions include:

	Year Ended December 31, 2021	2020
Net actuarial gains	$ 4,012	$ 2,081
Amortization of net actuarial losses	235	261
Settlements	1,141	–
Total decrease recognized in net assets without donor restrictions	$ 5,388	$ 2,342

The components of net periodic pension cost were as follows:

	Year Ended December 31, 2021	2020
Interest cost	$ 4,170	$ 4,959
Expected return on plan assets	(6,801)	(6,435)
Recognized net actuarial losses	235	261
Net periodic pension cost	$ (2,396)	$ (1,215)

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

	Year Ended December 31, 2021	2020
Used to determine projected benefit obligation		
Weighted-average discount rate	2.95%	2.65%
Used to determine pension cost		
Weighted-average discount rate	2.65%	3.35%
Weighted-average expected long-term rate of return on plan assets	5.00%	5.00%

The Pension Plans' assets are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. The Pension Plans' assets are managed solely in the interest of the participants and their beneficiaries. Diversification is achieved by allocating funds to various asset classes and investment styles and by retaining multiple investment managers with complementary styles, philosophies, and approaches.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

The expected long-term rate of return on the Pension Plans' assets is based on historical and projected rates of return for current and planned asset categories and the target allocation in the investment portfolio. As of December 31, 2021 and 2020, the target investment allocation for the Pension Plans was 70% and 60% debt securities, 27% and 36% equity securities, and 3% and 4% alternative investments, respectively.

The following table presents the Pension Plans' financial instruments as of December 31, 2021, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 12:

	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 3,237	$ 3,237	$ –	$ –
Debt securities				
U.S. government agencies and sponsored entities	34,952	–	34,952	–
Corporate bonds	57,185	–	57,185	–
Equity securities				
Domestic equities	3,536	3,536	–	–
Foreign equities	2,141	2,141	–	–
Exchange traded funds				
Domestic equity	18,209	18,209	–	–
Foreign equity	5,458	5,458	–	–
Alternative strategy mutual funds	5,249	5,249	–	–
Total plan assets	$ 129,967	$ 37,830	$ 92,137	$ –

The following table presents the Pension Plans' financial instruments as of December 31, 2020 measured at fair value on a recurring basis by the valuation hierarchy defined in Note 12:

	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 3,295	$ 3,295	$ –	$ –
Debt securities				
U.S. government agencies and sponsored entities	30,857	–	30,857	–
Corporate bonds	52,366	–	52,366	–
Equity securities				
Domestic equities	4,766	4,766	–	–
Foreign equities	5,675	5,675	–	–
Exchange traded funds				
Domestic equity	29,245	29,245	–	–
Foreign equity	6,896	6,896	–	–
Alternative strategy mutual funds	8,242	8,242	–	–
Total plan assets	$ 141,342	$ 58,119	$ 83,223	$ –

For the years ended December 31, 2021 and 2020 (dollars in thousands)

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

2022	$ 6,891
2023	7,070
2024	7,259
2025	7,452
2026	7,599
2027-2031	39,150

10. General and Professional Liability Program

The System has a self-insured revocable trust that covers its subsidiaries and their respective employees for professional and general liability claims within a specified level. A self-insured retention of $2,000 was established for the year ended December 31, 2001 was increased to $7,500 and $15,000 effective January 1, 2002 and 2003, respectively, and had remained at $15,000 through March 31, 2020. Effective April 1, 2020, the self-insured retention increased to $20,000. Claims above the self-insured retention are insured by claims-made coverage that is placed with Adhealth Limited (Adhealth), a Bermuda company. Adhealth has purchased reinsurance through commercial insurers for the excess limits of coverage.

The professional and general liability trust funds are recorded in the accompanying consolidated balance sheets as assets whose use is limited in the amount of $459,497 and $446,294 at December 31, 2021 and 2020, respectively. The related accrued claims are recorded in the accompanying consolidated balance sheets as other current liabilities in the amount of $112,505 and $101,484 and as other noncurrent liabilities in the amount of $361,369 and $362,964 at December 31, 2021 and 2020, respectively. These liabilities are based upon actuarially determined estimates using a discount rate of 3.75% at December 31, 2021 and 2020. The related estimated insurance recoveries are recorded as other assets in the amount of $9,724 and $10,719 in the accompanying consolidated balance sheets at December 31, 2021 and 2020, respectively.

11. Commitments and Contingencies

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

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

See Note 14 for discussion of the COVID-19 pandemic and contingencies related to this significant event.

Notes to Consolidated Financial Statements

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12. Fair Value Measurements

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value, on a recurring basis, into a three-tier fair value hierarchy. Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement, which should be determined based on assumptions that would be made by market participants.

In accordance with the Fair Value Measurement Topic of the ASC (ASC 820), investments that are valued using NAV as a practical expedient are excluded from this three-tier hierarchy. For all other investments measured at fair value, the hierarchy prioritizes the inputs used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement). Level inputs are defined as follows:

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

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

Level 3 – based on prices or valuation techniques that require inputs that are both significant to the fair value of the financial asset or liability and are generally less observable from objective sources. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value. The System has no financial assets or financial liabilities with significant Level 3 inputs.

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

Notes to Consolidated Financial Statements

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Recurring Fair Value Measurements

The fair value of financial instruments measured at fair value on a recurring basis at December 31, 2021 was as follows:

	Total	Level 1	Level 2	Level 3
ASSETS				
CASH AND CASH EQUIVALENTS	$ 506,777	$ 504,726	$ 2,051	$ –
INVESTMENTS AND ASSETS WHOSE USE IS LIMITED				
Cash and cash equivalents	382,355	382,355	–	–
Debt securities				
U.S. government agencies and sponsored entities	3,311,876	–	3,311,876	–
Foreign government agencies and sponsored entities	299,462	–	299,462	–
Corporate bonds	83,288	–	83,288	–
Mortgage backed	38,280	–	38,280	–
Other asset backed	26,253	–	26,253	–
Short-term investments	5,377	–	5,377	–
Domestic equity securities	131,818	131,818	–	–
Exchange traded and mutual funds				
Domestic equity	1,314,482	1,314,482	–	–
Foreign equity	667,974	667,974	–	–
Fixed income	977,468	977,468	–	–
	7,238,633	3,474,097	3,764,536	–
Total	$ 7,745,410	$ 3,978,823	$ 3,766,587	$ –

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

The fair value of financial instruments measured at fair value on a recurring basis at December 31, 2020 was as follows:

	Total	Level 1	Level 2	Level 3
ASSETS				
CASH AND CASH EQUIVALENTS	$ 1,210,037	$ 1,151,642	$ 58,395	$ –
INVESTMENTS AND ASSETS WHOSE USE IS LIMITED				
Cash and cash equivalents	355,339	355,339	–	–
Debt securities				
U.S. government agencies and sponsored entities	3,475,149	–	3,475,149	–
Foreign government agencies and sponsored entities	2,154	–	2,154	–
Corporate bonds	294,329	–	294,329	–
Mortgage backed	27,991	–	27,991	–
Other asset backed	20,805	–	20,805	–
Short-term investments	179,571	–	179,571	–
Domestic equity securities	128,341	128,341		
Exchange traded and mutual funds				
Domestic equity	928,408	928,408	–	–
Foreign equity	426,361	426,361	–	–
Fixed income	735,294	735,294	–	–
	6,573,742	2,573,743	3,999,999	–
Total	$ 7,783,779	$ 3,725,385	$ 4,058,394	$ –

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

	December 31, 2021	December 31, 2020
Investments and assets whose use is limited measured at fair value	$ 7,238,633	$ 6,573,742
Hedge funds and private equity funds	1,014,704	872,397
Commingled funds	340,700	373,704
Accrued interest	13,583	9,909
Total	$ 8,607,620	$ 7,829,752
Investments	$ 7,716,423	$ 6,951,313
Assets whose use is limited:		
Current	438,224	433,910
Noncurrent	452,973	444,529
Total	$ 8,607,620	$ 7,829,752

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

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

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

13. Functional Expenses

The System's resources and activities are primarily related to providing healthcare services. Corporate services include certain administration, finance and accounting, human resources, legal, information technology, and other functions.

Expenses by functional classification for the year ended December 31, 2021 consist of the following:

	Healthcare Services	Corporate Services	Total
Employee compensation	$ 7,015,218	$ 415,512	$ 7,430,730
Purchased services and professional fees	1,793,026	199,613	1,992,639
Supplies	2,474,517	5,187	2,479,704
Other	1,891,414	93,610	1,985,024
Total	$ 13,174,175	$ 713,922	$ 13,888,097

Expenses by functional classification for the year ended December 31, 2020 consist of the following:

	Healthcare Services	Corporate Services	Total
Employee compensation	$ 5,782,767	$ 381,875	$ 6,164,642
Purchased services and professional fees	1,746,689	163,804	1,910,493
Supplies	2,207,708	6,148	2,213,856
Other	1,552,397	87,792	1,640,189
Total	$ 11,289,561	$ 639,619	$ 11,929,180

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

14. Significant Events

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenue for most services were significantly impacted beginning in mid-March 2020 through early May 2020 as various policies were implemented by federal, state and local governments such as suspension of elective procedures. Since that time, gradual improvement in volumes and related revenue has been experienced and as COVID-19 volumes surge, the System's hospitals monitor non-emergent procedures based on COVID-19 volumes, available staffing, and capacity. Certain of the System's hospitals experienced COVID-19 surges early in 2021 and in the third quarter of 2021, requiring voluntary monitoring of elective and non-emergent procedures. The System's response to the COVID-19 pandemic continues to require supplies utilized at a higher rate and purchased at elevated prices. Labor rates have increased primarily due to certain contract, overtime and other premium rate labor costs being incurred to support our clinical staff and address the surge of COVID-19 patients. The COVID-19 pandemic's impact to the System is driven by many factors, most of which are beyond the System's control. As such, the ultimate impact to the System and its financial condition is presently unknown.

In response to COVID-19, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), was enacted on March 27, 2020. The CARES Act authorizes funding to hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (Provider Relief Fund). Grant payments from the Provider Relief Fund are intended to reimburse healthcare providers for healthcare related expenses and/or lost revenue attributable to the COVID-19 pandemic. The System began receiving Provider Relief Funds in April 2020. During the years ended December 31, 2021 and 2020, the System recognized approximately $78,000 and $539,000, respectively, of Provider Relief Funds as other revenue in the accompanying consolidated statements of operations and changes in net assets.

The CARES Act provides for an expansion of the Medicare Accelerated and Advance Payment Program (Accelerated Payment Program), which allows inpatient acute care hospitals to request accelerated payments of up to 100% of their Medicare payment amount for a six-month period. In 2020, the System received approximately $446,000 from the Accelerated Payment Program. Consistent with the terms and conditions of the program, repayments began in April 2021. Amounts owed under the Accelerated Payment Program totaled $265,000 and $446,000 as of December 31, 2021 and 2020, respectively, and are included in other current liabilities in the accompanying consolidated balance sheets. Repayments will continue based upon the terms and conditions of the program.

The CARES Act also allowed for deferred payment of the employer portion of certain payroll taxes between March 27, 2020 and December 31, 2020. As of December 31, 2020, the System had deferred payroll tax payments of approximately $164,000, of which approximately $82,000 is included in accounts payable and accrued liabilities and approximately $82,000 is included in other noncurrent liabilities in the accompanying consolidated balance sheet. In December 2021, the System repaid $82,000 of the deferred payroll taxes in accordance with the terms of the program. The remaining $82,000 is due December 31, 2022 and is included in accounts payable and accrued liabilities in the consolidated balance sheet as of December 31, 2021.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

15. Subsequent Events

The System evaluated events and transactions occurring subsequent to December 31, 2021 through March 1, 2022, the date the accompanying consolidated financial statements were issued. During this period, there were no subsequent events, other than those discussed in Note 1, that required recognition in the accompanying consolidated financial statements nor were there any additional nonrecognized subsequent events that required disclosure.

Notes to Consolidated Financial Statements

For the years ended December 31, 2021 and 2020 (dollars in thousands)

16. Fourth Quarter Results of Operations (Unaudited)

The System's operating results for the three months ended December 31, 2021 are presented below:

Revenue	
Net patient service revenue	$ 3,831,542
Other	267,006
Total operating revenue	4,098,548
Expenses	
Employee compensation	2,048,272
Supplies	658,668
Purchased services	298,154
Professional fees	221,188
Other	380,086
Interest	21,676
Depreciation and amortization	203,402
Total operating expenses	3,831,446
Income from Operations	267,102
Nonoperating Gains (Losses)	
Investment Return	228,777
Other	(1,231)
Total nonoperating gains, net	227,546
Excess of revenue and gains over expenses	494,648
Noncontrolling interests	(2,980)
Excess of Revenue and Gains over Expenses Attributable to Controlling Interest	491,668
Other changes in net assets without donor restrictions, net	27,129
Increase in net assets with donor restrictions, net	4,091
Increase in Net Assets	$ 522,888

Report of Independent Auditors

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

Opinion

We have audited the consolidated financial statements of Adventist Health System Sunbelt Healthcare Corporation (the System), which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the consolidated financial position of the System at December 31, 2021 and 2020, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles gemerally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

Report of Independent Auditors

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Ernst + Young LLP

Orlando, Florida
March 1, 2022

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Cost/Sq. Ft.		DGSF		DGSF				
	New	Mod.	New	Circ.	Mod.	Circ.	New Const. $	Modernization $	Total Cost
Reviewable									
Levels III & II Stations		$ 794.57			11,350			$ 9,018,353	$ 9,018,353
Nursing Suite		$ 791.54			1,145			$ 906,311	$ 906,311
Triage and Observation		$ 797.70			1,585			$ 1,264,360	$ 1,264,360
contingency		$ 41.83						$ 588,896	$ 588,896
		$ 836.50			14,080			$ 11,777,920	$ 11,777,920
Non-Reviewable									
Elevator Lobby		$ 777.07			538			$ 418,063	$ 418,063
Prayer Room		$ 772.42			160			$ 123,588	$ 123,588
Administrative		$ 777.19			320			$ 248,701	$ 248,701
Neonatologist's Office		$ 775.60			360			$ 279,217	$ 279,217
Staff Areas		$ 773.41			290			$ 224,289	$ 224,289
Family Area		$ 773.06			300			$ 231,918	$ 231,918
contingency								$ 80,304	$ 80,304
					1,968			$ 1,606,080	$ 1,606,080
Total		$ 834.00			16,048			$ 13,384,000	$ 13,384,000

ATTACHMENT 36C

#22-033

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

AdventHealth Hinsdale Level III Nursery

2026 Projected Patient Days:		2,507

Year 2 OPERATING COST per PATIENT DAY

Salaries & Benefits		$3,981,442
Medical Supplies		$1,021,828
		$5,003,270
per Adjusted Patient Day:	$	1,995.72

YEAR 2 CAPITAL COST per PATIENT DAY

Interest, Dep. & Amort	$	78,745
per Patient Day:	$	31.41

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

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