

**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: HSHS St. Mary's Hospital		
Street Address: 1800 E. Lake Shore Drive		
City and Zip Code: Decatur, IL 62521		
County: Macon	Health Service Area: 4	Health Planning Area: D-04

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

Exact Legal Name: St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis
Street Address: 1800 E. Lake Shore Drive
City and Zip Code: Decatur, IL 62521
Name of Registered Agent: Paige Toth
Registered Agent Street Address: 4936 Laverna Road
Registered Agent City and Zip Code: Springfield, IL 62707
Name of Chief Executive Officer: Theresa Rutherford
CEO Street Address: 1800 E. Lake Shore Drive
CEO City and Zip Code: Decatur, IL 62521
CEO Telephone Number: 217-464-2966

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which 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: Paige Toth
Title: Associate General Counsel
Company Name: Hospital Sisters Health System
Address: 4936 Laverna Road
Telephone Number: Springfield, IL 62707
E-mail Address: Paige.Toth@hshs.org
Fax Number: N/A

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

Name: Daniel Lawler
Title: Partner

Company Name: Barnes & Thornburg LLP
Address: One North Wacker Dr., Suite 4400, Chicago, IL 60606
Telephone Number: (312) 214-4861
E-mail Address: Daniel.Lawler@btlaw.com
Fax Number: (312) 759-5646

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

Exact Legal Name: Hospital Sisters Health System
Street Address: 4936 Laverna Road
City and Zip Code: Springfield, IL 62707
Name of Registered Agent: Amy Bulpitt
Registered Agent Street Address: 4936 Laverna Road
Registered Agent City and Zip Code: Springfield, IL 62707
Name of Chief Executive Officer: Damond Boatwright
CEO Street Address: 4936 Laverna Road
CEO City and Zip Code: Springfield, IL 62707
CEO Telephone Number: 217-523-4747

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which 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: Amy Bulpitt
Title: Sr. VP & Chief Legal Officer
Company Name: Hospital Sisters Health System
Address: 4936 Laverna Road
Telephone Number: Springfield, IL 62707
E-mail Address: Amy.Bulpitt@hshs.org>
Fax Number: N/A

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

Name: Daniel Lawler
Title: Partner
Company Name: Barnes & Thornburg LLP

Address: One North Wacker Dr., Suite 4400, Chicago, IL 60606
Telephone Number: (312) 214-4861
E-mail Address: Daniel.Lawler@btlaw.com
Fax Number: (312) 759-5646

Post Permit Contact

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

Name: Jill Crum, MSN, RN
Title: Chief Nursing Officer
Company Name: HSHS St. Mary's Hospital
Address: 1800 E. Lake Shore Drive
Telephone Number: (217) 464-2406
E-mail Address: Jill.Crum@hshs.org
Fax Number: (217) 464-1616

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis
Address of Site Owner: 1800 E. Lake Shore Drive, Decatur, IL 62521
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis	
Address: 1800 E. Lake Shore Drive, Decatur, IL 62521	
☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Other	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
- 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
- ☒ 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 applicant HSHS St. Mary's Hospital is located at 1800 E. Lake Shore Drive, Decatur, Illinois. The applicant proposes a major modernization to its facility and a demolition of unneeded space. The project includes:

- Modernization of existing space including:
 - Modernizing the medical/surgical department and reduction of medical/surgical bed count from 88 beds to 30 beds.
 - Modernizing the Intensive Care Unit (ICU) and reduction of ICU bed count from 14 beds to 6 beds.
 - Relocating and modernizing the operating rooms (ORs) and recovery stations in previously built shell-space approved in Project #09-002, and reducing ORs from 8 rooms to 4 rooms.
 - Reducing PACU stations from 8 to 6; increasing Stage 2 recovery stations from 4 to 20.
 - Modernization of a medical office building on the hospital campus.
- Demolition of unneeded space in the main hospital a structure built in 1958, and demolition of three smaller buildings on the campus.
- Upgrading electrical, plumbing, HVAC, information technology and life safety systems.
- Modernizing administrative space and other non-clinical space.
- Relocating the heli-pad.

The total project cost is \$89 million. The amount of modernized space is 105,776 gsf and the amount of demolished space is approximately 219,000 gsf. There is no new construction in the project.

The project is classified as non-substantive because it is a modernization project only and does not include a new or replacement facility, the establishment of a category of service, the discontinuation of services, or the addition of beds.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$98,028	\$401,972	\$500,000
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$3,827,327	\$15,694,292	\$19,521,619
Off Site Work	\$198,773	\$815,086	\$1,013,859
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$11,690,588	\$32,503,233	\$44,193,821
Contingencies	\$1,751,250	\$8,150,121	\$9,901,371
Architectural/Engineering Fees	\$918,894	\$3,768,006	\$4,686,900
Consulting and Other Fees	\$637,786	\$3,544,645	\$4,182,431
Movable or Other Equipment (not in construction contracts)	\$2,286,355	\$2,713,645	\$5,000,000
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$0	\$0	\$0
Other Costs to Be Capitalized	\$0	\$0	\$0
Acquisition of Building or Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$21,409,001	\$67,590,999	\$89,000,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$21,409,001	\$67,590,999	\$89,000,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$21,409,001	\$67,590,999	\$89,000,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: \$ _____ Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service ☐ Yes ☒ No If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): September 30, 2026
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☒ Purchase orders, leases or contracts pertaining to the project have been executed. ☒ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☐ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS <u>ATTACHMENT 8</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

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

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

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert 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: HSHS St. Mary's Hospital			CITY: Decatur		
REPORTING PERIOD DATES: From: January 1, 2021 to: December 31, 2021					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	88	2,953	13,593	-58	30
Obstetrics					
Pediatrics					
Intensive Care	14	613	3,481	-8	6
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	102	3,566	17,074	-66	36

Source: 2021 Hospital Profile as adjusted by Project #23-006 approving discontinuation of all beds in the Obstetric, Pediatrics, Comprehensive Physical Rehabilitation, and Acute Mental Illness categories of services and reduction of 20 Medical/Surgical beds.

CERTIFICATION

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o 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).
- o 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).
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of*:

St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis

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

SIGNATURE

PRINTED NAME

PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 3rd day of August, 2023

Signature of Notary

Seal

OFFICIAL SEAL
CHRISTINA KENDALL
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 10/25/25

*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 3rd day of August, 2023

Signature of Notary

Seal

OFFICIAL SEAL
CHRISTINA KENDALL
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 10/25/25

CERTIFICATION

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

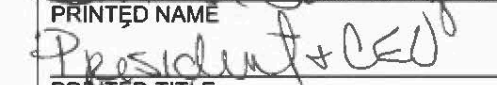
- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its 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.

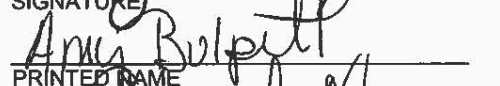
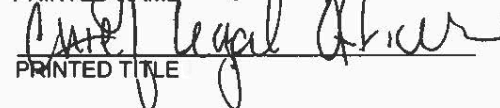
This Application is filed on the behalf of*:

Hospital Sisters Health System

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

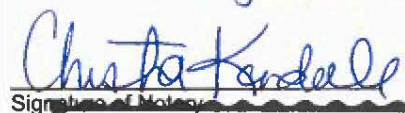

 SIGNATURE

 PRINTED NAME

 PRINTED TITLE


 SIGNATURE

 PRINTED NAME

 PRINTED TITLE

Notarization:

Subscribed and sworn to before me
 this 3rd day of August, 2023

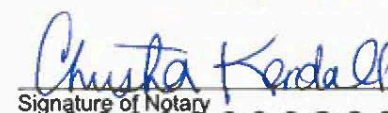

 Signature of Notary

Seal
OFFICIAL SEAL
CHRISTINA KENDALL
 NOTARY PUBLIC, STATE OF ILLINOIS
 My Commission Expires 10/25/25

*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
 this 3rd day of August, 2023


 Signature of Notary

Seal
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CHRISTINA KENDALL
 NOTARY PUBLIC, STATE OF ILLINOIS
 My Commission Expires 10/25/25

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	MET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

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

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

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion, or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria, and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

- Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:
- Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Medical/Surgical	88	30
☐ Obstetric		
☐ Pediatric		
☒ Intensive Care	14	6

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (Formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	
APPEND DOCUMENTATION AS <u>ATTACHMENT 19</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Operating Rooms	8	4
☒ Stage 1 Recovery Stations	8	6
☒ Stage 2 Recovery Stations	4	20

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS <u>ATTACHMENT 31</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

APPEND DOCUMENTATION AS ATTACHMENT-33, 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)

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:

☒ X	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, variable or permanent interest rates over the debt time, 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 <u>ATTACHMENT 34</u>, 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.

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

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 to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

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

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		30-32
2	Site Ownership		33
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		34-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		36
5	Flood Plain Requirements		37-39
6	Historic Preservation Act Requirements		40-83
7	Project and Sources of Funds Itemization		84-87
8	Financial Commitment Document if required		88-92
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10	Discontinuation		
11	Background of the Applicant		94
12	Purpose of the Project		95-148
13	Alternatives to the Project		149-150
14	Size of the Project		151
15	Project Service Utilization		152
16	Unfinished or Shell Space		
17	Assurances for Unfinished/Shell Space		
18	Master Design and Related Projects		
	Service Specific:		
19	Medical Surgical Pediatrics, Obstetrics, ICU		153-154
20	Comprehensive Physical Rehabilitation		
21	Acute Mental Illness		
22	Open Heart Surgery		
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26	Selected Organ Transplantation		
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31	Clinical Service Areas Other than Categories of Service		155
32	Freestanding Emergency Center Medical Services		
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	Financial and Economic Feasibility:		
34	Availability of Funds		156-232
35	Financial Waiver		233
36	Financial Viability		
37	Economic Feasibility		234-235
38	Safety Net Impact Statement		
39	Charity Care Information		236-237

ATTACHMENT 1**Applicant Identification and Certificates of Good Standing**

Included with this attachment are Certificates of Good Standing for the applicants:

1. HSHS St. Mary's Hospital
2. Hospital Sisters Health System

File Number 3528-159-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

ST. MARY'S HOSPITAL, DECATUR, OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 2302703112 verifiable until 01/27/2024

Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 27TH day of JANUARY A.D. 2023 .

Alexi Giannoulas
SECRETARY OF STATE

File Number 5163-355-5



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

HOSPITAL SISTERS HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 26, 1978, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 2302703346 verifiable until 01/27/2024
Authenticate at: <https://www.ilsos.gov>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 27TH
day of JANUARY A.D. 2023 .***

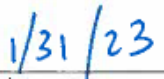
Alexi Giannoulas
SECRETARY OF STATE

ATTACHMENT 2**Attestation of Site Ownership**

The undersigned is an authorized representative of the applicant facility HSHS St. Mary's Hospital, located at 1800 E. Lake Shore Drive, Decatur, IL, and hereby attests that the site of the licensed applicant facility is owned by Hospital Sisters Health System.



Amy Bulpitt
Chief Legal Officer
Hospital Sisters Health System



Dated

ATTACHMENT 3
Operating Entity/Licensee

Included with this Attachment is the licensee's Certificate of Good Standing. All direct owners of a 5% or more interest in the applicant facility are identified in the organizational chart included with Attachment 4.

File Number 3528-159-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

ST. MARY'S HOSPITAL, DECATUR, OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

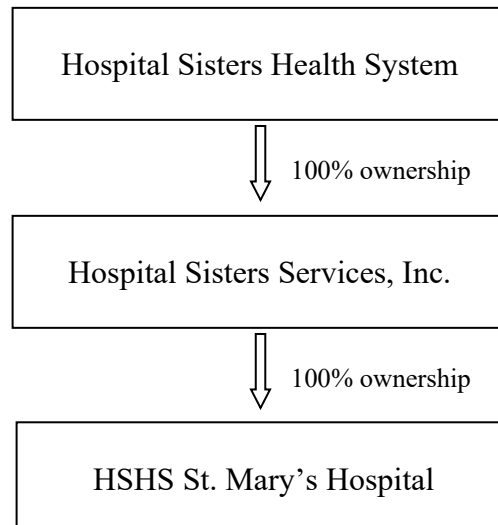


Authentication #: 2302703112 verifiable until 01/27/2024
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 27TH day of JANUARY A.D. 2023 .


SECRETARY OF STATE

ATTACHMENT 4
Organizational Chart



ATTACHMENT 5
Flood Plain Requirements

Attached is documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas, including a map of the proposed project location showing any identified floodplain areas.

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 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.

- Applicant: HSHS St. Mary's Hospital 1800 East Lake Shore Drive
 (Name) (Address)
 Decatur IL 62521 (217) 464-2966
 (City) (State) (ZIP Code) (Telephone Number)
- Project Location: 1800 East Lake Shore Drive Decatur, IL
 (Address) (City) (State)
 Macon Decatur
 (County) (Township) (Section)

- 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? Yes___ No X ?

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: _____

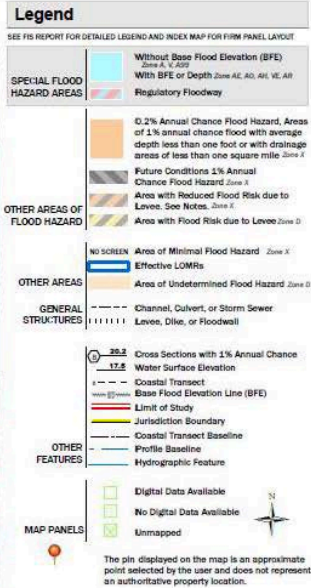
(City) (State) (ZIP Code) (Telephone Number)

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

National Flood Hazard Layer FIRMette



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 11/26/2023 at 3:48 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

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

ATTACHMENT 6**Historic Preservation Act Requirements**

The Historic Preservation Act clearance letter from the Illinois Department of Natural Resources dated July 28, 2023 is included with this Attachment.

The applicant's request for clearance is also attached as it includes photographs identifying the structures to be demolished and areas to be modernized.



Illinois
Department of
**Natural
Resources**

JB Pritzker, Governor • Natalie Phelps Finnie, Director
One Natural Resources Way • Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Macon County

Decatur

Partial Demolition and Modernization, HSHS St. Mary's Hospital

1800 E. Lake Shore Dr.

SHPO Log #020062123

July 28, 2023

Daniel Lawler

Barnes & Thornburg LLP

One North Wacker Dr., Suite 4400

Chicago, IL 60606-2833

Dear Mr. Lawler:

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

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

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

If you have any further questions, please contact Rita Baker, Cultural Resources Manager, at 217/785-4998 or at Rita.E.Baker@illinois.gov.

Sincerely,

A handwritten signature in cursive script that reads "Carey L. Mayer".

Carey L. Mayer, AIA

Deputy State Historic

Preservation Officer

BARNES & THORNBURG LLP

One North Wacker Drive, Suite 4400
Chicago, IL 60606-2833 U.S.A.
(312) 357-1313
Fax (312) 759-5646
www.btlaw.com

Daniel Lawler
Partner
312-214-4861
daniel.lawler@btlaw.com

June 20, 2023

Via Overnight Delivery

Illinois Historic Preservation Agency
Attn: Review and Compliance
1 Old State Capitol Plaza
Springfield, IL 62701-1512

**RE: HSHS St. Mary's Hospital, Decatur
Historic Preservation Act Determination Request**

Dear Review and Compliance Staff:

In accordance with the Illinois State Agency Historic Resources Preservation Act, 20 ILCS 3420/1 *et seq.*, HSHS St. Mary's Hospital ("St. Mary's") seeks a formal determination from the Illinois Historic Preservation Agency (the "Agency") as to whether St. Mary's proposed project to modernize its existing facility and demolish a portion of an existing structure connected to the existing facility (the "Project") affects historic resources. The Project will be located on St. Mary's campus at 1800 E. Lake Shore Drive, Decatur, Illinois 62521.

1. Project Description and Location

St. Mary's will be seeking approval from the Illinois Health Facilities and Services Review Board to modernize its main hospital building and a medical office building on the hospital campus at 1800 E. Lake Shore Drive, Decatur, Illinois, to demolish a portion of the main building and build a new exterior wall to the main building needed due to the demolition, and to demolish another medical office building on campus.

2. Topographical or Metropolitan Map

Maps showing the location of the proposed Project and an aerial photo of the site are attached as Exhibit 1.

3. Buildings/Structures in the Project Area

Photographs of the exteriors and interiors of facilities to be modernized and structures to be demolished are labeled and attached as Exhibit 2.

Illinois Historic Preservation Agency
June 20, 2023
Page 2

4. Address for Building/Structure

The address of the Project is 1800 E. Lake Shore Drive, Decatur, Illinois 62521.

Thank you for your consideration of our request for a historic preservation determination. If you have any questions or need any additional information, please feel free to contact me at 312-214-4861.

Very truly yours,

BARNES & THORNBURG LLP



Daniel J. Lawler

Enclosures

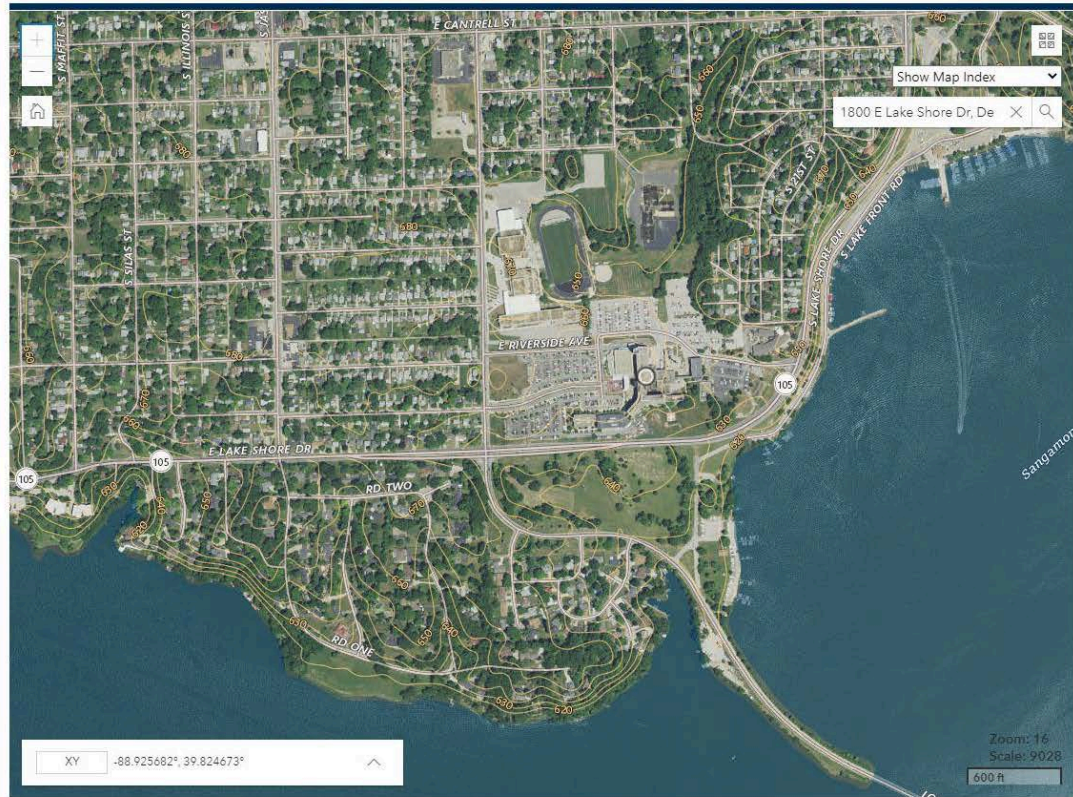
BARNES & THORNBURG LLP

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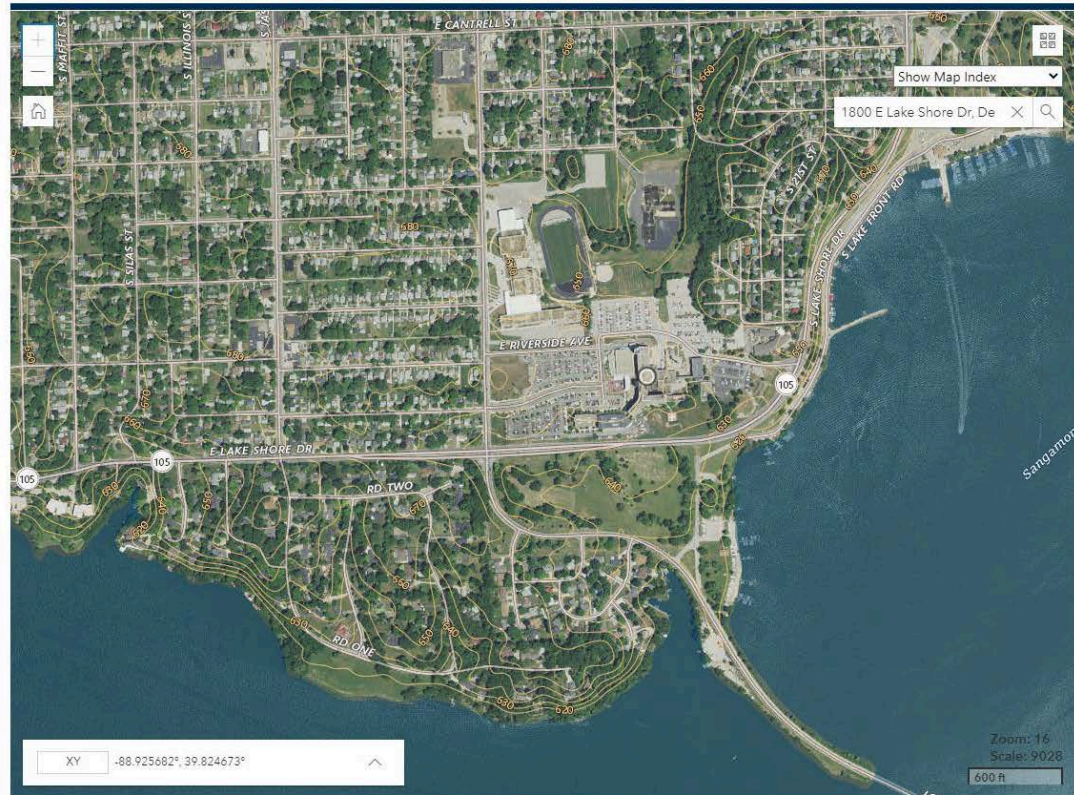
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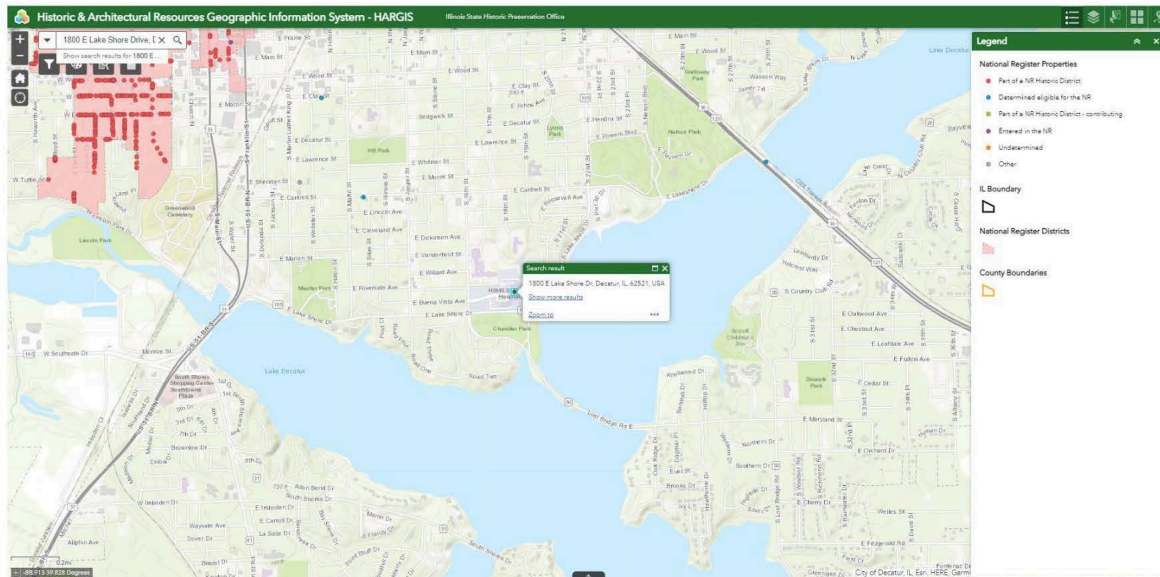
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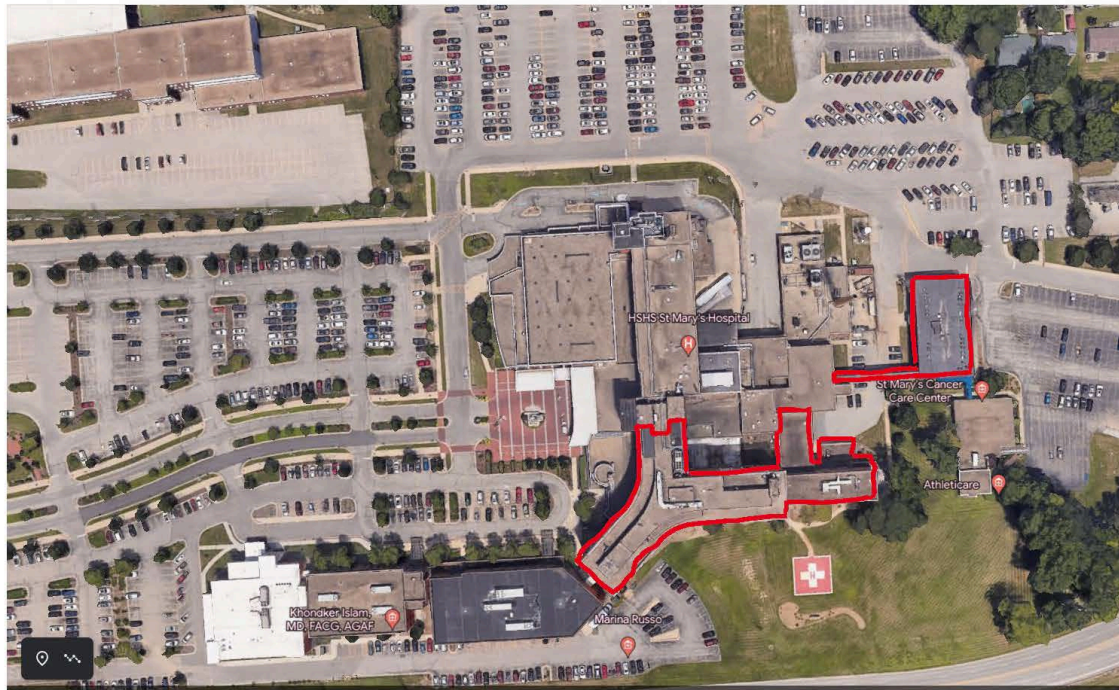
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1800 E. Lake Shore Drive, Decatur, Illinois
Structures to be demolished are outlined in red.

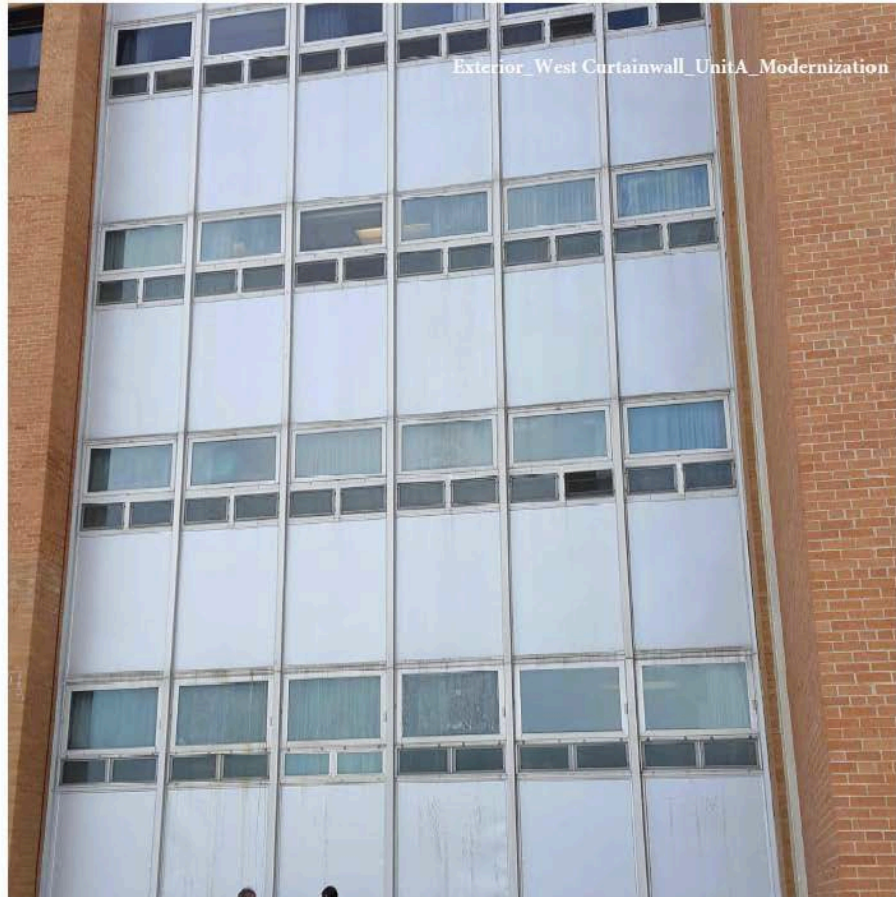
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Workroom_UnitA_SecondFloor_Surgery_Modernization

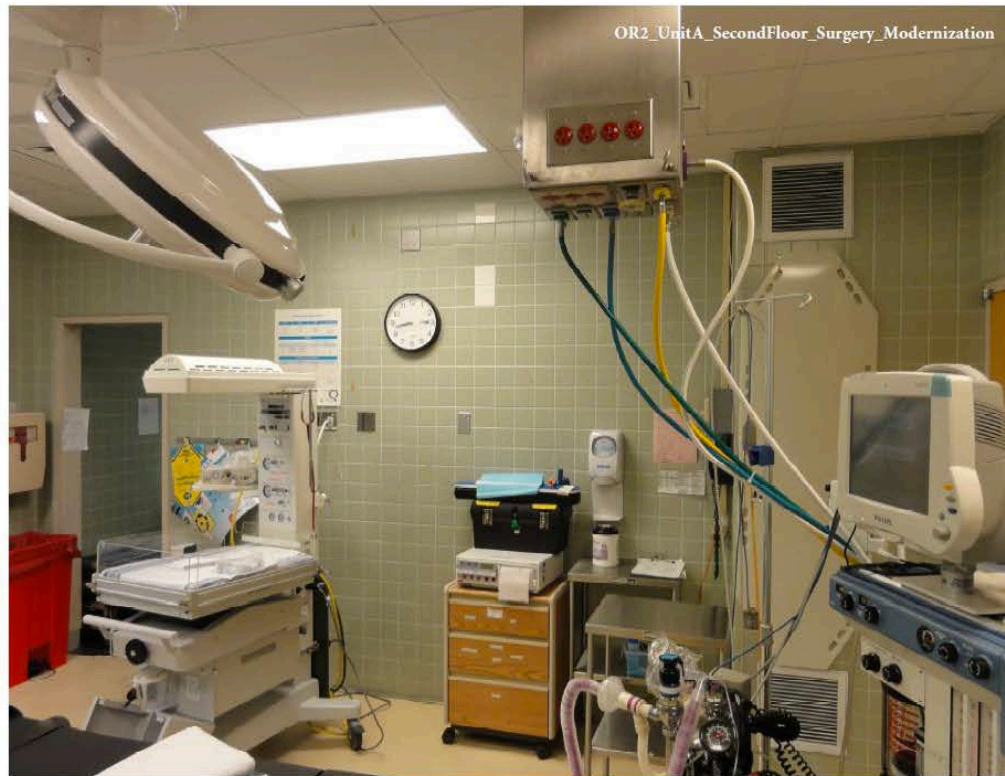


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OR_UnitA_SecondFloor_Surgery_Modernization

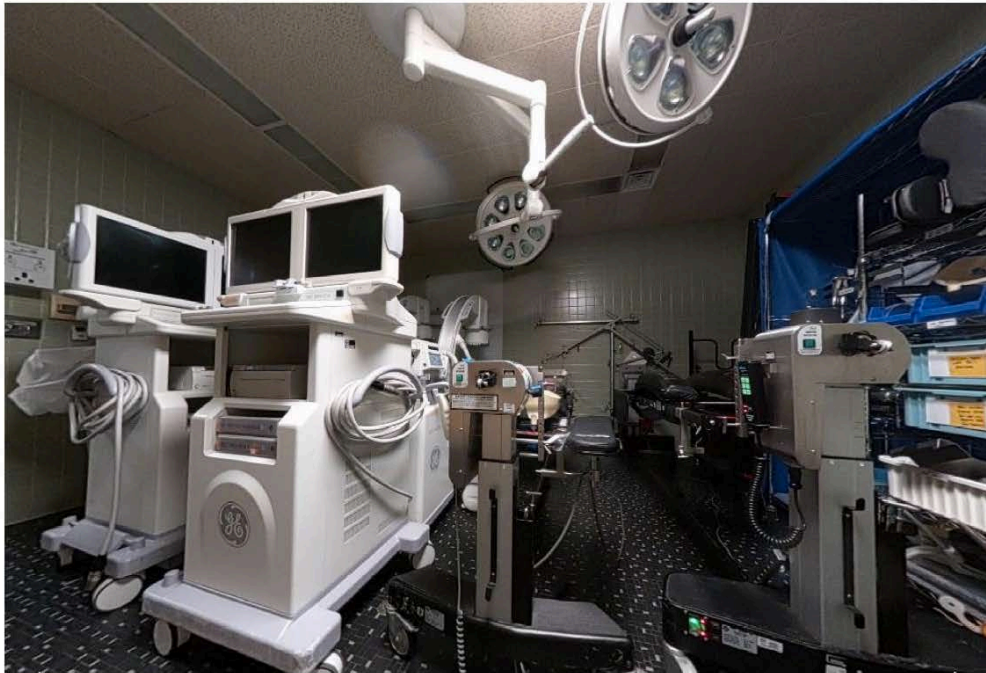


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EquipmentStorage_UnitA_SecondFloor__Surgery_Modernization



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Soiled_UnitA_SecondFloor_Surgery_Modernization



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OR Entry_UnitA_SecondFloor_Surgery_Modernization



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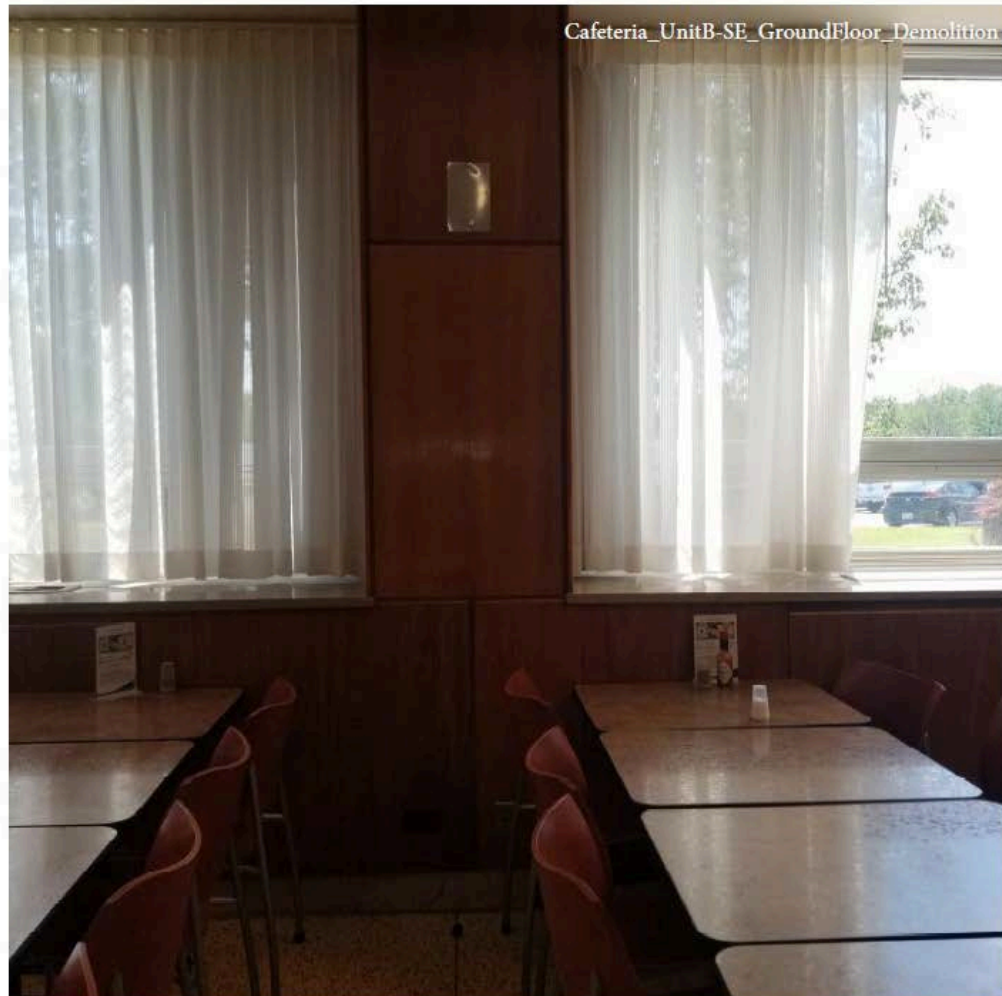
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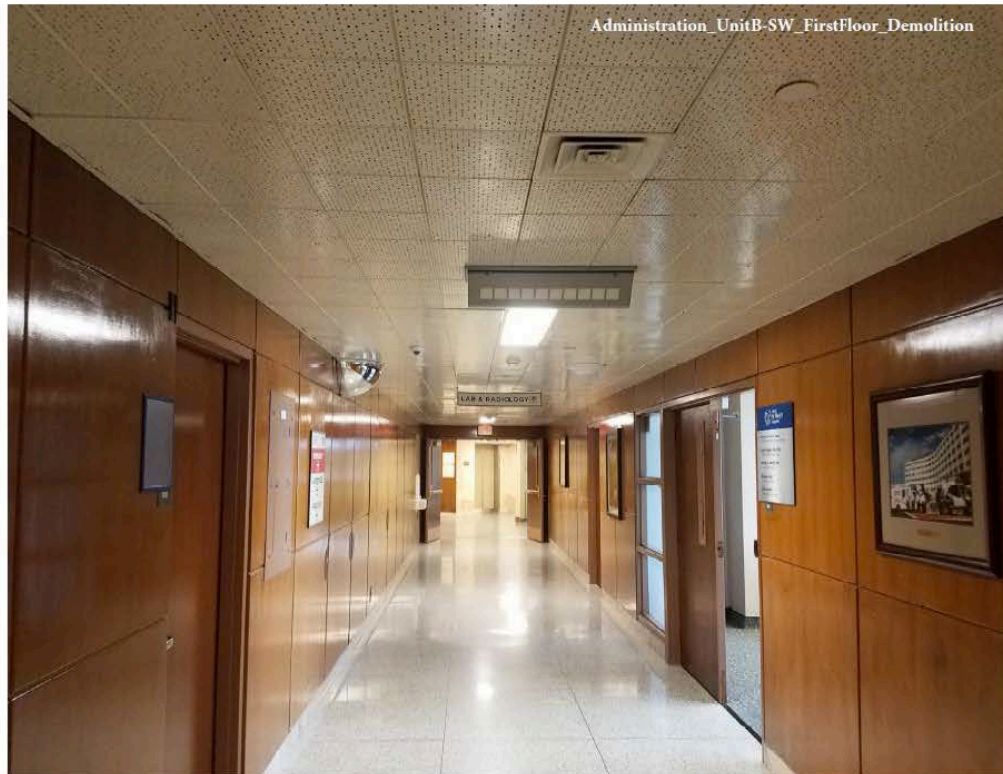
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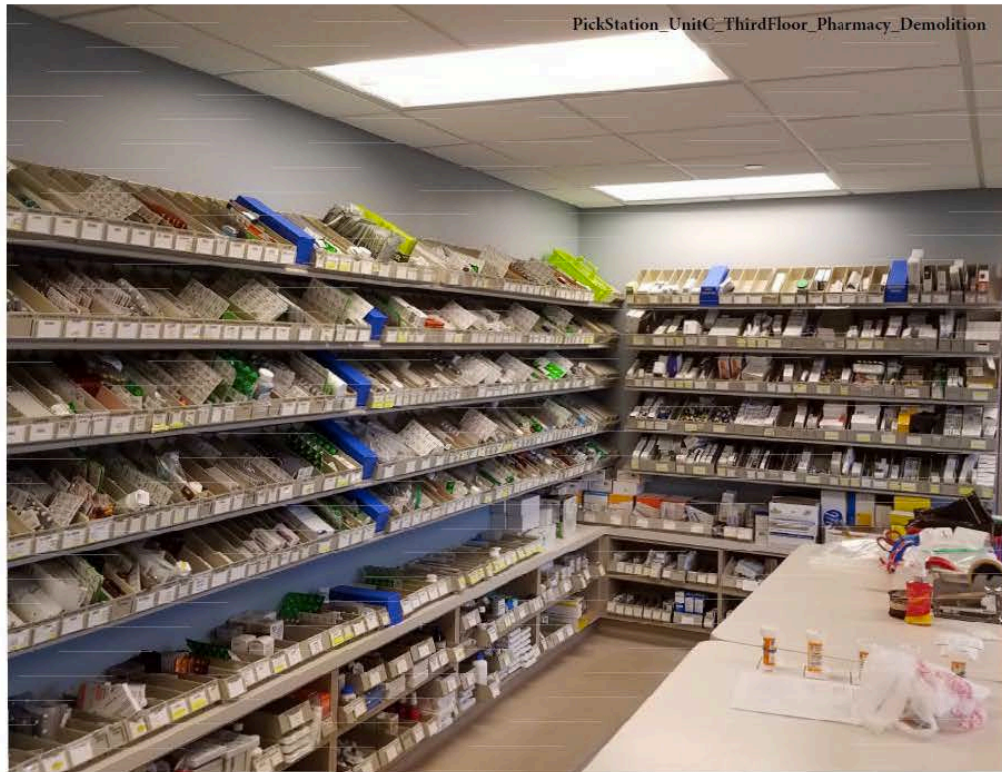
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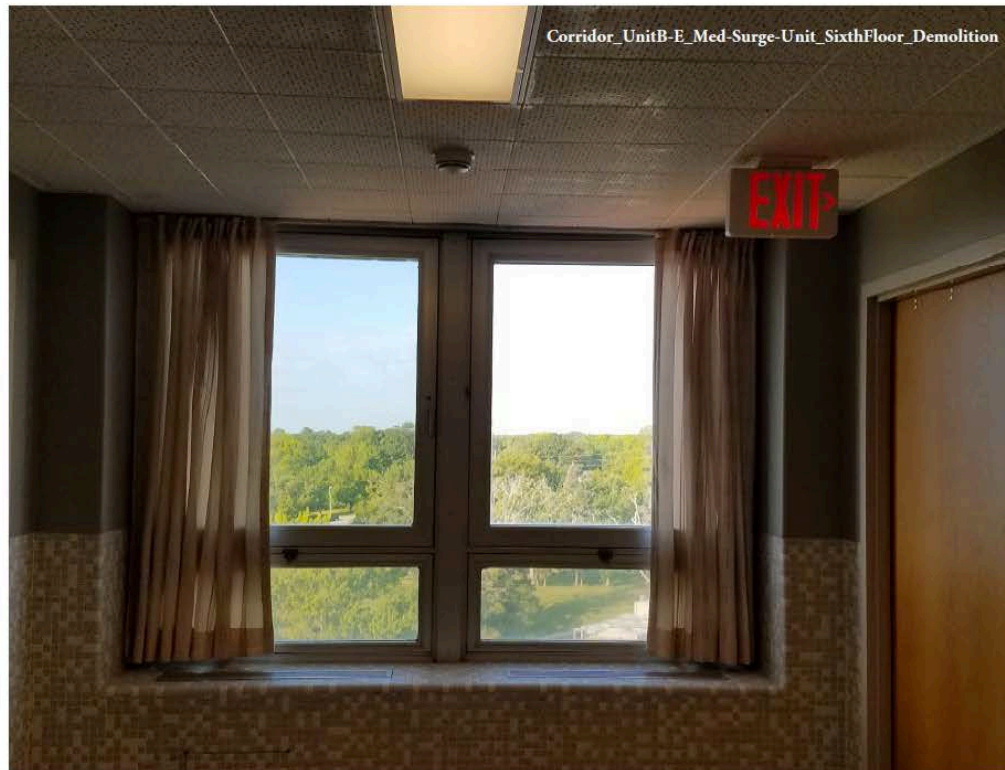
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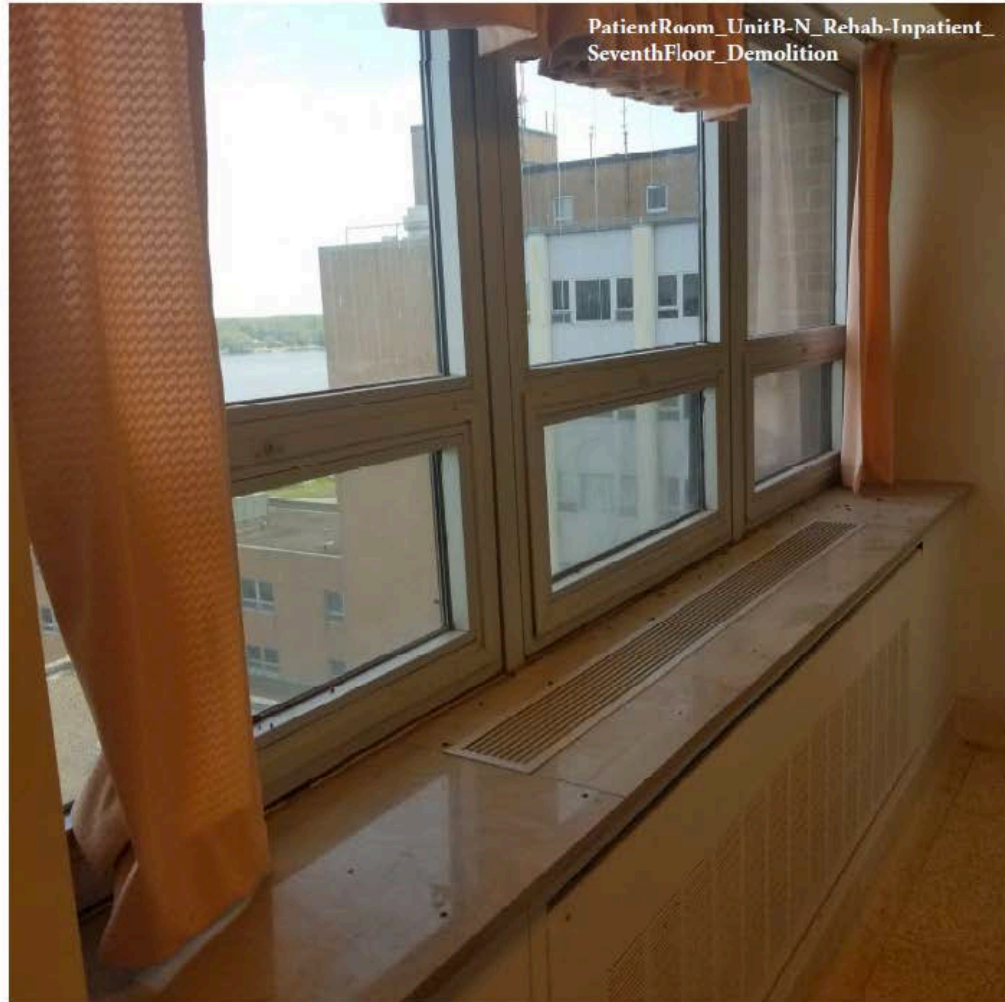
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Workroom_UnitB_Basement_SW_SterileProcessing_Demolition



ATTACHMENT 7**Project and Sources of Funds Itemization****Project Costs and Sources of Funds**

The line item costs attributed to clinical components were calculated as a percentage of clinical square footage when actual break-outs were not available.

Itemization of each line item:

Preplanning Costs - (\$500,000)- this includes:

- Pre-design services:
 - Estimating
 - Value Analysis
 - Constructability Reviews
 - Coordination Meetings
 - Schedule Analysis
 - Trade Partner Solicitation

Of the total amount, \$98,028 is the clinical Preplanning costs.

Site Preparation - (\$19,521,619) - this includes:

- Temporary Construction Measures
- Demolition
- Demolition – Make Existing Building Safe
- Earthwork & Site Utilities
- Site Improvements
- Abatement

Of the total amount, \$3,827,327 is the clinical Site Preparation cost.

Off Site Work- (\$1,013,859) - this includes:

- Off-Site Utility Relocation Allowance
- Helipad Relocation

Of the total amount, \$198,773 is the clinical Off Site Work cost.

Modernization Contracts - (\$44,193,821) -this includes:

- All modernization contracts/costs to complete the project. Includes Group I fixed equipment and GC's and Supervision. Costs are escalated to the mid-point of construction.

Of the total amount, \$11,690,588 is the clinical Modernization cost.

Contingencies - (\$9,901,371) - this includes:

- Allowance for unknown conditions required to complete the project.

Of the total amount, \$1,751,250 is the clinical Contingency cost.

Architectural / Engineering Fees - (\$4,686,900) - this includes:

- Programming
- Schematic Design:
 - Develop diagrammatic plans and documentation to describe the size and layout of each floor in a way that meets all programmatic and functional objectives, as well as accounting for all structure, shafts, elevators and stairs, communications and electrical closets, and all other design constraints.
 - Determine the capacity needed for all building systems (such as electrical, mechanical, plumbing, fire protection, and vertical transportation).
- Design Development:
 - Develop detailed drawings and documentation to describe the size and character of the interior space. Includes room layouts, structural, mechanical, electrical, plumbing, fire protection, medical gas, and technology.
 - The equipment and furniture consultants will prepare room-by-room FF&E requirement list. The requirements list identifies room name, item description, product specification, and total quantity required. The product specifications include installation requirements that will be provided to the architect/engineer to ensure that spaces and building systems are planned to appropriately accommodate the equipment.
- Construction Documents:
 - Provide drawings and specifications.
 - Prepare documentation for alternate bids.
 - Assist in filing Construction Documents for approval by City and State agencies.
 - Signage and Way Finding expertise.
- Bidding and Negotiation Phase Services:
 - Review and respond to bidder requests for information and clarifications to the Bid Documents.
 - Participate in pre-bid conferences and assist in evaluating contractor bid proposals.
 - Correspond, coordinate, and respond to authorities having jurisdiction during their reviews.
- Construction Administration Phase Services:
 - Advise and consult during Construction Phase
 - Attend weekly job progress meetings.
 - Provide on-site representation to review progress/quality of Work.
 - Prepare written interpretations of Contract Documents including Bulletins and information requests.
 - Correct Errors or Omissions in the drawings, specifications and other documents
 - Review and approve Contractor's submittals.
 - Submit notifications for work which does not conform to Contract Documents
 - Review and analyze requests for Change Orders
 - Assist Construction Manager with punchlist completion.
 - Assist Construction Manager with Final Completion including system testing and commissioning.

- Inspect Project after correction of Work period for deficiencies and update Construction Manager

Of the total amount, \$918,894 is the clinical Architectural / Engineering Fee.

Consulting and Other Fees - (\$4,182,431) - this includes:

- Charges for the services of various types of consulting.
- CON Application Fee
- Building Permits
- CM Project Management

Of the total amount, \$637,786 is the clinical Consulting and Other Fees cost.

Movable Equipment

- All furniture, furnishings, and equipment for the proposed project. Group I (fixed) equipment is included in the New Construction line item above. Group II and III medical equipment is included herein.

Equipment Type	Estimated Cost
Sterile Processing & Surgical Case Carts Misc equipment	\$1,004,285
Patient Monitoring	\$1,234,408
Other IV Pumps Warming Cabinets Biohazard Waste bins Defibrillator	\$480,057
Furnishings Waiting Room Furniture Sofa Sleepers Patient Recliners Side chairs Nightstands Monitor Arms Office/ Consult Room Furniture Pharmacy Casework	\$1,350,000
Technology Computers Monitors Workstations on Wheels Printers Televisions Device Integration Wireless Network Distributed Antenna System	\$880,450

Other	\$50,800
Artwork	
Signage	

Of the total amount, \$2,286,355 is the clinical component of the Moveable Capital Equipment cost.

ATTACHMENT 8**Financial Commitment Document**

By its signature on the Certification page of this application, the applicant certifies that its obligations under the executed construction contract are contingent upon the approval of the project by the Health Facilities and Services Review Board. The contract provides in §1.1.7:

“It shall be a condition precedent to the parties’ obligations to perform the activities listed under the Construction Phase of this Agreement that the Project obtain certificate of need approval by the Illinois Health Facilities & Services Review Board.”

Included with this Attachment are excerpts from the construction contract containing the above contingency requiring prior CON Board approval as a precondition of the agreement.

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AIA® Document A133® – 2019
**Standard Form of Agreement Between Owner and Construction Manager as
Constructor where the basis of payment is the Cost of the Work Plus a Fee with a Guaranteed
Maximum Price**

AGREEMENT made as of the 12th day of June in the year 2023
(In words, indicate day, month, and year.)

BETWEEN the Owner:
(Name, legal status, address, and other information)

Hospital Sisters Health System
3215 Executive Park Drive
Springfield, IL 62794

and the Construction Manager:
(Name, legal status, address, and other information)

Alberici Healthcare, LLC
8800 Page Avenue
St. Louis, MO 63114

for the following Project:
(Name, location, and detailed description)

HSHS – St. Mary's Hospital Right Sizing
1800 E Lake Shore Dr
Decatur, IL 62521

The Architect:
(Name, legal status, address, and other information)

Berners-Schober Associates, Inc.
310 Pine Street
Green Bay, Wisconsin 54301-5136

The Owner and Construction Manager agree as follows.

ADDITIONS AND DELETIONS:

The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed. A vertical line in the left margin of this document indicates where the author has added necessary information and where the author has added to or deleted from the original AIA text.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

AIA Document A201™–2017, General Conditions of the Contract for Construction, is adopted in this document by reference. Do not use with other general conditions unless this document is modified.

Init.

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TABLE OF ARTICLES

1	INITIAL INFORMATION
2	GENERAL PROVISIONS
3	CONSTRUCTION MANAGER'S RESPONSIBILITIES
4	OWNER'S RESPONSIBILITIES
5	COMPENSATION AND PAYMENTS FOR PRECONSTRUCTION PHASE SERVICES
6	COMPENSATION FOR CONSTRUCTION PHASE SERVICES
7	COST OF THE WORK FOR CONSTRUCTION PHASE
8	DISCOUNTS, REBATES, AND REFUNDS
9	SUBCONTRACTS AND OTHER AGREEMENTS
10	ACCOUNTING RECORDS
11	PAYMENTS FOR CONSTRUCTION PHASE SERVICES
12	DISPUTE RESOLUTION
13	TERMINATION OR SUSPENSION
14	MISCELLANEOUS PROVISIONS
15	SCOPE OF THE AGREEMENT

EXHIBIT A GUARANTEED MAXIMUM PRICE AMENDMENT

EXHIBIT B INSURANCE AND BONDS

ARTICLE 1 INITIAL INFORMATION

§ 1.1 This Agreement is based on the Initial Information set forth in this Section 1.1.

(For each item in this section, insert the information or a statement such as "not applicable" or "unknown at time of execution.")

§ 1.1.1 The Owner's program for the Project, as described in Section 4.1.1:

(Insert the Owner's program, identify documentation that establishes the Owner's program, or state the manner in which the program will be developed.)

HSHS St. Mary's Decatur Modernization Program, an approximately \$90 program currently in development.

§ 1.1.2 The Project's physical characteristics:

(Identify or describe pertinent information about the Project's physical characteristics, such as size; location; dimensions; geotechnical reports; site boundaries; topographic surveys; traffic and utility studies; availability of public and private utilities and services; legal description of the site, etc.)

Modernization of HSHS St. Mary's Hospital located at 1800 E Lake Shore Drive in Decatur, Illinois.

§ 1.1.3 The Owner's budget for the Guaranteed Maximum Price, as defined in Article 6:

(Provide total and, if known, a line item breakdown.)

To be determined via Guaranteed Maximum Price Amendment

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§ 1.1.4 The Owner's anticipated design and construction milestone dates:

.1 Design phase milestone dates, if any:

« June 14, 2023: All drawings and pricing (Need time for Owner/consultant to assemble)
 June 20, 2023: Application ready for Owner to submit to State (8 weeks prior to meeting date) »

.2 Construction commencement date:

« To be determined via Guaranteed Maximum Price Amendment »

.3 Substantial Completion date or dates:

« To be determined via Guaranteed Maximum Price Amendment »

.4 Other milestone dates:

« To be determined via Guaranteed Maximum Price Amendment »

§ 1.1.5 The Owner's requirements for accelerated or fast-track scheduling, or phased construction, are set forth below:

« N/A »

§ 1.1.6 The Owner's anticipated Sustainable Objective for the Project:

« N/A »

§ 1.1.6.1 If the Owner identifies a Sustainable Objective, the Owner and Construction Manager shall complete and incorporate AIA Document E234™-2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, into this Agreement to define the terms, conditions and services related to the Owner's Sustainable Objective. If E234-2019 is incorporated into this agreement, the Owner and Construction Manager shall incorporate the completed E234-2019 into the agreements with the consultants and contractors performing services or Work in any way associated with the Sustainable Objective.

§ 1.1.7 Other Project information:

(Identify special characteristics or needs of the Project not provided elsewhere.)

« It shall be a condition precedent to the parties' obligations to perform the activities listed under the Construction Phase of this Agreement that the Project obtain certificate of need approval by the Illinois Health Facilities & Services Review Board. The Owner shall timely commence and diligently pursue such approval, and the Construction Manager shall provide, to the extent reasonably necessary and at no cost to the Construction Manager, such information or other cooperation as may be required to obtain such approval. Nothing herein shall be construed to alter the Owner's obligation to pay for Preconstruction Services performed by the Construction Manager under the terms of this Agreement up to a preconstruction cap of \$500,000 or such greater amount as mutually agreed by the parties. »

§ 1.1.8 The Owner identifies the following representative in accordance with Section 4.2:

(List name, address, and other contact information.)

« Dean M.Kroll, AIA
 System Director Project Design & Construction
 Hospital Sisters Health System
 Direct: 920-433-8287
 Cell: 920-455-9121
 dean.kroll@hshs.org »

§ 1.1.9 The persons or entities, in addition to the Owner's representative, who are required to review the Construction Manager's submittals to the Owner are as follows:

(List name, address and other contact information.)

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.4 AIA Document A201™-2017, General Conditions of the Contract for Construction As used in AIA Document A201, the term "Contractor" shall be read to mean "Construction Manager"

.5 AIA Document E203™-2013, Building Information Modeling and Digital Data Exhibit, dated as indicated below:

(Insert the date of the E203-2013 incorporated into this Agreement.)

.6 Other Exhibits:

(Check all boxes that apply.)

☐ AIA Document E234™-2019, Sustainable Projects Exhibit, Construction Manager as Constructor Edition, dated as indicated below:

(Insert the date of the E234-2019 incorporated into this Agreement.)

☐ Supplementary and other Conditions of the Contract:

Document	Title	Date	Pages
AIA Document G201™-2013	Project Digital Protocol Form		
AIA Document G202™-2013	Building Information Modeling Protocol Form		
United States Conference of Catholic Bishops	Ethical and Religious Directives for Catholic Health Care Services, Sixth Edition	2018	30

.7 Other documents, if any, listed below:

(List here any additional documents that are intended to form part of the Contract Documents. AIA Document A201-2017 provides that the advertisement or invitation to bid, Instructions to Bidders, sample forms, the Construction Manager's bid or proposal, portions of Addenda relating to bidding or proposal requirements, and other information furnished by the Owner in anticipation of receiving bids or proposals, are not part of the Contract Documents unless enumerated in this Agreement. Any such documents should be listed here only if intended to be part of the Contract Documents.) Exhibit C – Construction Manager's Fee Sheet, dated March 22, 2022

This Agreement is entered into as of the day and year first written above.

DocuSigned by:

Damond Boatwright

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OWNER (Signature)

Damond Boatwright

President and CEO

(Printed name and title)

Trevor Ladner

CONSTRUCTION MANAGER (Signature)

Trevor Ladner, Authorized Representative

(Printed name and title)

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ATTACHMENT 9

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total		Gross Square Feet That is	
Dept./ Area	Cost	Existing	Proposed	New Const.	Modernization	As Is	Vacated Space
REVIEWABLE							
ICU	\$911,234	13,425	1,810		698	1,112	11,615
Medical/Surgery Inpatient Unit	\$10,257,774	30,210	10,019		10,019		20,191
Surgery	\$3,434,890	17,925	2,544		2,544		15,381
PACU	\$1,073,064	2,930	884		884		2,046
Endoscopy	\$957,623	2,990	876		876		2,114
Patient Prep-Hold-Recovery	\$3,183,990	8,530	2,998		2,998		5,532
Outpatient Clinic (Pain/Cardiova	\$974,306	15,680	2,198		2,198		13,482
Emergency	\$616,120	23,390	23,390		521	22,869	0
Total Clinical	\$21,409,001	115,080	44,719		20,738	23,981	70,361
NON-REVIEWABLE							
Hospital Staff, Public & Support	\$57,200,249	249,908	221,444		66,650	154,794	28,464
Infrastructure	\$10,390,750	29,875	20,750		18,388	2,362	9,125
Total Non-clinical	\$67,590,999	279,783	242,194		85,038	157,156	37,589
TOTAL	\$89,000,000	394,863	286,913		105,776	181,137	107,950

The Vacated Space column reflects the change in size of the departments. As described in Attachment 12, some departments, such as Medical/Surgical, are being relocated from the portion of the building to be demolished and the Vacated Space for Medical/Surgical will be demolished. Other departments, such as Intensive Care, are being reduced in size and the Vacated Space for those departments is being modernized and utilized by other hospital departments.

ATTACHMENT 11**Background of the Applicants**

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

HSHS owns and operates the following hospitals in Illinois:

Facility	Location	Illinois License Number	Expiration Date	Joint Commission Accreditation Number
St. John's Hospital	Springfield	0002451	6/30/24	ID #7432
St. Elizabeth's Hospital	O'Fallon	0006064	11/3/23	ID #7242
St. Anthony's Memorial Hospital	Effingham	0002279	12/31/23	ID #7335
St. Joseph's Hospital	Highland	0005892	8/22/24	ID #2825
St. Francis Hospital	Litchfield	0002386	12/31/23	ID #7374
St. Joseph's Hospital	Breese	0002527	6/30/24	ID #7250
St. Mary's Hospital	Decatur	0002592	6/30/24	ID #4605
HSHS Holy Family Hospital	Greenville	0005355	10/25/23	*
HSHS Good Shepherd Hospital	Shelbyville	0002154	6/30/24	**

*Accredited by Accreditation Commission for Health Care (ACHC)

**NIAHO Hospital Accreditation Program Certificate Number PRJC-494196-2013-MSL-USA

- 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.**

Other than the facilities listed above in paragraph 1, HSHS does not own or operate, directly or indirectly, any other health care facilities in Illinois.

- 3. 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.**

By the signatures on the Certification page of this application, the applicants attest that no adverse action has been taken against the applicant facility during the three years prior to the filing of this applications. For purposes of this certification, the term "adverse action" has the meaning given to in 77 Illinois Administrative Code 1130.140.

- 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.**

By the signatures on the Certification page of this application, the applicants authorize HFSRB and DPH to 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.

ATTACHMENT 12**Purpose of the 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.**

This project is the result of an in-depth discernment process by Hospital Sisters Health System and its purpose is to maintain a financially viable facility in Decatur that provides quality healthcare services to the patients in the greater Macon County region in accordance with the guiding principles of Franciscan Ministry of the Hospital Sisters Health System.

St. Mary's has been in the Decatur community for over a century and has undertaken planning and actions that will allow it to continue there into the future. St. Mary's is one of the top five employers in Decatur, according to decturedc.com, and intends to remain so. No reduction of employee FTEs is anticipated as a result of this project as there are no reduction of services and beds are only being reduced to remove excess capacity and space; St. Mary's intends to provide the same level of services that it now provides, but in modernized and more efficient space. Any future changes in FTEs would be the result of factors arising in the normal course of operations. As addressed below, this project and St. Mary's prior Project #23-006 will improve St. Mary's financial operations.

St. Mary's has faced significant operating losses in recent years while at the same time needing capital improvements were required to modernize the hospital's aging infrastructure. The attached article from Gist Healthcare states that more rural facilities have already closed in 2023 than in the previous two years combined and the majority of rural hospitals that have not closed are experiencing negative operation margins, with almost one in three at immediate or high risk of closure due to declining volumes, shifting payer mix, increased labor and supply costs, and reductions in federal and state funding. A similar assessment of the dire situation for rural hospitals is made in a June 2023 article entitled "Rural Hospitals at Risk of Closing" from the Center for Healthcare Quality & Payment Reform, also included with this attachment.

St. Mary's has been among the "at risk" hospitals with net operating losses totaling almost \$62 million and averaging over \$12 million per year. (See Table below.) In FY 2022 alone, St. Mary's operating loss was almost \$20 million. This financial performance is not sustainable.

Unsustainable Financial Performance

	FY18	FY19	FY20	FY21	FY22
Net Operating Income (<i>millions</i>)	(\$4.5)	(\$13.6)	(\$15.8)	(\$8.1)	(\$19.8)
% Net Operating Income	-3.2%	-9.1%	-9.9%	-4.7%	-11.2%

As a first step to address the financial losses, HSHS looked at which inpatient services could be maintained, and which should be discontinued. A number of services could no longer be continued due to financial losses, reduced patient volumes and loss of necessary staffing. Earlier this year, St. Mary's obtained approval from the Review Board to discontinue Obstetrics, Pediatrics, Comprehensive Physical Rehabilitation and Acute Mental Illness services. (Project

#23-006) The current project addresses the needed capital improvements and modernization of the hospital.

The current main hospital building was originally constructed in 1958 and this project will include modernization of approximately 105,000 gsf in that original building. The modernization will include the build-out of unfinished shell space on the second floor where the modernized operating rooms will be located. The shell space was approved in Project #09-002 and St. Mary's committed to return to the Review Board for CON approval of the build-out when plans for the space were developed. Modernization will also include portions of two other medical buildings on the hospital's campus and relocation of the helipad as addressed more fully in paragraph 3 below.

The project also includes demolition of approximately 219,000 gsf of unneeded space in the main hospital building with the addition of a curtainwall on the outer portions of the remaining structure. Other smaller buildings on the campus will be demolished as addressed in paragraph 3 below

The categories of service being modernized are Medical/Surgical and the Intensive Care Unit (ICU). This includes a reduction of beds that reflects declining patient admissions and reduced Average Length of Stays. The Medical/Surgical department will be reduced from 88 beds to 30 beds. ICU will be reduced from 14 beds to 6 beds.

Operating rooms will be modernized, as noted above, and the number of operating rooms will be reduced from 8 ORs to 4 ORs. The number of Post-Anesthetic Care Unit (Stage 1) stations will be reduced from 8 stations to 6 stations. The Stage 2 recovery stations will be increased from 4 stations to 20 stations based on four recovery rooms per OR and two recovery rooms for each of the two existing endoscopy suites.

The chart below summarizes the change in bed capacity and key rooms:

Service/Key Room	Current	Proposed
Medical/Surgical beds	88	30
Intensive Care Unit beds	14	6
Operating Rooms	8	4
Stage 1 Recovery Stations	8	6
Stage 2 Recovery Stations	4	20

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

St. Mary's serves Macon County and surrounding areas. The following tables identifies the top 20 zip codes by patient discharges and represents over 86% of the hospital's patient volume.

Zip Code	FY22	
	Discharges	% Total
62521 - DECATUR	1,770	31.2%
62526 - DECATUR	1,101	19.4%
62522 - DECATUR	536	9.5%
61951 - SULLIVAN	367	6.5%
62549 - MT ZION	246	4.3%
62550 - MOWEAQUA	99	1.7%
61727 - CLINTON	82	1.4%
61914 - BETHANY	81	1.4%
62544 - MACON	72	1.3%
62501 - ARGENTA	61	1.1%
62557 - PANA	55	1.0%
61818 - CERRO GORDO	54	1.0%
62535 - FORSYTH	51	0.9%
62513 - BLUE MOUND	51	0.9%
61937 - LOVINGTON	50	0.9%
62565 - SHELBYVILLE	48	0.8%
62523 - DECATUR	45	0.8%
62510 - ASSUMPTION	43	0.8%
61911 - ARTHUR	43	0.8%
62568 - TAYLORVILLE	41	0.7%
Top 20 Zips Sub-total	4,896	86.3%
Other	775	13.7%
Grand Total	5,671	

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

St. Mary's main hospital building was constructed in 1958 and does not have the infrastructure to support the state-of-the-art medical technology that defines 21st Century health care. The aging infrastructure now requires significant investment to continue patient services. This includes:

- Portions of the building require a new hospital curtain wall.
- Many of the major systems (including the main steam boilers, electrical infrastructure, HVAC piping and exterior envelope) are original to the building and need repairs.
- Large areas of the structure must have upgraded fire sprinklers to meet the NFPA Life Science Code.
- Many patient rooms still lack patient shower rooms as well as many of the modern conveniences of current healthcare facilities.
- The Medical/Surgical department and ICU are not efficiently designed for modern health care delivery, and the units are much larger than needed for St. Mary's current and expected patient volumes.

- The Operating Rooms are outdated and in need of modernization.

Additional factors driving the need to modernize its 55 year old main hospital building are:

- Over the past 10-15 years, health care has changed dramatically due to technology and better care coordination. The trend is projected to continue for the coming decade.
- Hospital inpatient discharge volumes are projected to be flat or drop by 1% due to the accelerated surgical outpatient shift and the gradual scaling of risk-based payment models, remote monitoring and home healthcare.
- Forecasts for patient volume changes by 2029 (*Resource listed in paragraph 4 below*):
 - Hospital inpatient volumes are expected to be flat or drop by 1% due to the accelerated surgical outpatient shift and the gradual scaling of risk-based payment models.
 - Non-inpatient surgeries will increase: Hospital outpatient departments +19% and ambulatory surgery centers +25%.
 - Home-based care +15%.
 - Office-based diagnostics, laboratory testing and imaging +19%.

In order to address the above, St. Mary's proposes in this project the following:

- Modernization of 105,776 gsf, mostly in the main hospital building referred to as "Unit A" in the description below.
- Demolition of approximately 219,000 gsf of the main hospital building, referred to as "Unit B", and construction of a new curtainwall on Unit A where Unit B is removed. Unit B can be identified as the Y-shaped portion of the main hospital building in the photographs in Attachment 6 and in floor plans included with this Attachment.
- Demolition of smaller unneeded buildings on the hospital campus.
- Modernization of parts of an existing medical office building on campus.
- Modernization of Medical/Surgical, and reduction of both Medical/Surgical and ICU bed count to reflect current and expected patient volumes.
- Modernization of Operating Rooms and reduction of rooms to reflect current and expected patient volumes.

The project includes the following specific components:

A. Architectural Components:

Architectural floor plans for the project are included with this Attachment.

1. Demolition

All remodeling work and department relocations will be completed prior to the demolition of the existing south patient tower (Unit B), the existing Chapel addition (Unit C) and an attached northwest medical office building. Portions of the basement, ground, and first floors of Unit B will remain intact to support programmed functions. Where older sections of the tower, medical office building and Chapel addition are removed, new exterior building envelope and

structural reinforcement will be provided along the entire perimeter cut line to enclose the portions of the building that remain.

The northwest medical office building and first floor connecting link will be demolished at the end of the project, and the site restored, graded and seeded. A pad will be poured to accommodate a mobile PET-CT trailer adjacent to the existing outpatient Cancer treatment clinic, which remains.

Building demolition includes exterior building envelope, roofing membrane and insulation, flashing, windows, canopy, entrance frames, concrete floor slabs, concrete columns and beams, concrete foundation walls and footings, interior partitions, millwork, doors, door frames and door hardware.

2. New Work

All new and modernized areas will adhere to both HSHS Design Standards and Illinois Administrative Code requirements.

New drives, drop off areas, loading zones and parking shall be bituminous paving with formed concrete curbs and gutters. The site will be graded to provide positive drainage for storm water to underground storage or on grade retention areas with connection to the city storm sewer. The existing helipad will be relocated to the northwest side of the site to be adjacent to the Emergency Department. Existing parking areas shall be modified to accommodate the helipad location and provide the required clearances around the helipad per FAA restrictions. The relocated helipad shall be a poured in place concrete slab, with required markings.

Space will be remodeled in both in two existing medical office buildings to relocate the outpatient Cardiovascular Clinics (first floor) and the Pain Clinic (third floor).

Basement level exterior envelope replacement will consist of poured in place reinforced concrete foundation wall and perimeter insulation, provided where the existing buildings are removed. Building envelope assemblies shall comply with the IECC Energy Code and NFPA 285 fire rated construction. All areas where the curtainwall bi-passes the floor assembly shall be fire stopped to comply with the two hour floor assembly. Between the concrete columns and the curtainwall, a two hour firestopping joint will be provided to accommodate future fire rated room enclosures.

Existing roofs scheduled for replacement shall be replaced with fully adhered EPDM roofing set on tapered insulation with depths meeting the building energy code requirements. Insulation shall have tapers to encourage positive drainage to roof drains or through wall scuppers. Parapet caps or coping stones will be inspected and provided with new copper flashing and cap, or sealed and caulked where necessary. New stainless steel flashings and wall receivers will be provided as necessary to accommodate the increased insulation heights. Rusty equipment support structures penetrating the roof assemblies shall be repainted prior to installation of the new roofing materials.

Floor by floor work in the existing buildings include the following:

Basement Floor: Most of the basement floor will remain unchanged with the following exceptions:

Storage functions and both carpenter and bed repair workshops will be either closed or relocated to existing basement floor space.

The portions of Unit B and C which contain the storage, carpenter and bed repair workshops, and a vehicle garage will be demolished. A new exterior envelope and foundation wall will be provided along the entire perimeter of the exposed functions where demolition occurs.

Ground Floor: An existing storage space on the north end of Unit A, ground floor will be modernized to accommodate new electrical substation gear. Most of the Ground floor will remain unchanged with the following exceptions:

The existing Central Sterile department will be relocated as noted to the second floor. The existing café and dining service will be relocated as noted to the first floor. The Foundation (community outreach) offices will be consolidated and relocated as noted to the first floor. The large conference room located in Unit C, below the existing chapel, will be closed.

The Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The portions of Unit B and C which contain the Central Sterile, Dining, offices and conference rooms noted above will be demolished. A new exterior envelope will be provided along the entire perimeter of the exposed functions where demolition occurs. A new stair shaft will be constructed to connect the basement and ground floor areas as well as create an exit for both floors.

First Floor: The existing Radiology department, Woman's imaging clinic and Outpatient admitting located in Unit A will remain unchanged. The existing wound and Infusion clinic will receive minor cosmetic updates. The Emergency department will have three existing offices converted to an open bay Behavioral Health patient holding space with area for up to five patients and a private bathroom. The Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The existing admitting offices, Business office and lounge located in Unit B will be modernized to accommodate a relocated Chapel, relocated gift shop and a dietary serving kitchen and dining room. The balance of Unit B which includes the existing administrative offices, existing medical staff support spaces, and a cardiovascular clinic will be closed and/or relocated as noted. The Cardiovascular clinic will be relocated to the MOB to the west.

The existing lab, which is located in Unit C, will be modernized to accommodate the relocated administrative offices of Hospital leadership, hospitalists, case managers, community outreach and medical staff services area. The existing Chapel, located in Unit C will be relocated to the front of the Hospital, modernizing and existing public lounge space.

Punched windows and curtainwall as indicated on the plans will be replaced. All lintels at new windows will be refinished prior to installation of new window assemblies. Foil faced NFPA286 compliant insulation will be installed along the exterior wall in the areas of the new windows, sealed tight to create a vapor tight exterior assembly. Roofs in areas as indicated on the drawings will be replaced with new flashings, facias or coping caps.

Minor structural portions of Unit B will be left intact as noted above. The remainder of both Unit B and Unit C, including the MOB to the east, will be demolished.

First Floor Medical Office Building: Unoccupied suites on the first floor of the 1750 MOB will have limited remodel work for relocation of the PHI CV Clinic and SMD CV Clinic currently located in Unit B. Existing lab & dressing rooms to be converted to exam rooms, a finished opening between the Prairie & SMD suites to be created for colleague access, back of house to be remodeled for provider & colleague shared offices.

Second Floor: The Surgical Department will be modernized to create four same sized Operating Rooms, with dedicated scrub functions, dedicated staff lockers, physician lounge, and Anesthesiology work areas. A GI procedure suite will be created with two procedure rooms, scope cleaning functions and nursing support spaces. Sterile processing will be relocated to the second floor to be directly adjacent Surgery. The Sterile Processing Department will include a washer for surgical carts, instrument washers, a decontamination room, Clean work room, Sterilizers and a cool down area. The sterile supply storage will be located directly behind the new operating rooms to provide surgical staff direct access to sterile supplies.

A six station PACU will be created which includes one isolation room, in addition to required nursing support functions. The PACU will have direct access to both Surgery corridor and patient Prep-recovery. The modernized Stage Two patient Prep-recovery department will hold 20 new patient prep areas, including one isolation room, and also include all required nursing support functions.

The 3,000 sf pharmacy is going into the vacated Endoscopy Department on the second floor, and will be modernized to include both non-sterile and sterile compounding rooms with a shared ante room. The Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

Punched windows within the renovated area of Unit A and within the new pharmacy space and adjoining areas as indicated on the plans will be replaced. All lintels at new windows will be refinished prior to installation of new window assemblies. Foil faced NFPA286 compliant insulation will be installed along the exterior wall in the areas of the new windows, sealed tight to create a vapor tight exterior assembly. Roofs in areas as indicated on the drawings will be replaced with new flashings, facias or coping caps .

The portion of Unit B scheduled to remain on the first floor will receive a new EPDM roof on tapered insulation and a vapor retarder. The flashings at the new chapel area skylights will be repaired as indicated. The existing planting bed located at the exterior curtainwall along the main lobby will be modified to drain onto the adjacent roof via (2) cut in scuppers.

The existing Patient prep-hold functions located in Unit B, the existing sleep lab located in Unit B will be closed. Unit B will be demolished at the end of the project.

The Pain Clinic, which is located in Unit C MOB attached to the east end of Unit B will be relocated to the third floor of the MOB adjacent the Hospital to the west. Unit C MOB will be demolished at the end of the project.

Third Floor: The space previously occupied by the Obstetrics and Nursery located in Unit A will be closed, and the space remodeled for Medical/Surgical beds. The unit will be modernized to provide 18 medical-surgical beds with associated nursing support services, and private bathrooms. The balance of the floor will include offices for a social worker, charge nurse, and hospitalist, as well as providing a public waiting area and public restrooms. A corridor will be added on the north end of the unit to connect the Inpatient unit to the single elevator serving ER and Surgery. The Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The curtain wall at the south end of Unit A will be replaced with a new curtain wall as part of this project. The interior portion of the exterior wall assembly including window sills will be replaced as part of this work. Punched windows within the renovated area of unit A will be replaced. All lintels at new windows will be refinished prior to installation of new window assemblies. Foil faced NFPA286 compliant insulation will be installed along the exterior wall and sealed tight to create a vapor tight exterior assembly. Roofs in areas as indicated on the drawings will be replaced with new flashings, facias or coping caps .

The space previously occupied by the Post-Partum inpatient unit located in Unit B will be closed. The remaining Unit B spaces previously used for Obstetrics support, training and Staff sleep rooms will be closed. The existing Pharmacy, located in Unit C (the eastern attached medical office building) will be relocated to a space on the Second Floor of Unit A.. Staff sleep rooms and pastoral care offices will be relocated to other remaining portions of Unit A. A new waiting room will be constructed in the portion of Unit B to remain.

Unit B and the MOB portion of Unit C (where the existing Pharmacy is located) will be demolished at the end of the project.

Third Floor Medical Office Building: Existing 1770 3rd floor suites 300 & 309 are unoccupied and will be remodeled to provide space for relocation of the Pain Clinic. Suites 300 & 309 remodel work to include two treatment rooms with a centrally located med-storage & supply area, one additional exam room, nurse work area, and storage space. The combined suites will include a connection to the common corridor and back-of-house office space & break room.

Fourth Floor: The existing ICU located in Unit A will be modernized as follows: Four existing ICU rooms and associated Nursing support functions will remain unchanged on the northern end

of Unit A. Two ICU rooms will be converted to function as Universal Acuity swing beds. The balance of the fourth floor in Unit A will be modernized to create twelve additional Medical/Surgical beds and associated nursing support spaces. The modernization will provide spaces for public restrooms, staff break room, offices, and a public waiting room. The Respiratory Therapy work room, utility and lounge will remain unchanged. The Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The existing Oncology Inpatient Unit (20 Beds) and the Med-Surge Inpatient unit (17 beds) located in Unit B on the Fourth floor will be closed. Unit B will be demolished at the end of the Project. A new storage room will be constructed in the portion of Unit B to remain.

The curtain wall at the south end of Unit A will be replaced with a new curtain wall as part of this project. The interior portion of the exterior wall assembly including window sills will be replaced as part of this work. The remaining exterior wall assemblies and windows were recently replaced under a separate project. All new work will be performed to maintain the integrity of the previously constructed building envelope.

The roof of the penthouse will be replaced as part of this project. The roof assembly consists of a partially pitched structure and a flat portion of structure. A combination of tapered insulation and flat insulation will be used to pitch water to the roof drainage. New facias will be provided around the perimeter of this roof to accommodate the revised insulation heights.

Fifth Floor: The Administrative offices and Pulmonary testing rooms located in Unit A will also be closed. The administrative offices will be consolidated (reduced in number of offices required) and relocated to an area on the first floor. There is no remodeling work scheduled for this floor of Unit A other than the Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The curtain wall at the south end of Unit A will be replaced with a new curtainwall as part of this project. The interior portion of the exterior wall assembly including window sills will be replaced as part of this work. The remaining finishes shall be patched to match the existing surrounding areas.

The space previously occupied by Behavioral Health Program located in Unit B on the fifth floor will be closed. Unit B will be demolished at the end of the Project. A new waiting room will be constructed in the portion of Unit B to remain.

Sixth Floor: Existing Cath and Vascular Lab services and the Cardiac Diagnostic Clinic located in Unit A will remain. There is no remodeling work scheduled for this floor of Unit A other than the Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure.

The curtain wall at the south end of Unit A will be replaced with a new curtainwall as part of this project. The interior portion of the exterior wall assembly including window sills will be replaced as part of this work. The remaining finishes shall be patched to match the existing surrounding areas.

The existing Med-surge inpatient unit located in Unit B on the sixth floor will be closed. Unit B will be demolished at the end of the project. A new waiting room will be constructed in the portion of Unit B to remain.

Seventh Floor: Space previously occupied by the inpatient Behavioral Health program in Unit A will be closed. There is no remodeling work scheduled for this floor of Unit A other than the Trash and Laundry chutes will be removed and the shafts closed with compliant 2HR fire rated construction. The remaining shafts will be used for vertical distribution of infrastructure. The curtain wall at the south end of Unit A will be replaced with a new curtain wall as part of this project. The interior portion of the exterior wall assembly including window sills will be replaced as part of this work. The remaining finishes shall be patched to match the existing surrounding areas. Space previously occupied by the Rehab Inpatient unit and the Outpatient rehab clinic located in Unit B will be closed. A new waiting room will be constructed in the portion of Unit B that remains following demolition of most of Unit B.

Eighth Floor: Minor portions of the eighth floor, which maintain access to the equipment rooms and top of elevator shafts will remain unchanged. A new exterior envelope will be provided to enclose the portions of the floor which remain after demolition is complete. The existing remaining stair shaft must be re-worked to provide access to this newly enclosed area. The stair currently provides access to the ninth-floor area above the two bank elevators and ductwork has closed off the access to the stair traveling down to the seventh floor. A roof access hatch and ladder from the remaining Unit B mechanical space shall be provided to the 9th floor roof.

The masonry wall of the 4 bank elevators will be re-pointed as part of this project. The parapet cap stones remaining from the north end of unit B will be removed or capped as part of the re-roofing.

Unit A's roof will be replaced. Tapered insulation will be added to improve the waterflow to the roof drains. The exterior stair at the north end of this roof as required to access the elevator will be reworked as part of this re-roofing work.

Unit B, which includes the existing mechanical penthouse, will be demolished at the end of the project.

Ninth Floor: The ninth floor above both the four bank and two bank elevators will remain unchanged. The roof above the 4 bank elevators will remain untouched. The roof of the remaining portion of unit B will be replaced. Ninth floor areas which can only be accessed from Unit B will be demolished at the end of the project.

B. Electrical Components

The main aspects of the electrical system upgrades and replacement include those described below.

Two new 4160V service drops will be provided into the building serving a total of three unit substations or transformers. These will serve new and existing panels and equipment throughout the facility. The existing emergency generator and distribution equipment will remain. A new interior generator and distribution equipment will be added. The existing normal power and emergency power risers within the facility will be upgraded/replaced to serve new and re-utilized distribution equipment which will serve new and existing branch circuit panels. The existing fire alarm, paging, nurse call, telecommunications and other miscellaneous systems will be expanded/revised as required to accommodate the renovations. New Systems Risers will be provided to replace the existing risers being removed as part of the demolition work. The project will be designed to conform to the requirements of the IECC 2021 Energy Code. Energy efficient LED fixtures shall be specified to optimize the lumens per watt of the lighting system.

The two existing 5KV Utility Services will be removed/replaced. Unit substations #1, #2, #3, #4, #5, #6 and #7 along with associated primary feeders and switches will be disconnected/removed. The associated primary and secondary feeders, switchboards, panels, and circuits will be removed. All the ATS's and panels within the 8th floor penthouse will be disconnected and removed. Old/obsolete normal power branch panels within the patient tower floor areas remaining will be disconnected and removed along with associated circuits/conduit and wiring. Care will be taken to keep certain unit substations up and operational for use in providing temporary power to other areas as demolished. Other area power sources (like ER and chiller feeds) can be utilized to the extent possible for temporary power.

The emergency and normal power distribution equipment in the ER area will remain but feeders may need to be redone/replaced. The abandoned generator #1 will be removed from the facility. The old/obsolete emergency branch panels within the remodeling areas of the patient tower floors will be disconnected and removed along with associated circuits/conduit and wiring.

The existing fire alarm, paging, nurse call, telecommunications and other miscellaneous systems will be expanded/revised as required to accommodate the renovations. New systems risers will be provided to replace the existing risers being removed as part of the demolition work.

New primary utility service feeders will be routed through the building to serve the new unit substations #1, #2, and #3 via new primary switches. The new service switchboards will be 120/208 Volts and 480/277 Volts, 3-phase, 4-wire sized to accommodate the current loads with future capacity..

The exterior primary connection to Ameren will be upgraded to provide the following:

1. Two new 4160V, 3-phase connections to the overhead primary line behind the hospital.
2. The two primary connections will feed to a main-tie-main pad mounted distribution cabinet for redundant feeder configuration.
3. From each circuit A and B, new pad mounted switchgear will be provided to both feed the new loop 4160 primary into the building feeding the new (3) unit substations, as well

as to feed the existing cancer center service transformer. Both pad mounted fused switchgear units will be sized and provided to provide for future connection to the remaining 4160V feeds serving the hospital.

4. In feeding the new unit substations, a loop configuration for two circuits A and B will be installed. This will provide redundancy in the feeder to easily bypass a fault condition or other electrical situation that might cause prolonged outages.

A diesel generator will be added to the existing emergency system.

To back up the 800T chiller, new conduit, wiring and distribution will be added and amended in the mechanical room spaces to accommodate the correct connection and transfer scheme.

New electrical connections will be provided to all mechanical and plumbing equipment/loads and associated controls including boiler burners, chiller and associated pumps, water heaters, booster and circulation pumps and softeners.

New Data/Voice IDF rooms will be provided on each, or at a minimum on every other floor of the tower, stacked with service entrance conduit sleeves, fiber risers, racks, patch panels, cabling, supports, jacks/outlets, and faceplates.

New fixtures specified within the project will be provided with energy-efficient LED sources to optimize the fixture lumens/watt. Dimming will be provided as required or requested. Patient rooms will be provided with local, low voltage lighting controls. Occupancy sensors will be provided as required for automatic shut-off of fixtures in non-patient care areas.

Emergency egress light fixtures and exit signs will be circuited to the emergency life safety branch panel as required by code. Battery unit fixtures will be provided in all electrical/mechanical spaces.

New helipad lighting will be provided at the new pad and connected to the life safety branch lighting panel. Parking lot lighting will be modified as required by the new helipad. New, fully cut-off LED pole mounted luminaires will be provided.

A new/revised paging system will be provided in the renovated areas. The intent is to upgrade the amplifiers and backbone risers for better operation. The area speakers and cabling will be reused as much as possible to keep costs within reason. The card access control and security IP camera systems will be expanded as directed by the owner.

C. Fire Protection Components

The work consists primarily of completing sprinkler coverage in remodeled areas. The design and installation of the fire protection system shall be compliant with the latest edition of NFPA 13, in addition to state and local codes. The existing fire alarm system will be expanded per NFPA 72. New connections to fire protection mains will be made, and new mains and risers routed through the remodeled areas.

D. HVAC Components

The current HVAC system is outdated and in need of replacement and upgrades. The boiler room steam plant consists of three boilers, two of them are original to the building built in 1958. A single air unit presently serves the ground floor conference room and chapel, a two position damper is operated to select which area is ventilated/conditioned by the system. The air unit is original to the building constructed in 1958 and is operating well beyond expected useful life. There are comfort heating hot water heat exchangers and associated pumps located in the boiler room. The pumps are original to the building and the controls are obsolete pneumatics. The hot water heat exchangers were installed in 1978 and are at the end of normal operating life. The kitchen and bakery hoods and associated exhaust duct system are original to the hospital. The duct system and fan are in part of the building being eliminated.

Boilers #1 and #2 will each be upgraded with the installation of new operating controls and burners. The upgrade package will consist of new modulating high turn down, low NOx, low excess air, dual fuel natural gas/#2 fuel oil burners, new electric/microprocessor-controlled feed water level controls with electric control valves, digital steam pressure sensors, O2 trim. Each of these features will contribute to better fuel efficiency, reduced load cycling, less maintenance, fewer tune ups and restore combustion efficiency, increase steam capacity and reliability.

As part of the chilled water plant, infrastructure upgrade and replacement, the existing 12" tangential air separator will be removed and replaced with a high performance 14" Spirotherm Spirovent combination air eliminator/dirt separator. The air eliminator/dirt separator will improve chiller system efficiency by eliminating entrained air and also remove the circulating dirt (system mud) that resides in the portions of the system not part of the renovation project. Eliminating the air will improve heat transfer efficiency, reduce corrosion within the system and aid with reducing the need for chemical controls in the system.

The installation of a new generator will include extending fuel oil supply and return from capped connections at the existing installation through to a new day tank and from the day tank to the engine connections.

Air units throughout the hospital will be refurbished and obsolete pneumatic building automation controls will be replaced with modern digital electric to achieve improved control and remote monitoring.

Existing ductwork, piping and other systems being remodeled will be removed from the site and recycled in accordance with local recycling practices to reduce the impact of the construction waste on the local environment. System service interruptions due to demolition activities will be pre-scheduled between the contractor and owner to coordinate the least impact in patient care operations.

HVAC systems being expanded or installed for the remodeling will be designed to minimize energy usage and meet or exceed the baseline energy performance requirements of the 2021 International Energy Conservation Code and ASHRAE standard 90.1. New systems utilizing refrigerants will be selected to avoid CFC and HCFC based refrigerants. Ventilation systems will be designed to meet or exceed the requirements set forth in ASHRAE standard 62.1, *Ventilation for Acceptable Indoor Air Quality*; Standard 170, *Ventilation of Health Care*

Facilities; and the Illinois Hospital Licensing Part 250 Administrative Code Requirements. Heat recovery systems will be employed where possible to minimize the energy penalty of increased ventilation.

New air handling units will be selected as fully customizable units to match facility standards and will utilize building steam for heating and humidification, chilled water for cooling, UV-lights for cleaning coils, plenum fan walls, and high-level filtration systems (MERV 8 pre-filters, VERV 14 final filters min.). Units located on the roof will include a service aisle with adequate clearances, lighting, and heat to perform maintenance on the unit in winter.

Thermal comfort for each zone is evaluated against ASHRAE standard 55, *Thermal Environmental Conditions for Human Occupancy*. Zone temperature and humidity will be monitored and controlled in critical spaces as required by ASHRAE 170. In non-critical spaces, individual zone temperature will be monitored and controlled by the occupant. Where it makes sense, rooms with similar climates will be grouped together onto a single zone.

The existing building automation system (BAS) will be modernized and extended to integrate the new equipment and controllers installed in the renovated spaces. The system will be electronic with DDC controls and will integrate to the extent possible existing pneumatic equipment left after the remodeling into the new electronic system. All new equipment and zones will be integrated into the BAS for monitoring, alarm reporting and adjusting by facility staff.

Proper ventilation is critical to a healthy environment. New variable volume systems will be equipped with outdoor air monitoring stations, which will be interlocked with the building automation system to adjust dampers as the system changes, thereby managing and maintaining proper ventilation levels. During construction, an indoor air quality management plan will be specified to protect the HVAC system and adjacent occupied areas, maintaining a healthy environment for the building occupants as the remodeling takes place. At the end of construction all new air systems and modified systems will be balanced to ensure proper ventilation is provided in accordance with the design.

The surgical platform build out will require new air units. The surgery procedure rooms will have an air unit located on the roof directly above the area served. The other air units are intended to be located adjacent to the areas served. The limited floor to floor height will inhibit long duct runs and duct sizes. Each air unit will provide variable volume air flow, be configured with outdoor air/return air mixing box with dampers, air blender, MERV 8 pre-filters, steam or hot water heating coil, steam grid humidifiers, chilled water cooling, plenum supply fan, MERV 14 final filters, and return/exhaust fan. Variable volume terminals will be provided with digital room controls for room-to-room temperature control. Booster humidifiers will be provided to each procedure room. Room pressure monitors will be provided at each procedure room and at the sterile processing decontamination, clean work room and sterile storage rooms. Medium pressure steam (60 PSI) will be extended from the Ground Floor North Equipment Room 1050 vertically through to the second-floor sterile processing equipment expected to include instrument washers, cart washers, and autoclave sterilizers.

At the renovation to create Medical-Surgical rooms on the third floor, new ductwork, grilles, and diffusers will be provided from new supply, return, and exhaust duct systems. New VAV terminals with hot water duct heating coils and below window hot water convectors will

provide zone temperature controls. New thermostat controls will be digital/electric incorporated into the campus building automation system. A new variable volume air unit installed in a location to be determined will be provided. A nominal 10,000 CFM air unit is to be provided. The air unit will be equipped with an outdoor air intake, MERV 8 pre-filters, steam integral face and bypass heating coil, steam grid humidifier, chilled water cooling coil, plenum supply fans, and MERV 14 final filters.

The fourth-floor renovation will repurpose the current ICU into a reduced size ICU and Med Surge Patient Unit. The existing variable volume supply air system will be reconfigured to suit the renovation area. The existing VAV terminals with hot water reheat and associated thermostat controls will be salvaged and repurposed to the extent possible. New VAV terminals will be provided where necessary to suit the new room configuration. The existing return air and exhaust duct systems will also be reconfigured to suit the renovated area.

Renovations to create a new second floor pharmacy will entail a new air unit. The new air system will be equipped with VAV terminals having hot water heat for room to room thermostat zone controls. HEPA fan filter units will be provided within the clean rooms to achieve the desired clean room classification. An exhaust fan will be required for the hazardous drug compounding. The pharmacy will be constructed in accordance with USP 797 and USP 800 requirements. The new air unit assembly will be equipped with an outside air intake/return air damper mixing box, air blender, MERV 8 pre-filters, hot water or steam heating coil, chilled water cooling coil, plenum supply fan(s), MERV 14 final filters, and return/exhaust fan. Extend hot water, chilled water, and steam piping from the nearest available source.

E. Plumbing Components

The work consists of remodeling the basement through fourth floor of the hospital, and replacement of plumbing equipment supplying the hospital. Services to include storm, sanitary/vent, water piping and med gas piping/systems.

All new toilet rooms shall incorporate ADA accessible fixtures as required per codes. New water closets to be floor mounted, back, or bottom outlet with dual flush valves. New water closets shall utilize dual flush valves 1.6/1.1 gpf. New faucets and shower heads shall incorporate low flow 1.5 gpm aerators and shower heads.

Hot water return piping at the fourth floor ceilings to be replaced back to the water heaters, piping is in poor condition and is undersized. The older galvanized water piping to be replaced with new copper piping whenever possible.

Hospital roofs to be replaced with new materials. Roof drains and vertical storm piping to be removed. New roof areas require additional roof drains and new secondary drainage to be added.

Med gas outlets, zone valves and alarm panels to be removed and replaced. Med gas will be supplied to the remodeled rooms. New med gas piping, outlet quantities and components to be installed per NFPA-99 medical gas code. New zone valves boxes to be installed per wing/suite

and/or anesthetizing rooms. Each zone valve box includes an alarm panel. Provide new horizontal and vertical mains from med gas equipment.

4. Cite the sources of the documentation.

- https://herald-review.com/news/local/business/health-care/here-for-the-long-haul-providers-adapt-to-new-demands-amid-st-mary-s-closures/article_0ea8643a-15c3-11ee-a774-dba080f3478.html#tracking-source=home-top-story
- <https://www.aha.org/aha-center-health-innovation-market-scan/2021-06-15-3-ways-prepare-coming-shifts-care-delivery>
- <https://www.businesswire.com/news/home/20210604005089/en/Sg2-Impact-of-Change-Forecast-Predicts-Enormous-Disruption-in-Health-Care-Provider-Landscape-by-2029>
- the NFPA Life Science Code.
- NFPA 101: Chapter 18/19 HealthCare, Chapter 38 Business
- IBC: I-2 Hospital, B MOB
- Construction types:
 - NFPA 101: I (332) Hospital; II (000) MOB
 - IBC: IA Hospital; IIB MOB
 - Hospital and MOB will not be physically connected and separated enough that no fire wall is required.
- Accessibility:
 - ADA 2010
 - ICC/ANSI A117.1 – 2009
 - Illinois Accessibility Code – 2018
- Fire protection: NFPA 13, NFPA 14, NFPA 25 and NFPA 101.
- Plumbing: Illinois Plumbing Code, International Plumbing Code, NFPA-99 and City of Decatur, IL local codes.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

As noted above, much of the current hospital space, both clinical and non-clinical, is original to the main hospital building constructed in 1958. The project will provide modern, efficient space and programs that will improve patient care at reduced operating costs which will in turn improve the hospital's dire financial condition.

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

A significant factor for the improvement of St. Mary's operations is the reduction of the hospital's average length of stay, which was 5.8 in CY 2020. St. Mary's has implemented steps to reduce this metric and is targeting an average length of stay below 3.5 by the second year of project completion.



RURAL HOSPITALS AT RISK OF CLOSING

Many people across the country could not receive hospital care in their community when the pandemic began because over 150 rural hospitals had closed between 2005 and 2019. An additional 18 rural hospitals closed in 2020, more than any year in the previous decade. These closures were not caused by the pandemic, but by financial losses in previous years. Ten more rural hospitals closed in 2021 and 2022; the number was smaller than in 2019 because of the special financial assistance hospitals received during the pandemic. The pandemic aid has now ended, so closures are likely to increase.

Hundreds of Rural Hospitals Are at Risk of Closing

More than 600 rural hospitals – over 30% of all rural hospitals in the country – are at risk of closing. These hospitals are at risk because of the serious financial problems they are experiencing:

- **Losses on Patient Services:** Health insurance plans do not pay these hospitals enough to cover the cost of delivering services to patients. Their losses will likely be greater in the future due to the higher costs that all hospitals, particularly small rural hospitals, are experiencing because of inflation and workforce shortages. In the past, many of these hospitals have received grants, local tax revenues, or profits from other activities that have offset their losses on patient services, but there is usually no guarantee that these funds will continue to be available in the future or that they will be sufficient to cover higher costs.
- **Low Financial Reserves:** The hospitals do not have adequate net assets (i.e., assets other than buildings & equipment, minus debt) to offset their losses on patient services for more than 6-7 years.

There are hospitals at risk of closing in almost every state. In over half the states, 25% or more of the rural hospitals are at risk of closing, and in 16 states, 40% or more are at risk.

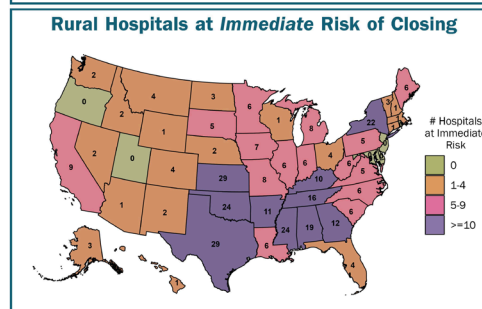
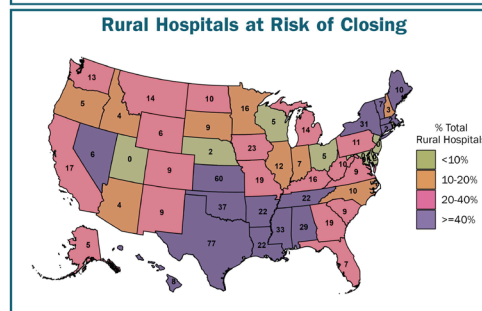
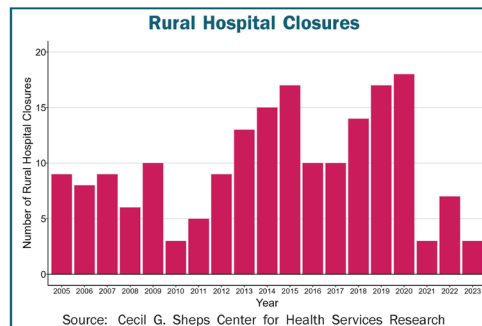
Many Rural Hospitals Are at Immediate Risk of Closing

Over 300 of these rural hospitals are at *immediate* risk of closing because of the severity of their financial problems:

- **Inadequate Revenues to Cover Expenses:** These hospitals have lost money delivering patient services over a multi-year period (excluding the first year of the pandemic), and they are unlikely to receive sufficient funds from other sources to cover those losses now that federal pandemic assistance has ended.
- **Very Low Financial Reserves:** The hospitals either have more debts than assets, or the amount of net assets they have could offset their losses for at most 2-3 years.

Loss of Rural Hospitals Would Reduce Access and Increase Disparities in Care

Most of the at-risk hospitals are located in isolated rural communities. Closure of the hospital would mean the residents of the community would have to travel a long distance for emergency or inpatient care. Moreover, in many small rural communities, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may be the only or principal source of primary care in the community. As a result, closure of the hospital would cause a loss of access to many essential healthcare services.



More information about rural hospitals is available at RuralHospitals.org

RURAL HOSPITALS AT RISK OF CLOSING								
State	Closures Since 2005	Current Rural Hospitals	Hospitals With Losses on Services ¹		Hospitals At Risk of Closing		Hospitals At Immediate Risk	
			Number	Percent	Number	Percent	Number	Percent
Kansas	9	104	86	83%	60	58%	29	28%
Texas	24	158	102	65%	77	49%	29	18%
Mississippi	5	74	48	65%	33	45%	24	32%
Oklahoma	9	78	58	74%	37	47%	24	31%
New York	6	51	41	80%	31	61%	22	43%
Alabama	7	52	34	65%	29	56%	19	37%
Tennessee	14	55	22	40%	22	40%	16	29%
Georgia	9	68	32	47%	19	28%	12	18%
Arkansas	2	50	37	74%	22	44%	11	22%
Kentucky	4	72	30	42%	16	22%	10	14%
California	9	56	33	59%	17	30%	9	16%
Michigan	2	64	24	38%	14	22%	8	12%
Missouri	10	57	30	53%	19	33%	8	14%
Iowa	1	93	66	71%	23	25%	7	8%
Illinois	5	71	19	27%	12	17%	6	8%
Indiana	3	53	14	26%	7	13%	6	11%
Louisiana	2	53	36	68%	22	42%	6	11%
Maine	3	25	14	56%	10	40%	6	24%
Minnesota	6	95	40	42%	16	17%	6	6%
North Carolina	11	53	19	36%	10	19%	6	11%
South Carolina	4	23	12	52%	9	39%	6	26%
West Virginia	5	28	14	50%	10	36%	6	21%
Pennsylvania	6	41	16	39%	11	27%	5	12%
South Dakota	2	48	14	29%	9	19%	5	10%
Virginia	2	29	10	34%	9	31%	5	17%
Colorado	0	42	16	38%	9	21%	4	10%
Florida	8	21	9	43%	7	33%	4	19%
Montana	0	55	35	64%	14	25%	4	7%
Ohio	2	70	17	24%	5	7%	4	6%
Alaska	1	17	10	59%	5	29%	3	18%
North Dakota	1	39	26	67%	10	26%	3	8%
Vermont	0	13	10	77%	7	54%	3	23%
Idaho	0	29	15	52%	4	14%	2	7%
Nebraska	2	71	28	39%	2	3%	2	3%
Nevada	2	13	11	85%	6	46%	2	15%
New Mexico	1	28	16	57%	9	32%	2	7%
Washington	1	40	26	65%	13	32%	2	5%
Arizona	4	27	15	56%	4	15%	1	4%
Connecticut	0	3	2	67%	2	67%	1	33%
Hawaii	0	12	10	83%	8	67%	1	8%
Massachusetts	1	5	3	60%	2	40%	1	20%
New Hampshire	0	17	7	41%	3	18%	1	6%
Wisconsin	1	75	22	29%	5	7%	1	1%
Wyoming	0	23	11	48%	6	26%	1	4%
Delaware	0	2	0	0%	0	0%	0	0%
Maryland	1	4	0	0%	0	0%	0	0%
New Jersey	1	0	0	0%	0	0%	0	0%
Oregon	0	32	14	44%	5	16%	0	0%
Rhode Island	0	0	0	0%	0	0%	0	0%
Utah	0	21	7	33%	0	0%	0	0%

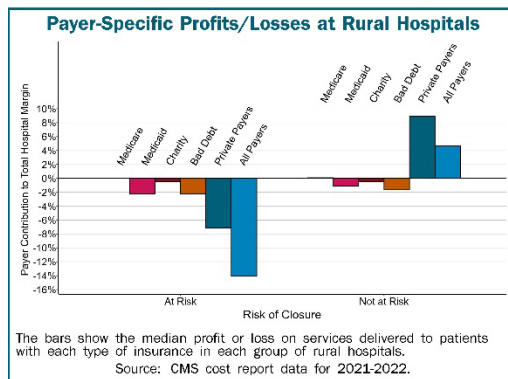
¹ Rural hospitals that had a negative margin (loss) on patient services in the most recent year available.

Data current as of July 2023

Closures Are Caused by Inadequate Payments from Private Payers

The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients. As shown below, although the at-risk hospitals are losing money on uninsured patients and Medicaid patients, losses on private insurance patients are the biggest cause of their overall losses.

Conversely, many other rural hospitals are *not* at risk of closing because they make profits on patient services. They receive payments from private health plans that not only cover the costs of delivering services to the patients with private insurance, but those payments also offset the hospitals' losses on services delivered to uninsured and Medicaid patients.



How to Prevent Rural Hospital Closures

Significant changes must be made in both the amounts and method of payment for rural hospital services in order to prevent more rural hospitals from closing in the future. Rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if the workers cannot get adequate healthcare services.

Require That Health Insurance Payments Cover the Cost of Services in Rural Communities

Payments that are sufficient to cover the cost of services at large hospitals will not be adequate at small rural hospitals because it costs more to deliver healthcare services in rural communities. This is not because rural hospitals are inefficient, but because of the smaller number of patients served relative to the fixed costs of the services. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher.

The biggest problem facing small rural hospitals is inadequate payments from private health plans. Most "solutions" for rural hospitals have focused on increasing Medicare or Medicaid payments or expanding Medicaid eligibility due to a mistaken belief that most rural patients are insured by Medicare and

Medicaid or are uninsured. In reality, about half of the services at the average rural hospital are delivered to patients with private insurance (both employer-sponsored insurance and Medicare Advantage plans). In most cases, the amounts these private plans pay, not Medicare or Medicaid payments, determine whether a rural hospital loses money.

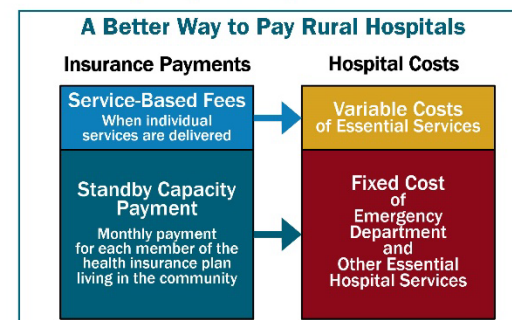
Rural hospitals should not be forced to eliminate inpatient care in order to receive higher payments for other services, as is required under the federal "Rural Emergency Hospital" program. This would make it harder for rural residents, particularly the elderly, to receive prompt, high-quality care when they are ill.

Increasing payments to levels sufficient to prevent closures of the at-risk hospitals would only cost about \$4 billion per year. This would represent an increase of only 1/10 of 1% in total national healthcare spending. Most of the higher spending would support primary care and emergency care, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close, because reduced access to preventive care and failure to receive prompt treatment will cause residents of the communities to be sicker and need more services in the future.

Create Standby Capacity Payments to Support the Fixed Costs of Essential Rural Services

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are paid nothing for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive **Standby Capacity Payments** from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and the Service-Based Fees would cover the variable costs of those services. More details on this approach are available in *A Better Way to Pay Rural Hospitals*.



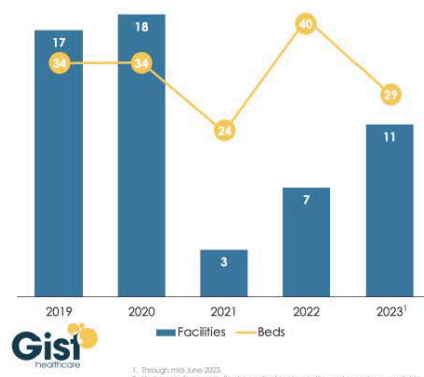
Rural hospital closures rising again with end of COVID aid

After a brief reprieve thanks to COVID relief funds, rural hospital closures are once again on the rise, with 11 facilities already closing in the first half of this year. **More rural facilities have already closed in 2023 than the previous two years combined, and this year is on pace to be the second-highest number of rural hospital beds lost since 2005.** And **the majority of rural hospitals that haven't closed are experiencing negative operating margins, with almost one in three at immediate or high risk of closure** due to declining volumes, shifting payer mix, and increased labor and supply costs. Leaders at rural hospitals now face difficult decisions including drastically cutting services, merging with a larger system, or closing their doors altogether. The Centers for Medicare and Medicaid Services (CMS) launched the Rural Emergency Hospital Program recently, designed to financially support small rural hospitals that convert to providing emergency services only, but so far program uptake has been limited. **While efforts to prop up hospitals will help to sustain access to care in the near term, rural communities ultimately need a new model for care**, with reimagined facilities, supported by enhanced virtual connections to specialists and higher-acuity services.

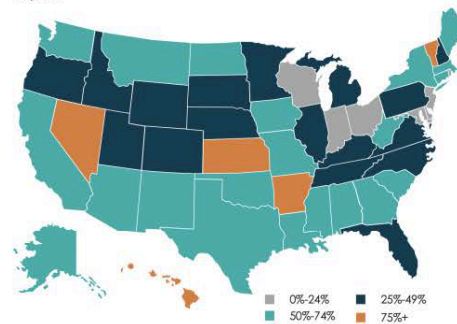
After COVID Reprieve, Rural Hospital Closures Rising Sharply in 2023

More Than Half of Rural Hospitals Losing Money on Operations

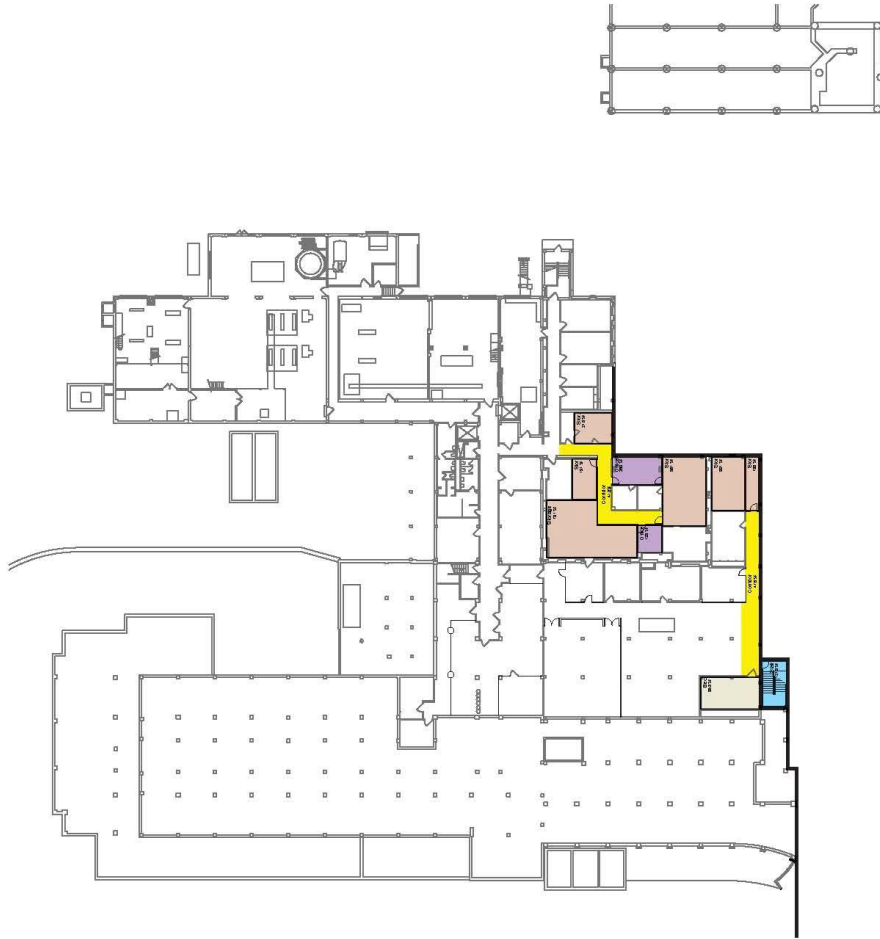
Number of Rural Hospital Closures and Average Bed Count, by Year



Percentage of Rural Hospitals With Negative Operating Margin² by State
May 2023

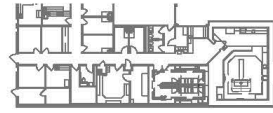


Source: "Rural Hospitals At Risk of Closing", Center for Healthcare Quality & Payment Reform, May 2023. "Rural Hospital Closures", The Carol G. Stegman Center for Health Services Research at UNC Chapel Hill, June 2023. GHI Healthcare analysis.



BASEMENT FLOOR PLAN
NO SCALE

A101

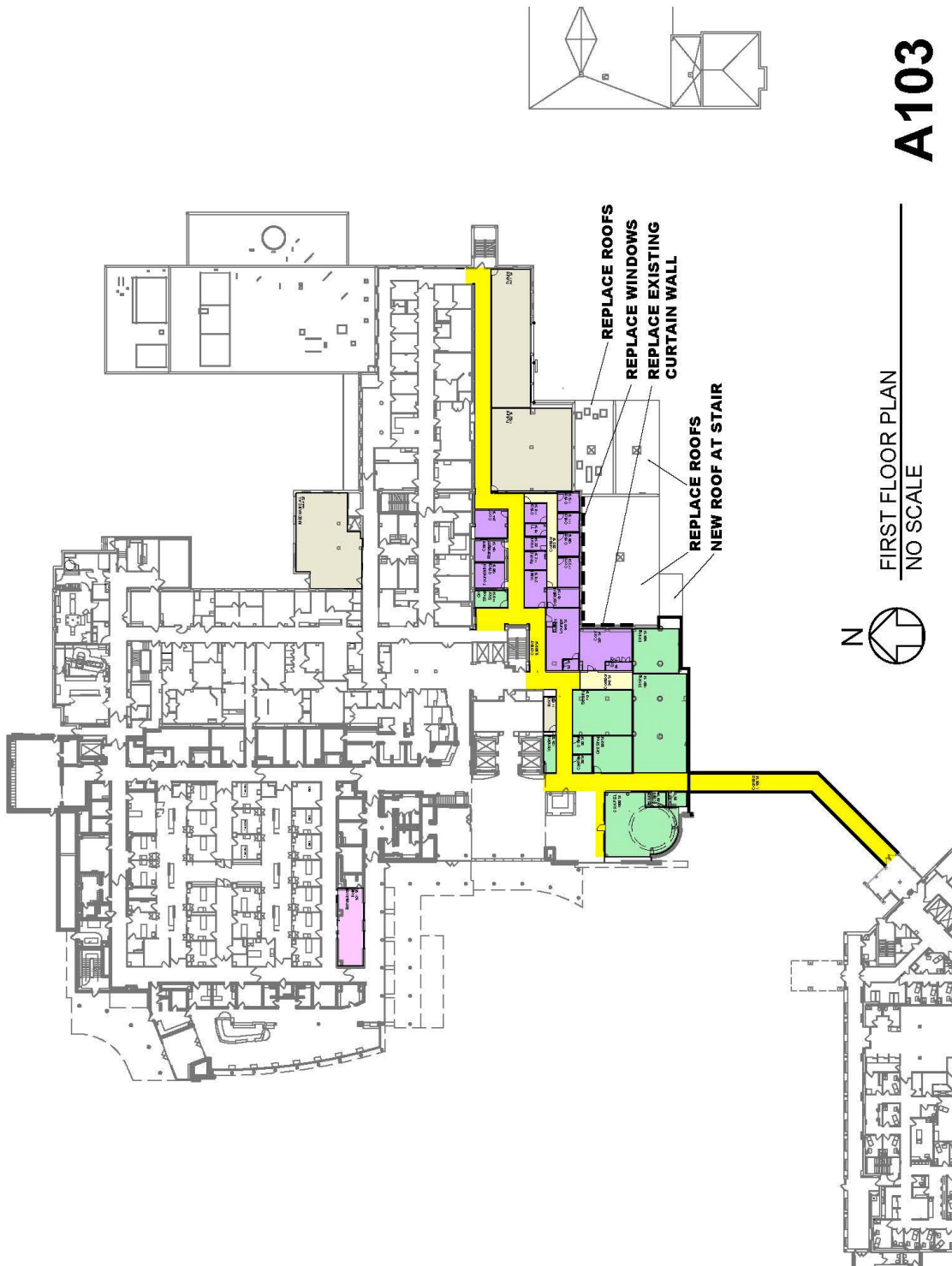


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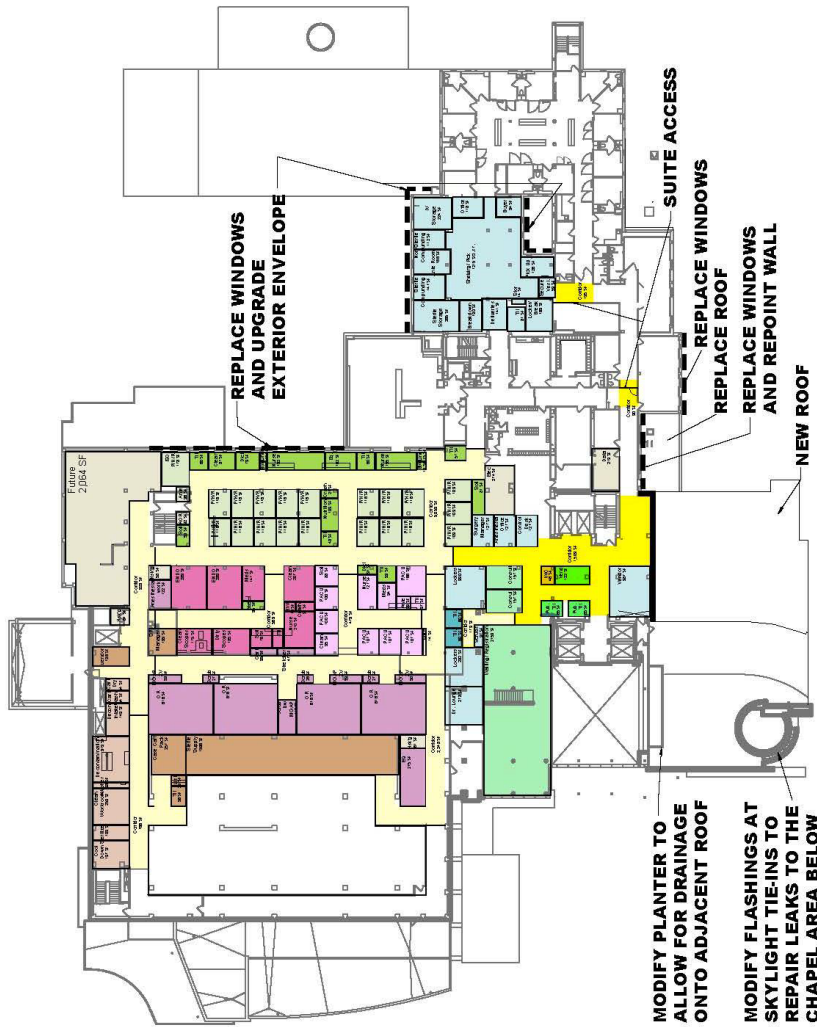
GROUND FLOOR PLAN
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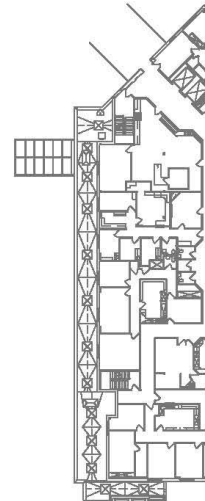
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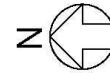
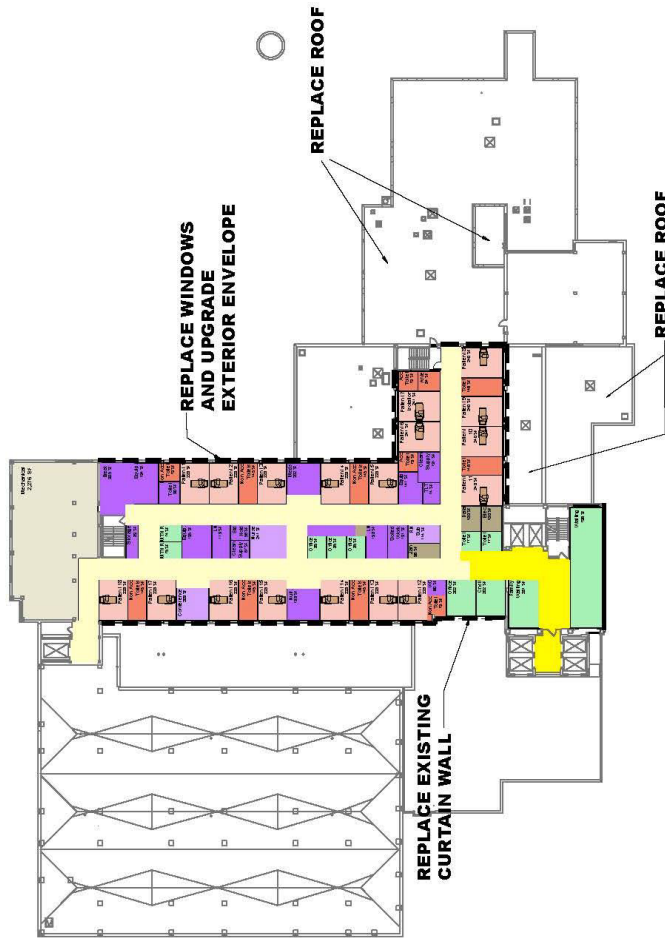
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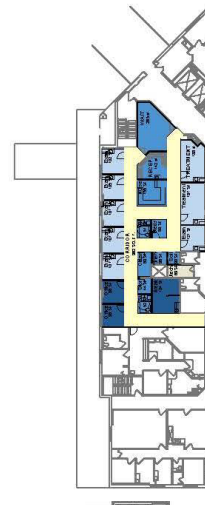
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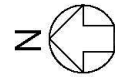
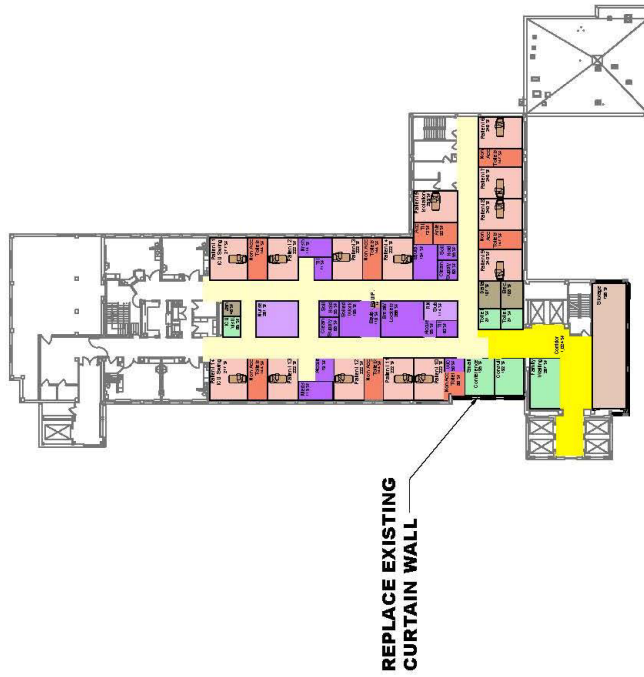


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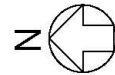
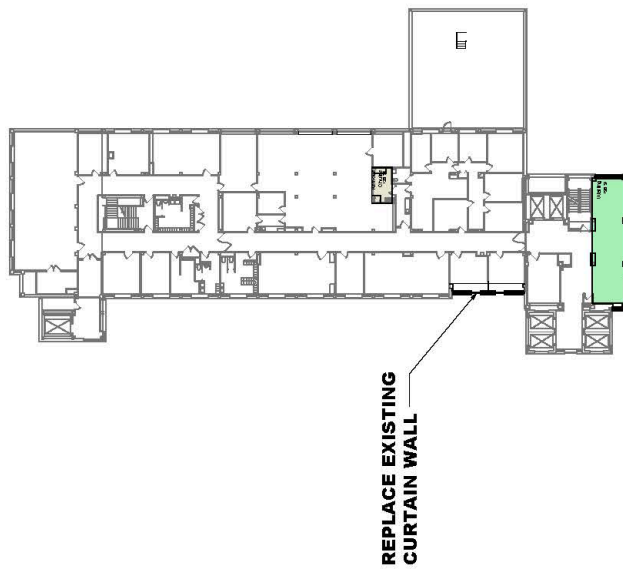
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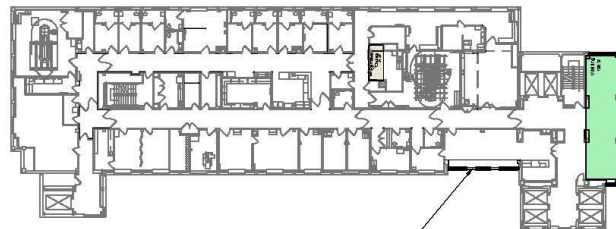
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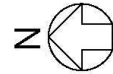


FIFTH FLOOR PLAN
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A107



REPLACE EXISTING
CURTAIN WALL

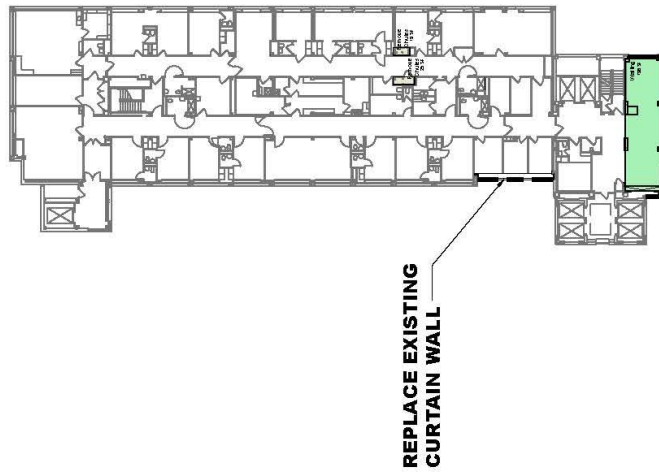
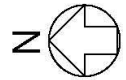


SIXTH FLOOR PLAN
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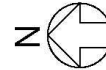
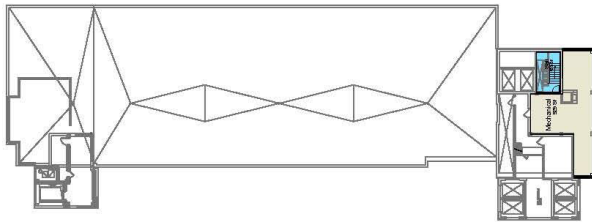
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A109

SEVENTH FLOOR PLAN
NO SCALE



REPLACE EXISTING
CURTAIN WALL

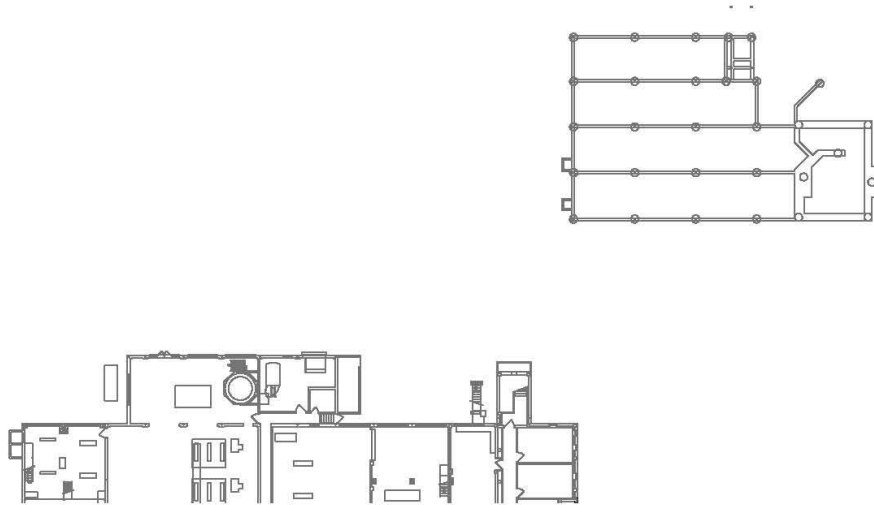
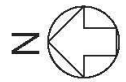


EIGHTH FLOOR PLAN
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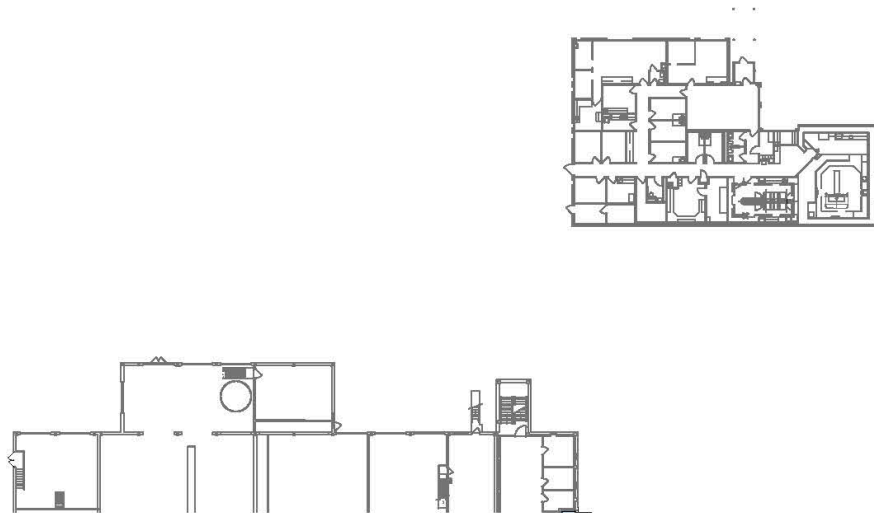
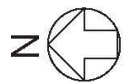
A201

CANCER CENTER
BASEMENT FLOOR PLAN
NO SCALE



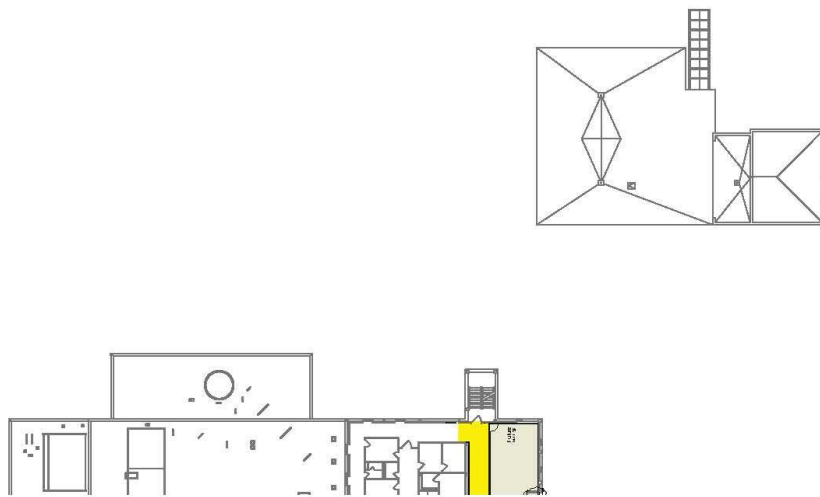
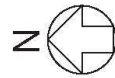
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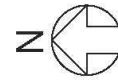
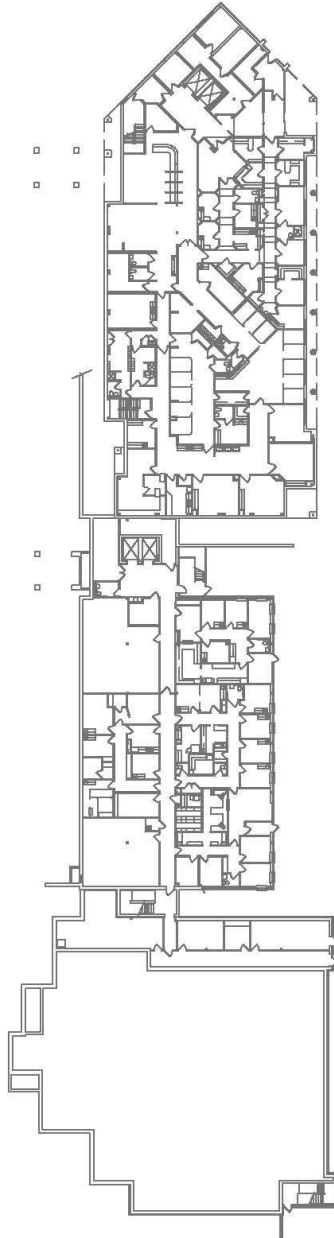
CANCER CENTER
GROUND FLOOR PLAN
NO SCALE



A203

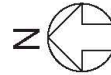
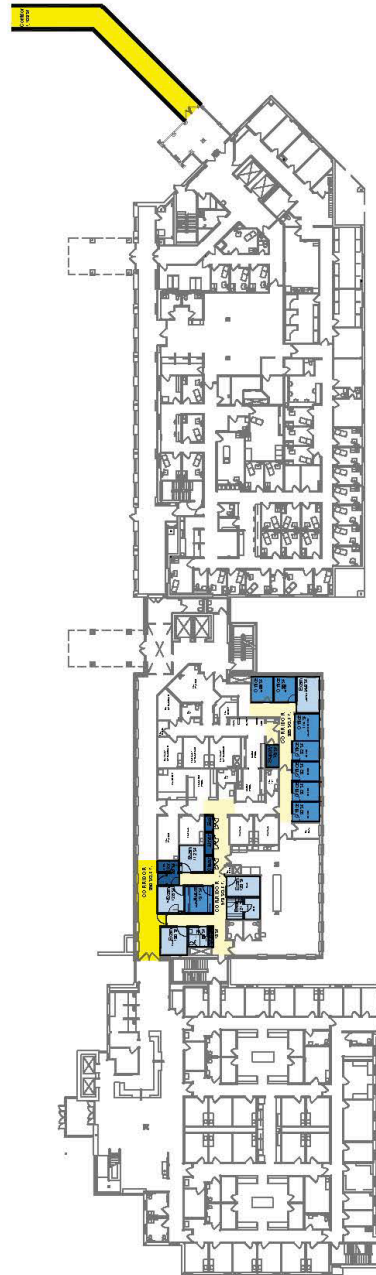
CANCER CENTER
FIRST FLOOR PLAN
NO SCALE





MEDICAL OFFICE BUILDINGS
GROUND FLOOR PLAN
NO SCALE

A302

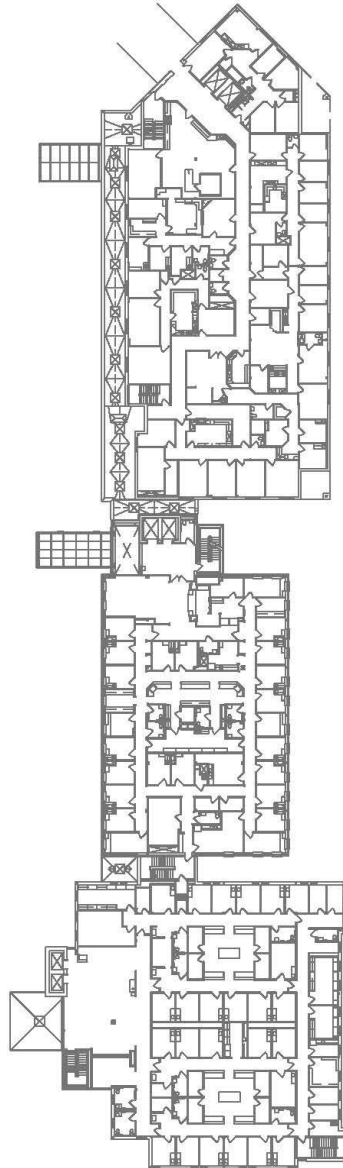
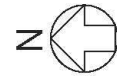


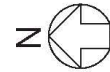
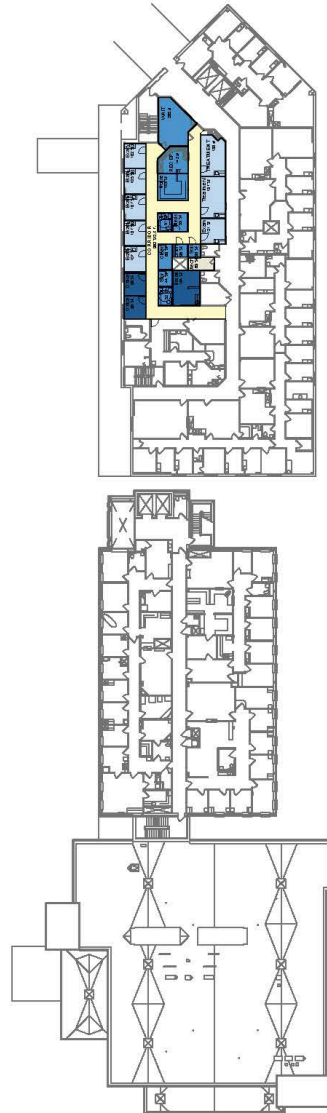
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FIRST FLOOR PLAN
NO SCALE

A303

A304

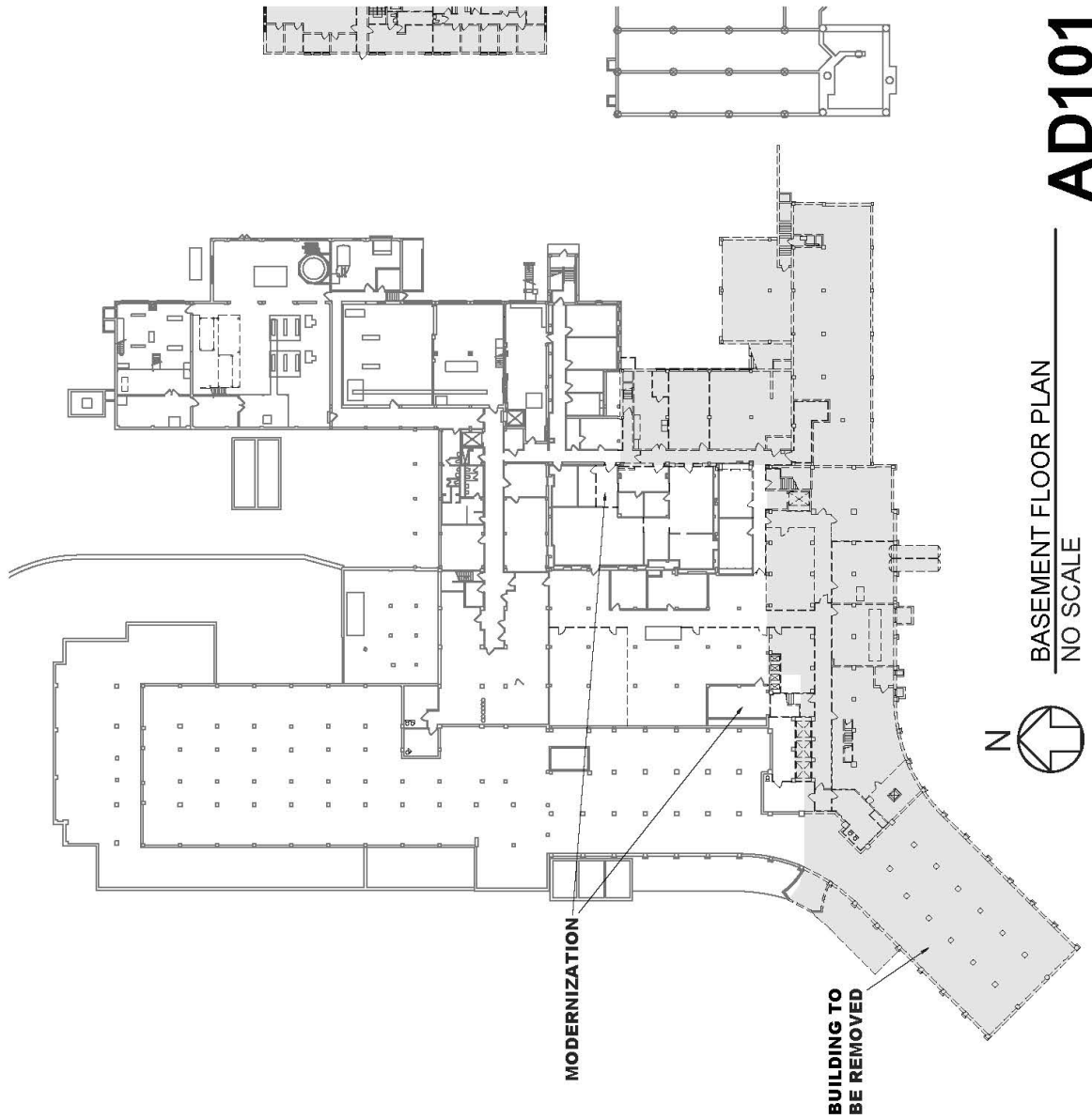
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SECOND FLOOR PLAN
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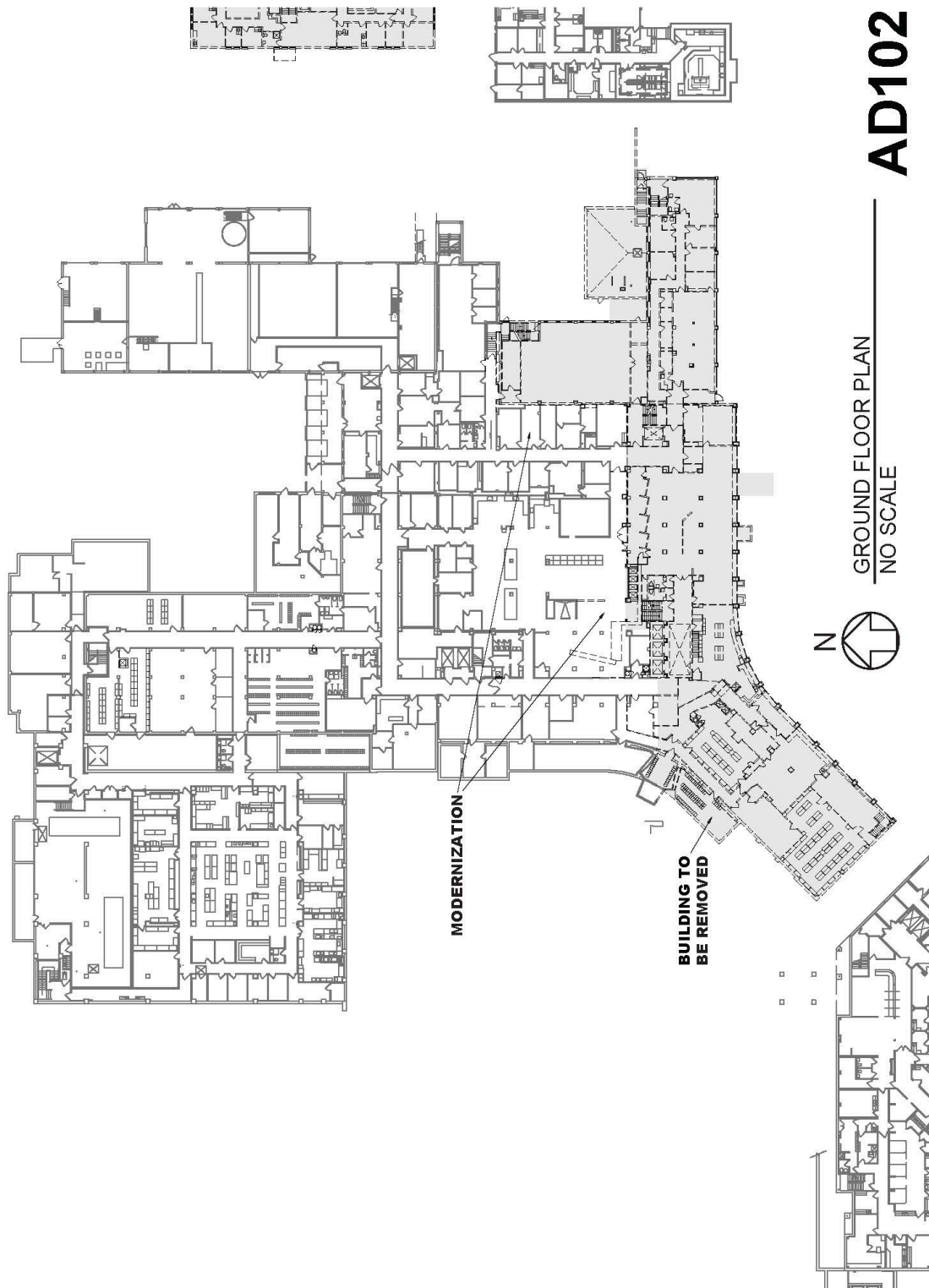
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THIRD FLOOR PLAN
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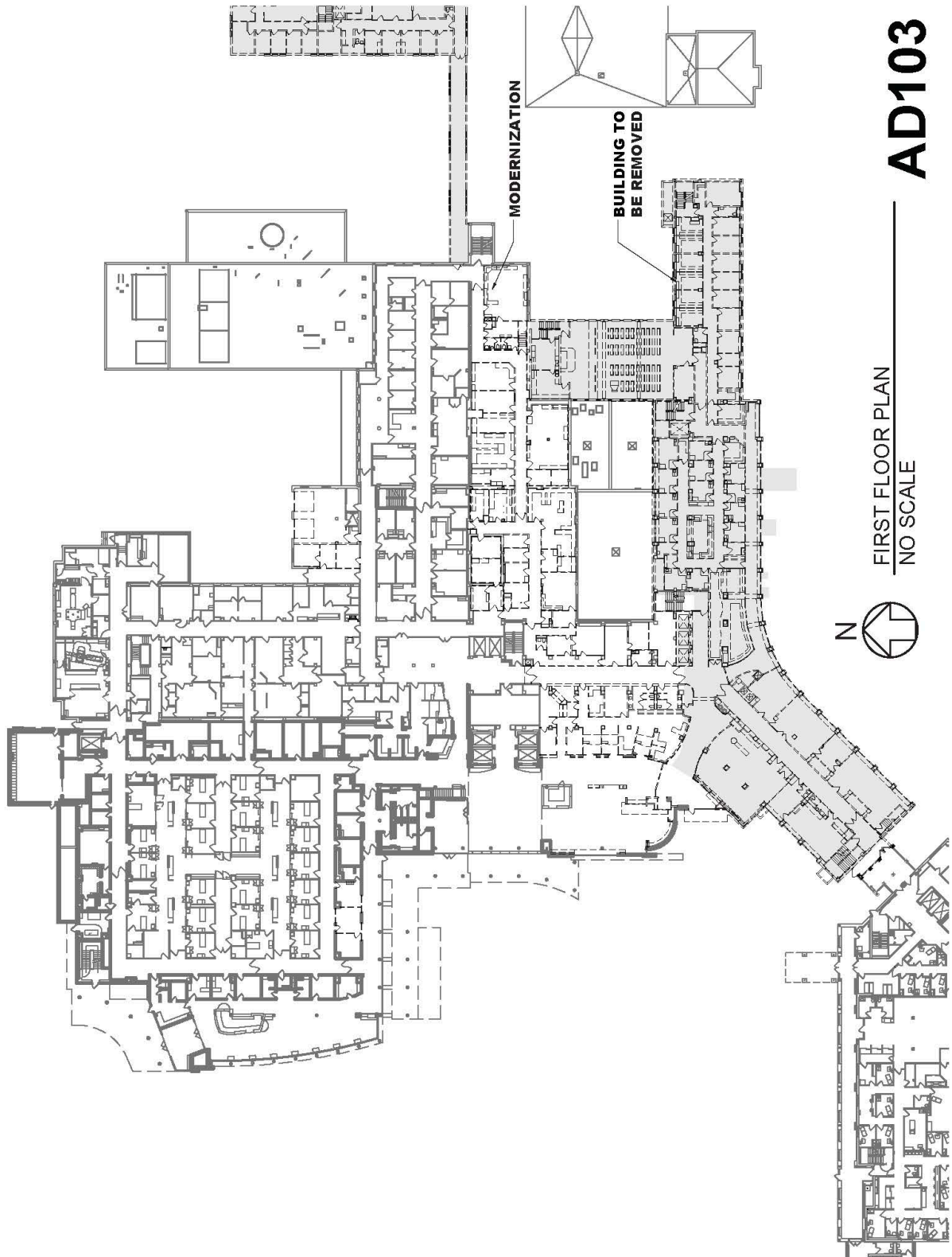
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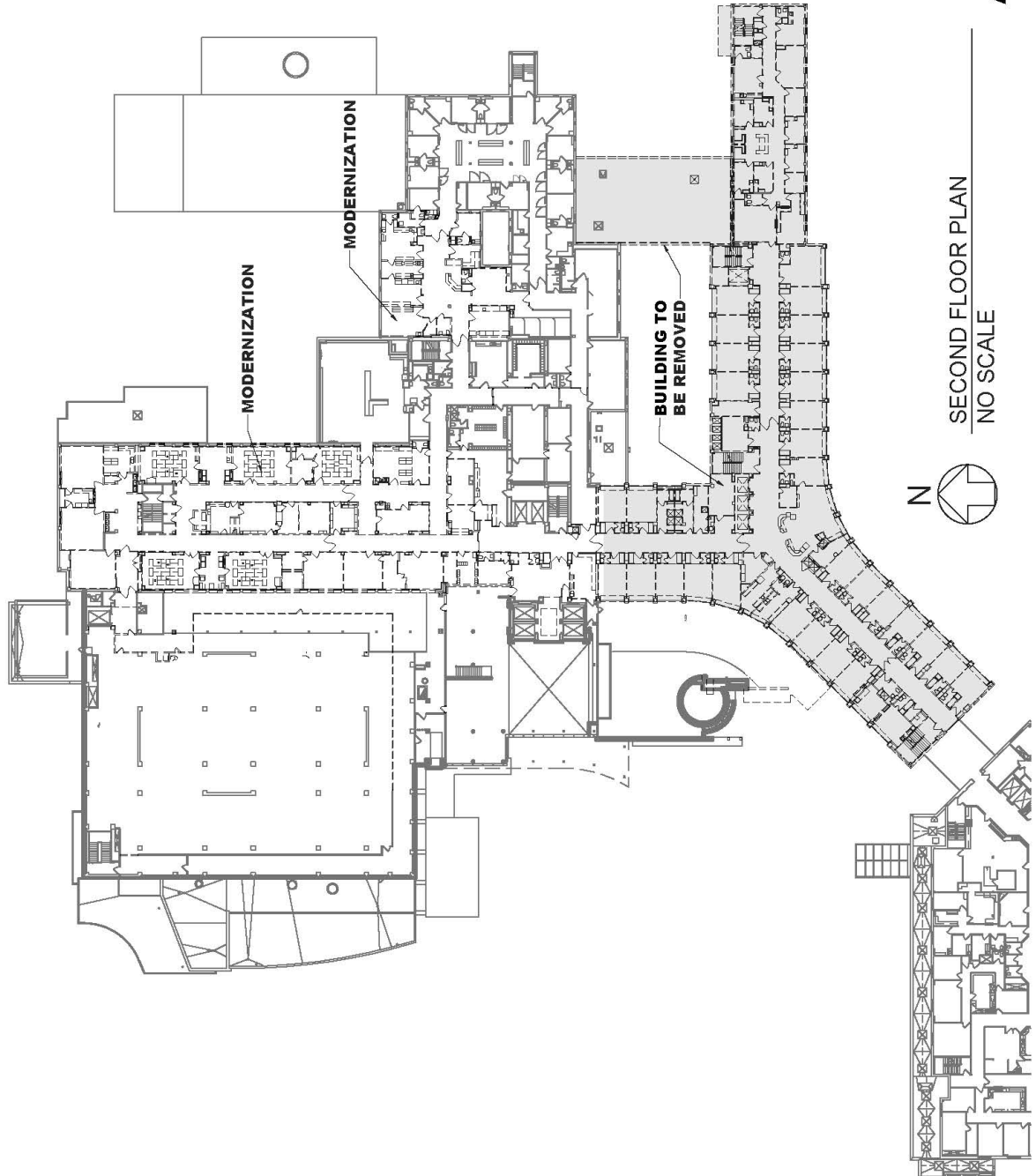
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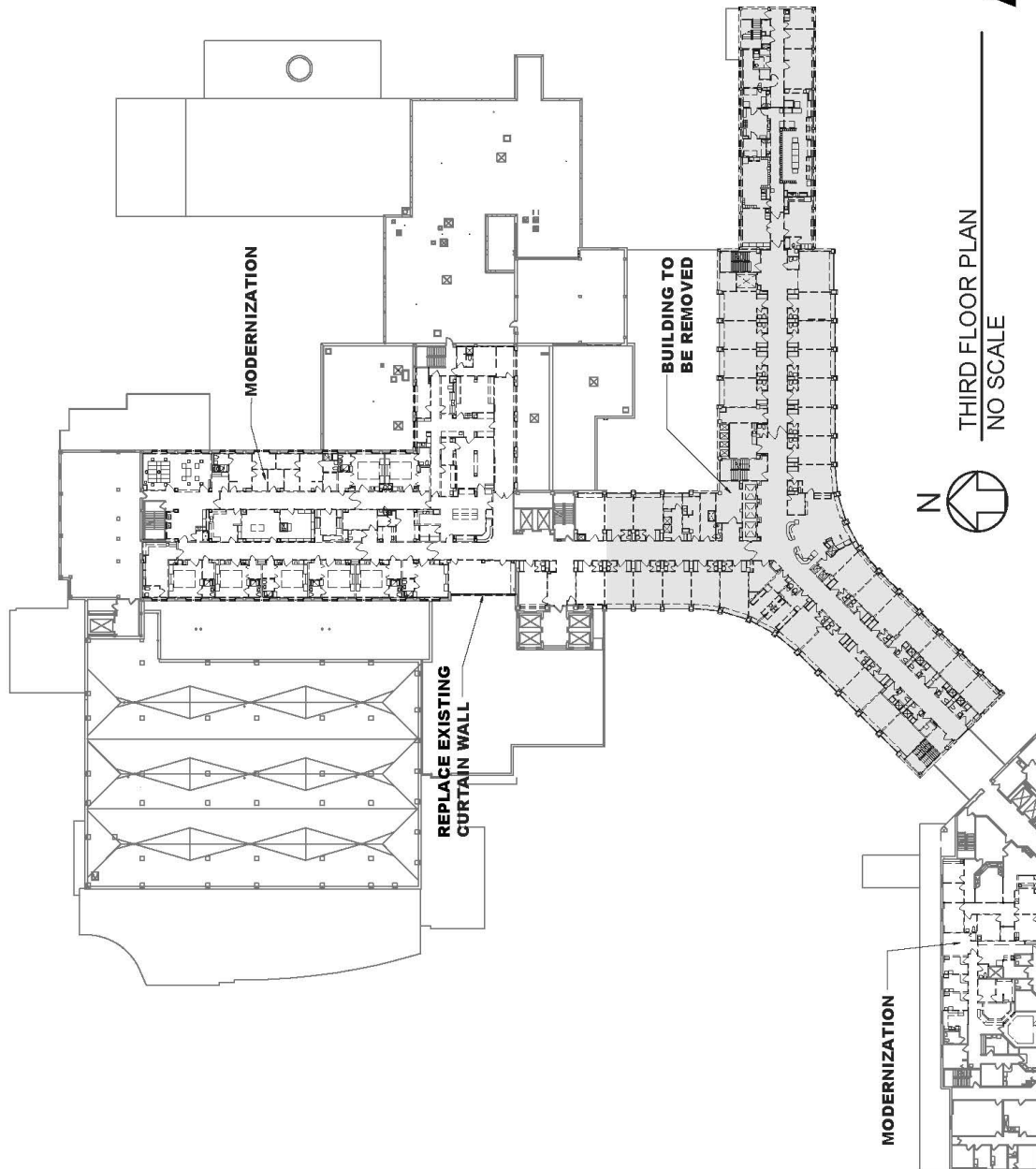
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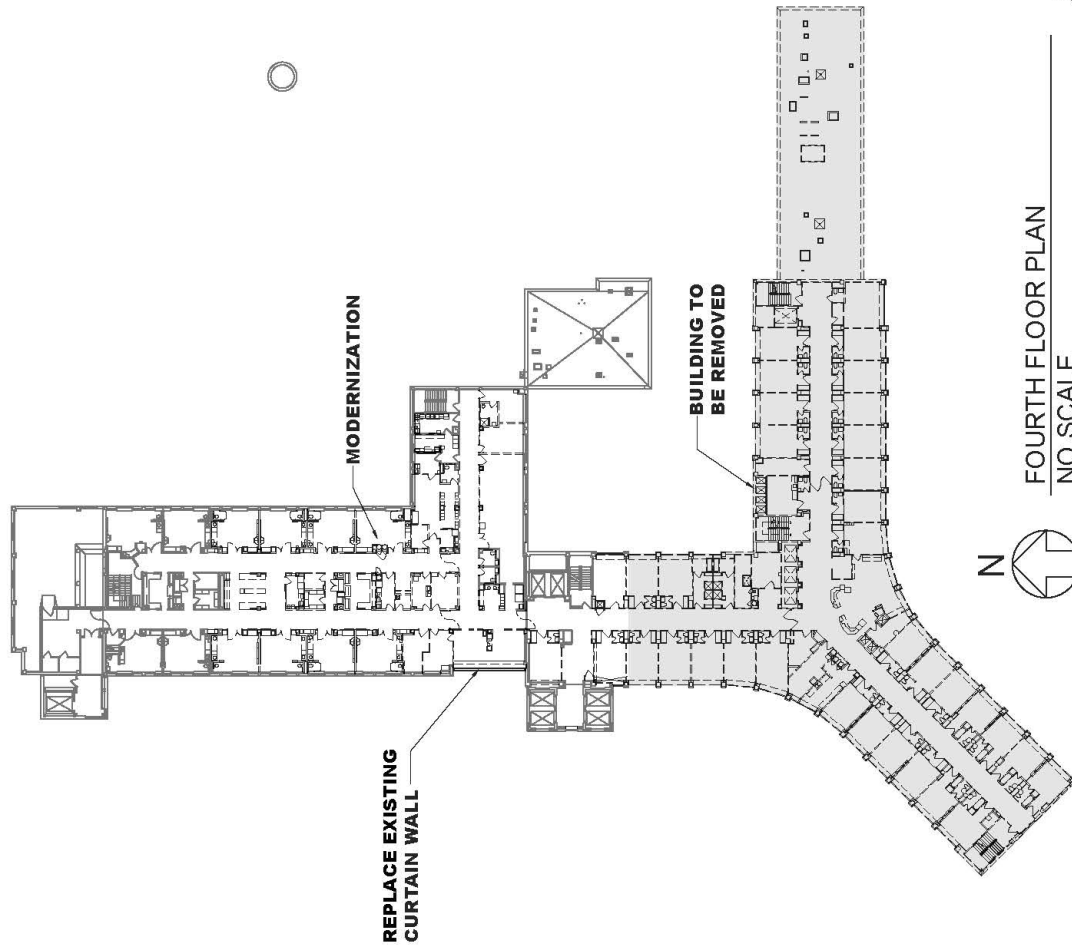
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AD105

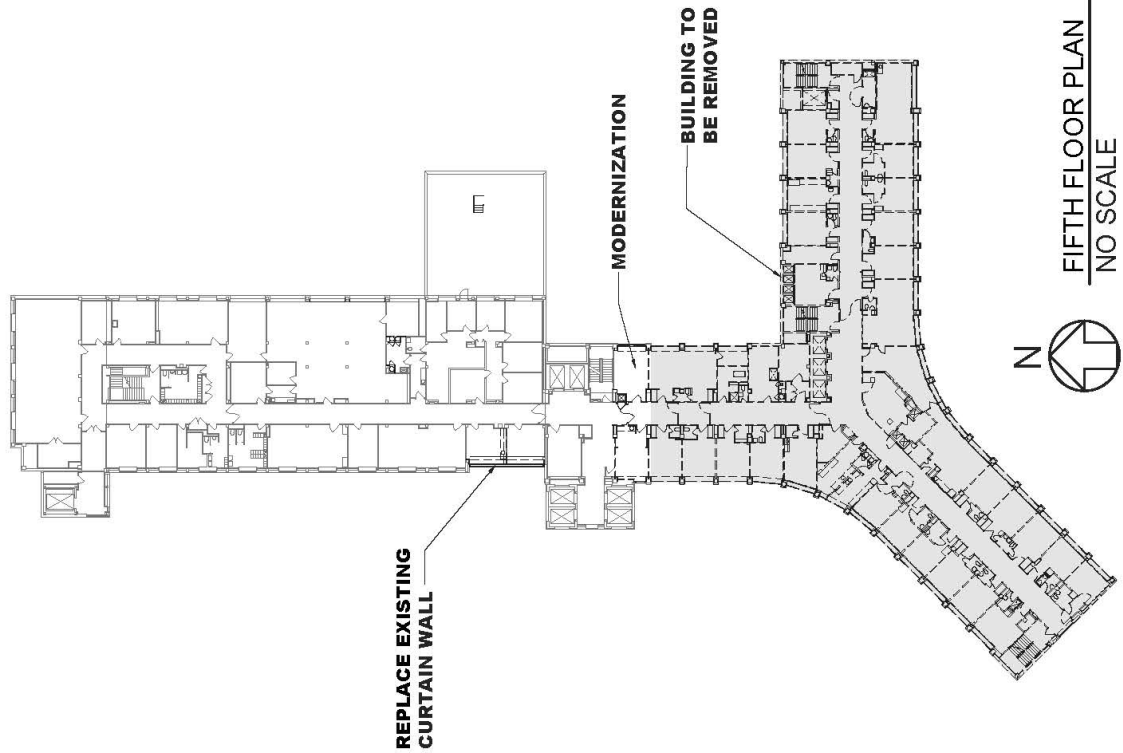
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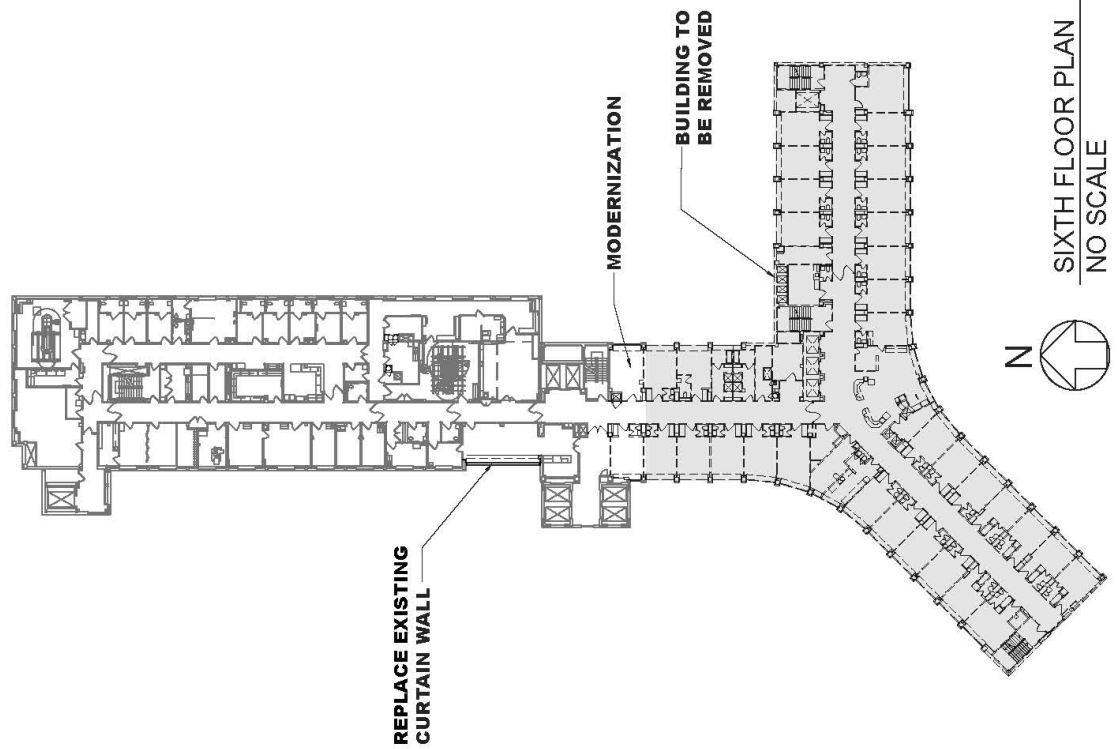
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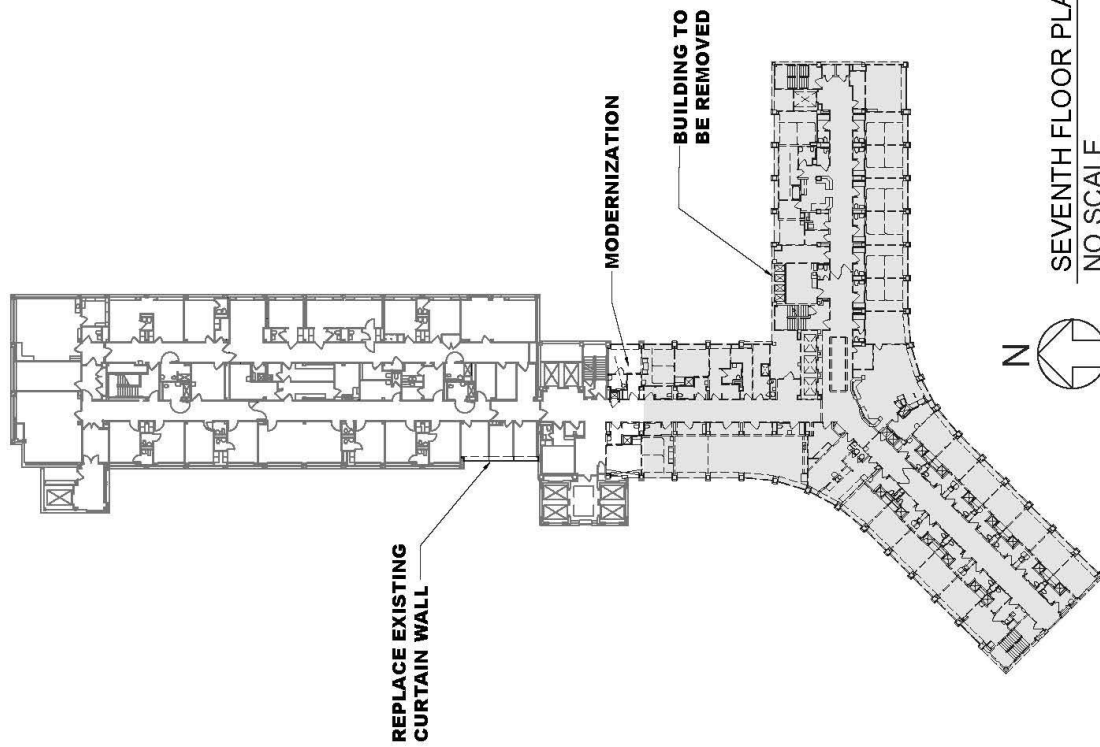
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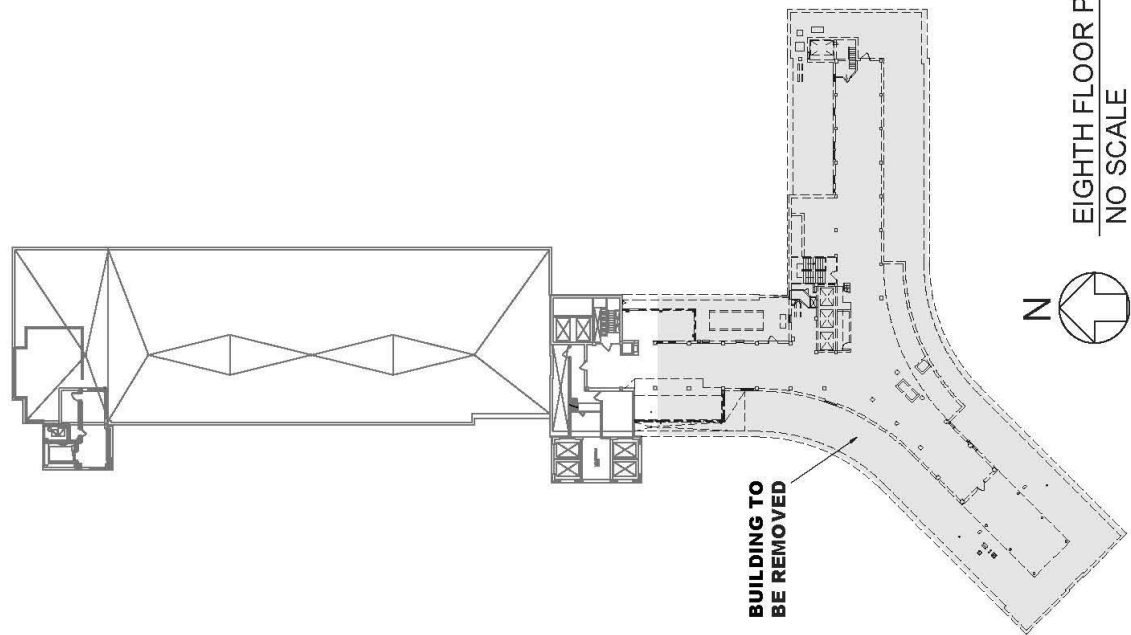
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AD108

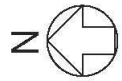


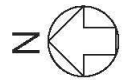
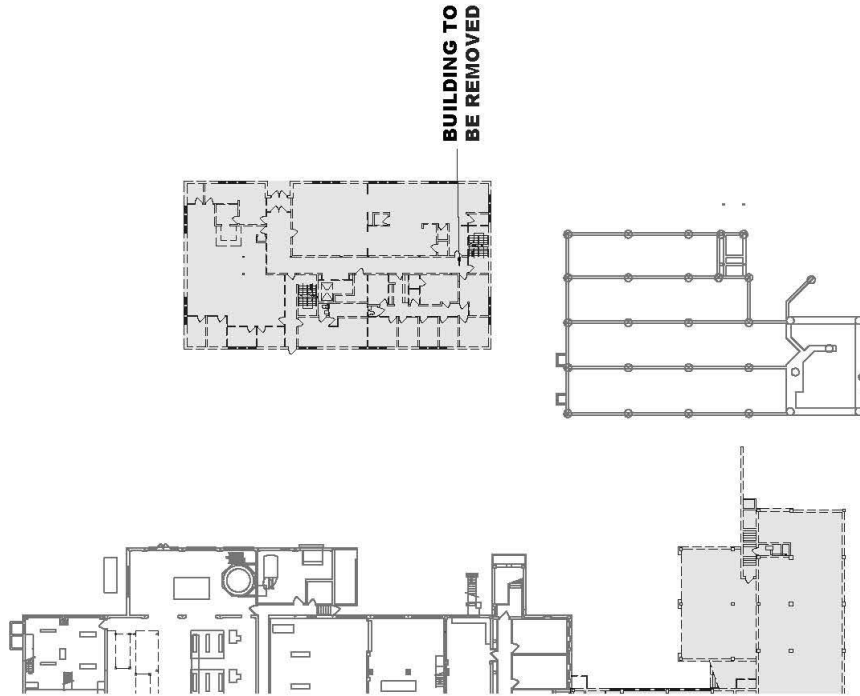




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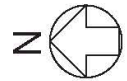
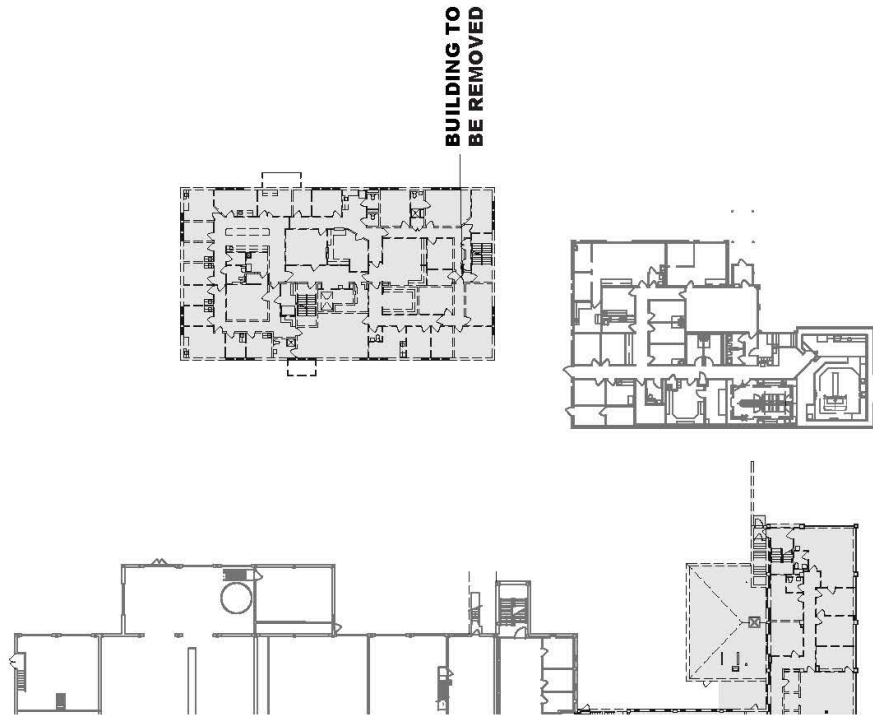
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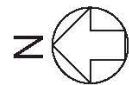
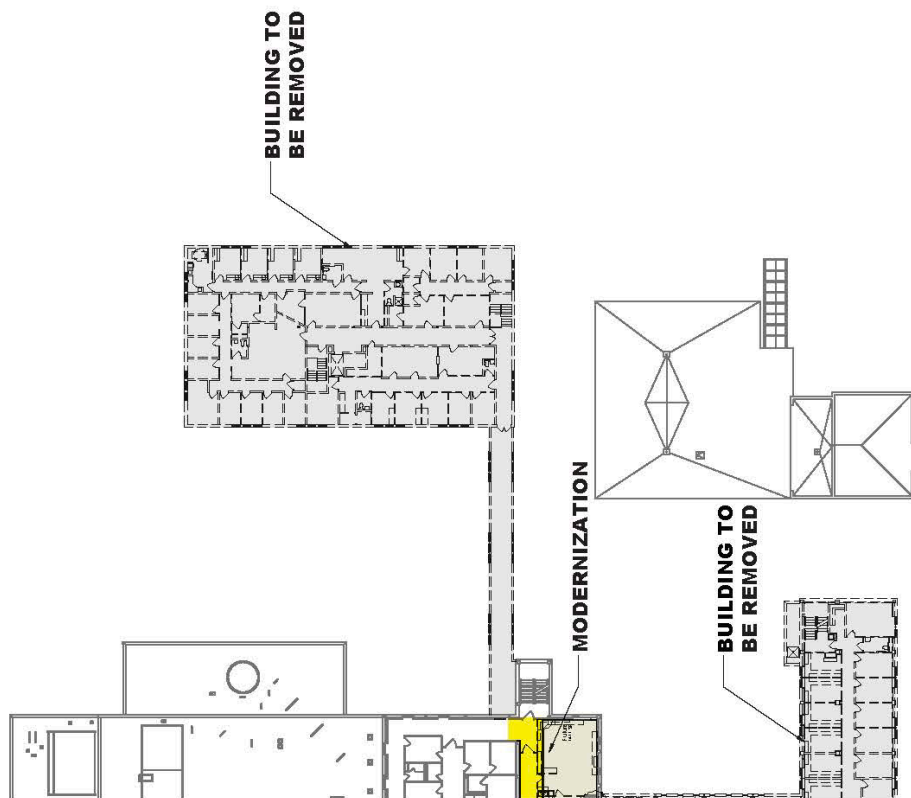
MEDICAL ARTS AND CANCER CENTER
BASEMENT FLOOR PLAN
NO SCALE

AD201



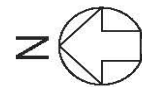
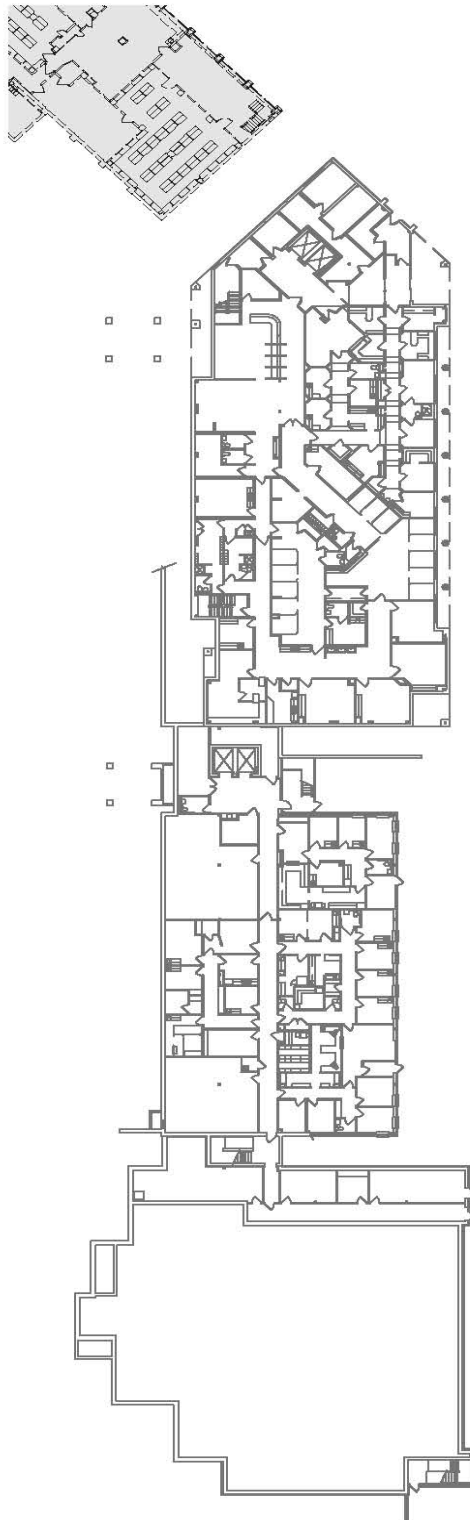
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GROUND FLOOR PLAN
NO SCALE

AD202



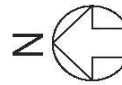
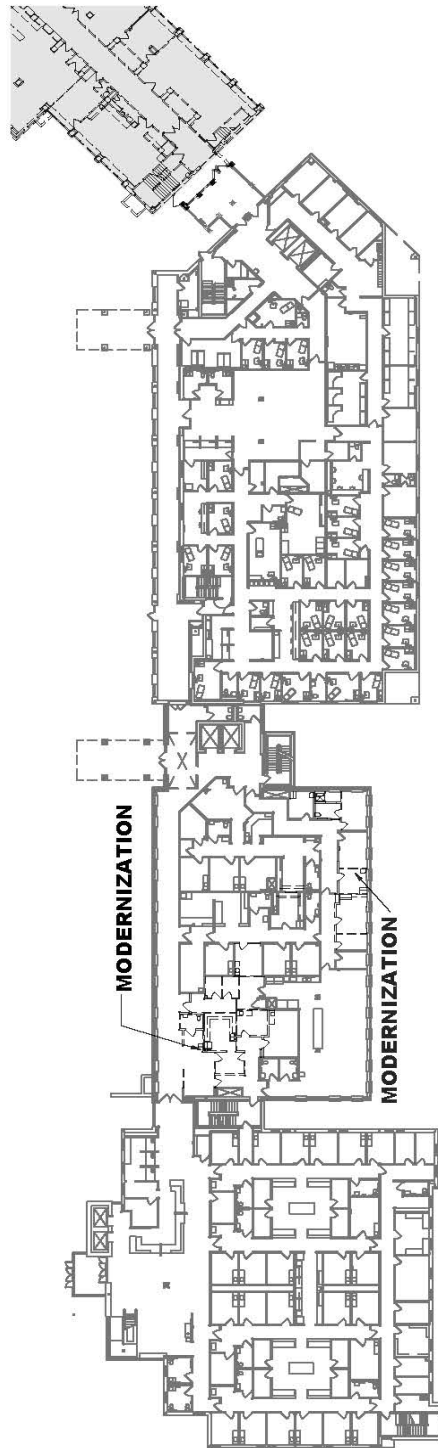
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FIRST FLOOR PLAN
NO SCALE

AD203



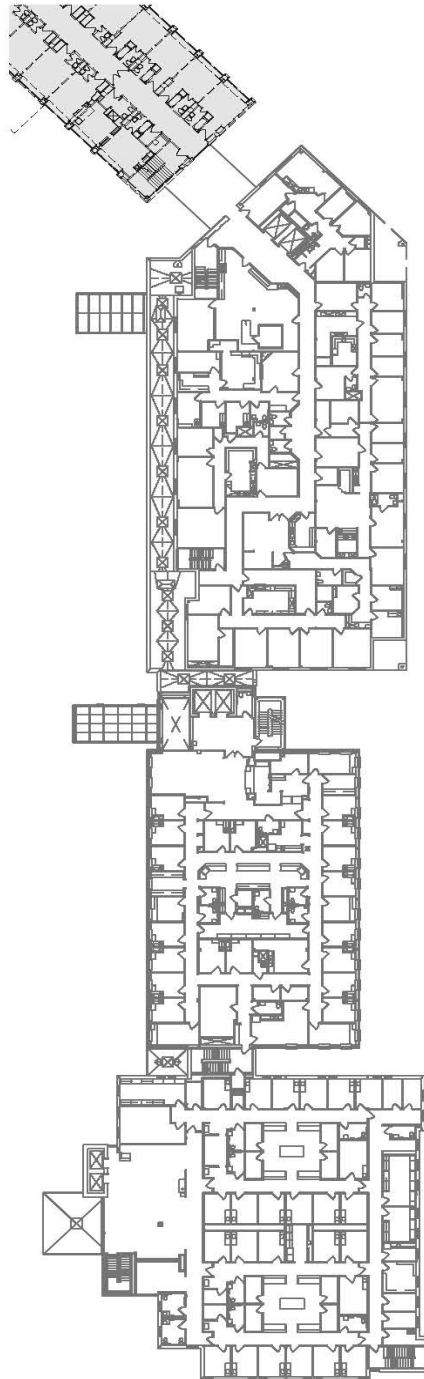
MEDICAL OFFICE BUILDINGS
GROUND FLOOR PLAN
NO SCALE

AD302



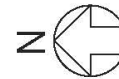
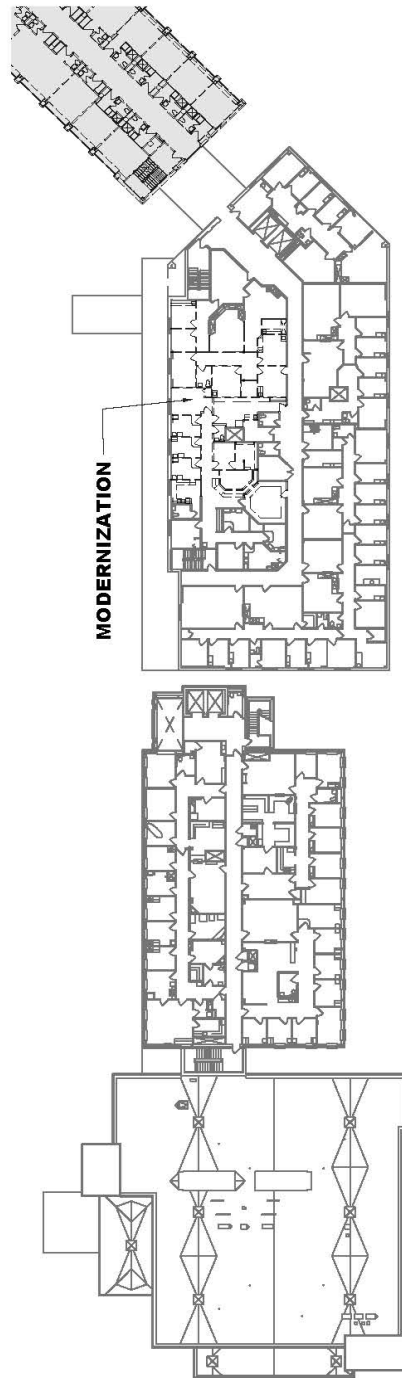
MEDICAL OFFICE BUILDINGS
FIRST FLOOR PLAN
NO SCALE

AD303



N
MEDICAL OFFICE BUILDINGS
SECOND FLOOR PLAN
NO SCALE

AD304



MEDICAL OFFICE BUILDINGS
THIRD FLOOR PLAN
NO SCALE

AD305

ATTACHMENT 13

Alternatives to the Project

This project is the result of an in-depth discernment process by Hospital Sisters Health System to maintain a financially viable facility in Decatur to provide quality healthcare services to the patients in the greater Macon County region in accordance with the guiding principles of Franciscan Ministry of the Hospital Sisters Health System.

The facility was faced with significant operating losses while at the same time needed capital improvements were required to modernize the hospital's aging infrastructure. In addition, underutilization was being driven by a combination of the trend away from inpatient care to outpatient combined with declining populations within St. Mary's service area. As a first step to address the financial losses, HSHS looked at which inpatient services could be maintained, and which should be discontinued. A number of services could no longer be continued due to financial losses, reduced patient volumes and loss of necessary staffing. Earlier this year, St. Mary's obtained approval from the Review Board to discontinue Obstetrics, Pediatrics, Comprehensive Physical Rehabilitation and Acute Mental Illness services. (Project #23-006) The current project addresses the needed capital improvements and modernization of the hospital.

The guiding principles were:

- a. **Community healthcare access:** Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community.
- b. **Poor and Vulnerable:** In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination
- c. **Stewardship and Sustainability:** A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.
- d. **Just treatment of colleagues:** A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being...

The following alternatives were considered during the discernment process:

1. **Proceed with capital improvements to existing facility without the discontinuation of services that were the subject of Project #23-006 and without any bed reduction.** This alternative was rejected because it would not have addressed the operating losses incurred by the underutilized services. In addition, St. Mary's could no longer maintain the services due to lack of staffing. Also, without a bed reduction, the modernization of the hospital would have been an

estimated \$200 million due in part to the need to replace exterior curtain wall of the building proposed to be demolished in this project. The cost of replacing the curtain wall alone was an estimated \$100 million, which is more than the proposed project cost of \$89 million. The alternative was rejected because of higher cost and it did not address the financial losses being incurred by service lines requiring discontinuation.

2. Proceed with capital improvements to the existing facility while maintaining some of the services discontinued in Project #23-006. This alternative was rejected because none of the discontinued services could be viably operated due to significant financial losses in each service line, underutilization and lack of staffing. In addition, modernization of the additional clinical space would have increased total project costs to \$110 to \$150 million. This alternative was rejected because of higher cost and failure to fully address operational losses being incurred by service lines requiring discontinuation

3. Build a replacement hospital in a new location. This alternative was rejected because the cost of a replacement hospital on a greenfield site was estimated between \$220 and \$281 million. This alternative was rejected because of higher costs.

ATTACHMENT 14**Size of the Project**

SIZE OF PROJECT						
Department/Service	#Key Rooms	Proposed DGSF	Propose DGSF/Room	STATE STANDARD (dgsf)	DIFFERENCE	MET STANDARD?
Medical Surgical	30	10,019	334	600	(-266)	Yes
ICU	6	1,810	302	685	(-383)	Yes
Surgery	4	2,544	636	2750	(-2,114)	Yes
Endoscopy Rooms	2	876	438	1100	(-662)	Yes
PACU Phase I	6	884	147	180	(-33)	Yes
Surgical Rec Phase II	20	2,998	150	400	(-250)	Yes
Emergency	21	23,390	1,114	900	+214	No

All of the above departments are below the State Standard with the exception of the Emergency Department. The Emergency Department is included in this project only because 521 gsf of the total 23,390 dgsf is being modernized. The modernization consists of having three existing offices converted to an open bay Behavioral Health patient holding space with area for up to five patients and a private bathroom.

ATTACHMENT 15**Project Service Utilization**

The projected utilization of services for which the Review Board has utilization standards is included in the table below.

UTILIZATION					
	DEPT./ SERVICE	PROJECTED PATIENT DAYS.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
2025	Med/Surg	8,641	79%	75%	Yes
2025	ICU	1,800	82%	60%	Yes

The above utilization rates are based on the reduced bed complement of 30 medical/surgical beds and 6 ICU beds. Approximately 18% of medical/surgical patient days are observation days and St. Mary's maintains six stations available for observation patients.

The projected patient days are lower than recent historical patients in both medical/surgical, which were 15,972 days and ICU which were 3,051 based on the 2020 Hospital Profile for St. Mary's. The historical numbers skewed higher, due in part to the pandemic and to a relatively high average length of stay. Utilization of inpatient services had been declining, and that decline is expected to resume. In addition, St. Mary's has been taking active measures to reduce its average length of stay.

ATTACHMENT 19**Specific Service: Medical Surgical and Intensive Care****Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care**

Category of Service	# Existing Beds	# Proposed Beds
☒ Medical/Surgical	88	30
☐ Obstetric		
☐ Pediatric		
☒ Intensive Care	14	6

1. Category of Service Modernization

The Medical/Surgical and ICU categories of service are being modernized. Both services are located in the main hospital building which was constructed in 1958. Due to declining inpatient volumes, the medical/surgical service has been highly underutilized. The medical/surgical occupancy rate in 2021 was 45.9% and is expected to decline further. In addition, some of the medical/surgical beds are in a portion of the building which also housed discontinued services, including Obstetrics, Comprehensive Rehabilitation, Pediatrics and Acute Mental Illness, so that there is now extensive unused space in the building. Furthermore, the outer curtainwall on that section of the building is in need of replacement. That portion of the building, identified as Unit B in the description of the project in Attachment 12 will be demolished as part of this project. Existing medical/surgical rooms are outdated and do not have private showers. This will be addressed in the project.

The hospital has not been cited by IDPH or JCAHO in connection with the current state of the facility. However, to meet anticipated fire safety measures, the fire protection system will be upgraded by the project.

2. Occupancy

With the reduced bed count for medical/surgical and ICU, occupancy standards will be met based on historical and expected patient volumes. The 2020 Hospital Profile shows that St. Mary's had a total of 15,282 medical/surgical patient days, including observation, and 3,051 ICU patient days. Based on the reduced bed count of 30 medical/surgical beds and 6 ICU beds, the historical patient days would create occupancy rates of over 100% for both services, compared to target occupancy rates of 75% for medical/surgical and 60% for ICU. St. Mary's does expect patient days to remain on the 2020 levels and that they will decline significantly by the time this project is completed. As noted in Attachment 15, the historical numbers skewed higher due in part to the pandemic and to a relatively high average length of stay. Utilization of inpatient services had been declining, and that decline is expected to resume. In addition, St. Mary's has been taking active measures to reduce its average length of stay.

1110.200(d)(4) Occupancy: Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

3. Performance Requirements

There is not a minimum bed capacity requirement for existing medical/surgical units. The minimum size unit for ICU is four beds, and that requirement is satisfied as the proposed project will have six ICU beds.

ATTACHMENT 31**Clinical Service Areas Other than Categories of Service****1. Indicate changes by Service:**

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Operating Rooms	8	4
☒ Stage 1 Recovery Stations	8	6
☒ Stage 2 Recovery Stations	4	20

2. Service Modernization:**a. Deteriorated Facilities**

The surgery department is located in the main hospital building which was constructed in 1958. The hospital has not been cited by IDPH or JCAHO in connection with the current state of the facility. However, to meet anticipated fire safety measures, the fire protection system will be upgraded by the project.

b. Service Utilization: The number of key rooms proposed in a replacement or modernization project shall be justified by the historical utilization for each of the latest 2 years, per utilization standards cited in Appendix B

The project includes a reduction of Operating Rooms from 8 to 4. Historical utilization shows that the four Operating Rooms are justified based on the utilization standard in Appendix B of Section 1100 of 1500 hours/room :

	2019	2020
Total Hours	5,699	4,919
ORs Justified	3.8	3.3

Source: 2019 and 2020 Hospital Profiles

There are no state utilization standards for recovery stations.

ATTACHMENT 34**Availability of Funds**

Section 1120.120, Availability of Funds – Review Criteria is not applicable as the Hospital Sisters Health System has an A+ rating from Fitch. Documentation of the Fitch rating is attached. The most recent audited financial statement of the consolidated Hospital Sisters Health System is also attached.

The Hospital Sisters Health System has cash and securities available to fund the project costs of \$89 million. As indicated on page 3 of the attached audited financial statement, the Hospital Sisters has over \$1.67 billion in assets whose use is limited or restricted, and these assets are available for capital projects.

Depending on bond market conditions and pricing in 2024, the applicants may opt to fund all or a portion of the project through a bond issuance. If that were to occur, the applicants would provide the Review Board with required notice of the change, and in no event would the project costs be above the approved permit amount as a result of the change in financing.

**RATING ACTION COMMENTARY****Fitch Revises Hospital Sisters Services, Inc. (IL)'s Outlook to Stable; Affirms IDR at 'A+'**

Tue 07 Mar, 2023 - 9:59 AM ET

Fitch Ratings - Austin - 07 Mar 2023: Fitch Ratings has affirmed Hospital Sisters Services, Inc.'s (d/b/a Hospital Sisters Health System, HSHS) 'A+' Issuer Default Rating (IDR) and the 'A+' ratings assigned to revenue bonds issued by the Illinois Finance Authority, Southwestern Illinois Development Authority, and Wisconsin Health & Educational Facilities Authority on behalf of HSHS.

Fitch has also affirmed the 'F1+' Short-Term rating on HSHS' variable rate debt supported by self-liquidity.

The Rating Outlook has been revised to Stable from Positive.

RATING ACTIONS**ENTITY / DEBT** ⚡**RATING** ⚡**PRIOR** ⚡

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Hospital Sisters Services Inc. (IL)
/General Revenues/1 LT

LT A+ Rating Outlook Stable Affirmed

A+ Rating Outlook
Positive

[VIEW ADDITIONAL RATING DETAILS](#)

SECURITY

The bonds are a joint and several liability of each member of the obligated group. The obligated group represents all fully owned hospitals and comprised the vast majority of system total assets and total operating revenue.

ANALYTICAL CONCLUSION

The 'A+' IDR is based on HSHS' strong financial profile assessment in the context of the system's midrange revenue defensibility and midrange operating risk profile assessments. The system enjoys a diverse revenue base with 15 hospitals in multiple markets over two states.

The Stable Rating Outlook considers that as HSHS continues to execute on strategies, which it believes will help it rebound from the pressures of rising labor and supply costs, its operational metrics should improve over time. Fitch expects that over time the system should return to profitable operations and an operating EBITDA margin at in the 6%-7% range. In addition, Fitch believes capital-related ratios should improve. Fitch notes that even in a stress case of the forward-looking scenario analysis, net adjusted debt-to-adjusted EBITDA and cash-to-adjusted debt are reasonably consistent with a 'aa' financial profile.

HSHS' Short-Term rating based on self-liquidity is 'F1+'. Per Fitch's criteria, an 'A+' IDR maps to an 'F1' Short-Term rating. HSHS' 'F1+' Short-Term rating also considers the systems robust coverage of demand debt supported by internal liquidity.

KEY RATING DRIVERS

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HSHS has broad market reach across multiple markets in Illinois and Wisconsin. While the system is the market leader in certain key markets, the system faces competition in many core areas such as Springfield (Memorial Health) and Green Bay (Advocate Aurora Health and Bellin Health).

As a diversified system operating in multiple markets, HSHS' service area quality is mixed, although generally stable, despite ongoing pressure from macro trends such as labor and inflation. The system's combined Medicaid and self-pay remains below Fitch's 25% threshold for a midrange assessment.

Operating Risk: 'bbb'

Operating Margins Challenged but Improving

Operating margins have been challenged over the past 18 months after HSHS posted a solid operating margin of 4.0% in fiscal 2021. HSHS operations have been affected by the economic headwinds that face the industry as a whole. Management noted that as its mitigation strategies are being executed, the system has seen the operational loss improve from a negative 9.5% for the first quarter of fiscal 2023 to a negative 2.6% for the second quarter of fiscal 2023. The system has continued to see growth of utilization, which has helped with the improved operations, but noted that the system has seen length of stay rise as patient throughput issues driven by the larger labor challenges which are affecting the industry. Fitch believes that as HSHS executes its strategies, it will be successful in addressing the challenges it faces such as patient throughput and labor challenges as HSHS strives to get back to breakeven results and then further improvement.

Capital spending plans are manageable in the coming years. Management has planned \$100 million of capital spending in fiscal 2023. HSHS scaled back its capital spending for fiscal 2023 as it focuses on strategies to improve operations. Looking forward, HSHS will flex its capital spending based on the improvement of cash flow to support a higher level of spend. While not fully defined, HSHS may issue debt within the next 24 months to support future capital needs. Fitch believes that HSHS has

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Strong Capital-Related Ratios in Forward-Looking Scenario Analysis Including Potential Debt Issuance

HSHS' capital-related metrics should remain consistent, even with a potential debt issuance in the next 24 months for future capital plans that are not fully defined, with a strong financial profile in Fitch's forward-looking scenario analysis, including in the stress case.

At mid-year fiscal 2023 (ended December 31), the system had just over \$750 million of debt and unrestricted cash, and investments measured more than \$1.3 billion (HSHS had repaid all Medicare advance payments as of Dec. 31, 2022). HSHS' defined benefit (DB) pension plan was 100% funded at FYE 2022 (relative to a projected benefit obligation of nearly \$2.6 billion). Because Fitch's calculation of adjusted debt includes only the portion of a DB plan below an 80% funded level, HSHS' adjusted debt is equivalent to its direct debt. Therefore, at FYE 2022, net adjusted debt was favorably negative.

Based on fiscal 2022 results, HSHS' net adjusted debt-to-adjusted EBITDA was favorably negative at -3.4x and cash-to-adjusted debt was approximately 180%. In the stress case of Fitch's forward-looking scenario analysis, net adjusted debt-to-adjusted EBITDA is favorably negative by year two and cash-to-adjusted debt is nearly 170% by year four.

Asymmetric Additional Risk Considerations

There are no asymmetric risk factors associated with HSHS' rating.

RATING SENSITIVITIES

Factors that could, individually or collectively, lead to negative rating action/downgrade:

--Reversion to weaker operating metrics, particularly if the operating EBITDA margin is expected to be sustained below 6%;

--Reversion to weaker operating metrics, particularly if the operating EBITDA margin is expected to be sustained below 6%;

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--Stabilization of operations such that the operating EBITDA is sustained at least in the 6%-7% range;

--Maintenance of cash-to-adjusted debt above 200%, even in a stress case scenario.

BEST/WORST CASE RATING SCENARIO

International scale credit ratings of Sovereigns, Public Finance and Infrastructure issuers have a best-case rating upgrade scenario (defined as the 99th percentile of rating transitions, measured in a positive direction) of three notches over a three-year rating horizon; and a worst-case rating downgrade scenario (defined as the 99th percentile of rating transitions, measured in a negative direction) of three notches over three years. The complete span of best- and worst-case scenario credit ratings for all rating categories ranges from 'AAA' to 'D'. Best- and worst-case scenario credit ratings are based on historical performance. For more information about the methodology used to determine sector-specific best- and worst-case scenario credit ratings, visit <https://www.fitchratings.com/site/re/10111579>.

CREDIT PROFILE

HSHS is comprised of 15 owned inpatient hospitals and a joint venture partnership hospital (Door County Medical Center). HSHS operates two divisions: Illinois (centered on Springfield, Decatur, and O'Fallon in metro east St. Louis) and Wisconsin (centered on Green Bay, Sheboygan, and Eau Claire and Chippewa Falls). In addition to hospital operations, HSHS has well over 1,000 fully aligned physicians and a physician clinical integration network (PCIN) with well over 2,000 providers, outpatient clinic facilities in multiple locations throughout Illinois and Wisconsin, and the Prevea Health managed care health plan in Wisconsin. Total operating revenue approached \$2.9 billion in audited fiscal 2022.

In addition to the sources of information identified in Fitch's applicable criteria specified below, this action was informed by information from Lumesis.

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Unless otherwise disclosed in this section, the highest level of ESG credit relevance is a score of '3'. This means ESG issues are credit-neutral or have only a minimal credit impact on the entity, either due to their nature or the way in which they are being managed by the entity. For more information on Fitch's ESG Relevance Scores, visit www.fitchratings.com/esg.

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Additional information is available on www.fitchratings.com

PARTICIPATION STATUS

The rated entity (and/or its agents) or, in the case of structured finance, one or more of the transaction parties participated in the rating process except that the following issuer(s), if any, did not participate in the rating process, or provide additional information, beyond the issuer's available public disclosure.

APPLICABLE CRITERIA

[U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria \(pub. 18 Nov 2020\) \(including rating assumption sensitivity\)](#)
[Public Sector, Revenue-Supported Entities Rating Criteria – Effective from September 1, 2021 to April 27, 2023 \(pub. 01 Sep 2021\) \(including rating assumption sensitivity\)](#)

APPLICABLE MODELS

Numbers in parentheses accompanying applicable model(s) contain hyperlinks to criteria providing description of model(s).

Portfolio Analysis Model (PAM), v2.0.0 (1)

ADDITIONAL DISCLOSURES

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[Dodd-Frank Rating Information Disclosure Form](#)

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Southwestern Illinois Development Authority (IL)

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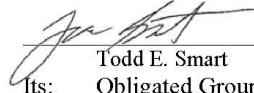
- (xi) Updated asset allocation table provided under the heading "SELECTED OPERATIONAL, STATISTICAL AND FINANCIAL INFORMATION - Investment Policy";

The information provided in the attached Exhibit B is true and correct as of the date of this Annual Report.

IN WITNESS WHEREOF the undersigned has executed and delivered the Annual Report to the Dissemination Agent, for distribution for the benefit of Holders of the Bonds, all as of this 25th day of October, 2022.

HOSPITALSISTERS SERVICES, INC.

By:



Todd E. Smart

Its: Obligated Group Agent

Hospital Sisters Services, Inc.

This report is delivered in satisfaction of the obligations created by the Disclosure Agreement dated February 8, 2017 (the "Master Agreement") and, executed and delivered by Hospital Sisters Services, Inc. (the "Corporation") in connection with the issuance of the Bonds listed on Exhibit C. Terms used herein and not otherwise defined shall have the meanings ascribed thereto in the Disclosure Agreement.

Section 2 of the Disclosure Certificate requires the Corporation to provide an Annual Report which updates certain information which was originally provided in its Official Statement dated January 18, 2017 (the "Official Statement") relating to the issuance of the Bonds.

FINANCIAL INFORMATION

Attached to this Annual Report as EXHIBIT A are the audited consolidated financial statements of the Corporation for the fiscal years ended 2021 and 2022 which have been prepared in accordance with generally accepted accounting principles as promulgated from time to time by the Financial Accounting Standards Board, and have been audited by the accounting firm, KPMG, LLP.

INFORMATION REGARDING THE CORPORATION AND RESULTS FROM OPERATIONS

Attached to this Annual Report as EXHIBIT B is the following information, substantially similar in form and scope to the financial information and operating data originally set forth in Appendix A to the Official Statement under the captions

- (i) List of Obligated Group
- (ii) List of Affiliates of the Corporation
- (iii) Total licensed and staffed beds of Obligated Group
- (iv) Updated tables provided under the heading "SELECTED OPERATIONAL, STATISTICAL, AND FINANCIAL INFORMATION – Condensed Consolidated Balance Sheet of Hospital Sisters Health System";
- (v) Updated table provided under the heading "SELECTED OPERATIONAL, STATISTICAL, AND FINANCIAL INFORMATION – Consolidated Summary Statements of Operations of Hospital Sisters Health System";
- (vi) Updated table provided under the heading "SELECTED OPERATIONAL, STATISTICAL AND FINANCIAL INFORMATION – Obligated Group Relative to HSHS";
- (vii) Updated Income Available for Debt Service table provided under the heading "SELECTED OPERATIONAL, STATISTICAL AND FINANCIAL INFORMATION – Coverage of Historical and Pro Forma Historical Maximum Annual Debt Service" (Historical Maximum Annual only) for the most recent fiscal year;
- (viii) Updated information provided under the heading "SELECTED OPERATIONAL, STATISTICAL, AND FINANCIAL INFORMATION – Outstanding Indebtedness of the Obligated Group;
- (ix) Updated table provided under the heading "SELECTED OPERATIONAL, STATISTICAL AND FINANCIAL INFORMATION – Historical and Pro Forma Capitalization" (Historical Only);
- (x) Updated table provided under the heading "SELECTED OPERATIONAL, STATISTICAL, AND FINANCIAL INFORMATION – Liquidity and Investments";

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*An Affiliate of
Hospital Sisters
Health System*

**HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES**

Springfield, Illinois

Consolidated Financial Statements and Supplementary Information

June 30, 2022 and 2021

(With Independent Auditors' Report Thereon)



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

Independent Auditors' Report

The Board of Directors
Hospital Sisters Health System:

Report on the Audit of the Consolidated Financial Statements

Opinion

We have audited the consolidated financial statements of Hospital Sisters Health System and its subsidiaries (the System), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and changes in net assets without donor restriction, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the System as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

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 Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the System 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 Consolidated Financial Statements

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

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

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' 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 consolidated financial statements.

KPMG LLP, a Delaware limited liability partnership and a member firm of the KPMG global organization of independent member firms affiliated with KPMG International Limited, a private English company limited by guarantee.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES
Springfield, Illinois

Consolidated Balance Sheets

June 30, 2022 and 2021

(Dollars in thousands)

Assets	2022	2021
Current assets:		
Cash and cash equivalents	\$ 91,035	100,879
Receivables:		
Patients' accounts	350,826	363,378
Due from third-party reimbursement programs	—	1,654
Other	<u>37,304</u>	<u>35,428</u>
Total receivables	388,130	400,460
Current portion of assets whose use is limited or restricted	132,798	205,084
Inventories and supplies	69,168	63,033
Prepaid expenses	<u>31,479</u>	<u>30,676</u>
Total current assets	712,610	800,132
Assets whose use is limited or restricted, net of current portion	1,673,615	2,020,139
Property, plant, and equipment, net	1,596,523	1,610,574
Right-of-use assets – operating leases, net	148,459	166,369
Accrued pension benefit asset	48,347	—
Other assets	<u>89,627</u>	<u>90,137</u>
	\$ <u>4,269,181</u>	<u>4,687,351</u>
Liabilities and Net Assets		
Current liabilities:		
Current installments of long-term debt	\$ 35,506	35,142
Long-term debt subject to short-term remarketing agreements	64,870	64,870
Current portion of operating lease liabilities	22,328	23,135
Current portion of estimated self-insurance liabilities	73,106	76,903
Accounts payable	144,522	131,440
Accrued liabilities	283,630	358,369
Estimated payables under third-party reimbursement programs	<u>87,770</u>	<u>107,544</u>
Total current liabilities	711,732	797,403
Long-term debt, excluding current installments	544,239	578,430
Operating lease liabilities, net of current portion	129,266	145,493
Estimated self-insurance liabilities	92,186	103,817
Derivative instruments	30,328	50,521
Accrued pension benefit liability	—	1,256
Other noncurrent liabilities	<u>38,854</u>	<u>154,555</u>
Total liabilities	<u>1,546,605</u>	<u>1,831,475</u>
Net assets:		
Net assets without donor restrictions	2,649,047	2,781,383
Net assets with donor restrictions	<u>73,529</u>	<u>74,493</u>
Total net assets	<u>2,722,576</u>	<u>2,855,876</u>
	\$ <u>4,269,181</u>	<u>4,687,351</u>

See accompanying notes to consolidated financial statements.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Consolidated Statements of Operations and Changes in Net Assets without Donor Restriction

Years ended June 30, 2022 and 2021

(Dollars in thousands)

	<u>2022</u>	<u>2021</u>
Patient service revenue	\$ 2,719,320	2,571,809
Other revenues:		
Investment return	(3,622)	4,530
Net assets released from restrictions used for operations	2,694	2,339
Other	<u>145,343</u>	<u>219,709</u>
Total revenues	<u>2,863,735</u>	<u>2,798,387</u>
Expenses:		
Salaries and wages	949,538	881,742
Employee benefits	241,866	203,727
Pension expense – service cost	50,472	59,065
Professional fees	153,800	141,583
Supplies	470,323	443,127
Depreciation and amortization	147,214	144,912
Interest	12,359	11,231
Purchased services and other	<u>905,325</u>	<u>793,899</u>
Total expenses	<u>2,930,897</u>	<u>2,679,286</u>
Income (loss) from operations	(67,162)	119,101
Nonoperating gains (losses):		
Investment return	(138,797)	324,027
Pension gain, other than service cost	59,982	83,236
Pension gain (expense), mark-to-market adjustment	(8,353)	213,102
Change in fair value of interest rate swaps	<u>20,193</u>	<u>21,249</u>
Revenues and gains in excess (deficient) of expenses and losses	(134,137)	760,715
Other changes in net assets without donor restriction:		
Net assets released from restrictions used for the purchase of property, plant, and equipment	1,784	4,298
Recognition of change in pension funded status	<u>17</u>	<u>54</u>
Change in net assets without donor restriction	<u>\$ (132,336)</u>	<u>765,067</u>

See accompanying notes to consolidated financial statements.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2022 and 2021

(Dollars in thousands)

	<u>2022</u>	<u>2021</u>
Net assets without donor restrictions:		
Revenues and gains in excess (deficient) of expenses and losses	\$ (134,137)	760,715
Other changes in net assets without donor restriction:		
Net assets released from restrictions used for the purchase of property, plant, and equipment	1,784	4,298
Recognition of change in pension funded status	17	54
Change in net assets without donor restriction	<u>(132,336)</u>	<u>765,067</u>
Net assets with donor restrictions:		
Investment return	(1,636)	3,319
Contributions	5,150	4,819
Net assets released from restrictions	<u>(4,478)</u>	<u>(6,637)</u>
Change in net assets with donor restrictions	<u>(964)</u>	<u>1,501</u>
Change in net assets	(133,300)	766,568
Net assets at beginning of year	<u>2,855,876</u>	<u>2,089,308</u>
Net assets at end of year	<u>\$ 2,722,576</u>	<u>2,855,876</u>

See accompanying notes to consolidated financial statements.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES
Springfield, Illinois

Consolidated Statements of Cash Flows

Years ended June 30, 2022 and 2021

(Dollars in thousands)

	<u>2022</u>	<u>2021</u>
Cash flows from operating activities:		
Change in net assets	\$ (133,300)	766,568
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Pension expense, mark-to-market adjustment	8,353	(213,102)
Recognition of change in pension funded status	(17)	(54)
Income from equity basis investments	(2,917)	(6,534)
Cash distributions received from equity basis investments	—	161
Restricted contributions and investment return, net	(3,514)	(5,799)
Amortization of bond issuance costs and premiums/discounts included in interest expense	(3,254)	(5,523)
Depreciation and amortization	147,214	144,912
Reduction in the carrying amount of ROU assets	23,109	25,880
Change in net unrealized gains and losses on investments	257,654	(243,812)
Net realized gains on sale of investments	(97,969)	(67,615)
Change in the fair value of interest rate swaps	(20,193)	(21,249)
Changes in assets and liabilities:		
Patients' accounts receivable	12,552	(18,437)
Other receivables	(1,876)	(19,668)
Inventories and supplies	(6,135)	(1,156)
Prepaid expenses	(803)	111
Net amounts due to third-party reimbursement programs	(18,120)	29,846
Accounts payable and accrued liabilities	(61,657)	(82,426)
Operating lease liabilities	(22,233)	(24,800)
Estimated self-insurance liabilities and other noncurrent liabilities	(189,068)	(36,602)
Net cash provided by (used in) operating activities	<u>(112,174)</u>	<u>220,701</u>
Cash flows from investing activities:		
Acquisition of property, plant, and equipment, net	(133,163)	(123,744)
Gross purchases of investments	(2,107,062)	(2,198,003)
Gross proceeds from sale or maturity of investments	2,366,187	1,987,725
Change in other assets	<u>3,427</u>	<u>(2,574)</u>
Net cash provided by (used) in investing activities	<u>129,389</u>	<u>(336,596)</u>
Cash flows from financing activities:		
Repayment of long-term debt	(29,975)	(27,713)
Repayment of finance leases	(598)	(5,411)
Restricted contributions and investment return, net	<u>3,514</u>	<u>5,799</u>
Net cash used in financing activities	<u>(27,059)</u>	<u>(27,325)</u>
Change in cash and cash equivalents	(9,844)	(143,220)
Cash and cash equivalents, at beginning of year	<u>100,879</u>	<u>244,099</u>
Cash and cash equivalents, at end of year	\$ <u>91,035</u>	\$ <u>100,879</u>
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	\$ 12,842	12,014

See accompanying notes to consolidated financial statements.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

(1) Organization and Purpose

Hospital Sisters Health System (HSBS), an Illinois not-for-profit corporation, considers all wholly owned or controlled entities as subsidiaries for consolidated financial statement purposes. The accompanying consolidated financial statements include the accounts of HSBS and its subsidiaries. HSBS is the parent corporation for several subsidiary corporations and exerts control through various reserved powers. The subsidiary corporations and controlled entities presented in the accompanying consolidated financial statements include Hospital Sisters Services, Inc. (HSSI), HSBS System Office (the SSC), Hospital Sisters of St. Francis Foundation, Inc. (the Foundation), and Kiara, Inc. HSSI, an Illinois not-for-profit holding company, is the sole member of 15 hospitals in Illinois and Wisconsin, Hospital Sisters Healthcare – West, Inc. (HCW), HSBS Medical Group, Inc., and HSBS Wisconsin Medical Group, Inc. (collectively, referred to as the Medical Group), Unity Limited Partnership, Kiara Clinical Integration Network (KCIN), Prairie Education & Research Cooperative (PERC), Renaissance Quality Insurance, Ltd. (RQIL), and Prairie Cardiovascular Consultants, Inc. (PCC). PCC is a medical practice in Illinois providing healthcare services to prevent and treat cardiovascular disease.

The hospitals are organized for the purpose of providing inpatient and outpatient healthcare services. HSSI formed the Medical Group for the purpose of affiliating with physicians. RQIL is a captive insurance company incorporated in the Cayman Islands to provide professional and general liability insurance coverage to HSBS and affiliates and workers compensation coverage for the hospitals.

Fifteen hospitals within HSSI have formed an Obligated Group for debt financing purposes with a Master Trust Indenture (MTI) (note 11).

The 15 hospitals, of which HSSI is the sole corporate member, are as follows:

Hospital	Location
	Illinois:
St. Joseph's Hospital (SJB)	Breese
St. Mary's Hospital (SMD)	Decatur
St. Anthony's Memorial Hospital (SAE)	Effingham
Holy Family Hospital (HFG)	Greenville
St. Joseph's Hospital (SJH)	Highland
St. Francis Hospital (SFL)	Litchfield
St. Elizabeth's Hospital (SEO)	O'Fallon
Good Shepherd Hospital (GSS)	Shelbyville
St. John's Hospital (SJS)	Springfield

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

Hospital	Location
	Wisconsin:
St. Joseph's Hospital (SJCF)	Chippewa Falls
Sacred Heart Hospital (SHEC)	Eau Claire
St. Mary's Hospital Medical Center (SMGB)	Green Bay
St. Vincent Hospital (SVGB)	Green Bay
St. Nicholas Hospital (SNS)	Sheboygan
St. Clare Memorial Hospital (SCO)	Oconto Falls

The SSC administers healthcare claims for the benefit of HSHS' colleagues. The SSC is supported by annual fees paid by the HSHS' affiliated hospitals and certain other HSHS-controlled entities to the SSC. The SSC utilizes these funds to provide centralized management and information services to the 15 affiliated hospitals and employee health administration. In addition, the SSC administers a centralized investment program and defined-contribution and defined-benefit pension plans on behalf of all HSHS entities.

The Foundation, an Illinois not-for-profit corporation, is an entity whose purpose is to solicit and administer philanthropic funds in support of Hospital Sisters Health System. The Foundation is structured into operating branches to administer gifts and bequests with and without donor restrictions at each ministry location.

Kiara, Inc., an Illinois for-profit corporation, provides a vehicle for joint ventures with physicians and an entry into those health-related services, which do not qualify as tax-exempt services, such as durable medical equipment, nonaffiliated electronic health records implementations, and real estate holdings. Kiara, Inc. is the sole stockholder of LaSante, Inc., LaSante Wisconsin, Inc. The operations of these three wholly owned subsidiaries are consolidated into the financial statements of Kiara, Inc. Effective July 1, 2020, PCC converted to an Illinois not-for-profit corporation.

All significant intercompany transactions have been eliminated in consolidation.

(2) Summary of Significant Accounting Policies

The significant accounting policies of HSHS are as follows:

(a) Presentation

Transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are classified as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating gains or losses. Nonoperating gains or losses include investment return, other than that which is associated with self-insurance programs, or funds held by trustee under indenture agreements, inherent contributions, and the change in fair value of the interest rate swaps.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

(b) Use of Estimates

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

(c) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less when purchased, excluding those amounts included as assets whose use is limited or restricted. Cash equivalents held by investment managers are treated as an investing activity in the consolidated statements of cash flows.

(d) Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets set aside by the board of directors for future capital improvements, self-insurance funding, and for other purposes over which the board of directors retains control and may at its discretion subsequently use for other purposes; assets held by third-party trustees under indenture agreements; and funds restricted by donors. Management classifies the current portion of assets whose use is limited or restricted based on the approximate amount of the current portion of long-term debt and self-insurance. Management designates the entire portfolio as a trading portfolio.

Investments in equity securities with readily determinable values and all investments in debt securities are measured at fair value in the accompanying consolidated balance sheets. Investment return on assets associated with self-insurance programs and assets deposited in funds held by trustee under indenture agreements are reported as other revenues. Investment return from all other investments is reported as nonoperating gains (losses), unless the income or loss is restricted by donor or law. Changes in net unrealized gains and losses on investments are included in revenues and gains in excess (deficient) of expenses and losses as all investments are trading securities.

(e) Inventories and Supplies

Inventories and supplies are stated at the lower of cost or market. Cost is determined on a first-in, first-out basis.

(f) Property, Plant, and Equipment

Property, plant, and equipment additions are stated at cost or fair value at the date of acquisition or donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method of accounting. Useful lives may be reassessed from time to time as facts and circumstances change regarding how assets are being used. Interest costs incurred on borrowed funds during the period of construction of major projects are capitalized as a component of the cost of acquiring those assets. Capitalized interest is reduced by the amount of investment income earned on unexpended proceeds from project-specific borrowings.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

(g) Leases

HSHS determines if an arrangement is or contains a lease at contract inception. HSHS recognizes a ROU asset and a lease liability at the lease commencement date if the lease period exceeds one year. Leases less than one year are expensed monthly as incurred.

Key estimates and judgments include how HSHS determines (1) the discount rate it uses to discount the unpaid lease payments to present value, (2) lease term, and (3) lease payments.

HSHS has elected to use the risk-free rate, which is the rate of a U.S. Treasury security for a period comparable to the lease term.

HSHS is obligated under finance leases covering certain medical and IT equipment that expire at various dates during the next six years and buildings that expire at various dates during the next 40 years.

HSHS also has noncancellable operating leases, primarily for office and medical equipment that expire over the next five years and for office space that expire over the next 25 years. These leases generally contain renewal options for periods ranging from one to five years. When HSHS is not reasonably certain to exercise these renewal options, the options are not considered in determining the lease term and associated potential option payments are excluded from lease payments. HSHS' leases generally do not include termination options for either party to the lease, restrictive financial or other covenants or residual value guarantees.

HSHS uses the long-lived assets impairment guidance in ASC Subtopic 360-10, *Property, Plant, and Equipment – Overall*, to determine whether a ROU asset is impaired, and if so, the amount of the impairment to recognize. No impairments were recorded for the years ended June 30, 2022 and 2021.

HSHS has elected not to recognize ROU assets and lease liabilities for short-term leases that have a lease term of 12 months or less. HSHS recognizes the lease payments associated with its short-term leases as an expense on a straight-line basis over the lease term. Variable lease payments associated with these leases are recognized and presented in the same manner as for all other leases.

(h) Other Assets – Joint Ventures

HSHS invests in various organizations that are not wholly owned or controlled by HSHS. Investments in affiliates in which HSHS has significant influence but does not control are reported on the equity method of accounting, which represents HSHS' equity in the underlying net book value. The equity method of accounting is discontinued when the investment is reduced to zero unless HSHS has guaranteed the obligations of the organization or is committed to provide additional capital support.

(i) Loss Reserves

HSHS is self-insured for professional and general liability, workers' compensation, and employee health claims. The provision for loss reserves includes the ultimate cost for both reported losses and losses incurred, but not reported as of the respective consolidated balance sheet dates. HSHS reports the amount predicted to settle within one year as the current portion of estimated self-insurance

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liabilities with the corresponding investments held as current portion of assets whose use is limited or restricted. The long-term portion is reported as estimated self-insurance liabilities with the corresponding investments held as assets whose use is limited or restricted.

The liability for loss reserves represents an estimate of the net cost of all such amounts that are unpaid at the consolidated balance sheet dates. The liability is based on projections and the historical claim experience of HSHS and gives effect to estimates of trends. Although management believes the estimate of the liability for claims is reasonable, it is possible HSHS' actual incurred claims will not conform to the assumptions' variability with respect to the assumptions utilized. The settlement of claims may vary from the liability for unpaid claims included in the accompanying consolidated financial statements.

(j) Derivative Instruments

HSHS accounts for derivatives and hedging activities in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Subtopic 815-10, *Accounting for Derivative Instruments and Hedging Activities*. The fair value of the interest rate swap programs is included as derivative instruments in the accompanying consolidated balance sheets. For HSHS, the derivatives are not designated as hedge instruments, and therefore, settlements on derivative instruments and the change in fair values of the interest rate swap agreements are recognized in the consolidated statements of operations and change in net assets without donor restriction as a component of nonoperating gains (losses).

(k) Asbestos Removal Costs

HSHS accounts for asbestos removal costs in accordance with ASC Subtopic 410-20, *Accounting for Conditional Asset Retirement Obligations*. HSHS is legally liable to remove asbestos from existing buildings prior to future remodeling or demolishing of the existing hospital buildings. The estimated asbestos removal cost at June 30, 2022 and 2021 is \$17,681 and \$17,835, respectively, and is included within other noncurrent liabilities in the accompanying consolidated balance sheets.

(l) Net Assets

Net assets and activities are classified into two classes based on the existence or absence of donor-imposed restrictions: Net assets without donor restrictions and net assets with donor restrictions. Net assets with donor restrictions represent those net assets whose use by HSHS have been limited by donors to a specific time period or purpose or have been restricted by donors to be maintained by HSHS in perpetuity.

(m) Gifts and Bequests

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then recorded at cost. The gifts are reported as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends, or purpose restriction is accomplished net assets are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as assets released from restrictions.

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Donor-restricted contributions whose restrictions are met within the same year as received are recorded as contributions without donor restriction. Contributions without donor restriction are included in other revenues.

Gifts of long-lived assets, such as property, plant, and equipment, are reported as gifts and bequests without donor restriction and are excluded from revenue and gains (deficient) in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. In the absence of explicit donor stipulations regarding how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(n) Revenues and Gains In Excess (Deficient) of Expenses and Losses

The consolidated statements of operations and change in net assets without donor restriction include revenues and gains in excess (deficient) of expenses and losses. Changes in net assets without donor restrictions that are excluded from revenues and gains in excess (deficient) of expenses and losses, include contributions of property, plant, and equipment (including assets acquired using contributions that by donor restrictions or grants were to be used for the purpose of acquiring such assets), net assets released from restrictions used for the purpose of property, plant, and equipment, and the change in pension funded status.

(o) Income Taxes

HSBS and the Foundation are Illinois not-for-profit organizations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Kiara, Inc. is an Illinois for-profit corporation that recognizes income taxes under the asset-and-liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using the enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

Kiara, Inc.'s tax effects of temporary differences that give rise to significant portions of the deferred tax assets at June 30, 2022 and 2021 are primarily the result of net operating loss carryforwards of \$7,434 and \$7,373 at June 30, 2022 and 2021, respectively, which expire at various future dates through 2039.

The net operating loss carryforwards result in a deferred tax asset of \$3,548 and \$3,650 at June 30, 2022 and 2021, respectively. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible.

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Management considers projected future taxable income and tax planning strategies in making this assessment. Based upon the level of historical taxable losses and projections for future taxable losses over the periods for which the deferred tax assets are deductible, management believes it is more likely Kiara, Inc. will not realize most of the benefits of these deductible differences. Full valuation allowances have been applied against the deferred tax assets attributable to the net operating loss carryforwards not realized as of June 30, 2022 and 2021 in the accompanying consolidated financial statements due to the uncertainty of realization.

HSBS recognizes the tax benefit from an uncertain tax position only if it is more likely than not the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. As of June 30, 2022 and 2021, HSBS does not have any liabilities for unrecognized tax benefits.

(p) Fair Value

HSBS records the fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis in accordance with the provisions of ASC Topic 820, *Fair Value Measurement*. ASC Topic 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

HSBS has certain investments in funds that do not have readily determinable fair values, including private investments, hedge funds, real estate, and other funds. ASC Subtopic 820-10-35 allows for HSBS to estimate the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value (NAV) per share or its equivalent as a practical expedient unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2022, HSBS had no plans or intentions to sell investments at amounts different from NAV.

(q) Pension

HSBS calculates and reports pension expense under the mark-to-market (MTM) methodology. Under this method, HSBS immediately recognizes actuarial gains and losses as a separate component of net periodic pension costs as of the financial reporting date.

Reported in the accompanying consolidated statements of operations and changes in net assets without donor restriction, pension expense/gain is reported in four elements: 1) pension expense - service cost; 2) nonoperating pension gain, other than service cost, which excludes the mark-to-market adjustment and service cost, comprising interest cost, assumed returns on plan assets, and recognition of prior service cost; and 3) nonoperating pension gain (expense), mark-to-market adjustment, which is the gains and losses resulting from change in the discount rates and/or the difference between actual experience and assumed experience, including the return on plan assets and 4) other changes in net assets without donor restriction – recognition of change in pension funded status.

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(r) Other Revenue

Other operating revenue includes revenue from nonpatient care services, clinical space rental revenue, contributions both unrestricted in nature and those released from restriction to support operating activities, related grant income, and other miscellaneous income.

Revenue from grants is recognized in accordance with ASC Subtopic 958-605, *Not-for-Profit Entities – Revenue Recognition*, as other operating revenue, when the conditions of the contributions are substantially met.

Revenue from non-grant sources is generally recognized at point of service for these transactions in accordance with ASC Topic 606, *Revenue from Contracts with Customers*.

(3) COVID Reporting

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient activity and related revenues for most services were significantly impacted starting in mid-March as various policies were implemented by Federal, state, and local governments in response to the COVID-19 pandemic that caused many people to remain at home and forced the closure of or limitations on certain businesses, as well as suspended elective surgical procedures until June 2020.

In March 2020, the Coronavirus Aid, Relief and Economic Security Act (CARES Act) was signed into law providing temporary and limited relief to hospitals during the COVID-19 outbreak.

For the periods ended June 30, 2022 and 2021, HSHS received \$36,884 and \$117,453 in general distributions under the CARES Act, respectively. These funds are not subject to repayment, provided HSHS is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on analysis of the compliance and reporting requirements of the CARES Act and the impact of the pandemic on operating results through June 30, 2022 and June 30, 2021, HSHS has recorded \$36,884 and \$127,054 as other operating revenue in the consolidated statements of operations and changes in net assets without donor restrictions, respectively.

In addition, HSHS received \$248,040 in accelerated Medicare payments under the Medicare Advanced Payment Program (APP) during FY 2020. To repay the APP funds, Medicare began to automatically recoup Medicare payments otherwise owed to HSHS each month starting in April 2021. As of June 30, 2022 and 2021, HSHS has recorded \$91,697 and \$116,593 of this contract liability as accrued liabilities and the remaining \$0 and \$112,101 as other noncurrent liabilities on the consolidated balance sheets, respectively.

The extent of the COVID-19 pandemic's impact on operating results and financial condition of HSHS has been and will continue to be driven by many factors, most of which are beyond HSHS's control and ability to forecast. Such factors include, but are not limited to, the availability of healthcare service provider resources; incremental expenses required for supplies and pharmaceuticals; and potential new virulent

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strains of the virus. Because of these and other uncertainties, HSHS cannot estimate the length or severity of the impact of the pandemic on the business and the results of its operations.

(4) Community Benefit

Consistent with its mission, HSHS provides medical care to all patients regardless of their ability to pay. In addition, HSHS provides services intended to benefit the poor and underserved, including those persons who cannot afford health insurance because of inadequate resources and/or are uninsured or underinsured, and to enhance the health status of the communities in which it operates.

The following summary has been prepared in accordance with the Catholic Health Association of the United States' policy document, A Guide for Planning and Reporting Community Benefit, released in May 2006. HSHS uses a cost-to-charge ratio to calculate the cost of charity care and the unpaid cost of Medicaid. The amounts in the following table reflect the quantifiable costs of HSHS' community benefit for the years ended June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Benefits for the poor:		
Charity care at cost	\$ 11,627	15,545
Unpaid cost of Medicaid and other public programs	146,076	142,847
Community health services	2,526	2,763
Other	4,769	5,600
	<u>164,998</u>	<u>166,755</u>
Benefits for the broader community:		
Community health services	1,685	2,340
Health professions education	37,315	19,129
Other	14,888	13,145
	<u>53,888</u>	<u>34,614</u>
Total community benefit	<u>\$ 218,886</u>	<u>201,369</u>

Benefits for the poor represent the cost of services provided to persons who cannot afford healthcare because of inadequate resources and who are uninsured or underinsured.

Benefits for the broader community represent the cost of services provided to other needy populations that may not qualify as poor, but that need special services and support. It also includes the cost of services for the general benefit of the communities in which HSHS operates. Many programs are targeted toward populations that may be poor, but also include those areas that may need special health services and support. These programs are not financially self-supporting.

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Charity care at cost represents the estimated cost of services provided to patients who cannot afford healthcare services due to inadequate resources. All or a portion of a patient's services may be considered charity care for which no payment is anticipated in accordance with HSHS' established policies.

Unpaid cost of Medicaid and other public programs represents the estimated cost of providing services to beneficiaries of public programs, including state Medicaid and indigent care programs, in excess of payments for those services. (See note 4 for an explanation of changes to the Medicaid reimbursement from the State of Illinois.)

Community health services are activities and services for which no patient bill exists although there may be nominal patient fees. These services are not expected to be financially self-supporting, although some may be partially supported by outside grants or funding.

Health professions education includes the unreimbursed cost of training health professionals, such as medical residents, nursing students, technicians, and students, in allied health professions.

Other benefits include subsidized health services, in-kind donations, and other benefits.

A related organization, the Foundation, funded \$7,969 and \$11,499 for charity care or other operating expenses on behalf of the hospitals during the years ended June 30, 2022 and 2021, respectively. The community benefits reported above are net of the contributions from the Foundation for such benefits.

HSHS also provides a significant amount of uncompensated care for patients, which is not included above, but is reported in the consolidated statements of operations and change in net assets without donor restriction as part of patient service revenue. Many of those patients are uninsured or underinsured, but did not apply for, or qualify for, charity care.

(5) Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which HSHS expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (managed care and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total charges. Performance obligations satisfied over time relate to inpatient acute care services. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided and HSHS does not believe it is required to provide additional goods or services to the patient. Performance obligations for patients that are in house at period-end generally complete within days or possibly weeks of period-end therefore are estimated on a pro rata basis.

HSHS determines the transaction price based on standard charges for goods and services provided, reduced by explicit price concessions provided to third-party payers, discounts provided to uninsured patients in accordance with HSHS's policy, and/or implicit price concessions provided to uninsured

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patients. Estimates of explicit price concessions are based on contractual agreements, its discount policy (or policies), and historical experience. Estimates of implicit price concessions are based on its historical collection experience with this class of patients.

Agreements with third-party payers typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payers follows:

Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are generally paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Certain patient services related to Medicare beneficiaries are paid based upon a cost reimbursement method, prospectively determined rates, established fee screens, or a combination thereof. The hospitals are reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the hospitals and audits by the Medicare fiscal intermediary. Certain outpatient services performed by the hospitals are reimbursed at a prospectively determined rate per service based upon their ambulatory payment classification.

Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed based upon per visit rates. Medicaid payment methodologies and rates for services are based on the amount of funding available to state Medicaid programs.

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital Assessment Program (collectively referred to herein as HAP) have been approved by CMS through December 31, 2022. Under HAP, the state receives additional federal Medicaid funds for the state's healthcare system, administered by the Illinois Department of Healthcare and Family Services. Included in the accompanying consolidated statements of operations and changes in net assets without donor restriction for the years ended June 30, 2022 and 2021 is \$101,059 and \$90,644, respectively, of patient service revenue from the HAP and \$48,324 and \$52,265, respectively, of other expense for provider taxes for the HSHS Illinois hospitals.

The State of Wisconsin has an assessment tax on the gross revenue of all Wisconsin hospitals, which is used to increase reimbursements made under its Medicaid program. During the years ended June 30, 2022 and 2021, the HSHS Wisconsin hospitals were assessed \$17,297 and \$17,225, respectively, related to this tax, which is included as a component of other expenses in the accompanying consolidated statements of operations and changes in net assets without donor restriction, and received \$21,550 and \$31,049, respectively, in supplemental Medicaid reimbursement, which is included as a component of patient service revenue in the accompanying consolidated statements of operations and change in net assets without donor restriction.

Other – HSHS has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined per diem rates.

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Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to interpretation. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge HSHS' compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims, or penalties would have upon HSHS. In addition, contracts with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (i.e., new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. During 2022 and 2021, changes to prior year variable consideration resulted in an increase of patient service revenue of \$2,714 and \$2,723, respectively, due to successful appeals, cost report settlements, and other adjustments to prior year.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. HSHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. HSHS estimates the transaction price for patients with deductibles and coinsurance and from those who are 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 explicit and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change.

HSHS provides care to patients regardless of their ability to pay. Therefore, HSHS has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (e.g., copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts HSHS expects to collect based on its collection history with those patients.

Patients who meet HSHS' criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue.

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Patient service revenue, net of explicit price concessions (but before implicit price concessions) recognized in the period by major payor is as follows:

	2022	2021
Medicare	35 %	36 %
Medicaid	13	12
Managed care	45	44
Commercial and other	6	6
Self-pay	1	2
	<u>100 %</u>	<u>100 %</u>

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

	2022	2021
Inpatient	\$ 935,553	856,260
Outpatient/ambulatory care	1,642,556	1,591,522
Physician services	141,211	124,027
	<u>\$ 2,719,320</u>	<u>2,571,809</u>

HSBS grants credit without collateral to its patients, most of whom are residents in the communities that it serves and are insured under third-party payor agreements. The mix of patient accounts receivable by major payor as of June 30 consists of the following:

	2022	2021
Medicare	33 %	32 %
Medicaid	9	10
Managed care	44	49
Self-pay	8	6
Commercial and other	6	3
	<u>100 %</u>	<u>100 %</u>

(6) Investment Composition and Fair Value Measurements**(a) Overall Investment Objective**

The overall investment objective of HSBS is to invest its assets in a prudent manner that will achieve an expected rate of return, manage risk exposure, and focus on downside protection. HSBS' invested assets maintain sufficient liquidity to fund a portion of HSBS' annual operating activities and structure

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the invested assets to maintain a high percentage of available liquidity. HSHS diversifies its investments among various asset classes incorporating multiple strategies and managers. The HSHS board approves the Investment Policy Statement (IPS). The investment subcommittee oversees the investment program in accordance with the IPS.

(b) Allocation of Investment Strategies

To manage risk, HSHS invests in fixed income, domestic equities, international equities, custom hedge funds, real assets, and private equity. HSHS engages outside portfolio managers as of June 30, 2022 as follows: 5 fixed income managers, 11 domestic equity managers, 6 international managers, 1 custom hedge fund portfolio manager (K2), 2 real estate managers, and 1 private equity manager (Hamilton Lane). Because of the inherent uncertainties for valuation of some holdings, the estimated fair values may differ from values that would have been used had a ready market existed.

The investment objective of the K2 Custom Solutions Hospital Sisters Fund is to achieve equity type returns with reduced volatility and risk. This is achieved through a diversified portfolio targeting allocations of long strategies and low volatility strategies and spread across 19 separate underlying funds.

A summary of the strategies used by the hedge fund manager are as follows:

- *Commodities* include investment entities that may trade in agricultural, metal, and energy markets at various stages of the commodity cycle.
- *Event Driven* includes investment entities that focus on identifying and analyzing securities that may benefit from the occurrence of specific corporate events.
- *Global Macro* includes investment entities, which invest in products that may benefit from overall economic and political events of various countries.
- *Insurance-Linked* includes investment entities with an income-based strategy that invest across instruments, the value of which is driven by insurance-related events primarily related to property and life insurance. Risk is managed by diversifying over geography, insurance type, and sensitivity to insured losses amongst other factors. The strategy is a tool to reduce overall investment risk as underlying insurance risk factors are less sensitive to general market factors.
- *Long/Short Equity* includes investment entities that invest both long and short, primarily in common stocks and debt instruments, based on the manager's perception of such securities being undervalued or overvalued by the market.
- *Multistrategy* includes investment entities that pursue multiple strategies to diversify risks and reduce volatility.
- *Relative Value* includes investment entities that utilize nondirectional strategies. Relative value investing involves trading around the mispricing of two related securities using various types of securities or instruments.

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- *Specialist Credit* includes investment entities that seek to generate superior risk-adjusted returns from a combination of capital appreciation and current income by opportunistically investing and trading in a diversified portfolio of credit-related securities and other instruments.
- *Structured Credit* includes investment entities that invest across structured credit markets, including agency and nonagency residential mortgage-backed securities, commercial mortgage-backed securities, and various asset-backed securities. Strategies can be trading oriented or directional and may include a hedging component to offset market risks.
- *Hedge Overlay Strategy* involves the measuring, monitoring, and management of the primary beta sensitivities contained within the fund. Futures, options, swaps, and exchange traded funds (ETF) positions will be taken (or overlaid) alongside the core portfolio in order to fine tune any market sensitivities or hedge any undersigned directional biases.

(c) Fair Value of Financial Instruments

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

- The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, receivables, accounts payable and accrued liabilities, and estimated payables under third-party reimbursement programs.
- Fair values of HSHS' investments held as assets whose use is limited or restricted are estimated based on prices provided by its investment managers and its custodian bank except pledges receivable and other, whereby carrying amounts approximate fair value. Fair value for cash equivalents, common stocks, foreign securities, U.S. government securities, corporate bonds, taxable municipals, and commingled mutual funds are measured using quoted market prices at the reporting date multiplied by the quantity held. The carrying value equals fair value.
- HSHS has two real estate fund investments for which quoted market prices are not available. The estimated fair value of these real estate fund investments includes estimates, appraisals, assumptions, and methods provided by external financial advisers and reviewed by HSHS.
- HSHS has one hedge fund investment for which quoted market prices are not available. The estimated fair value of these hedge fund investments includes estimates, appraisals, assumptions, and methods provided by external financial advisers and reviewed by HSHS.
- Fair value of interest rate swaps is determined using pricing models developed based on the LIBOR swap rate and other observable market data by financial advisers. The value was determined after considering the potential impact of collateralization and netting agreements, adjusted to reflect nonperformance risk of the counterparties and HSHS. The carrying value equals fair value.

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The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although HSHS believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

(d) Fair Value Hierarchy

ASC Topic 820 includes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that HSHS can access at the measurement date.
- Level 2 inputs are observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 inputs are unobservable inputs for the asset or liability.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. There were no transfers between Level 1, Level 2, or Level 3 for the fiscal year ended June 30, 2022 or 2021.

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The following table summarizes HSHS' fair values of cash and cash equivalents, assets whose use is limited or restricted by major category, and derivative instruments in the fair value hierarchy as of June 30, 2022, as well as related strategy, liquidity, and funding commitments:

	June 30, 2022			Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3		
Cash and cash equivalents	\$ 91,035	—	—	Daily	One
Assets whose use is limited or restricted excluding accrued interest and other of \$2,959 pledges receivable and other of \$65,187:					
Cash equivalents	68,980	—	—	Daily	One
Common stocks	291,723	—	—	Daily	One
U.S. government securities	—	87,056	—	Daily	One
Taxable municipals	—	15,368	—	Daily	Two
Corporate bonds	—	136,811	—	Daily	Two
Foreign securities	269,534	43,255	—	Daily	Three
Commingled mutual funds	—	217,397	—	Daily	Three
Subtotal	\$ 721,272	499,887	—		
Alternative Investments ¹ :					
JLL Income Property Trust, Inc.			89,718	Quarterly	Forty-five
Ares Industrial Real Estate Income Trust, Inc			53,840	Monthly	Three
Blackstone Private Credit fund			50,377	Quarterly	Forty-five
K2 multistrategy fund			293,337	See below	
Hamilton Lane Private Equity			120,871	See below	
Total financial assets			1,829,302		
Liabilities:					
Derivative instruments	\$ —	(30,328)	—		

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

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The following table summarizes HSHS' fair values of cash and cash equivalents, assets whose use is limited or restricted by major category, and derivative instruments in the fair value hierarchy as of June 30, 2021, as well as related strategy, liquidity, and funding commitments:

	June 30, 2021			Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3		
Cash and cash equivalents	\$ 100,879	—	—	Daily	One
Assets whose use is limited or restricted excluding accrued interest and other of \$3,150 pledges receivable and other of \$32,869:					
Cash equivalents	76,314	—	—	Daily	One
Common stocks	454,521	—	—	Daily	One
U.S. government securities	—	101,778	—	Daily	One
Taxable municipals	—	17,452	—	Daily	Two
Corporate bonds	—	199,083	—	Daily	Two
Foreign securities	410,701	64,775	—	Daily	Three
Commingled mutual funds	—	212,656	—	Daily	Three
Subtotal	\$ 1,042,415	595,744	—		
Real estate funds ¹ :					
JLL Income Property Trust, Inc.			90,760	Quarterly	Forty-five
J.P. Morgan U.S. Real Estate Income and Growth Fund			35,507	Quarterly	Sixty
Hedge funds ¹ :					
K2 multistrategy fund			460,311	See below	
Hamilton Lane Private Equity			65,346	See below	
Total financial assets			\$ 2,290,083		
Liabilities:					
Derivative instruments	\$ —	(50,521)	—		

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

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The following table presents information about the redemption terms and restrictions as of June 30, 2022 and 2021 for the alternative investments:

(i) *K2 Custom Solutions Hospital Sisters Fund*

	Fair value		Notice period (days) minimum/ maximum
	2022	2021	
Redemption terms:			
Monthly	\$ 161,335	262,377	15–90 Days
Quarterly	123,202	188,728	30–90 Days
Semiannual	4,400	4,603	60–90 Days
Annually	4,400	4,603	90 Days
Total	\$ 293,337	460,311	

(ii) *Hamilton Lane Private Equity*

On January 1, 2018, HSHS entered into an agreement to invest in the Hamilton Lane Private Equity Fund. The purpose of the private equity investment is to further diversify the Strategic Fund portfolio by reducing volatility and increasing the expected return. The Hamilton Lane Private Equity Fund looks to invest in various strategies, including primary, secondary, and co-investments involving credit, buyout, and venture/growth equity across all geographies. HSHS has expected contributions of \$200,000 to \$400,000 to fund the Hamilton Lane Private Equity Fund over a five-year period. The Strategic Fund has a target investment for private equity of 12% and is expected to be achieved over a seven-year investment horizon. These funds are illiquid for the duration of the seven-year investment term ending in 2025.

	June 30, 2022	
	Fair value	Unfunded commitment
Cash equivalents	\$ 2,322	—
Credit	11,774	5,952
Buyout	53,664	80,128
Co/direct investment	19,209	5,952
Secondaries	15,208	35,302
Venture/growth	18,694	12,406
Total	\$ 120,871	139,740

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A summary of assets whose use is limited or restricted as of June 30, 2022 and 2021 is as follows:

	<u>2022</u>	<u>2021</u>
Assets whose use is limited or restricted:		
By the board for capital improvements	\$ 1,444,698	1,841,414
Funds held for self-insurance – unrestricted	90,283	95,830
Funds held by RQIL – unrestricted	159,242	170,846
Funds with donor restriction	1,486	1,552
Investments held at the Foundation:		
Without donor restrictions	38,661	42,640
With donor restrictions	72,043	72,941
Total assets whose use is limited or restricted	<u>\$ 1,806,413</u>	<u>2,225,223</u>

The composition of investment return for the years ended June 30, 2022 and 2021 is as follows:

	<u>2022</u>	<u>2021</u>
Investment return:		
Interest and dividend income	\$ 15,630	20,449
Net realized gains on sale of investments	97,969	67,615
Change in net unrealized gains and losses	<u>(257,654)</u>	<u>243,812</u>
Total investment return	<u>\$ (144,055)</u>	<u>331,876</u>

Investment returns are included in the accompanying consolidated statements of operations and change in net assets without donor restriction, and changes in net assets for the years ended June 30, 2022 and 2021 as follows:

	<u>2022</u>	<u>2021</u>
Other revenue – investment return	\$ (3,622)	4,530
Nonoperating gains – investment return	(138,797)	324,027
Net assets with donor restrictions – investment return	<u>(1,636)</u>	<u>3,319</u>
Total investment return	<u>\$ (144,055)</u>	<u>331,876</u>

(7) Derivative Instruments

HSHS utilizes interest-rate-related derivative instruments to manage risk on its debt instruments. HSHS does not enter derivative instruments for any purpose other than cash flow hedging purposes and HSHS does not speculate using derivative instruments.

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By using derivative financial instruments to hedge exposures to changes in interest rates, HSHS is exposed to counterparty risk, tax risk, and market risk. Counterparty risk is the failure of the counterparty to perform under the terms of the derivative contract. HSHS minimizes the counterparty risk in derivative instruments by entering into transactions with high credit quality counterparties.

Basis risk is the adverse effect that HSHS takes on to the extent tax law changes impact the rates paid to a variable rate bondholder (either positively or negatively) that would affect the variable rate received from the counterparty under a swap that may not match the equivalent rate being paid. HSHS minimizes the tax risk in derivative instruments by maintaining enough cash reserves for potential tax law changes.

Market risk is the adverse effect on the value of the derivative instrument that results from a change in interest rates. The market risk associated with interest rate contracts is managed by establishing and monitoring parameters that limit the type and degree of market risk that may be undertaken.

HSHS is exposed to credit loss in the event of nonperformance by the counterparty to the interest rate swap agreements; however, this is not anticipated. During the year ended June 30, 2022 or 2021, neither HSHS nor its counterparties were required to post collateral.

HSHS maintains interest rate swap agreements which effectively change the interest rate exposure on a portion of its variable rate bonds to fixed rates. HSHS receives 72.55% of the 10-Year LIBOR Swap Rate (\$76,750 notional amount) and 67.00% of the one-month LIBOR (\$41,300 and \$100,425 notional amounts) and pays a fixed rate of 4.02% (\$76,750 notional amount) and 3.47% (\$41,300 and \$100,425 notional amounts). The interest rate swap agreements had a notional amounts outstanding of \$218,475 at June 30, 2022 and 2021, which will amortize through March 2036.

HSHS maintains a basis swap, where HSHS receives 67.00% of the 10-year LIBOR Swap Rate plus a fixed spread of 8.9 basis points and pays Securities Industry and Financial Markets Association (SIFMA) index rate. This basis swap had a notional amount outstanding of \$150,000 at June 30, 2022 and 2021, with a final maturity in May 2033.

HSSI and JPMorgan Chase Bank, N.A. (the Counterparty) entered the 2016 Swap simultaneously with the sale of the Series 2016 Bonds. The 2016 Swap is governed by an ISDA Master Agreement under the terms of which the provider will pay to HSSI an amount equal to the interest paid on the bonds, and HSSI will pay the Counterparty an amount equal to the SIFMA rate plus a spread. If the 2016 Swap is not extended, on the termination date, HSSI is obligated to pay to the Counterparty a termination payment if the market value of the Series 2016 Bonds is less than par. The 2016 swap has a notional amount of \$75,000 with a final maturity in December 2026.

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The following is a summary of the swaps as of June 30, 2022:

Type of interest swap	Notional amount	Settlement value	Fair value
Fixed payor	\$ 76,750	(9,896)	(10,252)
Basis	150,000	(1,905)	(2,017)
Fixed payor	41,300	(5,193)	(5,386)
Fixed payor	100,425	(12,666)	(13,138)
Total return	75,000	465	465
Fixed payor		<u>(29,195)</u>	<u>(30,328)</u>

The following is a summary of the swaps as of June 30, 2021:

Type of interest swap	Notional amount	Settlement value	Fair value
Fixed payor	\$ 76,750	(20,025)	(19,740)
Basis	150,000	6,039	5,994
Fixed payor	41,300	(11,025)	(10,876)
Fixed payor	100,425	(26,876)	(26,514)
Total return	75,000	615	615
Fixed payor		<u>\$ (51,272)</u>	<u>(50,521)</u>

(8) Property, Plant, and Equipment

A summary of property, plant, and equipment at June 30, 2022 and 2021 is as follows:

	2022	2021
Land	\$ 85,626	85,526
Land improvements	59,821	60,039
Buildings and permanent fixtures	1,957,097	1,866,621
Equipment and furnishings	1,395,246	1,369,638
Finance lease ROU assets	78,163	72,585
	<u>3,575,953</u>	<u>3,454,409</u>
Less accumulated depreciation	<u>2,052,173</u>	<u>1,961,723</u>
	<u>1,523,780</u>	<u>1,492,686</u>
Construction in progress	<u>72,743</u>	<u>117,888</u>
	<u>\$ 1,596,523</u>	<u>1,610,574</u>

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As of June 30, 2022, construction in progress represents various building and remodeling projects. These projects, which have remaining contracted costs at June 30, 2022 of \$39,998, will be financed with board-designated assets or from operations.

(9) Self-Insurance**(a) Workers' Compensation, Professional, and General Liability**

RQIL provides insurance coverage in addition to Workers' Compensation, Professional, and General Liability, but the associated liabilities for the other coverages are less than 2% of the total RQIL liabilities at June 30, 2022 and 2021.

HSHS is involved in litigation arising in the ordinary course of business. Reported claims are in various stages of litigation. Additional claims may be asserted against HSHS arising from services through June 30, 2022. It is the opinion of management that the estimated liabilities accrued at June 30, 2022 are adequate to provide for potential losses resulting from pending or threatened litigation.

Under the System's Workers' Compensation (WC), Professional, and General Liability (PGL) self-insurance program through RQIL, claims are reflected based upon actuarial estimation, including both reported and incurred but not reported claims, taking into consideration the severity of incidents and the expected timing of claim payments. At June 30, 2022 and 2021, funds held by RQIL were \$159,242 and \$170,846, respectively. The related current estimated self-insurance liabilities for June 30, 2022 and 2021 were \$55,382 and \$59,788, for WC and PGL, respectively. The related long-term estimated self-insurance liabilities for June 30, 2022 and 2021 were \$92,186 and \$103,817 for WC and PGL, respectively. At June 30, 2022 and 2021, the estimated self-insurance liability for all future claims payments reflects the actuarially determined outstanding losses at the undiscounted/expected level. These calculations take into consideration any liability that may be covered under an extended reporting endorsement and considered tail liability.

(b) Employee Health

The HSHS self-insurance program provides health insurance for employees. HSHS has developed internal techniques for estimating costs.

At June 30, 2022 and 2021, funds held by HSHS for health insurance liability for employees' self-insurance are \$90,283 and \$95,830, respectively, and are included in current and noncurrent assets whose use is limited or restricted. At June 30, 2022 and 2021, related estimated current self-insurance liabilities are \$17,724 and \$17,115, respectively.

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(10) Employee Benefit Plans**(a) Defined-Benefit Plan**

HSHS employees participate in The Hospital Sisters Health System Employees' Pension Plan (the Plan). This noncontributory, defined-benefit pension plan covers substantially all employees of HSHS who have completed 1,000 hours of employment during any calendar year subsequent to the commencement of employment. The Plan recognizes and funds the costs related to employee service using the projected unit credit actuarial cost method. The information below represents the aggregation of HSHS' pension financial status, which is determined by the consulting actuaries on a member-specific basis.

HSHS' retirement program covers all employees under one comprehensive retirement program that administers benefits under two different tracks. Employees hired or rehired on or after July 1, 2014 will receive their employer-provided retirement benefits based on a combination of a cash balance formula within the defined-benefit plan and an employer-matching contribution into HSHS defined-contribution plan. Employees hired before July 1, 2014 receive their employer-provided retirement benefits based on a final average pay formula within the defined-benefit plan.

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The following tables set forth the Plan's funded status, amounts recognized in HSHS' consolidated financial statements, and assumptions at June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 2,578,998	2,382,829
Service cost	50,472	59,065
Interest cost	64,045	62,557
Actuarial loss	(585,538)	152,938
Benefits paid	<u>(83,700)</u>	<u>(78,391)</u>
Benefit obligation at end of year	<u>\$ 2,024,277</u>	<u>2,578,998</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	\$ 2,577,742	1,997,970
Actual gain on plan assets	(456,782)	522,639
Employer contributions	48,425	146,278
Expenses paid	(13,061)	(10,754)
Benefits paid	<u>(83,700)</u>	<u>(78,391)</u>
Fair value of plan assets at end of year	<u>\$ 2,072,624</u>	<u>2,577,742</u>
Reconciliation of funded status:		
Funded status	\$ 48,347	(1,256)
Amounts recognized in the accompanying consolidated balance sheets:		
Accrued pension benefit asset (liability)	\$ 48,347	(1,256)
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Prior service cost	<u>\$ (31)</u>	<u>(48)</u>
	<u>\$ (31)</u>	<u>(48)</u>

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	<u>2022</u>	<u>2021</u>
Changes recognized in unrestricted net assets:		
Net (gain) loss arising during the period	\$ 8,353	(213,102)
Amortization of prior service credit	(17)	(54)
Amortization or settlement recognition of net gain (loss)	<u>(8,353)</u>	<u>213,102</u>
Total recognized in unrestricted net assets	<u>\$ (17)</u>	<u>(54)</u>
Total recognized in net periodic pension cost and unrestricted net assets	\$ (1,174)	(237,327)
Estimated amounts that will be amortized from unrestricted net assets over the next fiscal year:		
Prior service credit	(17)	(54)
Accumulated benefit obligation	1,901,304	2,359,909
Components of net periodic benefit cost:		
Service cost	\$ 50,472	59,065
Other components of net periodic benefit cost:		
Interest cost	64,045	62,557
Expected return on plan assets	(124,044)	(145,847)
Amortization of prior service cost	<u>17</u>	<u>54</u>
Net periodic benefit cost other than service cost	<u>(59,982)</u>	<u>(83,236)</u>
Net periodic benefit cost excluding MTM adjustment	(9,510)	(24,171)
MTM adjustment	<u>8,353</u>	<u>(213,102)</u>
Net periodic benefit cost	<u>\$ (1,157)</u>	<u>(237,273)</u>

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	<u>2022</u>	<u>2021</u>
Weighted average assumptions used to determine benefit obligations at June 30:		
Discount rate	4.89 %	3.15 %
Average rate of compensation increase	4.00 %	3.75 %
Measurement date	June 30, 2022	June 30, 2021
Weighted average assumptions used to determine net periodic benefit cost for the year ended June 30:		
Discount rate	3.15 %	3.19 %
Expected long-term return on plan assets	5.39 %	7.75 %
Average rate of compensation increase	3.75 %	3.00 %
Measurement date	June 30, 2021	June 30, 2020

The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual assets categories. The return is based on a weighted average of historical returns and forward-looking capital market assumptions.

The Plan's liability at the measurement date is determined by discounting cash flows by the corresponding annual spot rate on the client-specific yield curve. The spot rate approach uses the actuarially projected benefit payment cash flows for each future period over the life of the plan and discounts them back to the measurement date using the spot interest rate associated with each respective period in the high-quality corporate bond yield curve. The sum of the discounted amounts is the benefit obligation. Interest cost under the spot rate approach is determined by multiplying the individual spot rates from the exact same yield curve by each year's present value of future projected benefit payments. The sum of those products is the interest cost for the period. The same approach is used to calculate the plan's service cost, except that the actuarially projected benefit payment cash flows are associated with the plan's service cost and not the plan's projected benefit obligation.

The following benefit payments that reflect expected future service, as appropriate, are expected to be paid:

2023	\$ 96,037
2024	102,316
2025	108,721
2026	114,358
2027	119,195
2028-2032	648,838

The expected benefits are based on the same assumptions used to measure HSHS' benefit obligation at June 30, 2022 and 2021 and include estimated future employee service.

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As of June 30, 2022, HSHS updated the mortality assumption to use generational mortality improvements projected using the mortality projection scale MSS-2021. As of June 30, 2021, HSHS updated the mortality assumption to use generational mortality improvements projected using the mortality projection scale MSS-2020. The MSS-2021 and MSS-2020 scales are based on the Social Security Administration's rate of mortality improvement with each annual update to the scale using an additional year of data when compared to the prior scale. As a result of these changes, the projected benefit obligation decreased in 2022 and 2021 by approximately \$2,792 and \$5,375, respectively.

The Plan has developed an Investment Policy Statement (IPS), which is reviewed and approved by the HSHS board of directors. The IPS establishes goals and objectives of the fund, asset allocations, allowable and prohibited investments, socially responsible guidelines, and asset classifications. The IPS dictates that assets should be rebalanced back to target allocation on a quarterly basis. Investments are managed by independent managers. Management monitors the performance of these managers on a quarterly basis.

The table below lists the target asset allocation ranges and actual asset allocations as of June 30, 2022 and 2021:

Asset	Target range	Actual allocation at June 30	
		2022	2021
Equities	0%–70%	25 %	30 %
Debt securities	20%–100%	63	60
Alternative investments	0%–27%	11	8
Cash equivalents	0%–6%	1	2

(b) Overall Investment Objective

The overall investment objective of the Plan is to invest the Plan's assets in a prudent manner to best serve the participants of the Plan. Plan investment assets are to produce investment results that achieve the Plan's actuarial assumed rate of return, protect the integrity of the Plan, assist HSHS in meeting the obligations to the Plan's participants, manage risk exposures, focus on downside protection, and maintain enough liquidity in the portfolio to ensure timely cash outflows and beneficiary payments. The Plans' investments are diversified among various asset classes incorporating multiple strategies and managers to exceed a weighted benchmark return based upon policy asset allocation targets and standard index returns. Major investment decisions are authorized by the HSHS' retirement committee, which oversees the Plan's investment program in accordance with established plan documents and the investment policy statement.

(c) Allocation of Investment Strategies

The Plan maintains a percentage of assets in domestic and international equity stocks to achieve the expected rate of return. To manage risk exposure, up to 100% of the Plans' assets can be invested in a liability-driven investment strategy.

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The fair values of the Plan's assets at June 30, 2022, by asset category class, are as follows:

	June 30, 2022				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Pension plan assets excluding accrued interest of \$18,416:						
Cash equivalents	\$ 11,649	—	—	11,649	Daily	One
Common stocks	302,176	—	—	302,176	Daily	One
U.S. government securities	—	320,678	—	320,678	Daily	One
Commingled mutual funds	—	944,597	—	944,597	Daily	Three
Corporate bonds, notes, and debentures	—	52,102	—	52,102	Daily	Two
Foreign securities	176,020	23,066	—	199,086	Daily	Three
Subtotal	\$ 489,845	1,340,443	—	1,830,288		
Hedge funds ¹ :						
K2 multistrategy fund				147,010	Note 6(d)*	Note 6(d)*
Hamilton Lane Private Equity				76,910	Note 6(d)*	Note 6(d)*
Total assets at fair value				2,054,208		

* Liquidity terms are allocated the same as disclosed in note 6(d) for plan assets.

¹ Certain investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the change in plan assets rollforward.

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The fair values of the Plan's assets at June 30, 2021, by asset category class, are as follows:

	June 30, 2021				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
Pension plan assets excluding accrued interest of \$3,392:						
Cash equivalents	\$ 47,532	—	—	47,532	Daily	One
Common stocks	499,142	—	—	499,142	Daily	One
U.S. government securities	—	579,095	—	579,095	Daily	One
Commingled mutual funds	—	932,502	—	932,502	Daily	Three
Corporate bonds, notes, and debentures	—	36,110	—	36,110	Daily	Two
Foreign securities	268,677	13,646	—	282,323	Daily	Three
Subtotal	\$ 815,351	1,561,353	—	2,376,704		
Hedge funds ¹ :						
K2 multistrategy fund				169,149	Note 6(d)*	Note 6(d)*
Hamilton Lane Private Equity				28,497	Note 6(d)*	Note 6(d)*
Total assets at fair value				\$ 2,574,350		

* Liquidity terms are allocated the same as disclosed in note 6(d) for plan assets.

¹ Certain investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the change in plan assets rollforward.

(d) Fair Value of Financial Instruments

Fair value of Plan assets is determined using the same principle previously disclosed in note 6.

(e) 403(b) Program

HSHS' Tax Deferred Annuity Program is a 403(b) retirement saving plan for its colleagues. Colleagues hired or rehired on or after July 1, 2014 are eligible for an employer paid match of 50 cents per \$1 contributed by the participating colleague up to the first 4% of eligible pay for each calendar year. Eligible colleagues must have a minimum of 1,000 paid hours during the fiscal year to participate. For fiscal years ended June 30, 2022 and 2021, HSHS contributed \$6,746 and \$6,142, respectively, in matching contributions.

(11) Long-Term Debt and Lease Liabilities

Under the terms of the Obligated Group MTI, each member of the Obligated Group is jointly and severally liable for all obligations issued thereunder. Bonds issued are unsecured general obligations but carry covenants regarding withdrawals from the Obligated Group, issuance of additional debt, and creations of liens on property. Obligations outstanding under the Obligated Group MTI are issued through state authorities and comprise both serial and term bonds with varying maturities.

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As of June 30, 2022 and 2021, long-term debt consisted of the following:

Series	Interest rates		Final maturity dates	2022	2021
Fixed interest rate issues:					
2012A	1.85 %		June 30, 2041	\$ 50,160	50,160
2012B	4.000% and 5.000%		August 15, 2021	—	10,300
2012C	5.00 %		August 15, 2021	—	9,040
2012H	1.03 %		August 1, 2040	65,885	65,885
2012I	1.03 %		August 1, 2040	89,460	89,460
2014A	5.00 %		November 15, 2029	131,920	139,915
2016A	5.38 %		November 15, 2046	75,000	75,000
2017A	5.00 %		February 15, 2028	57,710	57,710
SCO	2.87 %		January 15, 2033	5,456	5,894
HFG	2.50 %		November 15, 2026	3,286	3,983
GSS	2.14 %		December 1, 2040	5,550	5,850
	<u>2022</u>	<u>2021</u>			
Variable interest rate issues:					
2012G	0.91%	0.03%	August 1, 2040	31,645	31,645
2017B	1.03% to 1.09%	0.10% to 0.11%	March 15, 2044	64,870	64,870
Total fixed and variable interest debt				580,942	609,712
Other				2,326	3,531
				583,268	613,243
Less unamortized bond issue costs				(1,528)	(1,942)
Plus unamortized bond issue premiums				9,744	13,412
Total debt				591,484	624,713
Total finance leases				53,131	53,729
Total debt and finance leases				644,615	678,442
Less:					
Current installments				30,235	29,214
Current installments of finance leases				5,271	5,928
Total current installments of long-term debt				35,506	35,142
Long-term debt subject to short-term remarketing agreements				64,870	64,870
Total long-term debt, excluding current installments				\$ 544,239	578,430

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

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(Dollars in thousands)

The Obligated Group's effective interest rates for variable debt for the years ended June 30, 2022 and 2021 are as follows:

	<u>2022</u>	<u>2021</u>
Variable interest rate issues:		
2012G	0.23	0.09
2017B	0.31	0.18

Bond issue premiums and costs are amortized over 10 years using the straight-line method. Bond issuance costs, net of amortization, are reported as other assets in the accompanying consolidated balance sheets.

HSSI has variable rate bonds, a portion of which have a put option available to the holder. If the put option is exercised, the bonds are presented to the bank, which in turn draws on the underlying direct pay letter of credit, if available. Self-liquidity bonds are backed by the financial assets of HSSI and are presented as long-term debt subject to short-term remarketing agreements in the accompanying consolidated balance sheets. The bond series and the underlying credit facility terms are described as follows as of June 30, 2022:

<u>Series</u>	<u>Term</u>
Series 2012G	Equal quarterly installments on the first business day of each January, April, July, or October whichever occurs first on or following the 367th day after the purchase date and paid in full no later than the third anniversary of the purchase date. Agreement expires July 1, 2023.
Series 2017B	Self-liquidity

Scheduled principal repayments on long-term debt and repayments based on the variable rate demand notes being put back (accelerated) to HSHS and a corresponding draw being made on the underlying credit facility of MTI debt, if available, are as follows:

	<u>Scheduled</u>	<u>Accelerated</u>
Year ending June 30:		
2023	\$ 30,235	95,105
2024	31,237	31,237
2025	28,373	28,373
2026	29,662	29,662
2027	31,018	31,018
Thereafter	<u>432,743</u>	<u>367,873</u>
	<u>\$ 583,268</u>	<u>583,268</u>

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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On October 1, 2019, HSSI renewed the Series 2012A direct placement bond with JPMorgan Chase Bank, N.A. The terms of the renewal include a 10-year hold period that ends on September 30, 2029 and a change from a variable rate to a fixed rate. The outstanding amount of the bond is \$50,160.

On September 10, 2020, HSSI restructured the Series 2012H and 2012I publicly traded variable rate bonds as a direct placement fixed rate bond with JPMorgan at a fixed rate of 1.03%. The restructured bonds have a four-year put feature maturing on November 15, 2024.

Lease Information as of and for the years ended June 30, 2022 and 2021:

The components of lease cost for the years ended June 30, 2022 and 2021, reported as part of other expenses in the consolidated statements of operations and changes in net assets without donor restriction, were as follows:

	<u>2022</u>	<u>2021</u>
Operating lease cost	\$ 27,748	29,253
Finance lease cost:		
Amortization of right of use assets	7,256	6,904
Interest on lease liabilities	<u>2,235</u>	<u>2,248</u>
Total finance lease cost	9,491	9,152
Variable lease cost	15,438	13,983
Sublease income	<u>(4,409)</u>	<u>(3,871)</u>
Total lease cost	<u>\$ 48,268</u>	<u>48,517</u>

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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(Dollars in thousands)

Amounts reported in the consolidated balance sheets as of June 30, 2022 and 2021 were as follows:

	<u>2022</u>	<u>2021</u>
Operating leases:		
Right of use assets – operating leases	\$ 173,187	192,249
Amortization	<u>(24,728)</u>	<u>(25,880)</u>
Right of use assets – operating leases, net	<u>\$ 148,459</u>	<u>166,369</u>
Current portion of operating lease liabilities	\$ 22,328	23,135
Operating lease liabilities, net of current portion	<u>129,266</u>	<u>145,493</u>
Total operating lease liabilities	<u>\$ 151,594</u>	<u>168,628</u>
Finance leases:		
Right of use assets – finance leases	\$ 78,163	72,585
Accumulated amortization	<u>(28,958)</u>	<u>(22,224)</u>
Property, plant, and equipment, net	<u>\$ 49,205</u>	<u>50,361</u>
Current installments of long-term debt	\$ 5,271	5,928
Long-term debt, net of current installment	<u>47,860</u>	<u>47,801</u>
Total finance lease liabilities	<u>\$ 53,131</u>	<u>53,729</u>

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

Other information related to leases as of June 30, 2022 and 2021 was as follows:

	<u>2022</u>	<u>2021</u>
Supplemental cash flow information:		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flow from operating leases	\$ (22,233)	(24,800)
Financing cash flow from finance leases	(598)	(5,411)
ROU assets obtained in exchange for lease obligations:		
Operating leases	7,138	12,860
Finance leases	7,017	752
Reductions to ROU assets resulting from reductions to lease obligations:		
Operating leases	(1,072)	(2,180)
Weighted average remaining lease term:		
Operating leases	10.0	10.5 years
Finance leases	20.4	20.2 years
Weighted average discount rate:		
Operating leases	1.9 %	1.9 %
Finance leases	4.2	4.2

Amounts disclosed for ROU assets obtained in exchange for lease obligations include amounts added to the carrying amount of ROU assets resulting from lease modifications and reassessments.

Maturities of lease liabilities under noncancellable leases as of June 30, 2022 are as follows:

	<u>Operating leases</u>	<u>Finance leases</u>	<u>Total</u>
Year ending June 30:			
2023	\$ 24,819	7,333	32,152
2024	22,348	5,749	28,097
2025	19,613	5,049	24,662
2026	17,060	4,670	21,730
2027	15,323	3,306	18,629
Thereafter	69,636	47,782	117,418
Total undiscounted lease payments	168,799	73,889	242,688
Less imputed interest	(17,205)	(20,758)	(37,963)
Total lease liabilities	\$ 151,594	53,131	204,725

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HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

(12) Cash and Cash Equivalents and Investments

HSHS holds cash balances that are optimized around large and predictable cash flows. To efficiently manage liquidity and capital, HSHS continually determines the necessary amount of cash and cash equivalents to hold in cash and money market funds to meet operational needs, and allocates the excess to a separate investment account that is expected to generate higher yielding returns while still maintaining a high degree of liquidity and a focus on capital preservation. As added insurance, a line of credit is also maintained in the unlikely event there is an unexpected immediate cash need. HSHS has one line of credit with BMO Harris Bank for \$50,000 through May 7, 2023. There were no draws on the line of credit at June 30, 2022. In relation to the long-term investments of HSHS, approximately 84% of the funds can be liquidated within one month and approximately 93% may be liquidated within two years.

As of June 30, unrestricted financial assets, reduced by amounts that are illiquid within one year, consist of the following:

	<u>2022</u>	<u>2021</u>
Cash and cash equivalents	\$ 91,035	100,879
Current portion of assets whose use is limited or restricted	132,798	205,084
Patient accounts receivable, net	350,826	363,378
Assets whose use is limited or restricted, net of current portion	1,673,615	2,020,139
Less assets with liquidity over one year	<u>(125,271)</u>	<u>(196,039)</u>
	<u>\$ 2,123,003</u>	<u>2,493,441</u>

(13) Functional Expenses

HSHS provides general healthcare services to residents within its respective geographic regions. Expenses related to providing these services for the years ended June 30, 2022 and 2021 are as follows:

	<u>June 30, 2022</u>		
	<u>Healthcare services</u>	<u>General and administrative</u>	<u>Total</u>
Salaries and wages	\$ 809,310	140,228	949,538
Employee benefits	228,370	13,496	241,866
Pension expense – service cost	43,197	7,275	50,472
Professional fees	98,095	55,705	153,800
Supplies	453,788	16,535	470,323
Depreciation	138,863	8,351	147,214
Interest	1,810	10,549	12,359
Purchased services and other	<u>733,375</u>	<u>171,950</u>	<u>905,325</u>
Total expenses	<u>\$ 2,506,808</u>	<u>424,089</u>	<u>2,930,897</u>

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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(Dollars in thousands)

	June 30, 2021		
	Healthcare services	General and administrative	Total
Salaries and wages	\$ 748,760	132,982	881,742
Employee benefits	197,253	6,474	203,727
Pension expense – service cost	52,970	6,095	59,065
Professional fees	84,052	57,531	141,583
Supplies	427,837	15,290	443,127
Depreciation	133,526	11,386	144,912
Interest	1,862	9,369	11,231
Purchased services and other	629,231	164,668	793,899
Total expenses	\$ 2,275,491	403,795	2,679,286

(14) Joint Ventures

Joint ventures are accounted for using the equity method of accounting and represent \$79,333 and \$76,588 of other long-term assets in the accompanying consolidated balance sheets at June 30, 2022 and 2021, respectively. The most significant of these investments, include the following:

- SVGB and SMGB (collectively referred to as the Green Bay Hospitals), each have a 25% interest in Prevea Health Systems, Inc. (Prevea)
- Southwest Illinois Health Ventures, Inc. and St. Elizabeth's Hospital on November 30, 2017 created Southwest Illinois Health Services Real Estate, LLP, which SEO has a 50% ownership interest
- Door County Memorial Hospital (held by SVGB) – 40% ownership interest
- Orange Cross Ambulance, Inc. (held by SNS) – 50% ownership interest

For the years ended June 30, 2022 and 2021, HSHS recognized income of \$2,917 and \$6,534, respectively, in investments in affiliated companies. This activity is included as a component of other revenues in the accompanying consolidated statements of operations and change in net assets without restriction. During 2021, HSHS received cash distributions of \$161 from the joint ventures.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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(Dollars in thousands)

The following table summarizes the unaudited aggregated financial information of unconsolidated affiliated companies of HSHS as of June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Total assets	\$ 250,347	254,139
Total liabilities	79,334	91,689
Total equity	171,013	162,450
Total net revenue	427,480	401,564
Net income	7,032	17,321

(15) Net Assets with Donor Restrictions

Net assets with donor restrictions that have been restricted by donors for the following purposes and restricted endowments are as follows as of June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Healthcare services	\$ 37,440	38,330
Capital expenditures	5,303	6,762
Catholic radio	276	258
Net assets with donor restrictions for specific purposes	<u>43,019</u>	<u>45,350</u>
Assets to be held in perpetuity, the income from which expendable to support nursing schools	4,810	3,600
Assets to be held in perpetuity, the income from which expendable to support specific operations of HSHS facilities	<u>25,700</u>	<u>25,543</u>
Net assets with donor restrictions for restricted endowments	<u>30,510</u>	<u>29,143</u>
Total net assets with donor restrictions	<u>\$ 73,529</u>	<u>74,493</u>

HSHS' endowments consist of individual donor-restricted endowment and board-designated endowment funds for a variety of purposes plus the following where the assets have been designated for endowment: pledge receivable, split-interest agreements, and other net assets. The endowment includes both donor-restricted endowment funds and funds designated by the board of directors to function as endowments. The net assets associated with endowment funds, including funds designated by the board of directors to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

Illinois is governed by the Uniform Prudent Management of Institutional Funds Act (UPMIFA). The board of directors of HSHS has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, HSHS classifies as net assets with donor restriction, (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulates to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund is classified as net assets with donor restriction until those amounts are appropriated for expenditure by HSHS in a manner consistent with the standard of prudence prescribed by UPMIFA.

HSHS has the following donor-restricted endowment activities during the years ended June 30, 2022 and 2021 delineated by net asset class:

	Without donor restriction	With donor restriction	2022 Total
Endowment net assets, beginning of year	\$ 7,581	37,804	45,385
Investment return:			
Investment income	(79)	(197)	(276)
Net depreciation (realized and unrealized)	(1,016)	(1,418)	(2,434)
Total investment return	(1,095)	(1,615)	(2,710)
Contributions and bequests	—	1,366	1,366
Appropriation of endowment assets for expenditure	(131)	(738)	(869)
Other	—	(15)	(15)
Endowment net assets, end of year	\$ 6,355	36,802	43,157

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HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

	<u>Without donor restriction</u>	<u>With donor restriction</u>	<u>2021 Total</u>
Endowment net assets, beginning of year	\$ 6,126	34,399	40,525
Investment return:			
Investment income	459	801	1,260
Net depreciation (realized and unrealized)	<u>1,852</u>	<u>2,562</u>	<u>4,414</u>
Total investment return	2,311	3,363	5,674
Contributions and bequests	—	473	473
Appropriation of endowment assets for expenditure	(841)	(280)	(1,121)
Other	<u>(15)</u>	<u>(151)</u>	<u>(166)</u>
Endowment net assets, end of year	<u>\$ 7,581</u>	<u>37,804</u>	<u>45,385</u>

HSHS has established a spending policy, which is evaluated and approved by the Foundation's board every year. The approved spending rate for fiscal year 2022 and 2021 is 4.63% and 4.36%, respectively. In establishing this policy, the long-term expected return on the endowment is considered. This is consistent with HSHS' objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term.

Endowment funds are commingled with the pooled investment fund administered by HSHS. HSHS relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). HSHS targets a diversified asset allocation of 24.0% fixed income, 19.0% domestic equities, 17.0% international equities, 16.0% custom hedge funds, 9.0% real assets, 12.0% private equity, and 3.0% private credit to achieve its long-term return objectives within prudent risk constraints.

As of June 30, 2022 and 2021, HSHS has funds that represent the unspent accumulation of earnings for endowment funds as follows:

	<u>2022</u>	<u>2021</u>
Unspent income from which is expendable to support nursing schools	\$ 1,136	1,543
Unspent income from which is expendable to support specific operations of HSHS facilities	<u>11,511</u>	<u>14,699</u>
	<u>\$ 12,647</u>	<u>16,242</u>

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

Springfield, Illinois

Notes to Consolidated Financial Statements

June 30, 2022 and 2021

(Dollars in thousands)

(16) Commitments and Contingencies**(a) Legal, Regulatory, and Other Contingencies and Commitments**

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

(b) Litigation

HSHS is involved in litigation arising in the ordinary course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the HSHS's future consolidated financial position or results of operations.

(c) Tax Exemption for Sales Tax and Property Tax

Public Act 97-0688 establishes standards for state sales tax and property tax exemptions in Illinois. The law establishes standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. HSHS certified in 2022 and 2021 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

(d) Investment Risk and Uncertainties

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

(e) Guarantee Agreement

During fiscal year 2014, the Obligated Group executed a Guarantee Agreement with JPMorgan Chase, N.A. to guaranty \$10,000 of debt for Touchette Regional Hospital in East Saint Louis, Illinois. The Obligated Group will be paid a fee of 0.90% of the average outstanding principal amount of the outstanding debt. Relative to the Guarantee Agreement, no amounts have been paid or accrued as of June 30, 2022 or 2021 and the agreement expires June 24, 2024. Touchette paid off the loan in full at the end of July 2022.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES

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Notes to Consolidated Financial Statements

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(Dollars in thousands)

During fiscal year 2014, the Obligated Group guaranteed all outstanding debt of Prevea. The Obligated Group will be paid 1.25% of the average outstanding principal amount of the outstanding notes. Included in the guarantee are \$2,920 taxable variable rate demand notes of PHP Insurance Plan, Inc. (PHP). PHP, a former health maintenance organization, sold its insurance license, changed its corporate structure, and became Prevea Ventures, LLC (PV). Prevea is the sole corporate member of PV. At June 30, 2022 and 2021, the clinic has commercial loans outstanding, which replaced these notes with balances of \$13,857 and \$14,756, respectively. At June 30, 2022 and 2021, PV has notes outstanding of \$1,492 and \$1,589, respectively.

(17) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, HSHS evaluated subsequent events after the consolidated balance sheet date of June 30, 2022 through October 18, 2022, which was the date the consolidated financial statements were issued, noting no items to disclose.

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES
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Consolidating Balance Sheet Information

June 30, 2022

(Dollars in thousands)

Assets	HSSI – Obligated Group	RQIL	Unity Limited Partnership	KCIN	Healthcare West	System Office
Current assets:						
Cash and cash equivalents	\$ 50,461	—	6,302	11,894	1,583	9,207
Receivables:						
Patients' accounts	336,466	—	3,024	—	—	—
Due from third-party reimbursement programs	(7,806)	—	—	—	—	—
Other	27,263	—	125	4,707	—	3,098
Total receivables	355,923	—	3,149	4,707	—	3,098
Current portion of assets whose use is limited or restricted	46,428	60,027	—	—	—	26,343
Inventories and supplies	56,935	—	—	—	—	557
Prepaid expenses	14,703	—	—	9	—	15,116
Total current assets	524,450	60,027	9,451	16,610	1,583	54,321
Assets whose use is limited or restricted	1,883,191	99,215	18,569	—	11,781	108,597
Property, plant, and equipment, net	1,439,563	—	4,731	—	1,861	124,936
Right of use assets – operating leases, net	89,877	—	—	—	—	12,495
Accrued pension benefit liability	36,649	—	—	—	—	8,412
Other assets	111,455	—	—	—	—	13,524
	<u>\$ 4,085,185</u>	<u>159,242</u>	<u>32,751</u>	<u>16,610</u>	<u>15,225</u>	<u>322,285</u>
Liabilities and Net Assets						
Current liabilities:						
Current installments of long-term debt	\$ 32,321	—	—	—	—	3,080
Long-term debt subject to short-term remarketing agreements	64,870	—	—	—	—	—
Current portion of operating lease liabilities	13,384	—	—	—	—	2,146
Current portion of estimated self-insurance liabilities	—	55,382	—	—	—	—
Accounts payable	137,042	4,259	2,829	4,543	125	(791)
Accrued liabilities	209,427	386	60	254	—	28,851
Estimated payables under third-party reimbursement programs	79,964	—	—	—	—	—
Total current liabilities	537,008	60,027	2,889	4,797	125	33,286
Long-term debt, excluding current installments	1,215,373	—	—	—	—	30,252
Operating lease liabilities, net of current portion	78,256	—	—	—	—	10,730
Estimated self-insurance liabilities	—	92,186	—	—	—	—
Derivative instruments	30,328	—	—	—	—	—
Other noncurrent liabilities	18,310	—	13,437	—	300	6,334
Total liabilities	1,879,275	152,213	16,326	4,797	425	80,602
Net assets:						
Net assets without donor restrictions	2,204,424	7,029	16,425	11,813	14,800	241,683
Net assets with donor restrictions	1,486	—	—	—	—	—
Total net assets	2,205,910	7,029	16,425	11,813	14,800	241,683
Stockholder's equity	—	—	—	—	—	—
	<u>\$ 4,085,185</u>	<u>159,242</u>	<u>32,751</u>	<u>16,610</u>	<u>15,225</u>	<u>322,285</u>

See accompanying independent auditors' report.

Schedule 1

Medical Group	Health Care Fund	Flex Plan	Foundation	Klara, Inc.	PCC	PERC	Mission Outreach	Eliminations	Total
5,291	—	1,911	—	1,707	84	2,448	147	—	91,035
7,892	—	—	—	—	3,444	—	—	—	350,826
—	—	—	—	—	—	—	—	7,806	—
4,266	—	167	—	1,289	3,414	572	27	(7,624)	37,304
12,158	—	167	—	1,289	6,858	572	27	182	388,130
—	—	—	—	—	—	—	—	—	132,798
781	—	—	—	2,205	—	—	8,690	—	69,168
1,236	—	—	—	15	340	60	—	—	31,479
19,466	—	2,078	—	5,216	7,282	3,080	8,864	182	712,610
45,382	90,283	—	110,704	7,335	7,386	1,223	1,236	(711,287)	1,673,615
22,808	—	—	—	1,881	693	25	25	—	1,596,523
40,364	—	—	—	3,778	1,945	—	—	—	148,459
1,901	—	—	—	—	1,297	88	—	—	48,347
39	—	—	—	61	268	—	—	(35,720)	89,627
129,960	90,283	2,078	110,704	18,271	18,871	4,416	10,125	(746,825)	4,269,181
14	—	—	—	88	—	3	—	—	35,506
—	—	—	—	—	—	—	—	—	64,870
6,531	—	—	—	323	383	—	—	(439)	22,328
—	17,724	—	—	—	—	—	—	—	73,106
5,807	4,436	1,047	—	807	1,078	81	14	(16,755)	144,522
27,649	4,727	—	—	350	11,535	331	60	—	283,630
—	—	—	—	—	—	—	—	7,806	87,770
40,001	26,887	1,047	—	1,568	12,996	415	74	(9,388)	711,732
37	—	—	—	733	—	—	—	(702,156)	544,239
34,745	—	—	—	3,503	1,593	—	—	439	129,266
—	—	—	—	—	—	—	—	—	92,186
—	—	—	—	—	—	—	—	—	30,328
194	—	—	—	201	78	—	—	—	38,854
74,977	26,887	1,047	—	6,005	14,667	415	74	(711,105)	1,546,605
54,983	63,396	1,031	38,661	—	4,204	4,001	10,051	(23,454)	2,649,047
—	—	—	72,043	—	—	—	—	—	73,529
54,983	63,396	1,031	110,704	—	4,204	4,001	10,051	(23,454)	2,722,576
—	—	—	—	12,266	—	—	—	(12,266)	—
129,960	90,283	2,078	110,704	18,271	18,871	4,416	10,125	(746,825)	4,269,181

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES
Springfield, Illinois

Consolidating Statement of Operations Information and Change in Net Assets without Donor Restriction

Year ended June 30, 2022

(Dollars in thousands)

	HSSI – Obligated Group	RQIL	Unity Limited Partnership	KCIN	Healthcare West	System Office
Patient service revenue	\$ 2,550,585	—	27,524	—	—	—
Other revenues	—	—	—	—	—	—
Investment return	—	(22,401)	(3,059)	—	—	—
Net assets released from restrictions used for operations	2,085	—	—	—	—	8
Other	81,816	27,216	2,016	10,089	832	265,928
Total revenues	2,634,486	4,815	26,481	10,089	832	265,936
Expenses:						
Salaries and wages	583,247	—	14,027	—	—	118,283
Employee benefits	159,563	—	6,159	—	—	33,946
Pension expense, service cost	31,949	—	—	—	—	8,275
Professional fees	137,395	—	679	754	10	9,163
Supplies	463,626	—	626	2	13	2,074
Depreciation and amortization	110,637	—	609	—	259	29,444
Interest	11,791	—	—	—	—	507
Purchased services and other	1,129,280	4,815	4,882	8,320	354	83,463
Total expenses	2,627,488	4,815	26,982	9,076	636	285,155
Income (loss) from operations	6,998	—	(501)	1,013	196	(19,219)
Nonoperating gains (losses):						
Investment return	(149,818)	—	—	—	(905)	23,918
Pension gain, other than service cost	48,462	—	—	—	—	7,190
Pension gain, mark-to-market adjustment	(1,853)	—	—	—	—	(6,117)
Change in fair value of interest rate swaps	20,193	—	—	—	—	—
Revenues and gains in excess (deficient) of expenses and losses	(76,018)	—	(501)	1,013	(709)	5,772
Other changes in net assets without donor restriction:						
Net assets released from restrictions used for the purchase of property, plant, and equipment	5,877	—	—	—	—	80
Recognition of change in pension funded status	—	—	—	—	—	—
Transfers (to) from affiliates	(63,920)	—	—	3,100	—	—
Change in net assets without donor restriction	\$ (134,061)	—	(501)	4,113	(709)	5,852

See accompanying independent auditors' report.

Schedule 2

Medical Group	Health Care Fund	Flex Plan	Foundation	Kiara, Inc.	PCC	PERC	Mission Outreach	Eliminations	Total
105,024	—	—	—	—	36,187	—	—	—	2,719,320
—	(5,586)	—	—	(563)	—	—	—	27,987	(3,622)
—	—	—	2,694	—	—	—	—	(2,093)	2,694
136,197	188,774	130	10,222	7,050	29,692	4,149	8,701	(627,469)	145,343
241,221	183,188	130	12,916	6,487	65,879	4,149	8,701	(601,575)	2,863,735
160,182	—	—	—	3,053	68,086	2,660	—	—	949,538
24,832	190,550	191	—	574	8,958	410	1	(183,318)	241,866
7,016	—	—	—	—	3,114	118	—	—	50,472
4,725	—	—	—	197	702	175	—	—	153,800
10,297	—	—	—	193	1,040	9	24	(7,581)	470,323
5,760	—	—	—	242	245	15	3	—	147,214
1	—	—	—	60	—	—	—	—	12,359
50,117	—	—	6,020	2,319	20,107	534	6,442	(411,328)	905,325
262,930	190,550	191	6,020	6,638	102,252	3,921	6,470	(602,227)	2,930,897
(21,709)	(7,362)	(61)	6,896	(151)	(36,373)	228	2,231	652	(67,162)
(3,796)	—	—	(6,702)	—	(1,316)	(88)	(90)	—	(138,797)
2,600	—	—	—	—	1,705	25	—	—	59,982
(1,013)	—	—	—	—	458	172	—	—	(8,353)
—	—	—	—	—	—	—	—	—	20,193
(23,918)	(7,362)	(61)	194	(151)	(35,526)	337	2,141	652	(134,137)
—	—	—	1,704	—	—	—	—	(5,877)	1,784
—	—	—	—	—	—	17	—	—	17
33,871	—	—	(5,877)	151	26,949	—	—	5,726	—
9,953	(7,362)	(61)	(3,979)	—	(8,577)	354	2,141	501	(132,336)

HOSPITAL SISTERS HEALTH SYSTEM AND SUBSIDIARIES
Springfield, Illinois

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2022

(Dollars in thousands)

	HSSI – Obligated Group	RQIL	Unity Limited Partnership	KCIN	Healthcare West	System Office
Net assets without donor restriction:						
Revenues and gains in excess (deficient) of expenses and losses	\$ (76,018)	—	(501)	1,013	(709)	5,772
Other changes in net assets without donor restriction:						
Net assets released from restrictions use for the purchase of property, plant, and equipment	5,877	—	—	—	—	80
Recognition of change in pension funded status	—	—	—	—	—	—
Transfers (to) from affiliates	(63,920)	—	—	3,100	—	—
Change in net assets without donor restriction	(134,061)	—	(501)	4,113	(709)	5,852
Net assets with donor restrictions:						
Investment return	(85)	—	—	—	—	—
Contributions	19	—	—	—	—	80
Transfers (to) from affiliates	—	—	—	—	—	—
Net assets released from restrictions	—	—	—	—	—	(80)
Change in net assets with donor restrictions	(66)	—	—	—	—	—
Change in net assets	(134,127)	—	(501)	4,113	(709)	5,852
Net assets at beginning of year	2,340,037	7,029	16,926	7,700	15,509	235,831
Net assets at end of year	\$ 2,205,910	7,029	16,425	11,813	14,800	241,683

See accompanying independent auditors' report.

Schedule 3

Medical Group	Health Care Fund	Flex Plan	Foundation	Klara, Inc.	PCC	PERC	Mission Outreach	Eliminations	Total
(23,918)	(7,362)	(61)	194	(151)	(35,526)	337	2,141	652	(134,137)
—	—	—	1,704	—	—	—	—	(5,877)	1,784
—	—	—	—	—	—	17	—	—	17
33,871	—	—	(5,877)	151	26,949	—	—	5,726	—
9,953	(7,362)	(61)	(3,979)	—	(8,577)	354	2,141	501	(132,336)
—	—	—	(1,551)	—	—	—	—	—	(1,636)
—	—	—	5,051	—	—	—	—	—	5,150
—	—	—	—	—	—	—	—	—	—
—	—	—	(4,398)	—	—	—	—	—	(4,478)
—	—	—	(898)	—	—	—	—	—	(964)
9,953	(7,362)	(61)	(4,877)	—	(8,577)	354	2,141	501	(133,300)
45,030	70,758	1,092	115,581	—	12,781	3,647	7,910	(23,955)	2,855,876
54,983	63,396	1,031	110,704	—	4,204	4,001	10,051	(23,454)	2,722,576

**HOSPITAL SISTERS SERVICES, INC. –
OBLIGATED GROUP**
Springfield, Illinois
Consolidating Balance Sheet Information
June 30, 2022
(Dollars in thousands)

Assets	St. Elizabeth's O'Fallon, Illinois	St. Joseph's Breese, Illinois	St. Mary's Decatur, Illinois	St. Anthony's Effingham, Illinois	Holy Family Greenville, Illinois	St. Joseph's Highland, Illinois	St. Francis Litchfield, Illinois
Current assets:							
Cash and cash equivalents	\$ (6)	389	(8,067)	(74)	1,594	1	(13)
Receivables:							
Patients' accounts	40,848	7,878	20,042	19,710	1,914	6,211	6,275
Due from third-party reimbursement programs	2,583	189	352	243	—	(17)	40
Other	6,322	2,144	3,780	1,008	321	58	1,217
Total receivables	49,754	10,011	24,174	20,961	2,235	6,252	7,532
Current portion of assets whose use is limited or restricted	19,578	2,208	—	—	—	—	446
Inventories and supplies	6,091	737	5,263	4,777	254	782	1,038
Prepaid expenses	2,789	208	1,857	309	150	142	362
Total current assets	78,216	13,551	25,227	25,973	4,233	7,177	9,365
Assets whose use is limited or restricted, net of current portion	(19,532)	159,651	712	417,449	1,802	16,796	94,247
Property, plant, and equipment, net	231,348	32,954	101,701	80,677	14,418	33,470	26,142
Right of use assets – operating leases, net	31,167	866	252	4,032	552	7,079	477
Accrued pension benefit asset	5,037	1,968	1,526	947	12	106	(101)
Other assets	1,568	—	—	150	—	—	—
	<u>\$ 327,804</u>	<u>208,990</u>	<u>129,418</u>	<u>529,228</u>	<u>21,017</u>	<u>64,628</u>	<u>130,130</u>
Liabilities and Net Assets							
Current liabilities:							
Current installments of long-term debt	\$ 2,840	520	1,470	1,403	714	2,401	219
Long term-debt subject to short-term remarketing agreements	16,738	1,898	2,646	1,808	—	3,550	861
Current portion of operating lease liabilities	2,258	114	156	1,376	209	360	141
Accounts payable	13,703	2,639	7,218	3,773	2,011	1,149	1,626
Accrued liabilities	20,246	4,282	14,499	10,853	3,889	6,866	4,661
Estimated payables under third-party reimbursement programs	25,861	1,456	10,607	5,144	908	1,011	1,860
Total current liabilities	81,846	10,899	36,596	24,357	7,531	15,137	9,468
Long-term debt, excluding current installments	539,202	12,833	180,159	14,088	37,990	34,431	7,217
Operating lease liabilities, net of current portion	29,867	752	86	2,656	344	6,954	336
Derivative instruments	40	2,494	7	6,520	—	274	1,452
Other noncurrent liabilities	—	3,150	2,094	256	493	—	1,071
Total liabilities	850,755	29,928	218,952	47,877	46,358	56,796	19,544
Net assets (deficit):							
Net assets without donor restrictions	(322,951)	179,062	(89,810)	481,351	(26,551)	7,832	110,586
Net assets with donor restrictions	—	—	276	—	1,210	—	—
Total net assets (deficit)	<u>(322,951)</u>	<u>179,062</u>	<u>(89,534)</u>	<u>481,351</u>	<u>(25,341)</u>	<u>7,832</u>	<u>110,586</u>
	<u>\$ 327,804</u>	<u>208,990</u>	<u>129,418</u>	<u>529,228</u>	<u>21,017</u>	<u>64,628</u>	<u>130,130</u>

See accompanying independent auditors' report.

Schedule 4

Good Shepherd Shelbyville, Illinois	St. John's Springfield, Illinois	St. Joseph's Chippewa Falls, Wisconsin	Sacred Heart Eau Claire, Wisconsin	St. Mary's Green Bay, Wisconsin	St. Vincent Green Bay, Wisconsin	St. Clare Oconto Falls, Wisconsin	St. Nicholas Sheboygan, Wisconsin	Hospital Sisters Services, Inc.	Eliminations	Total
2,172	2,141	142	1,180	(180)	21,533	2,880	13,714	11,035	—	50,481
1,830	80,589	5,975	28,219	18,870	78,119	6,108	14,077	—	—	336,466
(52)	(10,329)	—	—	125	(1,344)	294	110	—	—	(7,806)
224	1,712	243	3,018	734	43,803	1,352	1,593	154	(40,420)	27,263
2,002	71,972	6,218	31,237	19,729	120,578	7,754	15,780	154	(40,420)	355,923
—	—	1,946	6,968	3,862	9,058	450	1,912	—	—	46,428
201	15,334	448	5,486	2,981	9,843	1,470	2,250	—	—	56,935
215	4,028	181	1,104	88	2,737	68	448	—	—	14,703
4,590	93,473	8,945	45,965	26,480	163,749	12,632	34,105	11,189	(40,420)	524,450
11,934	3,581	117,511	535,903	116,738	354,035	21,259	44,114	6,991	—	1,883,191
7,491	426,017	22,004	107,796	62,182	215,230	11,359	86,794	—	—	1,439,563
207	11,801	399	13,176	6,220	9,148	890	3,611	—	—	89,877
(44)	18,338	141	3,845	764	2,586	38	1,506	—	—	36,849
—	1,425	—	1,449	9,137	89,142	—	1,555	7,029	—	111,455
24,178	554,635	149,000	708,134	221,501	833,870	46,178	151,685	25,209	(40,420)	4,085,185
300	11,435	860	2,806	1,556	4,133	450	1,214	—	—	32,321
—	23,359	1,101	4,162	2,306	5,410	—	1,142	—	—	84,970
76	2,788	97	1,811	451	2,270	152	1,125	—	—	13,384
444	34,412	1,878	19,207	5,591	35,596	1,812	5,772	111	—	137,042
1,843	44,848	5,651	16,330	8,070	71,798	25,871	7,832	2,708	(40,420)	209,427
38	28,235	606	2,143	440	81	1,006	588	—	—	79,964
2,701	145,076	10,293	48,459	18,414	119,268	29,291	17,673	2,819	(40,420)	537,008
5,250	264,735	10,758	29,394	16,286	40,207	5,006	9,611	8,216	—	1,215,373
131	9,217	302	11,445	5,863	6,975	759	2,559	—	—	78,256
—	222	1,894	8,687	1,950	6,061	—	727	—	—	30,328
565	7,545	—	1,068	266	883	30	389	500	—	16,310
8,647	426,795	23,247	87,043	42,779	173,394	35,086	30,959	11,535	(40,420)	1,879,275
15,531	127,840	125,753	611,091	178,722	860,476	11,092	120,726	13,674	—	2,204,424
—	—	—	—	—	—	—	—	—	—	1,486
15,531	127,840	125,753	611,091	178,722	860,476	11,092	120,726	13,674	—	2,205,910
24,178	554,635	149,000	708,134	221,501	833,870	46,178	151,685	25,209	(40,420)	4,085,185

**HOSPITAL SISTERS SERVICES, INC. –
OBLIGATED GROUP**
Springfield, Illinois

Consolidating Statement of Operations Information and Change in Net Assets without Donor Restriction

Year ended June 30, 2022

(Dollars in thousands)

	St. Elizabeth's O'Fallon, Illinois	St. Joseph's Besse, Illinois	St. Mary's Decatur, Illinois	St. Anthony's Effingham, Illinois	Holy Family Greenville, Illinois	St. Joseph's Highland, Illinois	St. Francis Litchfield, Illinois
Patient service revenue	\$ 284,781	89,865	163,428	154,760	20,862	49,917	56,701
Other revenues:							
Net assets released from restrictions used for operations	—	—	—	—	—	—	1
Other	4,708	3,046	13,332	6,324	2,097	1,710	3,758
Total revenues	289,489	72,911	176,760	161,084	22,959	51,627	60,459
Expenses:							
Salaries and wages	73,514	13,902	47,955	42,820	6,420	11,045	12,901
Employee benefits	16,894	4,296	12,873	13,533	2,010	3,050	3,961
Pension expense, service cost	3,194	759	2,411	2,367	133	616	683
Professional fees	14,242	2,990	10,316	9,824	2,703	3,455	4,763
Supplies	54,733	5,459	29,597	18,064	2,149	5,185	9,143
Depreciation and amortization	13,654	2,890	8,109	4,891	767	2,139	2,130
Interest	2,368	227	356	292	55	1,686	453
Purchased services and other	106,775	26,126	84,856	53,461	13,495	16,541	14,834
Total expenses	285,364	56,649	196,573	145,252	27,732	43,717	48,968
Income (loss) from operations	4,125	16,262	(19,813)	15,832	(4,773)	7,910	11,490
Nonoperating income (loss):							
Investment return	(213)	(12,693)	(20)	(33,423)	(43)	(1,393)	(7,484)
Pension gain, other than service cost	5,026	1,089	3,529	2,708	66	787	1,220
Pension gain, mark-to-market adjustment	(2,250)	(425)	663	(2,029)	163	(321)	(887)
Change in fair value of interest rate swap	966	1,208	3	3,532	—	195	601
Revenues and gains in excess (deficient) of expenses and losses	7,654	5,441	(15,838)	(13,380)	(4,587)	7,158	4,940
Other changes in net assets without donor restriction:							
Net assets released from restrictions used for the purchase of property, plant, and equipment	1,394	532	213	147	3	—	742
Transfer (to) from affiliate	(26,861)	(2,298)	(12,750)	(1,337)	(813)	(1,204)	(129)
Change in net assets without donor restriction	\$ (17,813)	3,675	(28,175)	(14,570)	(5,397)	5,954	5,553

See accompanying independent auditors' report.

Schedule 5

Good Shepherd Shelbyville, Illinois	St. John's Springfield, Illinois	St. Joseph's Chippewa Falls, Wisconsin	Sacred Heart Eau Claire, Wisconsin	St. Mary's Green Bay, Wisconsin	St. Vincent Green Bay, Wisconsin	St. Clare Oconto Falls, Wisconsin	St. Nicholas Sheboygan, Wisconsin	Hospital Sisters Services, Inc.	Eliminations	Total
15,495	587,440	45,390	198,077	139,293	611,648	36,683	116,245	—	—	2,550,585
—	1,065	68	175	27	382	51	318	—	—	2,085
1,355	34,155	2,296	6,140	5,748	13,982	6,534	2,854	256	(26,477)	81,816
16,850	622,660	47,754	204,392	145,068	626,012	43,268	119,415	256	(26,477)	2,834,486
4,709	148,477	15,304	51,740	26,919	99,627	8,486	19,395	—	33	583,247
1,294	41,689	3,854	13,194	7,771	27,868	2,089	5,269	—	(62)	159,563
86	7,168	1,236	3,779	1,885	6,112	353	1,167	—	—	31,949
1,440	58,417	4,213	6,187	5,023	20,348	1,846	1,586	—	(9,978)	137,395
1,449	122,674	4,512	31,940	30,896	117,954	10,784	19,015	—	(28)	463,626
676	31,048	2,342	11,221	5,417	16,028	1,529	5,796	—	—	110,637
87	4,222	148	561	191	765	91	289	—	—	11,791
9,001	209,461	15,955	115,391	61,350	333,612	14,347	70,416	1	(16,442)	1,129,280
18,742	623,166	47,564	234,023	139,452	624,304	39,525	122,943	1	(26,477)	2,627,488
(1,892)	(496)	190	(29,631)	5,616	1,708	3,743	(3,528)	255	—	6,998
(1,017)	(1,258)	(9,675)	(44,066)	(10,372)	(24,916)	(1,737)	(970)	(538)	—	(149,818)
10	12,095	2,075	5,347	2,829	9,938	109	1,854	—	—	48,482
29	625	367	1,466	—	661	364	(279)	—	—	(1,853)
—	2,081	805	5,146	364	5,196	—	116	—	—	20,193
(2,870)	13,027	(6,238)	(61,738)	(1,563)	(7,413)	2,479	(3,007)	(283)	—	(76,018)
36	971	35	1,294	129	316	8	57	—	—	5,877
(864)	(26,957)	(70)	(185)	(393)	(11,560)	(12)	(52)	21,365	—	(83,920)
(3,498)	(12,959)	(6,273)	(60,629)	(1,827)	(18,657)	2,475	(3,002)	21,082	—	(134,061)

**HOSPITAL SISTERS SERVICES, INC. –
OBLIGATED GROUP**
Springfield, Illinois

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2022

(Dollars in thousands)

	St. Elizabeth's O'Fallon, Illinois	St. Joseph's Ereese, Illinois	St. Mary's Decatur, Illinois	St. Anthony's Effingham, Illinois	Holy Family Greenville, Illinois	St. Joseph's Highland, Illinois	St. Francis Litchfield, Illinois
Net assets without donor restriction:							
Revenues and gains in excess (deficient) of expenses and losses	\$ 7,854	5,441	(15,838)	(13,380)	(4,587)	7,158	4,940
Other changes in net assets without donor restriction:							
Net assets released from restrictions used for the purchase of property, plant, and equipment	1,394	532	213	147	3	—	742
Transfer from (to) affiliate	(26,861)	(2,298)	(12,750)	(1,337)	(813)	(1,204)	(129)
Change in net assets without donor restriction	(17,813)	3,675	(28,175)	(14,570)	(5,397)	5,954	5,553
Net assets with donor restrictions:							
Investment return	—	—	1	—	(86)	—	—
Contributions	—	—	17	—	2	—	—
Transfer from (to) affiliate	—	—	—	—	—	—	—
Net assets released from restrictions	—	—	—	—	—	—	—
Change in net assets with donor restrictions	—	—	18	—	(84)	—	—
Change in net assets	(17,813)	3,675	(28,157)	(14,570)	(5,481)	5,954	5,553
Net assets (deficit) at beginning of year	(305,138)	175,387	(81,377)	485,921	(19,860)	1,878	105,033
Net assets (deficit) at end of year	\$ (322,951)	179,062	(89,534)	481,351	(25,341)	7,832	110,586

See accompanying independent auditors' report.

Schedule 6

Good Shepherd Shelbyville, Illinois	St. John's Springfield, Illinois	St. Joseph's Chippewa Falls, Wisconsin	Sacred Heart Eau Claire, Wisconsin	St. Mary's Green Bay, Wisconsin	St. Vincent Green Bay, Wisconsin	St. Clare Oconto Falls, Wisconsin	St. Nicholas Sheboygan, Wisconsin	Hospital Sisters Services, Inc.	Eliminations	Total
(2,870)	13,027	(6,238)	(61,738)	(1,563)	(7,413)	2,479	(3,007)	(283)	—	(76,018)
36 (664)	971 (26,957)	35 (70)	1,294 (185)	129 (393)	316 (11,560)	8 (12)	57 (52)	— 21,365	— —	5,877 (83,920)
(3,498)	(12,959)	(6,273)	(60,629)	(1,827)	(18,657)	2,475	(3,002)	21,082	—	(134,081)
—	—	—	—	—	—	—	—	—	—	(85)
—	—	—	—	—	—	—	—	—	—	19
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	(66)
(3,498)	(12,959)	(6,273)	(60,629)	(1,827)	(18,657)	2,475	(3,002)	21,082	—	(134,127)
19,029	140,799	132,026	671,720	180,549	679,133	8,617	123,728	(7,408)	—	2,340,037
15,531	127,840	125,753	611,091	178,722	660,476	11,092	120,726	13,674	—	2,205,910



KPMG LLP
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200 E. Randolph Street
Chicago, IL 60601-6436

Independent Auditors' Report

The Board of Directors
Hospital Sisters Services, Inc.:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Hospital Sisters Health System and its subsidiaries (HSHS), which comprise the consolidated balance sheet as of June 30, 2022 and 2021, and the related consolidated statements of operations and change in net assets without restriction, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated October 18, 2022. The consolidated financial statements of Hospital Sisters Health System and its subsidiaries include the amounts of Hospital Sisters Services, Inc. – Obligated Group (Obligated Group) obligated under a Restated Master Trust Indenture (MTI) dated February 1, 2017, as supplemented.

In connection with our audit, nothing came to our attention that caused us to believe that the Obligated Group failed to comply with the terms, covenants, provisions, or conditions of Section 409, inclusive, of the Indenture dated February 1, 2017, with The Bank of New York Mellon, N.A. as Master Trustee, insofar as they relate to accounting matters. However, our audit was not directed primarily toward obtaining knowledge of such noncompliance. Accordingly, had we performed additional procedures, other matters may have come to our attention regarding the Obligated Group's noncompliance with the above-referenced terms, covenants, provisions, or conditions of the Indenture, insofar as they relate to accounting matters.

This report is intended solely for the information and use of the board of directors and management of HSHS The Bank of New York Mellon, N.A., requesting Qualifying Obligation holders, as defined in the MTI, and the Southwestern Illinois Development Authority, and is not intended to be and should not be used by anyone other than these specified parties.

KPMG LLP

Chicago, Illinois
October 18, 2022

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HOSPITAL SISTERS SERVICES, INC. – OBLIGATED GROUP

Unaudited Historical Debt Service Coverage Ratio

Year ended June 30, 2022

(Dollar amounts in thousands)

Income available for debt service:		
Revenues and gains deficient of expenses and losses	\$	(76,018)
Plus:		
Depreciation and amortization, excluding accelerated depreciation and amortization		110,637
Interest expense		11,791
Pension expense, mark-to-market adjustment		1,853
Change in fair value of interest rate swaps		(20,193)
Change in unrealized gains and losses included in investment returns		<u>226,376</u>
Total income available for debt service	\$	<u>254,446</u>
Debt service requirements	\$	40,561
Historical debt service coverage ratio		6.27
Minimum ratio requirement		1.10

HOSPITAL SISTERS SERVICES, INC. – OBLIGATED GROUP

Unaudited Historical Debt Service Coverage Ratio

Year ended June 30, 2022

(Dollar amounts in thousands)

Income available for debt service	\$	254,446
Maximum annual debt service		47,065
Historical maximum annual debt service coverage ratio		5.41
Minimum ratio requirement		1.10

ATTACHMENT 35**Financial Waiver**

Documentation of the A+ bond rating of the The Hospital Sisters Health System by Fitch is included with Attachment 34.

ATTACHMENT 37**Economic Feasibility**

A. Reasonableness of Financing Arrangements: Not Applicable. This project is currently proposed to be financed with Cash and Securities.

B. Conditions of Debt Financing: Not Applicable. This project is currently proposed to be financed with Cash and Securities.

C. Reasonableness of Project and Related Costs

The Cost and Gross Square Feet by Department Table is included on the following page of this Attachment.

D. Projected Operating Costs

Projected Direct Operating Expenses - FY28

Total Direct Operating Costs	\$ 83,240,793
Patients Days	9,819
Direct Cost per Patient Day	\$ 8,478

E. Total Effect of the Project on Capital Costs

Projected Capital Costs - FY28

Patient Days	9,819
Total Projected Cost	\$ 78,300,000
Useful Life (years)	30
Total Annual Depreciation	\$ 2,610,000
Depreciation Cost per Patient Day	\$ 266

Note: \$10.7 million is operating expense allocated for demolition.

Department	Cost and Gross Square Feet by Department of Service										Total Cost						
	A		B		C		D		E			F		G		H	
	Cost / Square Foot				Gross Square Feet		Circ. %		Mod.			Circ. %		Const. Cost		Mod. Cost	
	New	Mod.			New									(AxC)	(BxE)	(G+H)	
Clinical	\$ 563.73				20,738				\$ 11,690,588				\$ 11,690,588		\$ 11,690,588		
Intensive Care Unit		\$ 712.88				698				\$ 497,588			\$ 497,588		\$ 497,588		
Intensive Care Unit		\$ 712.88				698				\$ 497,588			\$ 497,588		\$ 497,588		
Medical Surgical Unit		\$ 559.07				10,019				\$ 5,601,355			\$ 5,601,355		\$ 5,601,355		
Medical Surgical Unit		\$ 559.07				10,019				\$ 5,601,355			\$ 5,601,355		\$ 5,601,355		
Diagnostic and Treatment - High Resource Intensive		\$ 653.64				6,426				\$ 4,200,259			\$ 4,200,259		\$ 4,200,259		
Post Anesthesia Recovery		\$ 662.85				884				\$ 585,957			\$ 585,957		\$ 585,957		
Prep & Recovery		\$ 579.94				2,998				\$ 1,738,648			\$ 1,738,648		\$ 1,738,648		
Surgery Suite		\$ 737.29				2,544				\$ 1,875,654			\$ 1,875,654		\$ 1,875,654		
Diagnostic and Treatment - Medium Resource Intensive		\$ 387.03				3,595				\$ 1,391,387			\$ 1,391,387		\$ 1,391,387		
Cardiovascular Clinic		\$ 261.33				958				\$ 250,353			\$ 250,353		\$ 250,353		
Emergency Department		\$ 645.76				521				\$ 336,439			\$ 336,439		\$ 336,439		
Endoscopy		\$ 596.94				876				\$ 522,919			\$ 522,919		\$ 522,919		
Pain Clinic		\$ 227.16				1,240				\$ 281,676			\$ 281,676		\$ 281,676		
Non-Clinical	\$ 382.22				85,038				\$ 32,503,232				\$ 32,503,232		\$ 32,503,232		
Support Areas		\$ 425.68				45,815				\$ 19,502,648			\$ 19,502,648		\$ 19,502,648		
Clean Utility, Soiled Utility, Janitor Closets, Breakrooms, Staff Restrooms, Corridors & Waiting		\$ 405.80				42,535				\$ 17,260,608			\$ 17,260,608		\$ 17,260,608		
Pharmacy Corridors & Support		\$ 683.55				3,280				\$ 2,242,039			\$ 2,242,039		\$ 2,242,039		
Administration		\$ 347.29				9,727				\$ 3,378,058			\$ 3,378,058		\$ 3,378,058		
Administration		\$ 347.29				9,727				\$ 3,378,058			\$ 3,378,058		\$ 3,378,058		
Public / Amenities		\$ 416.44				11,108				\$ 4,625,811			\$ 4,625,811		\$ 4,625,811		
Cafeteria Serving		\$ 401.68				3,211				\$ 1,289,779			\$ 1,289,779		\$ 1,289,779		
Chapel & Gift Shop		\$ 432.19				1,796				\$ 776,205			\$ 776,205		\$ 776,205		
Connecting Link		\$ 639.65				1,103				\$ 705,538			\$ 705,538		\$ 705,538		
Waiting		\$ 406.56				1,689				\$ 686,678			\$ 686,678		\$ 686,678		
Public Corridors		\$ 352.86				3,309				\$ 1,167,611			\$ 1,167,611		\$ 1,167,611		
Building Components		\$ 271.74				18,388				\$ 4,996,716			\$ 4,996,716		\$ 4,996,716		
Building Enclosure		\$ 161.25				9,391				\$ 1,514,300			\$ 1,514,300		\$ 1,514,300		
Vertical Circulation		\$ 2,095.74				426				\$ 892,786			\$ 892,786		\$ 892,786		
Mechanical / Electrical Spaces / Equipment		\$ 302.14				8,571				\$ 2,589,630			\$ 2,589,630		\$ 2,589,630		
Clinical + Non-Clinical	\$ 417.81				105,776				\$ 44,193,821				\$ 44,193,821		\$ 44,193,821		

ATTACHMENT 38
Charity Care Information

The amount of charity care provided by the applicant facility and by Hospital Sisters Health System's other affiliated Illinois hospitals are included in the tables below.*

HSHS ST. MARY'S HOSPITAL, Decatur			
	2018	2019	2020
Net Patient Revenue (\$)	135,890,615	141,491,884	139,592,400
Amount of Charity Care (charges)	1.5% of net patient revenue	1.8% of net patient revenue	2.6% of net patient revenue
Cost of Charity Care (\$)	2,038,752	2,501,942	3,626,588

HSHS ST. JOHN'S HOSPITAL, Springfield			
	2018	2019	2020
Net Patient Revenue (\$)	504,568,621	474,418,110	7,089,001
Amount of Charity Care (charges)	0.7% of net patient revenue	1.1% of net patient revenue	1.4% of net patient revenue
Cost of Charity Care (\$)	3,735,064	5,717,962	7,089,001

HSHS ST. ELIZABETH'S HOSPITAL, O'Fallon			
	2018	2019	2020
Net Patient Revenue (\$)	176,952,794	209,923,705	236,229,960
Amount of Charity Care (charges)	2.2% of net patient revenue	2.4% of net patient revenue	2.0% of net patient revenue
Cost of Charity Care (\$)	3,968,739	4,957,179	4,677,255

HSHS ST. ANTHONY'S MEMORIAL HOSPITAL, Effingham			
	2018	2019	2020
Net Patient Revenue (\$)	141,407,019	141,549,301	133,797,725
Amount of Charity Care (charges)	1.4% of net patient revenue	1.5% of net patient revenue	1.6% of net patient revenue
Cost of Charity Care (\$)	1,992,352	2,054,382	2,124,114

HSHS ST. JOSEPH'S HOSPITAL, Breese			
	2018	2019	2020
Net Patient Revenue (\$)	58,428,110	57,565,569	51,076,177
Amount of Charity Care (charges)	1.6% of net patient revenue	1.4% of net patient revenue	1.6% of net patient revenue
Cost of Charity Care (\$)	948,599	794,098	807,372

HSHS HOLY FAMILY HOSPITAL, Greenville			
	2018	2019	2020
Net Patient Revenue (\$)	22,130,300	23,264,200	18,477,072
Amount of Charity Care (charges)	1.2% of net patient revenue	0.9% of net patient revenue	3.0% of net patient revenue
Cost of Charity Care (\$)	276,222	220,980	548,198

HSHS ST. FRANCIS HOSPITAL, Litchfield			
	2018	2019	2020
Net Patient Revenue (\$)	48,280,634	50,432,039	49,837,518
Amount of Charity Care (charges)	1.1% of net patient revenue	1.6% of net patient revenue	2.0% of net patient revenue
Cost of Charity Care (\$)	538,899	800,168	1,008,722

HSHS ST. JOSEPH'S HOSPITAL, Highland			
	2018	2019	2020
Net Patient Revenue (\$)	34,901,482	42,467,496	41,475,768
Amount of Charity Care (charges)	2.3% of net patient revenue	1.5% of net patient revenue	1.5% of net patient revenue
Cost of Charity Care (\$)	790,487	653,071	621,484

HSHS GOOD SHEPHERD HOSPITAL, Shelbyville			
	2018	2019	2020
Net Patient Revenue (\$)	14,677,805	15,502,498	12,264,800
Amount of Charity Care (charges)	0.9% of net patient revenue	2.6% of net patient revenue	1.2% of net patient revenue
Cost of Charity Care (\$)	128,398	404,244	151,281

*Source: 2018, 2019, and 2020 Hospital Profile