HOSPITAL FINANCIAL ASSISTANCE REPORT

OFFICE OF THE ATTORNEY GENERAL • STATE OF ILLINOIS

Pursuant to 77 Ill. Adm. Code 4500.60, each Illinois hospital must annually provide, in conjunction with the filing of either its Community Benefits Report as required by the Community Benefits Act or its Worksheet C Part I as required by the Hospital Uninsured Patient Discount Act, a Hospital Financial Assistance Report to the Office of the Attorney General. This form shall be completed and filed with the Office of the Attorney General as described below.

Reporting Hospital: Genesis Medical Center-Silvis

Mailing Address: 801 Illini Drive

City, State, Zip: Silvis, IL 61282

Reporting Period: 07/01/2022 through 06/30/2023

Taxpayer Number: 36-3616314

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1. Attach a copy of each Hospital Financial Assistance Application form used during the reporting period. If more than one form was used, identify the date any amended form was adopted.
2. Attach a copy of the Presumptive Eligibility Policy in effect during the reporting period, which shall identify each of the criteria used by the hospital to determine whether a patient is presumptively eligible for Hospital Financial Assistance.
3. Provide the following Hospital Financial Assistance statistics for the hospital during the reporting period:
   - A) The number of Hospital Financial Assistance Applications submitted to the hospital, both complete and incomplete, during the most recent fiscal year: a) 1,271
   - B) The number of Hospital Financial Assistance Applications the hospital approved under its Presumptive Eligibility Policy during the most recent fiscal year: b) 1,178
   - C) The number of Hospital Financial Assistance Applications the hospital approved outside its Presumptive Eligibility Policy during the most recent fiscal year: c) 59
   - D) The number of Hospital Financial Assistance Applications denied by the hospital during the most recent fiscal year: d) 148
   - E) The total dollar amount of financial assistance provided by the hospital during the most recent fiscal year based on actual cost of care: e) $ 869,560

4. If the Reporting Hospital annually files a Community Benefits Plan Report with the Office of the Attorney General pursuant to the Community Benefits Act, the Hospital Financial Assistance Report shall be filed at the same time as the Community Benefits Plan Report is filed each year. All records and certifications required to be filed under this Part in conjunction with the filing of its Community Benefits Report as required by the Community Benefits Act shall be submitted to:

   Charitable Trusts Bureau
   Office of the Illinois Attorney General
   100 West Randolph Street, 11th Floor
   Chicago, Illinois 60601

5. If the Reporting Hospital is not required to annually file a Community Benefits Plan Report with the Office of the Attorney General, the Hospital Financial Assistance Report shall be filed jointly with its Worksheet C Part I from its most recently filed Medicare Cost Report pursuant to the Hospital Uninsured Patient Discount Act. All records and certifications required to be filed under this Part in conjunction with the filing of its Worksheet C as required by the Hospital Uninsured Patient Discount Act shall be submitted to:

   Health Care Bureau
   Office of the Illinois Attorney General
   100 West Randolph Street, 10th Floor
   Chicago, Illinois 60601

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6. If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Hospital Financial Assistance Application requirements, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

Fastag

7. If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Presumptive Eligibility Criteria, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

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Under penalty of perjury, I the undersigned declare and certify that I have examined this Hospital Financial Assistance Report and the documents attached thereto. I further declare and certify that this Hospital Financial Assistance Report and the documents attached thereto are true and complete.

Name and Title (CEO or CFO): Joseph Malas, VP Finance/CFO

Signature: Jo Malas

Date: 12-22-2023

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Where the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Hospital Financial Assistance Application requirements, complete the following additional certification:

I further declare and certify that each of the Hospital Financial Assistance Application requirements set forth in 77 Ill. Adm. Code 4500.30 are included in Hospital Financial Assistance Applications processed by Electronic and Information Technology.

Name and Title (CEO or CFO): Joseph Malas, VP Finance/CFO

Signature: Jo Malas

Date: 12-22-2023

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Where the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Presumptive Eligibility Criteria, complete the following additional certification:

I further declare and certify that each of the Presumptive Eligibility Criteria requirements set forth in 77 Ill. Adm. Code 4500.40 are included in Hospital Financial Assistance Applications processed by Electronic and Information Technology.

Name and Title (CEO or CFO): Joseph Malas, VP Finance/CFO

Signature: Jo Malas

Date: 12-22-2023

GENESIS

1227 E. Rusholme Street, Davenport, Iowa 52803
Tel 800-250-6020 or 563-421-3408; Fax 563-421-3608

For Services Provided By:

Genesis Medical Center Davenport
Genesis Medical Center Silvis
Genesis Medical Center DeWitt
Genesis Medical Center Aledo

Financial Assistance Application Instructions

Genesis Health System's mission is to provide quality, compassionate care to all of those in need. Staying true to this mission, Genesis provides a Financial Assistance program to all those in need in a fair non-discriminatory manner. Funds are set aside annually to assist those patients who indicate financial need. Requirements are based on percentages above the Federal Poverty Income Guidelines. This application does not guarantee financial assistance, but begins the review process for consideration. Genesis Health System-Silvis Campus and Genesis Medical Center Aledo offer uninsured Illinois residents alternative financial discounts. Please contact a customer service representative for more information about uninsured Illinois resident discounts. Customer Service representatives can be reached at **563-421-3408** or **800-250-6020**. To print a copy of the financial assistance application and instructions, visit www.genesishealth.com.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 1-877-305-5145 or online at www.IllinoisAttorneyGeneral.gov. Critical Access hospitals are not included in the uninsured discount act.

It is important to note you may also be able to receive free or discounted care. Completing this application will help Genesis Health System determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

If you are uninsured, a social security number is not required to qualify for free or discounted care. However, a social security number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by US mail, by electronic mail, or by fax to apply for free or discounted care within 60 days of receipt of the application.

The following items should be considered:

- A complete application must be returned within **60 calendar days** of your receipt of the application.
- All necessary information must be included with the completed application. If additional information is required, applicant will be contacted and will have **14 business days** from date contacted to provide the additional information. Failure to provide this information within time limit guidelines will result in a denial of financial assistance.

- Responsible parties receiving help from anyone in regard to living expenses must include a written statement from that party and a copy of their picture identification.
- Patients must have applied for medical benefits through the State Department of Human services if they qualify. Proof of denial/coverage should be included with all other documentation.
- Genesis reserves the right to request verification of income. Refusal to provide requested information in time limit guidelines will result in denial of financial assistance.
- Return a completed application to:

Genesis Medical Center
ATTN: Patient Financial Services Suite #2600 - FA
1401 West Central Park Avenue
Davenport, IA 52803
www.genesishealth.com

Financial Assistance will not be granted if:

- Any portion of an account balance is payable or expected to be payable by a third party. If proceeds from litigation or settlement resulting from an accident, injury or legal proceedings are received by the patient, reimbursement to the hospital of any financial assistance will be required.
- Any hospital balance is under $500. (Exception for Illinois Uninsured Discount) Multiple account balances cannot be combined to meet minimum balance requirements.
- Fraudulent information given at any time during the process. Examples include, but are not limited to, giving fraudulent name, address, employer/employment, income, and assets.
- Age of self balance is greater than 240 days.

The following items (when applicable) must be returned with the completed application.
Important: Please only send copies of documents as originals will not be returned.

- ❑ Copy of photo identification or equivalent documentation, i.e. Driver's License, Identification Card, or Temporary Visitor Driver's License
- ❑ Copies of 2 (two) most recent paycheck stubs **or** copy of most recent tax return **or** copy of most recent W-2 form and 1099 forms **or** written income verification from an employer if paid in cash
- ❑ Verification of monthly income from Social Security or Disability
- ❑ Verification of unemployment income
- ❑ Verification of pension and/or workers compensation benefits
- ❑ Copies of last 3 (three) months bank checking/savings statements
- ❑ A letter of support and a copy of the supporter's photo identification if the applicant receives help financially from another party
- ❑ Verification of Student Status
- ❑ Letter of decision regarding public funded health insurance
- ❑ Documentation showing the balance due on home (if you own)

These items are not required but may be included and taken into consideration:

- ❑ Documentation of outstanding medical bills
- ❑ Documentation of monthly pharmacy charges (medication expenses that occur each month)

If approved for financial assistance, you will be contacted via mail. If application results in a denial, a letter of appeal can be submitted and will be considered on a case-by-case basis. A written letter of appeal must be provided within 14 days of receiving a denial. A written appeal does not guarantee change of financial assistance decision.

For those persons that do not qualify for financial assistance based on current guidelines, extended interest-free payment plans are available. Please contact the business office to discuss your specific options.

Failure to return any required portion of this application or supporting documents may result in a denial of financial assistance. It is the patient's responsibility to contact Genesis if additional time is needed to gather necessary and required documentation.

Services Provided By:

❑ Genesis Medical Center Davenport
❑ Genesis Medical Center Silvis
❑ Genesis Medical Center DeWitt
❑ Genesis Medical Center Aledo

1227 E Rusholme St, Davenport IA 52803
Tel 800-250-6020 or 563-421-3408; Fax 563-421-3608

Internal Use Only:
FA_____ SELF UNC_____

FINANCIAL ASSISTANCE APPLICATION

I am requesting financial assistance in paying for health care services provided by Genesis. I understand I must provide certain information for a review and a determination of my eligibility. I further understand that completing this form does not guarantee any assistance. All information must be completed.

❑ Financial Assistance ❑ Illinois Uninsured Discount Act

Patient Name: _____ Patient Employer: _____

Patient Address: _____ Employer Address: _____

Patient Phone: _____ Employer Phone: _____

Patient SSN: _____ Patient Date of Birth: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

*Optional responses: *Race: _____ *Sex: _____ *Ethnicity: _____
*Preferred Language: _____

Responsible Party (guarantor) for payment of the bill:

Guarantor Name: _____ Guarantor Employer: _____

Guarantor Address: _____ Employer Address: _____

Guarantor Phone: _____ Employer Phone: _____

Guarantor SSN: _____ Guarantor Date of Birth: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Number of Dependents: _____

Dependents Name: _____ Age:__ Dependents Name: _____ Age:__

Dependents Name: _____ Age:__ Dependents Name: _____ Age:__

Dependents Name: _____ Age:__ Dependents Name: _____ Age:__

Resources (Income / Assets for the guarantor family) **Check one: Monthly or Annual**

Wages (Self)	$_____	Received: Monthly___ Annually____
(Spouse)	$_____	Received: Monthly___ Annually____
(Other family member)	$_____	Received: Monthly___ Annually____
Farm or self-employment	$_____	Received: Monthly___ Annually____
Public assistance	$_____	Received: Monthly___ Annually____
Social Security	$_____	Received: Monthly___ Annually____
Unemployment compensation	$_____	Received: Monthly___ Annually____
Strike benefits	$_____	Received: Monthly___ Annually____
Alimony	$_____	Received: Monthly___ Annually____
Child support	$_____	Received: Monthly___ Annually____
Military family allotments	$_____	Received: Monthly___ Annually____
Pensions	$_____	Received: Monthly___ Annually____
Income from dividends, interest, rent	$_____	Received: Monthly___ Annually____

Expenses / Liabilities (Monthly) for Guarantor

*Mortgage/Rent	$_____	Medical insurance	$_____
Utilities	$_____	Auto insurance	$_____
Telephone	$_____	Medical bills	$_____
Food	$_____	Hospital	$_____
Finance companies	$_____	Physician	$_____
Credit union	$_____	Medication	$_____
Auto loans	$_____		

Total Expenses $_____ /Month

* If none, source of housing _____

Do you own a home? Yes ( ) No ( ) If yes, estimated value: _____

Amount owed on mortgage: _____

The following items (when applicable) must be returned with the completed application.

Important: Please only send copies of documents as originals will not be returned.

- ❑ Copy of photo identification or equivalent documentation, i.e. Driver's License, Identification Card, or Temporary Visitor Driver's License
- ❑ Copies of 2 (two) most recent paycheck stubs **or** copy of most recent tax return **or** copy of most recent W-2 form and 1099 forms **or** written income verification from an employer if paid in cash
- ❑ Verification of monthly income from Social Security or Disability
- ❑ Verification of unemployment income
- ❑ Verification of pension and/or workers compensation benefits
- ❑ Copies of last 3 (three) months bank checking/savings statements
- ❑ A letter of support and a copy of the supporter's photo identification if the applicant receives help financially from another party
- ❑ Verification of Student Status
- ❑ Letter of decision regarding public funded health insurance
- ❑ Documentation showing the balance due on home (if you own)

These items are not required but may be included and taken into consideration:

- ❑ Documentation of outstanding medical bills
- ❑ Documentation of monthly pharmacy charges (medication expenses that occur each month)

ACKNOWLEDGEMENT AND SIGNATURE:

- I declare under penalty of perjury and cancellation of any previous agreements that the answers I have provided are true and correct to the best of my knowledge.
- I agree to inform the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household, or of any changes of address.
- I understand and grant permission for Genesis Health System, its affiliates and representatives to investigate and verify all information provided within this application. All statements will be subject to verification by contact with my employer, bank, credit bureaus, and record searches.
- I understand Genesis is required by law to keep all submitted information confidential.
- I further agree, that in consideration for receiving healthcare services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by Genesis or I may appeal the decision in writing with additional documentation.
- I understand that it is my responsibility to inform the hospital of future visits that should be considered for Financial Assistance.

Signature_____ **Date**_____

Genesis Health System
Board Policy

[i]**Subject:** Financial Assistance (aka Charity Care)	**Effective Date:** 03/19/96
Section: Board Policy	**Reviewed/Revised:** 01/05/23 01/06/22 01/07/21 01/09/20 01/10/19 07/01/18
Responsibility: • Genesis Health System Board of Directors • Vice President, Finance/CFO	**Review Cycle:** Annual
Approved by:	Page 1 of 15

I. POLICY:

The Board of Directors of Genesis Health System ("GHS") is committed to its mission to provide quality, compassionate care to all of those in need regardless of ability to pay. In support of this commitment, GHS maintains this Financial Assistance Program ("FAP") policy to provide assistance for eligible individuals with covered health care needs. GHS consists of Genesis Medical Center, Aledo; Genesis Medical Center, Davenport; Genesis Medical Center, DeWitt; Genesis Medical Center, Silvis; and related entities and business units. This FAP applies to the business units designated in Section II below.

II. APPLICABLE BUSINESS UNITS:

☐ All GHS Business Units:

☐ Crescent Laundry
☐ Crosstown Square
☐ Genesis Accountable Care Organization
☒ Genesis Convenient Care
☐ Genesis EAP
☒ Genesis Family Medical Center
☐ Genesis FirstMed Pharmacy
☒ Genesis Health Group
☒ Genesis Health Group, Aledo Rural Health
☒ Genesis Health Group, Erie Rural Health
☐ Genesis Health Services Foundation
☐ Genesis Home Medical Equipment
☐ Genesis Hospice
☒ Genesis Medical Center, Aledo
☒ Genesis Medical Center, Davenport
☒ Genesis Medical Center, DeWitt
☒ Genesis Medical Center, Silvis
☐ Genesis Occupational Health
☐ Genesis Philanthropy
☒ Genesis Psychology Associates
☐ Genesis VNA
☐ Genesis Workers Comp Plan & Trust

III. APPLICABLE ORGANIZATIONAL ROLES:

None

IV. PURPOSE:

To meet the needs of the community, GHS has established a fair and equitable Financial Assistance Program (FAP) to provide Financial Assistance that reflects the status of GHS as a non-profit healthcare provider, which promotes its mission. The FAP is focused on offering charity care at some level of payment relief for those patients who are unable to sustain the extraordinary burden of medical expenses due to limited income and resources. The FAP applies to any emergency and other Medically Necessary Care for eligible individuals and is intended to comply with the Code Section 501(r) Requirements.

V. DEFINITIONS:

Please see Appendix 1 for a complete list of definitions used in this FAP.

VI. GENERAL CONSIDERATIONS:

This policy will apply to all patients regardless of race, creed, sex, age or payer. Reasonable efforts will be taken to ensure that any language or hearing barriers are addressed, consistent with the Code Section 501(r) Requirements.

VII. PRACTICE/PROCEDURE:

A. SCOPE:

1. General. The FAP applies to all emergency and other Medically Necessary Care provided by GHS to eligible patients, including all such care provided in a GHS Hospital Facility by a Substantially-Related Entity. The FAP also applies to care provided by the Genesis Health Group in a GHS Hospital Facility.

2. Exclusions. Patient care that is not considered emergency or Medically Necessary Care, including but not limited to, elective (e.g., bariatric surgery), cosmetic, or other care deemed to be generally non-reimbursable by government payers shall not be considered eligible for charity care payment relief through the Financial Assistance Program.

3. Publicity. Each GHS Hospital Facility will widely publicize the availability of the FAP to all patients. The measures for widely publicizing the FAP are provided in Appendix 2.

4. Illinois Hospital Uninsured Discount Act. In addition to the Code Section 501(r) Requirements, GHS Hospital Facilities located in Illinois are subject to the Illinois Hospital Uninsured Discount Act and the Illinois Fair Patient Billing Act (together, the "Illinois Requirements"). In order to fully comply with the Illinois

Requirements, this FAP is supplemented by the GHS Miscellaneous Discount Policy.

5. Other Programs and Discounts. GHS will make available to all patients information on its FAP as well as other GHS and external programs that may provide payment assistance or coverage for service. This includes patient financing programs with external third parties; the GHS Miscellaneous Discount Policy, which encompasses prompt-pay discounts, other supplemental need-based discounts, and certain discounts provided in connection with the Illinois Requirements for patients at GHS Hospital Facilities located in Illinois. GHS will make affirmative efforts to assist patients in applying for public and private programs for which they may qualify and that may assist them in obtaining and paying for healthcare services.

B. ELIGIBILITY CRITERIA AND FINANCIAL ASSISTANCE:

1. Insured Status. Financial Assistance deemed as charity care may be available for patients who are uninsured or underinsured, if they meet applicable eligibility criteria. An uninsured patient is a patient who has no level of insurance or third-party payment assistance. An underinsured patient is a patient who has some level of insurance or third-party payment assistance but whose out-of-pocket expenses exceed his/her financial abilities.

2. Residency. Patients seeking Financial Assistance must seek non-emergent care from the GHS Hospital Facility closest to their actual residence. If appropriate treatment is not available at the applicable GHS Hospital Facility, then GHS may permit the patient to seek care at another GHS Hospital Facility. To determine residency, the patient must provide valid state-issued identification, a voter registration card, a vehicle registration card, a lease agreement, a utility bill (dated within 60 days), or mail addressed to the patient from a local, state or federal government entity or agency (dated within 60 days).

3. Minimum Balance. The minimum balance on any account to qualify for charity care through Financial Assistance must be equal to or greater than $500.00 (for care at GHS Illinois Hospital Facilities, the minimum balance is $300.00 only when applying for the IL Uninsured Discount Act).

4. FAP Application and Criteria. The primary criterion for determining eligibility for Financial Assistance Program is household income, including certain available net assets (excluding GHG Aledo), based on the information requested and provided in the FAP Application, as explained in Section VII.D. An individual will not be denied Financial Assistance based on information that has not be specified or required in the FAP or in the FAP Application.

5. Financial Assistance Sliding Scale. Effective January 1 of each calendar year, Financial Assistance shall be available pursuant to the sliding scale found in Appendix 3, which is based on the most current Federal Poverty Income Guidelines ("FPIG"). Consistent with the sliding scale, 100% Financial Assistance (i.e., full Charity Care) shall be provided to

documented homeless patients, deceased individuals without estates, and underinsured and the uninsured patients earning 200% or less of FPIG.

a. For Illinois residents receiving care at a GHS Illinois Hospital Facility, the maximum amount that may be collected in a twelve (12) month period for care is 25% of the patient's household income, subject to timely application and the patient's eligibility under the Illinois Requirements.

Furthermore, a patient determined to be eligible for Financial Assistance shall not be financially responsible more than AGB, as defined in Section VII.C., for emergency or other Medically Necessary Care. Discounts available under the FAP are based on gross charges applicable to the service. In addition to, or in lieu of, this FAP, patients may be eligible for discounts pursuant to the GHS Miscellaneous Discount Policy.

6. FPIG. The Patient Financial Services Department shall be responsible for updating the FPIG every calendar year.

7. Extenuating Circumstances. On occasion, extenuating circumstances may exist which would cause GHS to grant Financial Assistance to a patient who may otherwise not meet quantitative criteria. In such cases, the Revenue Cycle Administrator or appropriate Management staff will document why the assistance was granted and supporting documentation will be maintained.

8. Offsets. In the event a patient is awarded a settlement from pursuing legal proceedings or has received financial resources specifically identified to cover the care that was delivered, it is the obligation of the patient to inform GHS and make appropriate payment to GHS at that time. GHS may reverse the decision of Financial Assistance and document accordingly, to the extent allowed by the Code Section 501(r) Requirements.

9. Cooperation. Any patient who fails or refuses to provide requested information to a third party payor that results in a denial will not be eligible for the FAP. A patient who furnishes materially incorrect or fraudulent information in connection with this FAP may be deemed ineligible for Financial Assistance at the sole discretion of GHS.

C. AGB:

For purposes of the FAP, GHS calculates AGB using the look-back method consistent with the Code Section 501(r) Requirements. Members of the public may readily obtain the applicable AGB percentage for each GHS Hospital Facility and a description of the calculation in writing and free of charge by visiting www.genesishealth.com/patients-visitors/, contacting Patient Financial Services (see Section X for contact information), or visiting a GHS Hospital Facility.

D. APPLICATION PROCESS:

1. FAP Application. Patients seeking charity care through Financial Assistance must complete a FAP Application to document income and expenses (liabilities) unless they meet the presumptive eligibility criteria. GHS may ask for (but may not require of patients from its Illinois hospitals) a credit card statement to support the information provided in the FAP Application. FAP Applications may be found online at www.genesishealth.com/patients-visitors/, by contacting Patient Financial Services (see Section X for contact information), or visiting a GHS Hospital Facility.

2. Income Verification. Income (household income) will be estimated yearly by the patient supplying any of the following:

    - A copy of the most recent tax return
    - A copy of the most recent W-2 form and 1099 forms
    - Copies of the 2 most recent pay stubs
    - Written income verification from an employer if paid in cash

3. Completeness. GHS recognizes that not all patients are able to provide complete financial and/or social information. Therefore, approval for Financial Assistance may be determined based on available information.

4. Identification. To verify a patient's name, date of birth and/or address, the patient must provide any of the following:

    - A valid passport
    - A valid birth certificate
    - A certificate of citizenship, U.S. or foreign (including but not limited to DHS Forms N-560 or N-561)
    - An identification card issued by the U.S. or a foreign government (including but not limited to DHS Form I-197)
    - An official military record of service
    - A certification of a foreign birth (including but not limited to form FS-545)
    - A report of birth abroad (including but not limited to Form FS-240)
    - A Certificate of Report of Birth issued by the U.S. Department of State (Form DS-1350) or any similar form issued by a foreign government
    - A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database

- A government census record
- A certificate of naturalization, U.S. or foreign (including but not limited to DHS Forms N-550 or N-570)

If the patient is not able to provide a document from the above list, the patient must provide an alternate written means through which GHS can verify the patient's name, date of birth and/or address.

5. External Sources and Presumptive Eligibility. GHS may utilize an external source to perform an analysis for determining applicable levels of Financial Assistance when documentation is not able to be provided (i.e., presumptive eligibility). The external source will meet necessary privacy and accounting requirements and shall utilize relevant national database information. GHS may also utilize previously completed Financial Assistance applications to make presumptive eligibility determinations. In addition, demonstration of one or more of the following will result in a presumptive eligibility determination:

    a. Homelessness

    b. Deceased with no estate

    c. Mental incapacitation with no one to act on patient's behalf

    d. Medicaid eligibility, but not on date of service or for non-covered services

    e. Recent personal bankruptcy

    f. Incarceration in a penal institution

    In these instances where assistance is found to be appropriate, notice will be forwarded to patient via reduced balance on their statement, which shall include information regarding how to apply for potentially more generous Financial Assistance within a reasonable period of time.

6. Remaining Balance. All balances owing after Financial Assistance has been provided may be payable in monthly payments pursuant to the standard payment procedures of the GHS Hospital Facility.

7. Referral Sources. Patient referrals may come from the patient or anyone acting on his/her behalf, including medical staff, Continuum Services, Patient Access, and Patient Financial Services. In addition, Patient Financial Services shall routinely review the payment history of accounts to determine possible candidates with emphasis on those with demonstrated payment history that are willing but unable to pay more.

8. Timeline for Establishing Financial Assistance Eligibility.

    a. A FAP Application will be accepted and processed by GHS at any time during the Application Period pursuant to the procedures outlined in Section VII.E.

b. The information contained in a FAP Application is valid for sixty (60) days, and, after that time period expires, the application will need to be renewed.

c. Provisions specifically applicable to GHS Illinois Hospital Facilities:

i. GHS shall apply the presumptive eligibility criteria as soon as possible after a patient's receipt of healthcare services by the hospital and prior to the issuance of a bill for healthcare services.

ii. Every effort will be made to determine a patient's eligibility for Financial Assistance within sixty (60) days from any of the following: after discharge, from the date of service, after receipt of third party payment or after receiving government denial for Medicaid coverage or disability. This is in accordance with the Illinois Requirements. This provision shall not affect the timeframes established elsewhere in the FAP for notification of the availability of Financial Assistance or the patient's timeframe to apply.

E. BILLING AND COLLECTIONS PROCESS:

As described below, GHS will make reasonable efforts to determine whether a patient is eligible under this FAP for Financial Assistance before it engages in an extraordinary collection action, or ECA. Once a determination is made, GHS may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. Except as provided below, a patient may submit a FAP Application at any time during the Application Period, which is generally 240 days from the date of the first post-discharge bill as defined in Appendix 1. GHS will not be obligated to accept a FAP Application after 240 days from the date of the first post-discharge bill (including patients who have fully paid applicable charges) unless otherwise specifically required by the Code Section 501(r) Requirements. Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

a. Presumptive Eligibility Determinations. If a patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application submitted with respect to prior care), GHS will notify the patient of the basis for the determination and give the patient a reasonable period of time to apply for more generous assistance before initiating an ECA.

b. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, GHS will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement

for the care is sent to the patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one or more ECA(s) to obtain payment for care from a patient who has not submitted a FAP Application, GHS shall take the following actions:

i. Provide the patient with a written notice that indicates Financial Assistance is available for eligible individuals, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;

ii. Provide the patient with a Plain Language Summary; and

iii. Make a reasonable effort to verbally notify the individual about the FAP and the FAP Application process.

c. Incomplete FAP Applications. In the case of a patient who submits an incomplete FAP Application during the Application Period, GHS shall notify the patient in writing about how to complete the FAP Application and give the patient seven (7) calendar days to do so. Any pending ECAs shall be suspended during the reasonable opportunity, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.

d. Complete FAP Applications. In the case of a patient who submits a complete FAP Application during the Application Period, GHS shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

e. Restrictions on Deferring or Denying Care. In a situation where GHS intends to defer or deny, or require a payment before providing, Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP, the patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible patients and stating the deadline, if any, after which GHS will no longer accept and process an application submitted (or, if applicable, completed) by the patient for the previously-provided care at issue. This deadline shall be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement was provided for the previously provided care.

2. Determination Notification.

a. Determinations. Once a completed FAP Application is received on a patient's account, GHS will evaluate the FAP Application to determine eligibility and notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days. The notification

will include a determination of the amount for which the patient and/or responsible party will be financially accountable. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

b. Refunds. GHS will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

c. Reversal of ECA(s). To the extent a patient is determined to be eligible for Financial Assistance under the FAP, GHS will take all reasonably available measures to reverse any ECA taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien on the individual's property, and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

3. Appeals. The patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Patient Financial Services Department within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Patient Financial Services Department Manager for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to patient, legal guardian, and/or responsible party.

4. Collections. Upon conclusion of the above procedures, GHS may proceed with ECAs against uninsured and underinsured patients with delinquent accounts, as determined in GHS procedures for establishing, processing, and monitoring patient bills and payment plans. Additionally, GHS will consider all uninsured patient balances for evaluation of amounts to be identified as Incurred Adjustments; separate from provision for bad debt. To the extent applicable, GHS will utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts and shall comply with the Code Section 501(r) Requirements applicable to third parties.

VIII. ADMINISTRATION

A. General. The FAP is administered by the GHS Patient Financial Services Department at the direction of the Board of Directors of GHS.

B. Interpretation. GHS has the sole discretion to interpret, enforce, and administer this FAP consistent with all federal, state, and local laws, rules, and regulations that may apply.

C. Amendment. This FAP may be amended from time to time by the Board of Directors of GHS.

IX. PROVIDER LIST

A list of providers ("Provider List") that provide emergency or Medically Necessary Care at GHS Hospital Facilities is maintained and updated from time to time by Medical Affairs and can be accessed online via www.genesishealth.com, or by contacting Medical Affairs (see below for contact information), or visiting a GHS Hospital Facility.

GHS Medical Affairs
Genesis Health System
1401 West Central Park Avenue
Davenport, Iowa 52804
Phone: (563) 421-1288
Email: MedicalAffairs@genesishealth.com

X. PATIENT FINANCIAL SERVICES

For purposes of obtaining additional information about the Financial Assistance Program or for assistance in completing a Financial Assistance application, please contact the Patient Financial Services office at the following address and phone number:

Genesis Health System
Patient Financial Services
1401 West Central Park Avenue, Suite 2600
Davenport, Iowa 52804
Phone: (563) 421-3408
Toll Free: (800) 250-6020
Email: Patient Financial Services@genesishealth.com

X. REFERENCES:

A. GHS Managed Care Policy
B. GHS Miscellaneous Discount Policy
C. Fair Debt Collection and Practices Act
D. Federal Register, Annual Poverty Guidelines
E. Illinois Fair Patient Billing Act
F. Illinois Hospital Financial Assistance Under The Fair Patient Billing Act Regulations

XI. SUPERSEDES

N/A

Appendix 1

DEFINITIONS

Amounts Generally Billed or "AGB": The amounts generally billed for emergency or other Medically Necessary Care to individuals who have insurance covering such care, as further explained in Section VII.C.

Application Period: The period during which a Financial Assistance application may be submitted to GHS. Application Period begins on the date care is provided and ends on the later of the 240th day after the date the first post-discharge statement for the care is provided or either: (i) the date specified in a written notice from GHS regarding its intention to initial ECAs; or (ii) in the case of a patient who has been deemed presumptively eligible for Financial Assistance less than 100%, the end of the reasonable time to apply for Financial Assistance as described in Section 2.B.7.

Charity Care: Payment relief through the Financial Assistance Program for which GHS will not seek payment for services rendered based upon a determination that an individual does not have the ability to pay his or her full obligation.

Code Section 501(r) Requirements: The requirements of Section 501(r) of the Internal Revenue Code of 1986, as amended from time to time, and the related Treasury Regulations pertaining to financial assistance, limitations on charges, and billing and collections activities.

Deductibles and Co-Pays: Patient's financial liability for care as determined by individual insurance coverage benefits.

Extraordinary Collections Actions or "ECAs": For purposes of this FAP, ECAs are those activities identified under the Code Section 501(r) Requirements, which may include:

1. Selling an individual's debt to another party, unless the purchaser is subjected to certain restrictions as provided in the Code Section 501(r) Requirements.

2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

3. Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP.

4. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding.

Family Size: The number of individuals for whom a personal exemption is claimed on the patient's most recent Federal Income Tax return (in the case of a patient who is a dependent, the return of that patient's parent or guardian) . If no Federal Income Tax return is filed, then family size will consist of the patient, his or her documented spouse, and his or her documented dependents as defined by the Internal Revenue Code of 1986, as amended from time to time.

Federal Poverty Income Guidelines (FPIG): The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), which are used in comparing levels of applicable Financial Assistance available under the FAP.

Financial Assistance: Payment relief for which GHS will apply to a patient's financial obligation, including Charity Care, as indicated in Appendix 3, provided that an individual eligible for Financial Assistance will not be found financially responsible for more than AGB for emergency or other Medically Necessary Care.

Financial Assistance Program or "FAP": This program to provide Financial Assistance to eligible individuals in furtherance of GHS' mission and in compliance with the Code Section 501(r) Requirements.

Genesis Health System or GHS: For the purpose of this policy, this will consist of Genesis Medical Center, Aledo; Genesis Medical Center, Davenport; Genesis Medical Center, DeWitt; and Genesis Medical Center, Silvis; and related entities and business units.

GHS Hospital Facility: *The individual hospital facilities of GHS, as listed above.*

Household Income: As may be identified and requested on the FAP Application, cumulative total of gross income(s) for all members of a patient's household as shown on tax forms (income tax return), which may include, but is not limited to, the following:

1. Wages.
2. Self-employment income.
3. Unemployment compensation.
4. Social Security.
5. Social Security Disability.
6. Veterans' pension.
7. Veterans' disability.
8. Private disability.
9. Workers' compensation.
10. Retirement income.
11. Child support, alimony or other spousal support.
12. Other income.
13. Available net assets (excluding GHG Aledo), including, but not limited to, cash, bank and/or investment accounts, and real estate (all subject to applicable exclusions, including, Illinois residents receiving care at a GHS Illinois Hospital Facility, exclusions under the Illinois Requirements.

HMO: Health Maintenance Organization; Type of third party payor (insurance company).

Illinois Requirements: The Illinois Hospital Uninsured Discount Act and the Fair Patient Billing Act regulations, promulgated by the Office of the Illinois Attorney General (77 Ill. Admin. Code 4500.10-4500.60).

Incurred Adjustments: Amounts identified to be non-paid through contractual obligations of services rendered in accordance with Accounting Standards Codification (ASC) 606.

PPO: Preferred Provider Organization; Type of third party payor (insurance company).

Medically Necessary Care: As determined pursuant to a physician's order and/or clinical supervision during rendition of service, standard medical care required because of disease, disability, infirmity or impairment. Furthermore, Medically Necessary Care shall:

- Be consistent with the diagnosis and treatment of the patient's condition;
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- Be the least costly type of service which would reasonably meet the medical need of the patient.

Medicare Advantage Plan: Medicare replacement plan; can be HMO, PPO, or PFFS.

Self-Pay: Any account where anticipated reimbursement from a third party payor is not available.

Substantially-Related Entity: An entity treated as a partnership for federal tax purposes in which a GHS Hospital Facility owns a capital or profits interest, or a disregarded entity of which the GHS Hospital Facility is the sole member or owner, that provides emergency or other medically necessary services in a GHS Hospital Facility, unless the provision of such care is an unrelated trade or business described in section 513 of the Internal Revenue Code.

Appendix 2

MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE PROGRAM

Each GHS Hospital Facility will have a means of widely publicizing the availability of the FAP to all patients. The measures taken to widely publicize the FAP include, but are not limited, to the following:

1. For GHS Hospital Facilities in Illinois, a message on the healthcare bill, statement, invoice or summary of charges regarding eligibility for the Illinois Hospital Uninsured Patient Discount Act and instructions for application for Financial Assistance. In addition and for all other GHS Hospital Facilities, a conspicuous written notice will be included on the healthcare bill, statement, invoice or summary of charges that notifies and informs recipients about the availability of Financial Assistance under the FAP and includes the telephone number of Patient Financial Services and the direct website address where copies of the FAP, a description of the FAP Application process and a copy of the FAP Application, and a plain language summary of the FAP may be obtained.

2. Signs in the admission, emergency room, registration, and other appropriate areas provide the billing options form that explains that the provider offers a FAP and how to obtain more information. Such signs shall be posted in English and in any other language that is the primary language of at least five percent (5%) of the patients served by the applicable hospital annually.

3. Make paper copies of the FAP, the FAP Application, and plain language summary available upon request and without charge, both by mail and in public locations in all emergency room and admission areas. The FAP Applications for GHS' Illinois hospitals shall also comply with the Illinois Requirements (77 Ill. Admin. Code 4500.10-4500.60).

4. Designated staff that can explain the FAP.

5. Staff that can direct patients to appropriate patient representatives for explanation.

6. A notice located in a prominent place on the GHS website that Financial Assistance is available at the hospital, along with copy of the FAP, the FAP Application, and a plain language summary of the FAP.

7. For GHS Hospital Facilities in Illinois, provide contact information for patients to inquire about or dispute an itemized bill or statement. Response to inquiries must be made within two (2) business days of a telephone inquiry and ten (10) business days of a written inquiry in accordance with the Illinois Fair Patient Billing Act.

8. Notify and inform patients about the FAP by offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process.

9. Make available translations of the FAP, the FAP Application, and plain language summary in the language spoken by groups that constitute the lesser of 1,000 individuals or five percent (5%) of the community served by the applicable hospital or the population likely to be affected or encountered by the applicable hospital.

10. Take measures to notify and inform members of the community about the FAP, which includes sharing information with the GHS Community Health Needs Assessment Committee.

APPENDIX 3

Genesis Health System Financial Assistance Income Guidelines 2023

Family Size		Income based upon 200% of FPIG	Range </=200% FPIG 100% Writeoff	Range </=220% FPIG 90% Writeoff	Range </=240% FPIG 80% Writeoff	Range </=260% FPIG 70% Writeoff	Range </=280% FPIG 60% Writeoff	Range </=300% FPIG 50% Writeoff	Range </=320% FPIG 40% Writeoff	Range </=340% FPIG 30% Writeoff	Range </=360% FPIG 20% Writeoff	Range </=380% FPIG 10% Writeoff	Range Above 380% FPIG 0% Writeoff
1	$14,580	$29,160	$29,160	$32,076	$34,992	$37,908	$40,824	$43,740	$46,656	$49,572	$52,488	$55,404	$55,405
2	$19,720	$39,440	$39,440	$43,384	$47,328	$51,272	$55,216	$59,160	$63,104	$67,048	$70,992	$74,936	$74,937
3	$24,860	$49,720	$49,720	$54,692	$59,664	$64,636	$69,608	$74,580	$79,552	$84,524	$89,496	$94,468	$94,469
4	$30,000	$60,000	$60,000	$66,000	$72,000	$78,000	$84,000	$90,000	$96,000	$102,000	$108,000	$114,000	$114,001
5	$35,140	$70,280	$70,280	$77,308	$84,336	$91,364	$98,392	$105,420	$112,448	$119,476	$126,504	$133,532	$133,533
6	$40,280	$80,560	$80,560	$88,616	$96,672	$104,728	$112,784	$120,840	$128,896	$136,952	$145,008	$153,064	$153,065
7	$45,420	$90,840	$90,840	$99,924	$109,008	$118,092	$127,176	$136,260	$145,344	$154,428	$163,512	$172,596	$172,597
8	$40,560	$81,120	$81,120	$89,232	$97,344	$105,456	$113,568	$121,680	$129,792	$137,904	$146,016	$154,128	$154,129
9	$45,700	$91,400	$91,400	$100,540	$109,680	$118,820	$127,960	$137,100	$146,240	$155,380	$164,520	$173,660	$173,661
10	$50,840	$101,680	$101,680	$111,848	$122,016	$132,184	$142,352	$152,520	$162,688	$172,856	$183,024	$193,192	$193,193
11	$55,980	$111,960	$111,960	$123,156	$134,352	$145,548	$156,744	$167,940	$179,136	$190,332	$201,528	$212,724	$212,725
12	$61,120	$122,240	$122,240	$134,464	$146,688	$158,912	$171,136	$183,360	$195,584	$207,808	$220,032	$232,256	$232,257

Form AG-CBP-1
Rev 09/21

KWAME RAOUL
ATTORNEY GENERAL

Annual Non Profit Hospital Community Benefits Plan Report

Name of Hospital Reporting: Genesis Medical Center-Silvis

Mailing Address: 801 Illini Drive (Street Address/P.O. Box) Silvis, IL 61282 (City, State, Zip)

Physical Address (if different than mailing address):

(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: 07/01/22 (Month Day Year) **through** 06/30/23 (Month Day Year) **Taxpayer Number:** 36-3616314

If part of a health system, list the other Illinois hospitals included in the health system (Note: A separate report must be filed for each Hosp).

Hospital Name	Address	FEIN #
Genesis Medical Center-Aledo	409 NW 9th Ave. Aledo, IL 61231	45-4475683

1. **ATTACH Mission Statement:**
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and the date it was adopted.

2. **ATTACH Community Benefits Plan:**
The reporting entity must provide it's most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
   2. Identify the populations and communities served by the hospital.
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care**:
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services.

Charity Care..... $ 869,560

ATTACH Charity Care Policy:
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

4. **REPORT Community Benefits** actually provided other than charity care.

See instructions for completing Section 4 of Form AG-CBP-1 (Community Benefits Plan Annual Report Form For Not For Profit Hospital)

Community Benefit Type

Language Assistant Services		$ 65,567
Financial Assistance		$ 0
Government Sponsored		$ 6,428,848
Donations		$ 65,817
Volunteer Services		
a) Employee Volunteer Services	$ 438	
b) Non-Employee Volunteer Services	$	
c) Total (add lines a and b)		$ 438
Education		$ 0
Government-sponsored program services		$ 0
Research		$ 0
Subsidized health services		$ 16,818
Bad debts		$ 2,911,074
Other Community Benefits .... Community building		$ 1,841

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

Joseph Malas, VP Finance/CFO — 563-421-6508
Name/ Title (Please Print) — Phone: Area Code/ Telephone No.

J Malas — 12-22-2023
Signature — Date.

Dedra Wallace — 563-421-4190
Name of Person Completing Form — Phone: Area Code/ Telephone No.

wallaced@gonesishealth.com — 563-421-4582
Electronic / Internet Mail Address — FAX: AreaCode/FAXNo.

GENESIS

Our Mission:

Genesis Health System exists to provide compassionate, quality health services to all those in need.

1227 E. Rusholme St. | Davenport, IA 52803 | 563.421.1000 | www.genesishealth.com

Genesis Health System (GHS Illinois)

Community Benefit Plan

2021

The Genesis Health System Community Benefit Plan consists of several parts. Our efforts to improve the health of our community are described in Section I. Section II provides an overview of our charity care and support of community activities. The final section lists the initiatives designed to improve the health of our community.

1. Quad City Health Initiative

The sponsors of this study, Community Health Care, Inc., Genesis Health System, Muscatine County Public Health, Quad City Health Initiative, Rock Island County Health Department, Scott County Health Department and UnityPoint Health–Trinity, collaborate on improving health status and quality of life in the Quad Cities region. This work together is rooted in periodic, comprehensive community health assessments that meet the information and reporting needs of all partners. Understanding our community's health status is the foundation for developing community education, resources, and programs that will advance our community's health. The assessment informs the creation of community health improvement plans for the study sponsors. In addition, the study sponsors encourage other organizations also to use this information to inform strategic planning, grant writing and project development.

For the 2021 Quad Cities Community Health Assessment, our coordinated approach included primary data collection, secondary data analysis, and qualitative data gathering from community members in our bi-state area. The study sponsors engaged PRC, Inc. to collect secondary data and implement a community health survey. Select operations data from local providers also were summarized. Special consideration was given to how we could increase our understanding of topics such as the impact of COVID-19, health disparities, and social determinants of health. The following document provides PRC, Inc.'s bi-state findings in detail as well as information obtained through local partners. Documents produced as part of the 2021 Quad Cities Community Health Assessment process are available for review online at quadcities.healthforecast.net.

This Community Health Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Scott, Muscatine, and Rock Island counties — it is a follow-up to similar studies conducted in the Quad Cities Area (Scott and Rock Island counties) in 2002, 2007, 2012, 2015, and throughout the full three-county area in 2018. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are

most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.

▪ To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

II. Genesis Health System Charity Care and Community Support

Our mission is to care for all those in need, regardless of their ability to pay for services. We monitor our charity care and care to those unable to pay on a monthly basis in order to ensure that we are true to our mission.

Additionally, Genesis Health System encourages all staff to become involved in community activities during paid work time and through voluntary efforts. Our community support activities will include:

- ❑ Community Education and Outreach
- ❑ Health Screening
- ❑ Support Groups
- ❑ Counseling
- ❑ Self-Help
- ❑ Immunizations
- ❑ Other Community Programs
    - Family Support Services
    - In-Home Services
    - Meals/Nutrition Services
    - Transportation Services
- ❑ Cash and In-Kind Donations
- ❑ Medical Education and Research

III. Community Health Improvement Initiatives

Infant Health:
Multi-year plan in coordination with the Quad City Health Initiative, Unity Point QC, the Rock Island and Scott County Health Departments and Community Health Care to reduce the number of low birth weight infants.
·Form the multi-disciplinary task force – health care organization leaders, providers and target population
·Understand the size and scope of the health issue
·Determine the area of focus to reduce low birth weight births
·Implement strategies
·Evaluate progress

Mental Health:
·Continue our efforts to support community mental health programs through:
- Collaboration with Vera French to support programs such as "ACT" Assertive Community Treatment, MST Multisystemic therapy for teens, etc.
- Behavioral health services provided via our emergency department and inpatient unit

-Support Family Connects – moms with post-partum depression
·Participate in the Quad Cities Behavioral Health Coalition programs (e.g.the Zero Suicide Initiative)
·Advocate for improved funding for mental health services

Nutrition, Physical Activity and Weight:
·Collaborate with community partners to educate the public re the importance of healthy diet and regular exercise such as Be Healthy QC
·Implement a Food Pharmacy to help diabetic patients with limited resources obtain and use healthy foods to control their diabetes.
·Provision of exercise equipment at area parks.
·Continue Genesis programs:
-YMCA membership discount for staff and their families
-Healthy Lifestyle Sponsorships such as Bix 7
-Center for Weight Management and Bariatric Surgery

Access to Healthcare:
·Continue Genesis support for:
-421-DOCS – assistance for finding a primary care provider
-Recruiting primary care providers and specialists
·Expansion of Genesis emergency and convenient care services in growing population areas (e.g. Eldridge Convenient Care Clinic)
·Expansion of telehealth services for:
-Non-emergent, basic health care
-Consultations with specialists especially for patients living in rural areas

Diabetes Prevention and Treatment:
·Genesis Health System FY 2022 Strategic Goal - Achieve breakthrough performance in lowering the hemoglobin A1C rate to improve the health of our community. Achieved by:
-Continued monitoring of high risk patients
-Ongoing education
·Implementation of a Food Pharmacy to help diabetic patients, with limited resources, obtain and use healthy foods to control their diabetes.

Genesis Health System
Board Policy

Policy Title:	Community Benefits	Effective Date:	11/15/99
Department:	Board Policy	Reviewed/Revised:	7/15/11, 10/19/16, 01/09/20, 01/07/21, 01/06/22, 01/05/23
Owner Title:	Genesis Health System Board of Directors Foundation, Executive Director	Review Cycle:	Annual
Owner Signature:		Page 1 of 4	

I. POLICY:

All entities of Genesis Health System will document and report the community benefit activities provided to the communities which they serve.

II. APPLICABLE BUSINESS UNITS:

☒ All GHS Business Units:

- ☐ Crescent Laundry
- ☐ Crosstown Square
- ☐ Genesis Accountable Care Organization
- ☐ Genesis Convenient Care
- ☐ Genesis EAP
- ☐ Genesis FirstMed Pharmacy
- ☐ Genesis Family Medical Center
- ☐ Genesis Health Group
- ☐ Genesis Health Group, Aledo Rural Health
- ☐ Genesis Health Group, Erie Rural Health
- ☐ Genesis Health Services Foundation
- ☐ Genesis Home Medical Equipment
- ☐ Genesis Hospice
- ☐ Genesis Medical Center, Aledo
- ☐ Genesis Medical Center, Davenport
- ☐ Genesis Medical Center, DeWitt
- ☐ Genesis Medical Center, Silvis
- ☐ Genesis Occupational Health
- ☐ Genesis Philanthropy
- ☐ Genesis Psychology Associates
- ☐
- ☐ Genesis VNA
- ☐
- ☐ Genesis Workplace Services
- ☐ Genesis Workers Comp Plan & Trust
- ☐

III. APPLICABLE ORGANIZATIONAL ROLES:

All

IV. PURPOSE:

As a tax-exempt organization, Genesis Health System is accountable to our communities as well as governmental agencies. Community Benefit reporting is a formal mechanism through which Genesis Health System assures institutional compliance with community and governmental expectations. This compliance is critical for three reasons: accountability, positive community obligations, and organizational effectiveness.

We have developed a mechanism to collect and report Genesis Health System community benefit activities. Managers are asked to collect community benefit activities for themselves and their staff and ensure that the information is entered into the Community Benefits Inventory for Social Accountability ("CBISA") Software. The database can be queried at regular intervals, and the activities aggregated to generate a report that is shared internally and externally, totaling the Genesis Health System community benefit for the most recent fiscal year.

V. DEFINITIONS:

Community Benefit: Community benefit is defined as resources such as materials, employee time, and dollars that are donated by Genesis Health System and its entities that provide value to our community. Community benefit often includes services for the economically disadvantaged and the general community. Community benefit may include, but is not limited to:

Community Health Improvement

Health Professions Education

Subsidized Health Services

Research

Cash and In-Kind Contributions

Community-Building Activities

Community Benefit Operations

A. Community Health Improvement

Activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Such services do not generate patient care bills although they may involve a nominal fee.

B. Health Professions Education

Providing a clinical setting for undergraduate, internship and vocational training to students enrolled in an outside organization when there is no work requirement tied to training.

C. Subsidized Health Services

Clinical programs that are provided despite a financial loss so significant that negative margins remain after removing the effects of charity care, bad debt and Medicaid shortfalls. Nevertheless, the service is provided because it meets an identified

community need and if no longer offered, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.

D. Research

Clinical and community health research, as well as studies on health care delivery, (that are able to be generalized) shared with the public and funded by the government or a tax-exempt entity (including the organization itself). Do not count research where findings are used only internally or are proprietary.

E. Cash and In-Kind Contributions

Funds and in-kind services donated to individuals, community groups or other not-for-profit organizations not affiliated with Genesis Health System. In-kind services include hours contributed by staff to the community while on health care organization work time, overhead expenses of space donated to not-for-profit community groups (such as for meetings) and the donation of food, equipment, and supplies.

F. Community-Building Activities

Programs that address the root causes of health problems, such as poverty, homelessness, and environmental problems. These activities support the community by offering the expertise and resources of the health care organization. Costs for these activities include cash, in-kind donations, and budgeted expenditures for the development of a variety of community-building programs and partnerships.

G. Community Benefit Operations

Costs associated with determining community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.

VI. GENERAL CONSIDERATIONS:

A. See community benefit examples attached.

B. Responsibility for gathering and reporting employee community benefit data belongs to department managers.

C. All Genesis Health System entities will utilize the (CBISA) software for the tracking and reporting of community benefit activity for Genesis.

D. The Compliance Risk Officer will work in collaboration with the Genesis Health System Community Benefit Advisory Committee and GHS Business Units to create the annual community benefit reports for Genesis Health System.

VII. PRACTICE/PROCEDURE:

A. Availability of CBISA Software

a. Information Technology will assure access to the CBISA software for each reporting department.

b. For training on proper reporting of community benefits using the aforementioned software, go to http://lyonsoftware.com/support/narrated-powerpoints-2/.

c. Each manager will be responsible to designate a facility reporter to enter community benefit data into CBISA for that department.

d. Managers are encouraged to ensure community benefit information is entered into CBISA as it occurs.

B. Reporting Community Benefit

a. All tax-exempt entities of the Genesis Health System will report all charity and community benefit services.

b. Managers will document their contributions and those of their staff to the community in the CBISA database.

c. For all Genesis Health System and entity-sanctioned events, the Project Coordinator of the event is responsible for the documentation of the total community benefit for that event (including employee hours, supplies, supply cost, etc.)

d. An annual system-wide Community Benefit Report will be generated and made available for internal and external use as appropriate.

VIII. REFERENCES:

N/A

IX. SUPERSEDES:

N/A

X. CROSS REFERENCE:

N/A

XI. ENDORSEMENTS:

Genesis Health System Executive Group
Genesis Health System Community Benefit Advisory Committee – 10/17/19, 8/13/20, 6/17/21, 6/16/22
Genesis Health System Governance Committee – 11/12/19, 11/17/20, 11/16/21, 11/08/22
Genesis Health System Board of Directors – 1/9/20, 1/7/21, 1/6/22, 1/5/23

Genesis Health System
Board Policy

[i]**Subject:** Financial Assistance (aka Charity Care)	**Effective Date:** 03/19/96
Section: Board Policy	**Reviewed/Revised:** 01/05/23 01/06/22 01/07/21 01/09/20 01/10/19 07/01/18
Responsibility: • Genesis Health System Board of Directors • Vice President, Finance/CFO	**Review Cycle:** Annual
Approved by:	Page 1 of 15

I. POLICY:

The Board of Directors of Genesis Health System ("GHS") is committed to its mission to provide quality, compassionate care to all of those in need regardless of ability to pay. In support of this commitment, GHS maintains this Financial Assistance Program ("FAP") policy to provide assistance for eligible individuals with covered health care needs. GHS consists of Genesis Medical Center, Aledo; Genesis Medical Center, Davenport; Genesis Medical Center, DeWitt; Genesis Medical Center, Silvis; and related entities and business units. This FAP applies to the business units designated in Section II below.

II. APPLICABLE BUSINESS UNITS:

☐ All GHS Business Units:

☐ Crescent Laundry
☐ Crosstown Square
☐ Genesis Accountable Care Organization
☒ Genesis Convenient Care
☐ Genesis EAP
☒ Genesis Family Medical Center
☐ Genesis FirstMed Pharmacy
☒ Genesis Health Group
☒ Genesis Health Group, Aledo Rural Health
☒ Genesis Health Group, Erie Rural Health
☐ Genesis Health Services Foundation
☐ Genesis Home Medical Equipment
☐ Genesis Hospice
☒ Genesis Medical Center, Aledo
☒ Genesis Medical Center, Davenport
☒ Genesis Medical Center, DeWitt
☒ Genesis Medical Center, Silvis
☐ Genesis Occupational Health
☐ Genesis Philanthropy
☒ Genesis Psychology Associates
☐ Genesis VNA
☐ Genesis Workers Comp Plan & Trust

III. APPLICABLE ORGANIZATIONAL ROLES:

None

IV. PURPOSE:

To meet the needs of the community, GHS has established a fair and equitable Financial Assistance Program (FAP) to provide Financial Assistance that reflects the status of GHS as a non-profit healthcare provider, which promotes its mission. The FAP is focused on offering charity care at some level of payment relief for those patients who are unable to sustain the extraordinary burden of medical expenses due to limited income and resources. The FAP applies to any emergency and other Medically Necessary Care for eligible individuals and is intended to comply with the Code Section 501(r) Requirements.

V. DEFINITIONS:

Please see Appendix 1 for a complete list of definitions used in this FAP.

VI. GENERAL CONSIDERATIONS:

This policy will apply to all patients regardless of race, creed, sex, age or payer. Reasonable efforts will be taken to ensure that any language or hearing barriers are addressed, consistent with the Code Section 501(r) Requirements.

VII. PRACTICE/PROCEDURE:

A. SCOPE:

1. General. The FAP applies to all emergency and other Medically Necessary Care provided by GHS to eligible patients, including all such care provided in a GHS Hospital Facility by a Substantially-Related Entity. The FAP also applies to care provided by the Genesis Health Group in a GHS Hospital Facility.

2. Exclusions. Patient care that is not considered emergency or Medically Necessary Care, including but not limited to, elective (e.g., bariatric surgery), cosmetic, or other care deemed to be generally non-reimbursable by government payers shall not be considered eligible for charity care payment relief through the Financial Assistance Program.

3. Publicity. Each GHS Hospital Facility will widely publicize the availability of the FAP to all patients. The measures for widely publicizing the FAP are provided in Appendix 2.

4. Illinois Hospital Uninsured Discount Act. In addition to the Code Section 501(r) Requirements, GHS Hospital Facilities located in Illinois are subject to the Illinois Hospital Uninsured Discount Act and the Illinois Fair Patient Billing Act (together, the "Illinois Requirements"). In order to fully comply with the Illinois

Requirements, this FAP is supplemented by the GHS Miscellaneous Discount Policy.

5. Other Programs and Discounts. GHS will make available to all patients information on its FAP as well as other GHS and external programs that may provide payment assistance or coverage for service. This includes patient financing programs with external third parties; the GHS Miscellaneous Discount Policy, which encompasses prompt-pay discounts, other supplemental need-based discounts, and certain discounts provided in connection with the Illinois Requirements for patients at GHS Hospital Facilities located in Illinois. GHS will make affirmative efforts to assist patients in applying for public and private programs for which they may qualify and that may assist them in obtaining and paying for healthcare services.

B. ELIGIBILITY CRITERIA AND FINANCIAL ASSISTANCE:

1. Insured Status. Financial Assistance deemed as charity care may be available for patients who are uninsured or underinsured, if they meet applicable eligibility criteria. An uninsured patient is a patient who has no level of insurance or third-party payment assistance. An underinsured patient is a patient who has some level of insurance or third-party payment assistance but whose out-of-pocket expenses exceed his/her financial abilities.

2. Residency. Patients seeking Financial Assistance must seek non-emergent care from the GHS Hospital Facility closest to their actual residence. If appropriate treatment is not available at the applicable GHS Hospital Facility, then GHS may permit the patient to seek care at another GHS Hospital Facility. To determine residency, the patient must provide valid state-issued identification, a voter registration card, a vehicle registration card, a lease agreement, a utility bill (dated within 60 days), or mail addressed to the patient from a local, state or federal government entity or agency (dated within 60 days).

3. Minimum Balance. The minimum balance on any account to qualify for charity care through Financial Assistance must be equal to or greater than $500.00 (for care at GHS Illinois Hospital Facilities, the minimum balance is $300.00 only when applying for the IL Uninsured Discount Act).

4. FAP Application and Criteria. The primary criterion for determining eligibility for Financial Assistance Program is household income, including certain available net assets (excluding GHG Aledo), based on the information requested and provided in the FAP Application, as explained in Section VII.D. An individual will not be denied Financial Assistance based on information that has not be specified or required in the FAP or in the FAP Application.

5. Financial Assistance Sliding Scale. Effective January 1 of each calendar year, Financial Assistance shall be available pursuant to the sliding scale found in Appendix 3, which is based on the most current Federal Poverty Income Guidelines ("FPIG"). Consistent with the sliding scale, 100% Financial Assistance (i.e., full Charity Care) shall be provided to

documented homeless patients, deceased individuals without estates, and underinsured and the uninsured patients earning 200% or less of FPIG.

a. For Illinois residents receiving care at a GHS Illinois Hospital Facility, the maximum amount that may be collected in a twelve (12) month period for care is 25% of the patient's household income, subject to timely application and the patient's eligibility under the Illinois Requirements.

Furthermore, a patient determined to be eligible for Financial Assistance shall not be financially responsible more than AGB, as defined in Section VII.C., for emergency or other Medically Necessary Care. Discounts available under the FAP are based on gross charges applicable to the service. In addition to, or in lieu of, this FAP, patients may be eligible for discounts pursuant to the GHS Miscellaneous Discount Policy.

6. FPIG. The Patient Financial Services Department shall be responsible for updating the FPIG every calendar year.

7. Extenuating Circumstances. On occasion, extenuating circumstances may exist which would cause GHS to grant Financial Assistance to a patient who may otherwise not meet quantitative criteria. In such cases, the Revenue Cycle Administrator or appropriate Management staff will document why the assistance was granted and supporting documentation will be maintained.

8. Offsets. In the event a patient is awarded a settlement from pursuing legal proceedings or has received financial resources specifically identified to cover the care that was delivered, it is the obligation of the patient to inform GHS and make appropriate payment to GHS at that time. GHS may reverse the decision of Financial Assistance and document accordingly, to the extent allowed by the Code Section 501(r) Requirements.

9. Cooperation. Any patient who fails or refuses to provide requested information to a third party payor that results in a denial will not be eligible for the FAP. A patient who furnishes materially incorrect or fraudulent information in connection with this FAP may be deemed ineligible for Financial Assistance at the sole discretion of GHS.

C. AGB:

For purposes of the FAP, GHS calculates AGB using the look-back method consistent with the Code Section 501(r) Requirements. Members of the public may readily obtain the applicable AGB percentage for each GHS Hospital Facility and a description of the calculation in writing and free of charge by visiting www.genesishealth.com/patients-visitors/, contacting Patient Financial Services (see Section X for contact information), or visiting a GHS Hospital Facility.

D. APPLICATION PROCESS:

1. FAP Application. Patients seeking charity care through Financial Assistance must complete a FAP Application to document income and expenses (liabilities) unless they meet the presumptive eligibility criteria. GHS may ask for (but may not require of patients from its Illinois hospitals) a credit card statement to support the information provided in the FAP Application. FAP Applications may be found online at www.genesishealth.com/patients-visitors/, by contacting Patient Financial Services (see Section X for contact information), or visiting a GHS Hospital Facility.

2. Income Verification. Income (household income) will be estimated yearly by the patient supplying any of the following:

    - A copy of the most recent tax return
    - A copy of the most recent W-2 form and 1099 forms
    - Copies of the 2 most recent pay stubs
    - Written income verification from an employer if paid in cash

3. Completeness. GHS recognizes that not all patients are able to provide complete financial and/or social information. Therefore, approval for Financial Assistance may be determined based on available information.

4. Identification. To verify a patient's name, date of birth and/or address, the patient must provide any of the following:

    - A valid passport
    - A valid birth certificate
    - A certificate of citizenship, U.S. or foreign (including but not limited to DHS Forms N-560 or N-561)
    - An identification card issued by the U.S. or a foreign government (including but not limited to DHS Form I-197)
    - An official military record of service
    - A certification of a foreign birth (including but not limited to form FS-545)
    - A report of birth abroad (including but not limited to Form FS-240)
    - A Certificate of Report of Birth issued by the U.S. Department of State (Form DS-1350) or any similar form issued by a foreign government
    - A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database

- A government census record
- A certificate of naturalization, U.S. or foreign (including but not limited to DHS Forms N-550 or N-570)

If the patient is not able to provide a document from the above list, the patient must provide an alternate written means through which GHS can verify the patient's name, date of birth and/or address.

5. External Sources and Presumptive Eligibility. GHS may utilize an external source to perform an analysis for determining applicable levels of Financial Assistance when documentation is not able to be provided (i.e., presumptive eligibility). The external source will meet necessary privacy and accounting requirements and shall utilize relevant national database information. GHS may also utilize previously completed Financial Assistance applications to make presumptive eligibility determinations. In addition, demonstration of one or more of the following will result in a presumptive eligibility determination:

    a. Homelessness

    b. Deceased with no estate

    c. Mental incapacitation with no one to act on patient's behalf

    d. Medicaid eligibility, but not on date of service or for non-covered services

    e. Recent personal bankruptcy

    f. Incarceration in a penal institution

    In these instances where assistance is found to be appropriate, notice will be forwarded to patient via reduced balance on their statement, which shall include information regarding how to apply for potentially more generous Financial Assistance within a reasonable period of time.

6. Remaining Balance. All balances owing after Financial Assistance has been provided may be payable in monthly payments pursuant to the standard payment procedures of the GHS Hospital Facility.

7. Referral Sources. Patient referrals may come from the patient or anyone acting on his/her behalf, including medical staff, Continuum Services, Patient Access, and Patient Financial Services. In addition, Patient Financial Services shall routinely review the payment history of accounts to determine possible candidates with emphasis on those with demonstrated payment history that are willing but unable to pay more.

8. Timeline for Establishing Financial Assistance Eligibility.

    a. A FAP Application will be accepted and processed by GHS at any time during the Application Period pursuant to the procedures outlined in Section VII.E.

b. The information contained in a FAP Application is valid for sixty (60) days, and, after that time period expires, the application will need to be renewed.

c. Provisions specifically applicable to GHS Illinois Hospital Facilities:

i. GHS shall apply the presumptive eligibility criteria as soon as possible after a patient's receipt of healthcare services by the hospital and prior to the issuance of a bill for healthcare services.

ii. Every effort will be made to determine a patient's eligibility for Financial Assistance within sixty (60) days from any of the following: after discharge, from the date of service, after receipt of third party payment or after receiving government denial for Medicaid coverage or disability. This is in accordance with the Illinois Requirements. This provision shall not affect the timeframes established elsewhere in the FAP for notification of the availability of Financial Assistance or the patient's timeframe to apply.

E. BILLING AND COLLECTIONS PROCESS:

As described below, GHS will make reasonable efforts to determine whether a patient is eligible under this FAP for Financial Assistance before it engages in an extraordinary collection action, or ECA. Once a determination is made, GHS may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. Except as provided below, a patient may submit a FAP Application at any time during the Application Period, which is generally 240 days from the date of the first post-discharge bill as defined in Appendix 1. GHS will not be obligated to accept a FAP Application after 240 days from the date of the first post-discharge bill (including patients who have fully paid applicable charges) unless otherwise specifically required by the Code Section 501(r) Requirements. Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

a. Presumptive Eligibility Determinations. If a patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application submitted with respect to prior care), GHS will notify the patient of the basis for the determination and give the patient a reasonable period of time to apply for more generous assistance before initiating an ECA.

b. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, GHS will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement

for the care is sent to the patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one or more ECA(s) to obtain payment for care from a patient who has not submitted a FAP Application, GHS shall take the following actions:

i. Provide the patient with a written notice that indicates Financial Assistance is available for eligible individuals, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;

ii. Provide the patient with a Plain Language Summary; and

iii. Make a reasonable effort to verbally notify the individual about the FAP and the FAP Application process.

c. Incomplete FAP Applications. In the case of a patient who submits an incomplete FAP Application during the Application Period, GHS shall notify the patient in writing about how to complete the FAP Application and give the patient seven (7) calendar days to do so. Any pending ECAs shall be suspended during the reasonable opportunity, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.

d. Complete FAP Applications. In the case of a patient who submits a complete FAP Application during the Application Period, GHS shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

e. Restrictions on Deferring or Denying Care. In a situation where GHS intends to defer or deny, or require a payment before providing, Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP, the patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible patients and stating the deadline, if any, after which GHS will no longer accept and process an application submitted (or, if applicable, completed) by the patient for the previously-provided care at issue. This deadline shall be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement was provided for the previously provided care.

2. Determination Notification.

a. Determinations. Once a completed FAP Application is received on a patient's account, GHS will evaluate the FAP Application to determine eligibility and notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days. The notification

will include a determination of the amount for which the patient and/or responsible party will be financially accountable. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

b. Refunds. GHS will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

c. Reversal of ECA(s). To the extent a patient is determined to be eligible for Financial Assistance under the FAP, GHS will take all reasonably available measures to reverse any ECA taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien on the individual's property, and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

3. Appeals. The patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Patient Financial Services Department within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Patient Financial Services Department Manager for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to patient, legal guardian, and/or responsible party.

4. Collections. Upon conclusion of the above procedures, GHS may proceed with ECAs against uninsured and underinsured patients with delinquent accounts, as determined in GHS procedures for establishing, processing, and monitoring patient bills and payment plans. Additionally, GHS will consider all uninsured patient balances for evaluation of amounts to be identified as Incurred Adjustments; separate from provision for bad debt. To the extent applicable, GHS will utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts and shall comply with the Code Section 501(r) Requirements applicable to third parties.

VIII. ADMINISTRATION

A. General. The FAP is administered by the GHS Patient Financial Services Department at the direction of the Board of Directors of GHS.

B. Interpretation. GHS has the sole discretion to interpret, enforce, and administer this FAP consistent with all federal, state, and local laws, rules, and regulations that may apply.

C. Amendment. This FAP may be amended from time to time by the Board of Directors of GHS.

IX. PROVIDER LIST

A list of providers ("Provider List") that provide emergency or Medically Necessary Care at GHS Hospital Facilities is maintained and updated from time to time by Medical Affairs and can be accessed online via www.genesishealth.com, or by contacting Medical Affairs (see below for contact information), or visiting a GHS Hospital Facility.

GHS Medical Affairs
Genesis Health System
1401 West Central Park Avenue
Davenport, Iowa 52804
Phone: (563) 421-1288
Email: MedicalAffairs@genesishealth.com

X. PATIENT FINANCIAL SERVICES

For purposes of obtaining additional information about the Financial Assistance Program or for assistance in completing a Financial Assistance application, please contact the Patient Financial Services office at the following address and phone number:

Genesis Health System
Patient Financial Services
1401 West Central Park Avenue, Suite 2600
Davenport, Iowa 52804
Phone: (563) 421-3408
Toll Free: (800) 250-6020
Email: Patient Financial Services@genesishealth.com

X. REFERENCES:

A. GHS Managed Care Policy
B. GHS Miscellaneous Discount Policy
C. Fair Debt Collection and Practices Act
D. Federal Register, Annual Poverty Guidelines
E. Illinois Fair Patient Billing Act
F. Illinois Hospital Financial Assistance Under The Fair Patient Billing Act Regulations

XI. SUPERSEDES

N/A

Appendix 1

DEFINITIONS

Amounts Generally Billed or "AGB": The amounts generally billed for emergency or other Medically Necessary Care to individuals who have insurance covering such care, as further explained in Section VII.C.

Application Period: The period during which a Financial Assistance application may be submitted to GHS. Application Period begins on the date care is provided and ends on the later of the 240th day after the date the first post-discharge statement for the care is provided or either: (i) the date specified in a written notice from GHS regarding its intention to initial ECAs; or (ii) in the case of a patient who has been deemed presumptively eligible for Financial Assistance less than 100%, the end of the reasonable time to apply for Financial Assistance as described in Section 2.B.7.

Charity Care: Payment relief through the Financial Assistance Program for which GHS will not seek payment for services rendered based upon a determination that an individual does not have the ability to pay his or her full obligation.

Code Section 501(r) Requirements: The requirements of Section 501(r) of the Internal Revenue Code of 1986, as amended from time to time, and the related Treasury Regulations pertaining to financial assistance, limitations on charges, and billing and collections activities.

Deductibles and Co-Pays: Patient's financial liability for care as determined by individual insurance coverage benefits.

Extraordinary Collections Actions or "ECAs": For purposes of this FAP, ECAs are those activities identified under the Code Section 501(r) Requirements, which may include:

1. Selling an individual's debt to another party, unless the purchaser is subjected to certain restrictions as provided in the Code Section 501(r) Requirements.

2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

3. Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP.

4. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding.

Family Size: The number of individuals for whom a personal exemption is claimed on the patient's most recent Federal Income Tax return (in the case of a patient who is a dependent, the return of that patient's parent or guardian) . If no Federal Income Tax return is filed, then family size will consist of the patient, his or her documented spouse, and his or her documented dependents as defined by the Internal Revenue Code of 1986, as amended from time to time.

Federal Poverty Income Guidelines (FPIG): The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), which are used in comparing levels of applicable Financial Assistance available under the FAP.

Financial Assistance: Payment relief for which GHS will apply to a patient's financial obligation, including Charity Care, as indicated in Appendix 3, provided that an individual eligible for Financial Assistance will not be found financially responsible for more than AGB for emergency or other Medically Necessary Care.

Financial Assistance Program or "FAP": This program to provide Financial Assistance to eligible individuals in furtherance of GHS' mission and in compliance with the Code Section 501(r) Requirements.

Genesis Health System or GHS: For the purpose of this policy, this will consist of Genesis Medical Center, Aledo; Genesis Medical Center, Davenport; Genesis Medical Center, DeWitt; and Genesis Medical Center, Silvis; and related entities and business units.

GHS Hospital Facility: *The individual hospital facilities of GHS, as listed above.*

Household Income: As may be identified and requested on the FAP Application, cumulative total of gross income(s) for all members of a patient's household as shown on tax forms (income tax return), which may include, but is not limited to, the following:

1. Wages.
2. Self-employment income.
3. Unemployment compensation.
4. Social Security.
5. Social Security Disability.
6. Veterans' pension.
7. Veterans' disability.
8. Private disability.
9. Workers' compensation.
10. Retirement income.
11. Child support, alimony or other spousal support.
12. Other income.
13. Available net assets (excluding GHG Aledo), including, but not limited to, cash, bank and/or investment accounts, and real estate (all subject to applicable exclusions, including, Illinois residents receiving care at a GHS Illinois Hospital Facility, exclusions under the Illinois Requirements.

HMO: Health Maintenance Organization; Type of third party payor (insurance company).

Illinois Requirements: The Illinois Hospital Uninsured Discount Act and the Fair Patient Billing Act regulations, promulgated by the Office of the Illinois Attorney General (77 Ill. Admin. Code 4500.10-4500.60).

Incurred Adjustments: Amounts identified to be non-paid through contractual obligations of services rendered in accordance with Accounting Standards Codification (ASC) 606.

PPO: Preferred Provider Organization; Type of third party payor (insurance company).

Medically Necessary Care: As determined pursuant to a physician's order and/or clinical supervision during rendition of service, standard medical care required because of disease, disability, infirmity or impairment. Furthermore, Medically Necessary Care shall:

- Be consistent with the diagnosis and treatment of the patient's condition;
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- Be the least costly type of service which would reasonably meet the medical need of the patient.

Medicare Advantage Plan: Medicare replacement plan; can be HMO, PPO, or PFFS.

Self-Pay: Any account where anticipated reimbursement from a third party payor is not available.

Substantially-Related Entity: An entity treated as a partnership for federal tax purposes in which a GHS Hospital Facility owns a capital or profits interest, or a disregarded entity of which the GHS Hospital Facility is the sole member or owner, that provides emergency or other medically necessary services in a GHS Hospital Facility, unless the provision of such care is an unrelated trade or business described in section 513 of the Internal Revenue Code.

Appendix 2

MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE PROGRAM

Each GHS Hospital Facility will have a means of widely publicizing the availability of the FAP to all patients. The measures taken to widely publicize the FAP include, but are not limited, to the following:

1. For GHS Hospital Facilities in Illinois, a message on the healthcare bill, statement, invoice or summary of charges regarding eligibility for the Illinois Hospital Uninsured Patient Discount Act and instructions for application for Financial Assistance. In addition and for all other GHS Hospital Facilities, a conspicuous written notice will be included on the healthcare bill, statement, invoice or summary of charges that notifies and informs recipients about the availability of Financial Assistance under the FAP and includes the telephone number of Patient Financial Services and the direct website address where copies of the FAP, a description of the FAP Application process and a copy of the FAP Application, and a plain language summary of the FAP may be obtained.

2. Signs in the admission, emergency room, registration, and other appropriate areas provide the billing options form that explains that the provider offers a FAP and how to obtain more information. Such signs shall be posted in English and in any other language that is the primary language of at least five percent (5%) of the patients served by the applicable hospital annually.

3. Make paper copies of the FAP, the FAP Application, and plain language summary available upon request and without charge, both by mail and in public locations in all emergency room and admission areas. The FAP Applications for GHS' Illinois hospitals shall also comply with the Illinois Requirements (77 Ill. Admin. Code 4500.10-4500.60).

4. Designated staff that can explain the FAP.

5. Staff that can direct patients to appropriate patient representatives for explanation.

6. A notice located in a prominent place on the GHS website that Financial Assistance is available at the hospital, along with copy of the FAP, the FAP Application, and a plain language summary of the FAP.

7. For GHS Hospital Facilities in Illinois, provide contact information for patients to inquire about or dispute an itemized bill or statement. Response to inquiries must be made within two (2) business days of a telephone inquiry and ten (10) business days of a written inquiry in accordance with the Illinois Fair Patient Billing Act.

8. Notify and inform patients about the FAP by offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process.

9. Make available translations of the FAP, the FAP Application, and plain language summary in the language spoken by groups that constitute the lesser of 1,000 individuals or five percent (5%) of the community served by the applicable hospital or the population likely to be affected or encountered by the applicable hospital.

10. Take measures to notify and inform members of the community about the FAP, which includes sharing information with the GHS Community Health Needs Assessment Committee.

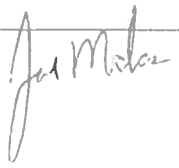
APPENDIX 3

Genesis Health System Financial Assistance Income Guidelines 2023

Family Size		Income based upon 200% of FPIG	Range </=200% FPIG 100% Writeoff	Range </=220% FPIG 90% Writeoff	Range </=240% FPIG 80% Writeoff	Range </=260% FPIG 70% Writeoff	Range </=280% FPIG 60% Writeoff	Range </=300% FPIG 50% Writeoff	Range </=320% FPIG 40% Writeoff	Range </=340% FPIG 30% Writeoff	Range </=360% FPIG 20% Writeoff	Range </=380% FPIG 10% Writeoff	Range Above 380% FPIG 0% Writeoff
1	**$14,580**	$29,160	$29,160	$32,076	$34,992	$37,908	$40,824	$43,740	$46,656	$49,572	$52,488	$55,404	$55,405
2	**$19,720**	$39,440	$39,440	$43,384	$47,328	$51,272	$55,216	$59,160	$63,104	$67,048	$70,992	$74,936	$74,937
3	**$24,860**	$49,720	$49,720	$54,692	$59,664	$64,636	$69,608	$74,580	$79,552	$84,524	$89,496	$94,468	$94,469
4	**$30,000**	$60,000	$60,000	$66,000	$72,000	$78,000	$84,000	$90,000	$96,000	$102,000	$108,000	$114,000	$114,001
5	**$35,140**	$70,280	$70,280	$77,308	$84,336	$91,364	$98,392	$105,420	$112,448	$119,476	$126,504	$133,532	$133,533
6	**$40,280**	$80,560	$80,560	$88,616	$96,672	$104,728	$112,784	$120,840	$128,896	$136,952	$145,008	$153,064	$153,065
7	**$45,420**	$90,840	$90,840	$99,924	$109,008	$118,092	$127,176	$136,260	$145,344	$154,428	$163,512	$172,596	$172,597
8	**$40,560**	$81,120	$81,120	$89,232	$97,344	$105,456	$113,568	$121,680	$129,792	$137,904	$146,016	$154,128	$154,129
9	**$45,700**	$91,400	$91,400	$100,540	$109,680	$118,820	$127,960	$137,100	$146,240	$155,380	$164,520	$173,660	$173,661
10	**$50,840**	$101,680	$101,680	$111,848	$122,016	$132,184	$142,352	$152,520	$162,688	$172,856	$183,024	$193,192	$193,193
11	**$55,980**	$111,960	$111,960	$123,156	$134,352	$145,548	$156,744	$167,940	$179,136	$190,332	$201,528	$212,724	$212,725
12	**$61,120**	$122,240	$122,240	$134,464	$146,688	$158,912	$171,136	$183,360	$195,584	$207,808	$220,032	$232,256	$232,257

Genesis Health System
GHS Administrative Policy

Policy Title:	Illinois Hospital Uninsured Discount Act	Effective Date:	4/1/09
Department:	Shared Business Services	Reviewed/Revised:	11/5/2020 09/02/2021 12/29/2021 03/06/2023
Owner Title:	Joe Malas VP of Finance/CFO	Review Cycle:	Annual

Owner Signature: 

I. POLICY:

Genesis Health System shall provide a discount from its charges to any uninsured patient who applies for the discount and has family income of not more than 600% of the current federal poverty income guidelines for all medically necessary health care services exceeding $150 in any one inpatient admission or hospital outpatient encounter. This discount applies to Illinois residents only and services must be received at an Illinois hospital based facility.

II. APPLICABLE BUSINESS UNITS:

- ☐ All GHS Business Units:

- ☐ Crescent Laundry
- ☐ Crosstown Square
- ☐ Genesis Accountable Care Organization
- ☐ Genesis Convenient Care
- ☐ Genesis EAP
- ☐ Genesis FirstMed Pharmacy
- ☐ Genesis Family Medical Center
- ☐ Genesis Health Group
- ☐ Genesis Health Group, Aledo Rural Health
- ☐ Genesis Health Group, Erie Rural Health
- ☐ Genesis Health Services Foundation
- ☐ Genesis Home Medical Equipment
- ☐ Genesis Hospice
- ☒ Genesis Medical Center, Aledo
- ☒ Genesis Medical Center, Davenport
- ☒ Genesis Medical Center, DeWitt
- ☒ Genesis Medical Center, Silvis
- ☐ Genesis Occupational Health
- ☐ Genesis Philanthropy
- ☐ Genesis Psychology Associates
- ☐ Genesis VNA
- ☐ Genesis Workers Comp Plan & Trust

III. APPLICABLE ORGANIZATIONAL ROLES:

All

IV. PURPOSE:

To meet the needs of the uninsured Illinois population who are unable to sustain the extraordinary burden of hospital medical expenses due to limited income and resources.

V. DEFINITIONS:

Illinois resident-A person who lives in Illinois and who intends to remain living in Illinois indefinitely.

VI. GENERAL CONSIDERATIONS:

N/A

VII. PRACTICE/PROCEDURE:

This pertains to Illinois residents only.

A. Verification of residency may be determined by the patient providing any one of the following:
   a. Any of the documents listed as acceptable family income documentation in section E.
   b. A valid government or state issued identification card.
   c. A recent residential utility bill.
   d. A lease agreement
   e. A vehicle registration card
   f. A voter registration card
   g. Mail addressed to the uninsured patient at an Illinois address from a government or other credible source.
   h. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency.
   i. A letter from a homeless shelter, transitional house, or other similar facility verifying that the uninsured patient resides at the facility.

B. Uninsured Patient- not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

C. Medically necessary services only- "medically necessary" services does not include any of the following:
   a. Social and vocational services.
   b. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

D. Eligibility is based on the following:

   a. Family income of not more than 600% of the federal poverty income guidelines for all medically necessary health care services exceeding $150 in any one inpatient admission or hospital outpatient encounter. See appendix 1 for Federal Poverty

guidelines.

b. For all health care services exceeding $150 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient more than its charges less the amount of the uninsured discount.
c. The maximum amount that may be collected in a 12 month period for health care services is 20% of the patient's family income, and is subject to the patient's continued eligibility.
d. The 12 month period to which the maximum amount applies shall begin on the first date of an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.
e. Discount may be applied for within 90 days of the date of discharge or date of service.

E. Acceptable family income documentation shall include any one of the following:

a. Copy of the most recent tax return
b. Copy of the most recent W-2 form or 1099 forms
c. Copies of the 2 most recent pay stubs
d. Written income verification from an employer if paid in cash
e. One other reasonable form of third party income verification deemed acceptable to the hospital.
f. The hospital may choose to certify the existence of assets owned by the patient and request that documentation be provided of the value of such assets.

F. Payment for services will be accepted in person or by mail. Methods of payment include cash, check, money order, or credit card. Visa and Master Card are accepted at all entities. Other credit cards may be accepted with the approval of the Revenue Cycle Administrator, the CFO, or the CEO of the individual organizations affiliated with Genesis Health System.

a. If Crime Victims benefits apply, a claim will be submitted to Crime Victims after the Illinois Hospital Uninsured discount is applied.

G. All over payments creating credit balances will be reviewed and resolved in a timely manner specific to appropriate procedure.

H. Each affiliate will have a means of communicating the availability of the Uninsured Illinois Hospital Discount Act to all patients. Examples of communication include but are not limited to:
a. A message regarding Financial Assistance on the healthcare bill or statement.
b. Placing Financial Assistance applications in appropriate areas.
c. Designating staff that can explain the Uninsured Illinois Hospital Discount Act.
d. Having staff direct patients to appropriate patient representatives for explanation.

I. Administrative Review

a. Written documentation shall be retained as cost reporting support documentation.
b. The Customer Service Representative will gather and assemble all the associated documents for each application for assistance. Approval levels will be as follows:

Dollar Level/Adjustment Balance	Level of Approval Required
<=$500	Representatives
$500.01 – $2,500.00	Supervisor
$2.500.01-$10,000	Director
$10,000.01 – $30,000.00	Revenue Cycle Administrator
>$30,000.01	VP of Finance/CFO

c. Should the patient not qualify for the discount they have the right to pursue the other Financial Assistance programs made available through Genesis Health System.

VIII. REFERENCES:

A. Amendment to Senate bill 2380
B. Financial Assistance Policy

IX. SUPERSEDES:

Financial Assistance Policy

X. CROSS REFERENCE:

Financial Assistance Policy

XI. ENDORSEMENTS:

Revenue Cycle Administrator 3/2014
Revenue Cycle Director 3/2014

Genesis Health System Financial Assistance Income Guidelines 2023

Family Size		Income based upon 200% of FPIG	Range </=200% FPIG 100% Writeoff	Range </=220% FPIG 90% Writeoff	Range </=240% FPIG 80% Writeoff	Range </=260% FPIG 70% Writeoff	Range </=280% FPIG 60% Writeoff	Range </=300% FPIG 50% Writeoff	Range </=320% FPIG 40% Writeoff	Range </=340% FPIG 30% Writeoff	Range </=360% FPIG 20% Writeoff	Range </=380% FPIG 10% Writeoff	Range Above 380% FPIG 0% Writeoff
1	$14,580	$29,160	$29,160	$32,076	$34,992	$37,908	$40,824	$43,740	$46,656	$49,572	$52,488	$55,404	$55,405
2	$19,720	$39,440	$39,440	$43,384	$47,328	$51,272	$55,216	$59,160	$63,104	$67,048	$70,992	$74,936	$74,937
3	$24,860	$49,720	$49,720	$54,692	$59,664	$64,636	$69,608	$74,580	$79,552	$84,524	$89,496	$94,468	$94,469
4	$30,000	$60,000	$60,000	$66,000	$72,000	$78,000	$84,000	$90,000	$96,000	$102,000	$108,000	$114,000	$114,001
5	$35,140	$70,280	$70,280	$77,308	$84,336	$91,364	$98,392	$105,420	$112,448	$119,476	$126,504	$133,532	$133,533
6	$40,280	$80,560	$80,560	$88,616	$96,672	$104,728	$112,784	$120,840	$128,896	$136,952	$145,008	$153,064	$153,065
7	$45,420	$90,840	$90,840	$99,924	$109,008	$118,092	$127,176	$136,260	$145,344	$154,428	$163,512	$172,596	$172,597
8	$40,560	$81,120	$81,120	$89,232	$97,344	$105,456	$113,568	$121,680	$129,792	$137,904	$146,016	$154,128	$154,129
9	$45,700	$91,400	$91,400	$100,540	$109,680	$118,820	$127,960	$137,100	$146,240	$155,380	$164,520	$173,660	$173,661
10	$50,840	$101,680	$101,680	$111,848	$122,016	$132,184	$142,352	$152,520	$162,688	$172,856	$183,024	$193,192	$193,193
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Genesis Health System
Administrative

Subject:	**Permissible Collections Practices**	Open/Distribution Date: Effective Date:	**5/15/05** **5/15/05**
Section:	Patient Financial Services	Reviewed/Revised:	06/10/21 5/13/22 03/06/23
Primary Responsibility:	Vice President Finance/Chief Financial Officer	Review Cycle:	**Annual**

Approved by: [Page 1 of 4]

I. POLICY

In support of its Mission, Genesis Health System (GHS) and its affiliates will maintain fair and consistent collection practices that treat all patients with dignity, respect and compassion. GHS will serve the emergency healthcare needs of everyone, regardless of ability to pay. GHS will facilitate financial assistance to patients with an inability to pay for part or all of the care they receive in a manner that is consistent with its Mission and values and which takes into account each individual's ability to contribute to the cost of his/her care.

II. APPLICABLE BUSINESS UNITS

☐ All GHS Business Units:

☐ Crescent Laundry
☐ Crosstown Square
☐ Genesis Accountable Care Organization
☒ Genesis Convenient Care
☐ Genesis EAP
☐ Genesis FirstMed Pharmacy
☒ Genesis Family Medical Center
☒ Genesis Health Group
☒ Genesis Health Group, Aledo Rural Health
☒ Genesis Health Group, Erie Rural Health
☐ Genesis Health Services Foundation
☒ Genesis Home Medical Equipment
☒ Genesis Hospice
☒ Genesis Medical Center, Aledo
☒ Genesis Medical Center, Davenport
☒ Genesis Medical Center, DeWitt
☒ Genesis Medical Center, Silvis
☐ Genesis Occupational Health
☐ Genesis Philanthropy
☒ Genesis Psychology Associates
☒ Genesis VNA
☐ Genesis Workers Comp Plan & Trust

III. APPLICABLE ORGANIZATIONAL ROLES

N/A

IV. PURPOSE

To establish standards for collection actions which assure all monies due are pursued and collected in a timely fashion and are consistent with the GHS Mission and Values. Written agreement with the standards outlined in the policy shall be required from outside collection agents acting on behalf of the organization.

V. DEFINITIONS

None

VI. GENERAL CONSIDERATIONS

N/A

VII. PRACTICE/PROCEDURE

Debt collection procedures are necessary in order for GHS to maintain a financially viable operation. These procedures must assure that monies due GHS are pursued and collected in a timely fashion, and shall be consistent with the Health System's Mission and Values. The following activities may be pursued by GHS, by an outside organization or collection agency on behalf of GHS:

A. Permissive Actions

1. Communications with patients (calls, letters, fax, e-mail, etc.) and their representatives, which are in compliance with the following statutory and regulatory mandates:

    a. Iowa Debt Collection Practices Act (IDCPA) – 537.7101 et seq. of the 2003 Iowa code.
    b. Illinois Collection Agency Act – 225 ILCX-425/1a. – In addition to 225 ILCS-425/1a et seq.of 2005 Illinois code, collections must also be in compliance with regulations promulgated by the Department of Professional Regulations, State of Illinois (Title 68, Part 1210).
    c. Fair Debt Collection Practices Act (FDCPA) – 15 U.S.C. Section 1692 et seq.
    d. HIPAA Privacy Regulations (Health Insurance Portability and Accountability Act of 1996, P.L. 104-191) and modifying regulations provided by the Department of Human Services – e.g. 45 C.F.R. 162 – HIPAA Standards for National Provider Identifier.
    e. Solicitation of Estimated Patient Payment Obligations at the time of service in accordance with the Emergency Medical Treatment and Active Labor Act – EMTALA – 42 U.S.C. Section 1395dd et seq. – See also 42 C.F.R. 489.20(q)I – Implementing regulations.
    f. When entering into a low-interest loan program for payment of outstanding debts for patients who have the ability to pay, but cannot meet the short-term payment requirements as defined in the Financial Assistance Policy, said agreements, if written, must be in compliance with 15 U.S.C Section 1600 et seq., as supplemented by the Federal Reserve Board's Regulation Z found

at 12 C.F.R. Part 226, and the Federal Reserve Board's Office Staff Commentary to Regulation Z (OSC). Unwritten agreements need not comply with Regulation Z, but shall be documented in the Agency's notes.

B. At discretion of Genesis, Genesis could report outstanding debts to the Credit Bureau after reasonable collection efforts have been made. Effective 1/1/2016 the first statement date will be reflected in Meditech for hospital accounts and communicated to all contracted collection vendors.

C. In the case of a deceased patient, collection efforts will be made four months after time of death or when the estate goes to probate, whichever occurs first.

D. Pursue legal action for individuals who have the means to pay, but are unwilling to pay. Legal action may be pursued for the portion of the unpaid amount. Management review by the CFO, VP of Legal Affairs, and Revenue Integrity Administrator (or designee) is required prior to proceeding with legal action to collect a judgment (i.e. garnishment of wages, debtors' exam).

E. Placement of judgment liens, other than by operation of law, may not be done without the approval of the CFO and/or Revenue Cycle Administrator (or designee). This means that a Memorandum of Judgment may not be filed with the Recorder of Deeds in the State of Illinois, pursuant to 735 ILCS 5/12-101 et seq., without the approval of the CFO and/or Revenue Cycle Administrator. Execution and levy pursuant to Chapter 626 of the Iowa Code on judgment liens created pursuant to Chapter 624.23 of the Iowa Code shall not be undertaken without the approval of the CFO and/or Revenue Cycle Administrator.

F. Prohibited Actions- A Rule to Show Cause may be pursued if the Debtor fails to show up for a Citation to Discover Assets (Illinois), or a Debtor's Examination (Iowa). However, if the patient does not show up at the hearing on the Rule to Show Cause, the Agency may not ask the Court to issue an Arrest Warrant or similar action for the Defendant's failure to comply with the Court's Order. Representatives of the collection agency are instructed to request the Court not to issue process that will result in the incarceration of the patient. If the results of the efforts of the Representative for the Agency are unsuccessful in convincing the Court not to issue a Warrant or process against the patient, the Representative shall immediately contact the Revenue Cycle Administrator (or Designee) and follow instructions received from the Director or the Director's Designee. The Representative for the Agency shall file with the Clerk of Court a written motion or request that the Court not issue process for the patient's failure to show up for the Rule to Show Cause, making it clear that it is the policy of GHS not to pursue body attachments or arrest warrants.

VIII. REFERENCES

A. American Hospital Association Guidelines on Hospital Billing and Collection Practices
B. Iowa Hospital Association Policy Statement on Hospital Billing and Collection Practices
C. Fair Debt Collection Practices Act – 15 U.S.C. 1692 et seq.
D. Health Insurance Portability and Accountability Act of 1996, P.L. 104 – 191 (HIPAA) – Privacy Regulations
E. Emergency Medical Transfer and Active Labor Act – 42 U.S.C. Section 1395dd et seq.
F. Iowa Debt Collection Practices Act – 537.7101 et seq.
G. Truth In Lending Regulations – 15 U.S.C. 1600 et seq.

H. Department of Professional Regulations – State of Illinois – Title 68, Part 1210

IX. SUPERSEDES

N/A

X. CROSS REFERENCE

Financial Assistance

XI. ENDORSEMENTS

N/A

Trinity Health

Consolidated Financial Statements as of and for the
years ended June 30, 2023 and 2022,
Supplemental Consolidating Schedules as of and for
the year ended June 30, 2023
and Independent Auditor's Reports

TRINITY HEALTH

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Trinity Health Corporation
Livonia, Michigan

Opinion

We have audited the consolidated financial statements of Trinity Health Corporation and its subsidiaries (the "Corporation"), which comprise the consolidated balance sheets as of June 30, 2023 and 2022, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, based on our audits and the report of the other auditors, the accompanying financial statements present fairly, in all material respects, the financial position of the Corporation as of June 30, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

We did not audit the combined financial statements of BayCare Health System, the Corporation's investment which is accounted for by the use of the equity method. The accompanying consolidated financial statements of the Corporation include its investment in the net assets of BayCare Health System of $4.4 billion and $4.0 billion as of June 30, 2023, and 2022, respectively, and its equity method income (loss) from BayCare Health System of $409.4 million and $(184.9) million for the years ended June 30, 2023 and 2022, respectively. The combined financial statements of BayCare Health System for the years ended December 31, 2022 and 2021, were audited by other auditors whose reports have been furnished to us, and our opinion, in so far as it relates to the amounts included for BayCare Health System, is based on the reports of the other auditors and the procedures that we considered necessary in the circumstances with respect to the inclusion of the Corporation's equity investment and equity method income in the accompanying consolidated financial statements taking into consideration the differences in fiscal years.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for a reasonable period of time.

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

Deloitte + Touche LLP

September 20, 2023

TRINITY HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2023 AND 2022
(In thousands)

ASSETS	2023	2022
CURRENT ASSETS:		
Cash and cash equivalents	$ 576,308	$ 643,363
Investments	5,266,635	5,717,088
Security lending collateral	349,985	502,981
Assets limited or restricted as to use - current portion	430,985	475,836
Patient accounts receivable	2,475,557	2,053,459
Estimated receivables from third-party payers	298,946	313,580
Other receivables	422,689	356,691
Inventories	409,193	383,736
Prepaid expenses and other current assets	225,464	171,547
Total current assets	10,455,762	10,618,281
ASSETS LIMITED OR RESTRICTED AS TO USE - noncurrent portion:		
Self-insurance, benefit plans and other	1,052,049	912,032
By Board	4,160,166	4,494,293
By donors	598,003	503,742
Total assets limited or restricted as to use - noncurrent portion	5,810,218	5,910,067
PROPERTY AND EQUIPMENT - Net	8,846,497	8,154,678
OPERATING LEASE RIGHT-OF-USE ASSETS	598,938	530,999
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	5,165,540	4,717,711
GOODWILL	848,078	814,131
PREPAID PENSION AND RETIREE HEALTH ASSETS	232,725	91,281
OTHER ASSETS	322,449	284,206
TOTAL ASSETS	$ 32,280,207	$ 31,121,354

LIABILITIES AND NET ASSETS	2023	2022
CURRENT LIABILITIES:		
Commercial paper	$ 99,538	$ 99,693
Short-term borrowings	616,335	632,730
Current portion of long-term debt	245,326	247,149
Current portion of operating lease liabilities	150,878	137,254
Medicare cash advances	-	389,485
Accounts payable and accrued expenses	1,551,303	1,453,495
Salaries, wages and related liabilities	1,065,904	1,198,363
Payable under security lending agreements	349,985	502,981
Estimated payables to third-party payers	286,409	341,683
Current portion of self-insurance reserves	303,658	324,166
Total current liabilities	4,669,336	5,326,999
LONG-TERM DEBT - Net of current portion	6,757,159	6,416,701
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	535,888	481,391
SELF-INSURANCE RESERVES - Net of current portion	1,151,235	1,158,241
ACCRUED PENSION AND RETIREE HEALTH COSTS	88,859	165,018
OTHER LONG-TERM LIABILITIES	751,728	675,696
Total liabilities	13,954,205	14,224,046
NET ASSETS:		
Net assets without donor restrictions	17,176,548	15,821,267
Noncontrolling ownership interest in subsidiaries	493,440	489,489
Total net assets without donor restrictions	17,669,988	16,310,756
Net assets with donor restrictions	656,014	586,552
Total net assets	18,326,002	16,897,308
TOTAL LIABILITIES AND NET ASSETS	$ 32,280,207	$ 31,121,354

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

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2023 AND 2022
(In thousands)

	2023	2022
OPERATING REVENUE:		
Net patient service revenue	$ 18,521,694	$ 17,042,518
Premium and capitation revenue	1,112,633	1,089,363
Net assets released from restrictions	37,404	30,270
Other revenue	1,914,987	1,771,527
Total operating revenue	21,586,718	19,933,678
EXPENSES:		
Salaries and wages	9,317,202	8,865,906
Employee benefits	1,742,152	1,644,251
Contract labor	933,039	626,294
Total labor expenses	11,992,393	11,136,451
Supplies	3,915,686	3,530,720
Purchased services and medical claims	2,925,846	2,654,415
Depreciation and amortization	858,770	876,099
Occupancy	864,120	751,891
Interest	261,911	225,797
Other	1,055,952	906,819
Total expenses	21,874,678	20,082,192
OPERATING LOSS BEFORE OTHER ITEMS	(287,960)	(148,514)
Gain on sale and dividend received	61,864	128,678
Restructuring costs	(40,046)	(72,568)
Restructuring costs - transfer of St. Francis Medical Center	(82,259)	-
Asset impairment charges	(83,261)	(113,864)
OPERATING LOSS	(431,662)	(206,268)
NONOPERATING ITEMS:		
Investment earnings (losses)	715,572	(1,015,043)
Equity in earnings (losses) of unconsolidated affiliates	421,882	(150,214)
Change in market value and cash payments of interest rate swaps	29,766	63,431
Other net periodic retirement cost	(163,024)	(50,332)
Inherent contributions	483,510	-
Other, including income taxes	(18,603)	262
Total nonoperating items	1,469,103	(1,151,896)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	1,037,441	(1,358,164)
EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(77,721)	(73,184)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES, NET OF NONCONTROLLING INTEREST	$ 959,720	$ (1,431,348)

	2023	2022
NET ASSETS WITHOUT DONOR RESTRICTIONS:		
Net assets without donor restrictions attributable to Trinity Health:		
Excess (deficiency) of revenue over expenses	$ 959,720	$ (1,431,348)
Net assets released from restrictions for capital acquisitions	31,237	28,786
Net change in retirement plan related items - consolidated organizations	338,872	(181,200)
Net change in retirement plan related items - unconsolidated organizations	13,567	(2,047)
Other	11,885	30,663
Increase (decrease) in net assets without donor restrictions attributable to Trinity Health	1,355,281	(1,555,146)
Net assets without donor restrictions attributable to noncontrolling interests:		
Excess of revenue over expenses attributable to noncontrolling interests	77,721	73,184
Dividends and other	(73,770)	(73,865)
Increase (decrease) in net assets without donor restrictions attributable to noncontrolling interests	3,951	(681)
NET ASSETS WITH DONOR RESTRICTIONS:		
Contributions:		
Program and time restrictions	46,698	41,000
Endowment funds	1,208	3,097
Net investment gains (losses):		
Program and time restrictions	20,081	(15,903)
Endowment funds	7,368	(18,672)
Net assets released from restrictions	(68,641)	(59,056)
Acquisitions	69,075	-
Other	(6,327)	(5,596)
Increase (decrease) in net assets with donor restrictions	69,462	(55,130)
INCREASE (DECREASE) IN NET ASSETS	1,428,694	(1,610,957)
NET ASSETS - BEGINNING OF YEAR	16,897,308	18,508,265
NET ASSETS - END OF YEAR	$ 18,326,002	$ 16,897,308

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

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2023 AND 2022
(In thousands)

	2023	2022
OPERATING ACTIVITIES:		
Increase (decrease) in net assets	$ 1,428,694	$ (1,610,957)
Adjustments to reconcile increase (decrease) in net assets to net cash used in operating activities:		
Depreciation and amortization	858,770	876,099
Amortization of right-of-use assets	144,375	126,033
Asset impairment charges	83,261	113,864
Change in net unrealized and realized gains and losses on investments	(629,711)	1,294,285
Change in market values of interest rate swaps	(37,337)	(87,240)
Undistributed equity in earnings of unconsolidated affiliates	(406,308)	193,042
Inherent contributions related to acquisitions	(483,510)	-
Loss on transfer of St. Francis Medical Center	22,842	-
Gain on sale of Gateway Health Plan L.P.	(8,000)	(128,678)
Dividend received from cost method investee	(53,864)	-
Deferred retirement items - consolidated organizations	(338,872)	181,200
Deferred retirement items - unconsolidated organizations	(13,567)	2,047
Restricted contributions and investment income received	(10,013)	(5,958)
Restricted contributions acquired	(69,075)	-
Other adjustments	44,796	13,609
Changes in:		
Patient accounts receivable	(151,211)	24,733
Estimated receivables from third-party payers	15,660	9,006
Prepaid pension and retiree health costs	(10,627)	(80,892)
Other assets	(49,956)	(44,488)
Medicare cash advances	(409,533)	(907,096)
Accounts payable and accrued expenses	(238,619)	55,529
Estimated payables to third-party payers	(68,365)	(39,437)
Self-insurance reserves and other liabilities	(178,107)	(135,917)
Accrued pension and retiree health costs	125,921	88,340
Total adjustments	(1,861,050)	1,548,081
Net cash used in operating activities	$ (432,356)	$ (62,876)

	2023	2022
INVESTING ACTIVITIES:		
Proceeds from sales of investments	$ 3,821,780	$ 5,239,199
Purchases of investments	(2,101,414)	(4,782,766)
Purchases of property and equipment	(960,385)	(908,283)
Proceeds from disposal of property and equipment	9,081	13,659
Cash proceeds from sale of Gateway Health Plan L.P.	8,000	323,378
Dividend received from cost method investee	53,864	-
Cash used for disposal of St. Francis Medical Center	(14,500)	-
Net cash used for acquisitions	(532,779)	(1,291)
Change in investments in unconsolidated affiliates	(36,283)	(20,505)
Change in other investing activities	(6,511)	12,511
Net cash provided by (used in) investing activities	240,853	(124,098)
FINANCING ACTIVITIES:		
Proceeds from issuance of debt	383,446	433,714
Repayments of debt	(189,975)	(324,337)
Net change in commercial paper	(155)	(301)
Dividends paid	(74,733)	(73,065)
Proceeds from restricted contributions and restricted investment income	10,164	6,259
Increase in financing costs and other	(2,314)	(4,092)
Net cash provided by financing activities	126,433	38,178
NET DECREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	(65,070)	(148,796)
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - BEGINNING OF YEAR	801,155	949,951
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 736,085	$ 801,155
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for interest - net of amounts capitalized	$ 265,414	$ 237,807
Accruals for purchases of property and equipment and other long-term assets	52,998	83,394
Unsettled investment trades and purchases	28,701	43,096
Unsettled investment trades and sales	6,247	9,736
Increase in security lending collateral	(152,997)	110,253
Increase in payable under security lending agreements	152,997	(110,253)

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

1. ORGANIZATION AND MISSION

Trinity Health Corporation, an Indiana nonprofit corporation headquartered in Livonia, Michigan, and its subsidiaries ("Trinity Health" or the "Corporation"), controls one of the largest health care systems in the United States. The Corporation is sponsored by Catholic Health Ministries, a Public Juridic Person of the Holy Roman Catholic Church. The Corporation operates a comprehensive integrated network of health services, including inpatient and outpatient services, physician services, managed care coverage, home health care, long-term care, assisted living care and rehabilitation services located in 26 states. The operations are organized into Regional Health Ministries, National Health Ministries and Mission Health Ministries ("Health Ministries"). The Mission statement for the Corporation is as follows:

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Community Benefit Ministry – Consistent with our Mission, Trinity Health provides medical care to all patients regardless of their ability to pay. In addition, Trinity Health provides services intended to benefit persons experiencing poverty and other vulnerabilities, including those persons who cannot afford health insurance or other payments, such as co-pays and deductibles because of inadequate resources and/or are uninsured or underinsured; and works to improve the health status of the communities in which it operates. In addition to the people Trinity Health provides directly with clinical care, our Mission extends to reach millions of people who live in our communities. Trinity Health lives our Mission, not only through the delivery of medical care but also through community service programs, such as street outreach programs to meet the needs of people experiencing homelessness, and Social Care Models to connect individuals to food, housing and other essential daily support.

Trinity Health is building on the legacy of our founders by making a transformational shift from being primarily focused on traditional episodic care to emphasizing total population health, which includes contributing to the overall health and well-being of our communities by impacting the social influencers of health, such as, through partnerships to increase affordable housing and food access. These costs have been included in the appropriate category below.

The following summary has been prepared in accordance with the Catholic Health Association of the United States' ("CHA"), *A Guide for Planning and Reporting Community Benefit, 2022 Edition.*

The quantifiable costs of the Corporation's community benefit ministry for the years ended June 30 are as follows (in thousands):

	2023	2022
Ministry for those experiencing poverty and other vulnerabilities:		
Financial assistance	$ 189,303	$ 191,594
Unpaid cost of Medicaid and other public programs	857,175	762,110
Programs for those experiencing poverty and other vulnerabilities:		
Community health improvement services	24,994	23,255
Subsidized health services	45,367	50,743
Financial contributions	21,622	22,174
Community building activities	1,611	1,570
Community benefit operations	4,197	4,699
Total programs for those experiencing poverty and other vulnerabilities	97,791	102,441
Ministry for those experiencing poverty and other vulnerabilities	1,144,269	1,056,145
Ministry for the broader community:		
Community health improvement services	12,878	11,657
Health professions education	215,301	215,232
Subsidized health services	44,979	40,762
Research	5,972	5,574
Financial contributions	34,821	30,980
Community building activities	1,724	1,396
Community benefit operations	8,397	9,081
Ministry for the broader community	324,072	314,682
Community benefit ministry	$ 1,468,341	$ 1,370,827

Ministry for those experiencing poverty and other vulnerabilities represents the financial commitment to seek out and serve those who need help the most, especially those who are experiencing poverty, are uninsured or face barriers to accessing health care, emphasizing the necessity to integrate social and clinical care. This is done with the conviction that health care is a basic human right.

Ministry for the broader community represents the cost of programs and activities aimed at improving the health and well-being of everyone living in the community. While these programs are not focused on specific, low-income population groups, they are accessible to and involve outreach for those experiencing poverty and other vulnerabilities. These programs are not intended to be financially self-supporting.

Financial assistance represents the cost of services provided to patients who cannot afford health care services due to inadequate resources and/or are uninsured or underinsured. A patient's service is classified as financial assistance in accordance with the Corporation's established policies as further described in Note 2. The cost of financial assistance is calculated using a cost-to-charge ratio methodology.

Unpaid cost of Medicaid and other public programs represents the cost (determined using a cost-to-charge ratio) of providing services to beneficiaries of public programs, including state Medicaid and indigent care programs, in excess of governmental and managed care contract payments.

Community health improvement services are activities and services carried out to improve community health and well-being, for which no patient bill exists. These services are not expected to be financially self-supporting, although some may be supported by outside grants or other funding. An example is the Corporation's Social Care program which was developed to address individual social needs, such as access to transportation, childcare, or affordable medications by facilitating connections between patients, healthcare providers and community partners that promote healthy behaviors. Other examples include social and environmental improvement activities that address the social influencers of health, community health education, free immunization services, free or low-cost prescription medications and rural and urban outreach programs. The Corporation actively collaborates with community groups and agencies to assist those in need in providing such services.

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

Subsidized health services are net costs for billed services that are subsidized by the Corporation. These include services offered despite a financial loss because they are needed in the community and either other providers are unwilling to provide the services, or the services would otherwise not be available in sufficient amount. Examples of services include free-standing community clinics, hospice care, mobile units and behavioral health services.

Research includes unreimbursed clinical and community health research and studies on health care delivery, which is generalizable and shared with the public.

Financial contributions are made by the Corporation to community organizations and are restricted to support community benefit activities. These amounts include special system-wide funds used to improve community health and well-being as well as resources contributed directly to programs, organizations and foundations for efforts on behalf of those experiencing poverty and other vulnerabilities. Amounts included here also represent certain in-kind donations.

Community building activities include programs that address the root causes of health problems and focus on policy, systems and environmental changes. Examples include advocacy for community health improvement, the costs of programs that improve the physical environment, promote economic development, enhance other community support systems, develop leadership skills through training and build community coalitions.

Community benefit operations include costs associated with dedicated staff, community health needs and asset assessments and other costs associated with community benefit strategy and operations.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation – The consolidated financial statements include the accounts of the Corporation, and all wholly-owned, majority-owned and controlled organizations. Investments where the Corporation holds less than 20% of the ownership interest are accounted for using the cost method. All other investments that are not controlled by the Corporation are accounted for using the equity method of accounting. The equity share of income or losses from investments in unconsolidated affiliates is recorded in other revenue if the unconsolidated affiliate is operational and projected to make routine and regular cash distributions; otherwise, the equity share of income or losses from investments in unconsolidated affiliates is recorded in nonoperating items in the consolidated statements of operations and changes in net assets. All material intercompany transactions and account balances have been eliminated in consolidation.

Use of Estimates – The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management of the Corporation to make assumptions, estimates and judgments that affect the amounts reported in the consolidated financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any.

The Corporation considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its consolidated financial statements, including the following: recognition of net patient service revenue, which includes explicit and implicit price concessions; financial assistance; premium revenue; recorded values of investments and derivatives; goodwill; evaluation of long-lived assets for impairment; reserves for losses and expenses related to health care professional and general liabilities; and risks and assumptions for measurement of pension and retiree health liabilities. Management relies on historical experience and other assumptions believed to be reasonable in making its judgments and estimates. Actual results could differ materially from those estimates.

Cash, Cash Equivalents and Restricted Cash – For purposes of the consolidated statements of cash flows, cash, cash equivalents and restricted cash include certain investments in highly liquid debt instruments with original maturities of three months or less.

The following table reconciles cash, cash equivalents and restricted cash shown in the statements of cash flows to amounts presented within the consolidated balance sheets as of June 30 (in thousands):

	2023	2022
Cash and cash equivalents	$ 576,308	$ 643,363
Restricted cash included in assets limited or restricted as to use - current portion		
Self-insurance, benefit plans and other	94,242	96,077
By donors	4,359	4,525
Total restricted cash included in assets limited or restricted as to use - current portion	98,601	100,602
Restricted cash included in assets limited as to use - noncurrent portion		
Self-insurance, benefit plans and other	28,723	24,251
By donors	32,453	32,939
Total restricted cash included in assets limited or restricted as to use - noncurrent portion	61,176	57,190
Total cash, cash equivalents, and restricted cash shown in the statements of cash flows	$ 736,085	$ 801,155

Investments – Investments, inclusive of assets limited or restricted as to use, include marketable debt and equity securities. Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value and are classified as trading securities. Investments also include investments in commingled funds, hedge funds and other investments structured as limited liability corporations or partnerships. Commingled funds and hedge funds that hold securities directly are stated at the fair value of the underlying securities, as determined by the administrator, based on readily determinable market values, or based on net asset value, which is calculated using the most recent fund financial statements. Limited liability corporations and partnerships are accounted for under the equity method.

Investment Earnings – Investment earnings include interest, dividends, realized gains and losses and unrealized gains and losses. Also included are equity earnings from investment funds accounted for using the equity method. Investment earnings on assets held by trustees under bond indenture agreements, assets designated by the Corporation's board of directors ("Board") for debt redemption, assets held for borrowings under the intercompany loan program, assets held by grant-making foundations, assets deposited in trust funds by a captive insurance company for self-insurance purposes, and interest and dividends earned on life plan communities advance entrance fees, in accordance with industry practices, are included in other revenue in the consolidated statements of operations and changes in net assets. Investment earnings, net of direct investment expenses, from all other investments and Board-designated funds are included in nonoperating investment income unless the income or loss is restricted by donor or law.

Derivative Financial Instruments – The Corporation periodically utilizes various financial instruments (e.g., options and swaps) to hedge interest rates, equity downside risk and other exposures. The Corporation's policies prohibit trading in derivative financial instruments on a speculative basis. The Corporation recognizes all derivative instruments in the consolidated balance sheets at fair value.

Securities Lending – The Corporation participates in securities lending transactions whereby a portion of its investments are loaned, through its agent, to various parties in return for cash and securities from the parties as collateral for the securities loaned. Each business day, the Corporation, through its agent, and the borrower determine the market value of the collateral and the borrowed securities. If on any business day the market value of the collateral is less than the required value, additional collateral is obtained as appropriate. The amount of cash collateral received under securities lending is reported as an asset and a corresponding payable in the consolidated balance sheets and is up to 105% of the market value of securities loaned. As of June 30, 2023 and 2022, the Corporation had securities loaned of $698.7 million and $748.6 million, respectively, and received collateral (cash and noncash) totaling $716.6 million and $774.7 million, respectively, relating to the securities loaned. The fees received for these transactions are recorded in nonoperating investment income in the consolidated statements of operations and changes in net assets. In addition, certain pension plans participate in securities lending programs with the Northern Trust Company, the plans' agent.

Patient Accounts Receivable, Estimated Receivables from and Payables to Third-Party Payers – An unconditional right to payment, subject only to the passage of time is treated as a receivable. Patient accounts receivable, including billed accounts and unbilled accounts for which there is an unconditional right to payment, and estimated amounts due from third-party payers for retroactive adjustments, are receivables if the right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. For patient accounts receivable, the estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient service revenue and accounts receivable.

The Corporation has agreements with third-party payers that provide for payments to the Corporation's Health Ministries at amounts different from established rates. Estimated retroactive adjustments under reimbursement agreements with third-party payers and other changes in estimates are included in net patient service revenue and estimated receivables from and payables to third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Assets Limited as to Use – Assets set aside by the Board for quasi-endowments, future capital improvements, future funding of retirement programs and insurance claims, retirement of debt, held for borrowings under the intercompany loan program, and other purposes over which the Board retains control and may at its discretion subsequently use for other purposes, assets held by trustees under bond indenture and certain other agreements, and self-insurance trust and benefit plan arrangements are included in assets limited as to use.

Donor-Restricted Gifts – Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as support with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or program restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions without donor restrictions included in other revenue in the consolidated statements of operations and changes in net assets.

Inventories – Inventories are stated at the lower of cost or market. The cost of inventories is determined principally by the weighted-average cost method.

Property and Equipment – Property and equipment, including internal-use software, are recorded at cost, if purchased, or at fair value at the date of donation, if donated. Finance lease right-of-use assets included in property and equipment represent the right to use the underlying assets for the lease term and are recognized at the lease commencement date based on the present value of lease payments over the term of the lease.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using either the straight-line or an accelerated method and includes finance lease right-of-use asset amortization and internal-use software amortization. The useful lives of property and equipment range from 2 to 75 years, and finance lease agreements have initial terms typically ranging from 3 to 30 years. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions and are excluded from the excess of revenue over expenses, 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 support with donor restrictions.

Right-of-Use Lease Assets and Lease Liabilities – The Corporation determines if an arrangement is a lease at inception of the contract. Right-of-use assets represent the right to use the underlying assets for the lease term and lease liabilities represent the obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. The Corporation uses the implicit rate noted within the contract, when available. Otherwise, the Corporation uses its incremental borrowing rate estimated using recent secured debt issuances that correspond to various lease terms, information obtained from banking advisors, and the Corporation's secured debt fair value. The Corporation does not recognize leases, for operating or finance type, with an initial term of 12 months or less ("short-term leases") on the consolidated balance sheet, and the lease expense for these short-term leases is recognized on a straight-line basis over the lease term within occupancy expense in the consolidated statements of operations and changes in net assets. The Corporation's finance leases are primarily for real estate. Finance lease right-of-use assets are included in property and equipment, with the related liabilities included in current and long-term debt on the consolidated balance sheet.

Operating lease right-of-use assets and liabilities are recorded for leases that are not considered finance leases. The Corporation's operating leases are primarily for real estate, vehicles, and medical and office equipment. Real estate leases include outpatient, medical office, ground, and corporate administrative office space. The Corporation's real estate lease agreements typically have an initial term of 2 to 10 years. The Corporation's equipment lease agreements typically have an initial term of 2 to 6 years. The real estate

leases may include one or more options to renew, with renewals that can extend the lease term from 5 to 10 years. The exercise of lease renewal options is at the Corporation's sole discretion. For accounting purposes, options to extend or terminate the lease are included in the lease term when it is reasonably certain that the option will be exercised. Operating lease liabilities represent the obligation to make lease payments arising from the leases and are recognized at the lease commencement date based on the present value of lease payments over the lease term.

Certain of the Corporation's lease agreements for real estate include payments based on common area maintenance expenses and others include rental payments adjusted periodically for inflation. These variable lease payments are recognized in occupancy expense, net, but are not included in the right-of-use asset or liability balances when they can be separately identified in the contract. The Corporation's lease agreements do not contain any material residual value guarantees, restrictions, or covenants.

Goodwill – Goodwill represents the future economic benefits arising from assets acquired in a business combination that are not individually identified and separately recognized.

Asset Impairments –

> ***Property, Equipment and Right-of-Use Lease Assets*** – The Corporation evaluates long-lived assets for possible impairment whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, the impairment recognized is calculated as the carrying value of the long-lived assets in excess of the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the assets.
>
> ***Goodwill*** – Goodwill is tested for impairment on an annual basis or when an event or change in circumstance indicates the value of a reporting unit may have changed. Testing is conducted at the reporting unit level. If the carrying amount of the reporting unit goodwill exceeds the implied fair value of that goodwill, an impairment loss is recognized in an amount equal to that excess. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Other Assets – Other assets include long-term notes receivable, reinsurance recovery receivables, definite- and indefinite-lived intangible assets other than goodwill and prepaid retiree health costs. The net balances of definite-lived intangible assets include noncompete agreements, physician guarantees and other definite-lived intangible assets with finite lives amortized using the straight-line method over their estimated useful lives, which generally range from 2 to 20 years. Indefinite-lived intangible assets primarily include trade names, which are tested annually for impairment.

Short-Term Borrowings – Short-term borrowings include puttable variable-rate demand bonds supported by self-liquidity or liquidity facilities considered short-term in nature.

Medicare Cash Advances – In April 2020, the Corporation requested and received accelerated Medicare payments of $1.6 billion for its acute care hospitals, which was provided through the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"). The repayment terms allow recipients to extend repayment for a full year before recoupment of the advance payments begins and limit the claim payment offset to 25% of the recipient's full Medicare payments for 11 months, followed by six months with claim offset limited to 50%. At the end of the 29-month period, any unapplied advance repayment amounts must be repaid by the Corporation. Claims for services provided to Medicare beneficiaries began being applied against the Corporation's cash advances in April 2021. Recoupment amounts were classified as current liabilities as they were expected to be repaid within one year as of June 30, 2022. As of June 30, 2023, the remaining balance was fully repaid.

Other Long-Term Liabilities – Other long-term liabilities include deferred compensation, asset retirement obligations, interest rate swaps and deferred revenue from entrance fees. Deferred revenue from entrance fees are fees paid by residents of facilities for the elderly upon entering into continuing care contracts, which are amortized to income using the straight-line method over the estimated remaining life expectancy of the resident, net of the portion that is refundable to the resident.

Net Assets with Donor Restrictions – Net assets with donor restrictions are those whose use by the Corporation has been limited by donors to a specific time period or program. In addition, certain net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Net Patient Service Revenue – The Corporation reports patient service revenue at the amount that reflects the consideration it is expected to be entitled to in exchange for providing patient care. These amounts are due from patients, third-party payers (including commercial payers and government programs) and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Corporation bills patients and third-party payers several days after the services are performed or the patient is discharged from a facility.

The Corporation determines performance obligations 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 expected charges. The Corporation believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in hospitals receiving inpatient acute care services, or receiving services in outpatient centers, or in their homes (home care). The Corporation measures performance obligations from admission to the hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to the patient, which is generally at the time of discharge or the completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to our patients and customers in a retail setting (for example, pharmaceuticals and medical equipment) and the Corporation does not believe that it is required to provide additional goods and services related to that sale.

Because patient service performance obligations relate to contracts with a duration of less than one year, the Corporation has elected to apply the optional exemption provided in Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 606-10-50-14(a) and, therefore, the Corporation is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks from the end of the reporting period.

The Corporation has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Corporation's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less. However, the Corporation does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

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

of implicit price concessions is based on historical collection experience with the various classes of patients using a portfolio approach as a practical expedient to account for patient contracts with similar characteristics, as collective groups rather than individually. The financial statement effect of using this practical expedient is not materially different from an individual contract approach.

Generally, patients who are covered by third-party payers are responsible for related deductibles and coinsurance, which vary in amount. The Corporation also provides services to uninsured and underinsured patients, and offers those uninsured and underinsured patients a discount, either by policy or law, from standard charges. The Corporation estimates the transaction price for patients with deductibles and coinsurance and for those who are uninsured and underinsured based on historical experience and current market conditions, using the portfolio approach. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the payer's or patient's ability to pay are recorded as bad debt expense in other expenses in the statement of operations and changes in net assets. 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 is as follows:

Medicare – Acute inpatient and outpatient services rendered to Medicare program beneficiaries are paid primarily at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Certain items are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediaries.

Medicaid – Reimbursement for services rendered to Medicaid program beneficiaries includes prospectively determined rates per discharge, per diem payments, discounts from established charges, fee schedules and cost reimbursement methodologies with certain limitations. Cost reimbursable items are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicaid fiscal intermediaries.

Other – Reimbursement for services to certain patients is received from commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for reimbursement includes prospectively determined rates per discharge, per diem payments and discounts from established charges.

Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions, and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates that have been recorded could change by material amounts.

Settlements with third-party payers for retroactive revenue 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 payer, correspondence from the payer 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 (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations.

Financial Assistance – The Corporation provides services to all patients regardless of ability to pay. In accordance with the Corporation's policy, a patient is classified as a financial assistance patient based on specific criteria, including income eligibility as established by the *Federal Poverty Guidelines,* as well as other financial resources and obligations.

Charges for services to patients who meet the Corporation's guidelines for financial assistance are not reported as net patient service revenue in the accompanying consolidated financial statements. Therefore, the Corporation has determined it has provided implicit price concessions to uninsured and underinsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Corporation expects to collect based on its collection history with those patients.

Self-Insured Employee Health Benefits – The Corporation administers self-insured employee health benefit plans for employees. The majority of the Corporation's employees participate in the programs. The provisions of the plans permit employees and their dependents to elect to receive medical care at either the Corporation's Health Ministries or other health care providers. Patient service revenue has been reduced by an allowance for self-insured employee health benefits, which represents revenue attributable to medical services provided by the Corporation to its employees and dependents in such years.

Premium and Capitation Revenue – The Corporation has certain Health Ministries that arrange for the delivery of health care services to enrollees through various contracts with providers and common provider entities. Enrollee contracts are negotiated on a yearly basis. Premiums are due monthly and are recognized as revenue during the period in which the Corporation is obligated to provide services to enrollees. Premiums received prior to the period of coverage are recorded as deferred revenue and included in accounts payable and accrued expenses in the consolidated balance sheets.

Certain of the Corporation's Health Ministries have entered into capitation arrangements whereby they accept the risk for the provision of certain health care services to health plan members. Under these agreements, the Corporation's Health Ministries are financially responsible for services provided to the health plan members by other institutional health care providers. Capitation revenue is recognized during the period for which the Health Ministry is obligated to provide services to health plan enrollees under capitation contracts. Capitation receivables are included in other receivables in the consolidated balance sheets.

Reserves for incurred but not reported claims have been established to cover the unpaid costs of health care services covered under the premium and capitation arrangements. The premium and capitation arrangement reserves are included in accounts payable and accrued expenses in the consolidated balance sheets. The liability is estimated based on actuarial studies, historical reporting, and payment trends. Subsequent actual claim experience will differ from the estimated liability due to variances in estimated and actual utilization of health care services, the amount of charges and other factors. As settlements are made and estimates are revised, the differences are reflected in current operations.

Other Revenue – Other revenue is recorded at amounts the Corporation expects to collect in exchange for providing goods or services not directly associated with patient care and recorded over the time in which obligations to provide goods or services are satisfied. Other revenue includes revenue from the following sources: grants, retail pharmacy, operating investment income, assisted and independent living, equity in earnings of unconsolidated affiliates if the unconsolidated affiliate is operational and projected to make routine and regular cash distributions, incentive revenue, and gainshare recognized under alternative payment models and ancillary services.

Grant Revenue – Where grants are determined to be contributions, unconditional grants are recognized as revenue when received. Conditional grants are recognized as revenue when the Corporation has complied with and substantially met the conditions associated with the grant. For grants that are not contributions, the Corporation recognizes revenue at the amount that reflects the consideration it is expected to be entitled to in exchange for providing services under the term of the grant agreement.

Income Taxes – The Corporation and substantially all of its subsidiaries have been recognized as tax-exempt pursuant to Section 501(a) of the Internal Revenue Code. The Corporation also has taxable subsidiaries, which are included in the consolidated financial statements. The Corporation includes penalties and interest, if any, with its provision for income taxes in other nonoperating items in the consolidated statements of operations and changes in net assets.

Excess (Deficiency) of Revenue Over Expenses – The consolidated statements of operations and changes in net assets includes excess (deficiency) of revenue over expenses. Changes in net assets without donor restrictions, which are excluded from excess (deficiency) of revenue over expenses, consistent with industry practice, include the effective portion of the change in market value of derivatives that meet hedge accounting requirements, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets received or gifted (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), net change in retirement plan related items, discontinued operations and cumulative effects of changes in accounting principles.

Forthcoming Accounting Pronouncements –

In June 2016, the FASB issued ASU No. 2016-13, "*Financial Instruments – Credit Losses (Topic 326)*". This guidance is intended to align the needs of the users of financial statements related to credit loss recognition and also addresses the potential weakness from the delayed recognition of credit losses, resulting in an overstatement of assets. The amendments replace the current incurred loss methodology, which delays recognition until it is probable a loss has occurred, with one that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. This guidance is effective for the Corporation beginning July 1, 2023. The adoption of this guidance did not materially impact the Corporation's financial position, or results of operations, but may require additional disclosures.

In October 2021, the FASB issued No. 2021-08, *"Business Combinations (Topic 805) – Accounting for Contract Assets and Contract Liabilities from Contracts with Customers"*. This guidance was issued to address the inconsistency in accounting related to recognition of an acquired contract liability and the payment terms and their effect on subsequent revenue by the acquirer. The amendments in this update require that the acquirer recognize, and measure contract assets and contract liabilities acquired in a business combination in accordance with Topic 606, as if it had originated the contracts, generally consistent with how they were recognized and measured in the acquiree's financial statements. This guidance is effective for the Corporation beginning July 1, 2024. The Corporation will apply this guidance in consideration of any future business combinations that may occur on or after July 1, 2024.

3. INVESTMENTS IN UNCONSOLIDATED AFFILIATES, BUSINESS ACQUISITIONS AND DIVESTITURES

Investments in Unconsolidated Affiliates – The Corporation and certain of its Health Ministries have investments in entities that are recorded under the cost and equity methods of accounting. As of June 30, 2023 and 2022, the Corporation maintained investments in unconsolidated affiliates with ownership interests ranging from 2.0% to 50.4%. As of June 30, 2023 the Corporation recognized a $53.9 million dividend for the spin off and sale of a subsidiary held by a group purchasing organization in which the Corporation holds a 6% interest that is accounted for under the cost method.

The Corporation's share of equity earnings or losses from entities accounted for under the equity method and the classification on the consolidated statements of operations and changes in net assets for the years ended June 30 are as follows (in thousands):

	2023	2022
Other revenue	$ 45,602	$ 56,444
Nonoperating items	421,882	(150,214)
Total equity in earnings (losses) of unconsolidated affiliates	$ 467,484	$ (93,770)

The most significant of these investments include the following:

BayCare Health System – The Corporation holds a 50.4% interest in BayCare Health System Inc. and Affiliates ("BayCare"), a Florida not-for-profit corporation exempt from state and federal income taxes. BayCare was formed in 1997 pursuant to a Joint Operating Agreement ("JOA") among the not-for-profit, tax-exempt members of the Trinity Health BayCare Participants, Morton Plant Mease Health Care, Inc., and South Florida Baptist Hospital, Inc. (collectively, the "Members"). BayCare consists of three community health alliances located in the Tampa Bay area of Florida, including St. Joseph's-Baptist Healthcare Hospital, St. Anthony's Health Care, and Morton Plant Mease Health Care. The Corporation has the right to appoint nine of the 21 voting members of the Board of Directors of BayCare; therefore, the Corporation accounts for BayCare under the equity method of accounting. As of June 30, 2023 and 2022, the Corporation's investment in BayCare totaled $4,402 million and $3,975 million, respectively.

Gateway Health Plan – The Corporation held a 50% interest in Gateway Health Plan, L.P., and subsidiaries ("GHP"), a Pennsylvania limited partnership. GHP had two general partners, Highmark Ventures Inc. ("Highmark"), formerly known as Alliance Ventures, Inc., and Mercy Health Plan ("MHP", a wholly owned subsidiary of the Corporation), each owning 1%. In addition to the general partners, there were two limited partners, Highmark and MHP, each owning 49%.

Effective August 31, 2021, the Corporation, through MHP, sold its 50% interest in GHP to the existing partner and parent owner, Highmark. As a result of the transaction, the Corporation received a $62.5 million dividend distribution on August 27, 2021. Furthermore, the Corporation recorded a gain on the sale of $128.7 million during fiscal year 2022 as well as an additional gain of $8.0 million related to final settlement during fiscal year 2023 in the consolidated statement of operations and changes in net assets.

Emory Healthcare/St. Joseph's Health System – The Corporation holds a 49% interest in Emory Healthcare/St. Joseph's Health System ("EH/SJHS"). EH/SJHS operates several organizations, including two acute care hospitals, St. Joseph's Hospital of Atlanta, and John's Creek Hospital. As of June 30, 2023 and 2022, the Corporation's investment in EH/SJHS totaled $221.5 million and $209.9 million, respectively.

Life Flight Network, LLC – The Corporation, through its subsidiary Saint Alphonsus Regional Medical Center, Inc. holds a 25% interest in Life Flight Network, LLC ("Life Flight"), an Oregon limited liability company and its affiliates. Life Flight was formed in 2019 pursuant to a JOA. The members of Life Flight, each owning 25%, are Saint Alphonsus Regional Medical Center, Inc., Legacy Emmanuel Hospital and Health Center, Oregon Health and Sciences University, and Providence Health System. Life Flight provides services, including both air and ground ambulance services, in the Pacific Northwest with 34 bases in Oregon, Washington, Idaho and Montana. The Corporation accounts for Life Flight under the equity method of accounting. As of June 30, 2023 and 2022, the Corporation's investment in Life Flight totaled $70.5 million and $72.5 million, respectively.

Mercy Health Network – The Corporation held a 50% interest in Mercy Health Network, dba MercyOne, ("MHN"), a nonstock-basis membership corporation with CommonSpirit Health ("CSH"), holding the remaining 50% interest. MHN was the sole member of Wheaton Franciscan Services, Inc. ("WFSI") that operates three hospitals in Iowa: Covenant Medical Center located in Waterloo, Sartori Memorial Hospital located in Cedar Falls and Mercy Hospital of Franciscan Sisters located in Oelwein. MHN is also the sole member of Central Community Hospital ("CCH"), a critical access hospital located in Elkader, Iowa.

On September 1, 2022, the Corporation completed a transaction with CSH through which the Corporation acquired CSH's 50% interest in MHN, and now wholly owns MHN. See "Acquisitions" subsequently in Note 3 for further information regarding this transaction. As of June 30, 2023 and 2022, the Corporation's investment in MHN totaled $0 million and $109.6 million, respectively.

Condensed consolidated balance sheets of BayCare, EH/SJHS, Life Flight and MHN as of June 30 are as follows (in thousands):

	2023		
	BayCare	EH/SJHS	Life Flight
Total assets	$ 11,526,730	$ 878,549	$ 371,904
Total liabilities	$ 2,616,025	$ 603,076	$ 61,758

	2022			
	BayCare	EH/SJHS	Life Flight	MHN
Total assets	$ 10,913,820	$ 843,603	$ 351,796	$ 336,400
Total liabilities	$ 2,842,405	$ 546,243	$ 33,702	$ 109,263

Condensed consolidated statements of operations of BayCare, EH/SJHS, Life Flight and MHN for the years ended June 30 are as follows (in thousands). MHN results are prior to the acquisition date of September 1, 2022, and for the 12 months ended June 30, 2022.

	2023			
	BayCare	EH/SJHS	Life Flight	MHN
Revenue, net	$ 4,908,652	$ 901,845	$ 221,935	$ 64,186
Excess (deficiency) of revenue over expenses	$ 812,195	$ 44,791	$ 24,052	$ (4,236)

	2022			
	BayCare	EH/SJHS	Life Flight	MHN
Revenue, net	$ 4,537,933	$ 907,806	$ 265,398	$ 429,155
Excess (deficiency) of revenue over expenses	$ (366,760)	$ 67,490	$ 92,750	$ (17,534)

The following amounts have been recognized in the accompanying consolidated statements of operations and changes in net assets related to the investments in BayCare, EH/SJHS, Life Flight, MHN, and GHP for the years ended June 30 (in thousands):

	2023			
	BayCare	EH/SJHS	Life Flight	MHN
Other revenue	$ -	$ -	$ -	$ (2,077)
Equity in earnings of unconsolidated organizations	409,428	11,316	6,013	-
Other changes in net assets without donor restrictions	15,549	-	-	-
Total	$ 424,977	$ 11,316	$ 6,013	$ (2,077)

	2022				
	BayCare	EH/SJHS	Life Flight	MHN	GHP
Other revenue	$ -	$ -	$ -	$ (8,767)	$ 1,650
Equity in earnings of unconsolidated organizations	(184,884)	33,551	23,188	-	-
Gain on sale of investments	-	-	-	-	128,678
Other changes in net assets without donor restrictions	7,032	-	-	-	(300)
Total	$ (177,852)	$ 33,551	$ 23,188	$ (8,767)	$ 130,028

The unaudited summarized financial position and results of operations for the entities accounted for under the equity method excluding BayCare, EH/SJHS, Life Flight, MHN, and GHP as of and for the years ended June 30 are as follows (in thousands):

	2023					
	Medical Office Buildings	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	Physician Hospital Organizations	Other Investees	Total
Total assets	$ 39,534	$ 291,618	$ 131,611	$ 146,731	$ 1,264,763	$ 1,874,257
Total liabilities	$ 28,502	$ 130,075	$ 101,784	$ 64,649	$ 484,695	$ 809,705
Revenue, net	$ 9,263	$ 270,238	$ 108,482	$ 31,799	$ 2,036,344	$ 2,456,126
Excess of revenue over expenses	$ 2,137	$ 9,993	$ 29,389	$ 2,359	$ 90,237	$ 134,115

	2022					
	Medical Office Buildings	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	Physician Hospital Organizations	Other Investees	Total
Total assets	$ 39,592	$ 183,153	$ 211,511	$ 106,988	$ 1,179,177	$ 1,720,421
Total liabilities	$ 27,560	$ 65,274	$ 135,898	$ 22,234	$ 444,389	$ 695,355
Revenue, net	$ 9,518	$ 180,509	$ 179,550	$ 50,680	$ 2,029,103	$ 2,449,360
Excess of revenue over expenses	$ 3,020	$ 16,127	$ 22,071	$ 5,031	$ 109,475	$ 155,724

Acquisitions:

MercyOne & MHN – On September 1, 2022, the Corporation completed a transaction with CSH through which (i) the Corporation acquired CSH's 50% interest in MHN, which is the sole member of WFSI and the MHN subsidiary that owns and controls CCH, thereby becoming the sole corporate member of MHN, (ii) MHN became the sole corporate member of Catholic Health Initiatives-Iowa, Corp. d/b/a MercyOne Des Moines Medical Center ("MercyOne Des Moines"), a regional health care system located in Des Moines, Iowa, and (iii) Trinity Home Health Services d/b/a Trinity Health At Home, a subsidiary of the Corporation, acquired certain home care, hospice, and home infusion pharmacy operations from an affiliate of CSH located in the vicinity of Des Moines ("Iowa Home Care Assets", and collectively with (i) and (ii), the "MercyOne Acquisition"). The completion of the acquisition marks a shared commitment to ensuring access to health care across Iowa. Operating as a part of Trinity Health, MercyOne will retain its name and brand while enhancing more integrated and unified care in the communities it serves.

The cash paid to CSH in consideration for the MercyOne Acquisition totaled $633.9 million. The Corporation is still in the process of assessing the economic characteristics of certain assets acquired and liabilities assumed. Based on purchase price paid, goodwill of $27.1 million was recorded on the consolidated balance sheet as of June 30, 2023.

For the year ended June 30, 2023, the Corporation's consolidated statements of operations and changes in net assets included operating revenue of $1,274.2 million, operating losses of $126.3 million, and deficiency of revenue over expenses of $104.7 million related to the operations of the MercyOne Acquisition.

North Ottawa Community Health System ("Grand Haven") – The Corporation's affiliate, Mercy Health Partners, completed a transaction with Grand Haven under which Mercy Health Partners became the sole member of Grand Haven on October 1, 2022. Grand Haven and its affiliates operate an acute care hospital, urgent care center, long-term care facility and provide hospice services in the communities surrounding Grand Haven, Michigan. The transaction will provide improved access to specialists, primary care and health care services, while improving care delivery and access close to home in the Corporation's West Michigan market. The fair value of identifiable assets acquired exceeded the fair value of liabilities assumed by $15.4 million which was recorded as an inherent contribution in nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2023.

For the year ended June 30, 2023, the Corporation's consolidated statements of operations and changes in net assets included operating revenue of $48.0 million, operating income of $0.1 million, and deficiency of revenue over expenses of $0.1 million related to the operations of Grand Haven.

Genesis Health System – On March 1, 2023, the Corporation and its affiliate, MHN, completed a transaction with Genesis Health System, an Iowa nonprofit corporation and Genesis Health System, an Illinois not-for-profit corporation (together "Genesis"), under which MHN became the sole member of each and acquired substantially all assets and liabilities except for certain foundation assets, liabilities, and net assets. Genesis and its affiliates operate four acute care hospitals, including two critical access hospitals, convenient care centers, physician practices, a long-term care facility joint venture, an independent living facility for seniors and hospice services in the communities in eastern Iowa and western Illinois. The fair value of identifiable assets acquired exceeded the fair value of liabilities assumed by $468.1 million that was recorded as an inherent contribution in nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2023. As part of the transaction the Corporation also agreed to a capital commitment as further disclosed in Note 5.

For the year ended June 30, 2023, the Corporation's consolidated statements of operations and changes in net assets included operating revenue of $262.4 million, operating losses of $7.6 million, and deficiency of revenue over expenses of $1.5 million related to the operations of Genesis.

Summarized balance sheet information is shown below as of the respective acquisition dates (in thousands):

	MercyOne	Grand Haven	Genesis
Estimated fair value of net tangible assets acquired:			
Cash	$ 58,987	$ 5,665	$ 43,112
Investments, current	90,277	-	2,064
Patient accounts receivable	174,100	5,620	91,254
Other current assets	56,324	2,972	51,957
Assets limited or restricted as to use - noncurrent portion	56,158	2,320	324,487
Property and equipment - net	436,682	22,864	210,292
Operating lease right-of-use assets	95,707	-	47,704
Investments in unconsolidated affiliates	60,783	-	49,079
Other long-term assets	16,630	1,761	19,139
Goodwill	27,064	-	-
Previously held investments in unconsolidated affiliates	(111,151)	-	-
Medicare cash advances	(19,648)	-	-
Other current liabilities	(156,811)	(11,877)	(123,015)
Long-term debt	-	(11,702)	(127,415)
Long-term portion of operating lease liabilities	(83,570)	-	(42,429)
Other long-term liabilities	(32,218)	(2,001)	(44,272)
Noncontrolling ownership interest in subsidiaries	-	-	(433)
Net assets with donor restrictions	(35,439)	(202)	(33,434)
Cash paid	$ 633,875	-	-
Inherent contribution		$ 15,420	$ 468,090

The amount of the Corporation's pro forma revenue, earnings and changes in net assets, had the MercyOne, Grand Haven and Genesis acquisitions occurred on July 1, 2021 are as follows for the years ended June 30 (in thousands):

	2023	2022
Total operating revenue	$ 22,325,938	$ 22,264,789
Excess (deficiency) of revenue over expenses net of noncontrolling interest	1,003,389	(1,408,633)
Change in net assets without donor restrictions	1,130,560	(1,871,679)
Change in net assets with donor restrictions	(1,043)	(298,648)

Divestiture:

St. Francis Medical Center ("SFMC") Trenton, N.J. – On December 22, 2022, the Corporation, through its subsidiary Maxis Health System ("Maxis"), transferred the membership interest of SFMC and certain subsidiaries as well as $14.5 million of cash, and certain inventory and equipment, to Capital Health System, Inc. ("Capital"). As a result of this transaction, restructuring costs of $82.3 million were incurred as further described in Note 14.

For the years ended June 30, 2023 and 2022, the Corporation's consolidated statements of operations and changes in net assets included operating revenue of $63.9 million and $142.8 million, respectively, and deficiency of revenue over expenses of $98.2 million (inclusive of restructuring costs) and $39.4 million, respectively, related to the operations of SFMC.

4. OPERATING REVENUE

Operating revenue consists primarily of net patient service revenue and premium and capitation revenue. Revenue from patient's deductibles and coinsurance are included in the categories presented below based on the primary payer. Premium revenue primarily results from the Corporation's health plans, which sell Medicare Advantage products, under several separate contracts with the Center for Medicare and Medicaid Services ("CMS"). Capitation revenue primarily results from the Corporation's Program of All-Inclusive Care for the Elderly ("PACE") that provides comprehensive medical and social services to participants, most of whom are dually eligible for both Medicare and Medicaid. The table below shows sources of net patient service revenue by primary payer for the years ended June 30 (in thousands):

	2023	2022
Net patient service revenue, by payer:		
Medicare	$ 7,664,186	$ 6,955,548
Blue Cross	3,712,146	3,438,938
Medicaid	2,982,936	2,801,076
Uninsured	344,743	317,485
Commercial and other	3,817,683	3,529,471
Net patient service revenue	$ 18,521,694	$ 17,042,518

The composition of net patient service revenue and other revenue based on service lines for the years ended June 30 (in thousands) are as follows:

	2023	2022
Net patient service revenue, by service line:		
Acute care - inpatient	$ 7,761,621	$ 7,516,594
Acute care - outpatient	7,746,966	6,873,733
Physician services	2,422,079	2,099,171
Long term care	198,117	186,637
Home health care	392,911	366,383
Net patient service revenue	18,521,694	17,042,518
Premium revenue	636,785	613,772
Retail pharmacy revenue	597,945	500,037
Capitation revenue	475,848	475,591
Grant revenue	200,878	281,354
Revenue from other sources	1,153,568	1,020,406
Total operating revenue	$ 21,586,718	$ 19,933,678

The CARES Act authorized $100 billion in funding to hospitals and other health care providers to be distributed through the Public Health and Social Services Emergency Fund, Provider Relief Funds ("PRF grants"). Also, the Paycheck Protection Program and Health Care Enhancement Act ("PPPHCE Act") enacted on April 24, 2020 provided an additional $75 billion in emergency appropriations to eligible providers for COVID-19 response including distributions to safety net hospitals to compensate for lost revenues and qualified expenses, loan forgiveness and capacity expansion. Furthermore, on December 27,

2020, the Consolidated Appropriations Act ("CAA Act," collectively the "Acts") provided additional guidance regarding recognition of PRF grants. During fiscal year 2022, the Corporation applied for and received PRF Phase 4 grants and Rural payments under the American Rescue Plan Act ("ARP Act") of 2021. PRF grants were intended to compensate health care providers for lost revenues and qualified expenses incurred in response to the COVID-19 pandemic and were not required to be repaid, provided that the recipients attested to and complied with certain terms and conditions, including limitations on balance billing and not using PRF grants to reimburse expenses or losses that other sources were obligated to reimburse.

PRF grants and Rural payments recognized as revenue, recorded in other revenue in the consolidated statements of operations and changes in net assets, totaled $0.8 million and $140.5 million for the years ended June 30, 2023 and 2022, respectively. The Corporation has recognized all grants received in other revenue in the statements of operations and changes in net assets through June 30, 2023. The Corporation has transferred both General Distribution and Targeted Distribution PRF grants amongst its subsidiaries. Compliance with the Department of Health and Human Services ("HHS") Provider Relief Fund General and Targeted Distribution Post-Payment Notice of Reporting Requirements is complex and subject to HHS audit. Transferred Targeted Distribution payments face an increased likelihood of an audit by HHS. There can be no assurance that HHS will not challenge the Corporation's compliance with these reporting requirements. The Corporation believes the amount of PRF grants and Rural payments recognized as grant revenue is appropriate under the guidance from HHS.

5. LONG-LIVED ASSETS

Property and Equipment:

A summary of property and equipment as of June 30 is as follows (in thousands):

	2023	2022
Land	$ 428,858	$ 346,425
Buildings and improvements	11,287,425	10,613,884
Equipment	7,524,260	7,226,485
Finance lease right-of-use assets	95,329	90,717
Total	19,335,872	18,277,511
Accumulated depreciation and amortization	(11,168,290)	(10,764,701)
Construction in progress	678,915	641,868
Property and equipment - net	$ 8,846,497	$ 8,154,678

As of June 30, 2023, commitments for capital projects totaled approximately $592.9 million. The outstanding commitments are primarily for new facility construction, expansion at existing campuses and related infrastructure updates.

In conjunction with the acquisition of Genesis as described in Note 3, the Corporation and MHN committed to allocate not less than $450 million of capital to Genesis over seven years with the commitment period ending March 1, 2030. The capital commitment period may be extended up to 18 months under certain cirmcumstances. The Corporation's related capital spending for Genesis through June 30, 2023 is $8.7 million.

Leases:

The following table presents the components of the Corporation's right-of-use assets and liabilities related to finance leases and their classification in the consolidated balance sheets as of June 30 (in thousands):

Component of Finance Lease Balances	Classification in Consolidated Balance Sheets	2023	2022
Assets:			
Finance lease right-of-use assets - net	Property and equipment	$ 72,369	$ 76,862
Liabilities:			
Current portion of finance lease liability	Current portion of long-term debt	12,310	10,770
Long-term portion of finance lease liability	Long-term debt	85,482	91,698

The components of lease expense and their classification in the consolidated statements of operations and changes in net assets for the years ended June 30 were as follows (in thousands):

Component of Lease Expenses	Classification in Statements of Operations and Changes in Net Assets	2023	2022
Operating lease expense	Occupancy	$ 165,562	$ 143,274
Finance lease expense:			
Amortization of right-of-use assets	Depreciation and amortization	9,457	8,647
Interest on lease liabilities	Interest	2,432	2,769
Total finance lease expense		11,889	11,416
Short-term lease expense	Occupancy	50,484	46,125
Total lease expense		$ 227,935	$ 200,815

The weighted average remaining lease term and weighted average discount rate as of and for the years ended June 30 were as follows:

Weighted average remaining lease term (years)	2023	2022
Operating leases	7.48	7.17
Finance leases	9.84	9.33

Weighted average discount rate	2023	2022
Operating leases	3.61%	2.53%
Finance leases	5.50%	5.49%

Supplemental cash flow information related to leases for the years ended June 30 was as follows (in thousands):

	2023	2022
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash outflows from operating leases	$ 189,561	$ 163,608
Operating cash outflows from finance leases	2,432	2,769
Financing cash outflows from finance leases	11,628	12,245
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	96,164	167,799
Finance leases	5,433	3,084

Future maturities of lease liabilities as of June 30, 2023 are presented in the following table (in thousands):

	Operating Leases	Finance Leases
2024	$ 170,941	$ 17,246
2025	143,099	13,877
2026	119,416	11,798
2027	91,173	11,331
2028	65,376	10,967
Thereafter	224,876	62,932
Total lease payments	814,881	128,151
Less: Imputed interest	(128,115)	(30,359)
Total lease obligations	686,766	97,792
Less: Current obligations	(150,878)	(12,310)
Long-term lease obligations	$ 535,888	$ 85,482

Goodwill:

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying consolidated financial statements of the Corporation as of June 30 (in thousands):

	2023	2022
As of July 1:		
Goodwill	$ 860,686	$ 859,191
Accumulated impairment loss	(46,555)	(39,064)
Total	814,131	820,127
Goodwill acquired during the year	34,470	1,495
Impairment loss	(523)	(7,491)
Total	848,078	814,131
As of June 30:		
Goodwill	895,156	860,686
Accumulated impairment loss	(47,078)	(46,555)
Total	$ 848,078	$ 814,131

Impairments:

During the year ended June 30, 2023, the Corporation recorded impairment charges of $83.3 million in the consolidated statement of operations and changes in net assets. Included in the total impairment charges was $41.9 million related to an acute care facility at one of the Health Ministries of the Corporation where material adverse trends in the most recent estimates of future undiscounted cash flows indicated that the carrying value of the long-lived assets were not recoverable from estimated future cash flows. The Corporation believes the most significant factor contributing to the continuing adverse financial trend at this location was a reduction in numerous volume indicators, combined with increased cost of staffing and other operating expenses. The total impairments were comprised of $52.2 million of property and equipment for aged buildings and structures, operating leased space and related furniture and equipment to be vacated or no longer used, $13.5 million related to unconsolidated equity method investments and $17.6 million of other assets.

During the year ended June 30, 2022, the Corporation recorded impairment charges of $113.9 million in the consolidated statement of operations and changes in net assets. Included in the total impairment charges were $73.7 million related to aged buildings and structures, operating leased space and related furniture and equipment to be vacated or no longer used. In addition, $30.2 million was primarily at certain long term care facilities, where the most recent estimates of future undiscounted cash flows indicated that the carrying value of the long-lived assets were not recoverable from estimated future cash flows. The Corporation believes the most significant factors contributing to the continuing adverse financial trends in these locations include continued declines in occupancy of continuing care facilities. Therefore, these assessments resulted in impairments of the buildings, leases and equipment. The Corporation also recorded impairment of $10.0 million of goodwill and other assets.

6. LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

A summary of short-term borrowings and long-term debt as of June 30 is as follows (in thousands):

	2023	2022
Short-term borrowings:		
Variable rate demand bonds with contractual maturities through 2049. Interest payable monthly at rates ranging from 0.64% to 4.46% during 2023 and 0.02% to 1.40% during 2022	$ 616,335	$ 632,730
Long-term debt:		
Tax-exempt revenue bonds and refunding bonds:		
Fixed-rate term and serial bonds, payable at various dates through 2053. Interest rates ranging from 1.25% to 5.0% during 2023 and 2022	$ 3,966,150	$ 3,584,535
Variable-rate term bonds, payable at various dates through 2051. Interest rates ranging from 1.10% to 5.83% during 2023 and 0.47% to 1.84% during 2022	337,460	338,835
Taxable revenue bonds:		
Fixed-rate term, payable through 2049. Interest rates ranging from 2.14% to 4.13% during 2023 and 1.03% to 4.13% during 2022	2,144,780	2,209,190
Variable-rate term, payable through 2051. Interest rates ranging from 5.27% to 5.83% during 2023	54,680	-
Notes payable to banks. Interest payable at rates ranging from 1.00% to 7.50% during 2023 and 1.34% to 5.00% during 2022, fixed and variable, payable in varying monthly installments through 2053	40,761	43,220
Financing lease obligations (excluding imputed interest of $30.4 million at June 30, 2023 and $35.3 million at June 30, 2022)	97,792	102,468
Other	60,267	62,293
Total long-term debt	6,701,890	6,340,541
Less current portion - net of current discounts	(245,326)	(247,149)
Unamortized debt issuance costs	(37,001)	(37,670)
Unamortized premiums - net	337,596	360,979
Long-term debt - net of current portion	$ 6,757,159	$ 6,416,701

Contractually obligated principal repayments on short-term borrowings and long-term debt are as follows (in thousands):

	Short-Term Borrowings	Long-Term Debt
Years ending June 30:		
2024	$ 16,920	$ 248,924
2025	22,120	139,312
2026	22,995	138,325
2027	23,920	143,082
2028	24,755	161,174
Thereafter	505,625	5,871,073
Total	$ 616,335	$ 6,701,890

A summary of interest costs on borrowed funds primarily under the revenue bond indentures during the years ended June 30 is as follows (in thousands):

	2023	2022
Interest costs incurred	$ 264,877	$ 227,485
Less capitalized interest	(2,966)	(1,688)
Interest expense included in operations	$ 261,911	$ 225,797

Obligated Group and Other Requirements – The Corporation has debt outstanding under a master trust indenture dated October 3, 2013, as amended and supplemented, the amended and restated master indenture ("ARMI"). The ARMI permits the Corporation to issue obligations to finance certain activities. Obligations issued under the ARMI are joint and several obligations of the obligated group established thereunder (the "Obligated Group," which currently consists of the Corporation). Proceeds from tax-exempt bonds and refunding bonds are to be used to finance the construction, acquisition and equipping of capital improvements. Proceeds from taxable bonds are to be used to finance corporate purposes or advance refund tax-exempt bonds. Certain Health Ministries of the Corporation constitute designated affiliates and the Corporation covenants to cause each designated affiliate to pay, loan or otherwise transfer to the Obligated Group such amounts necessary to pay the amounts due on all obligations issued under the ARMI. The Obligated Group and the designated affiliates are referred to as the Trinity Health Credit Group.

Pursuant to the ARMI, the Obligated Group agent (which is the Corporation) has caused the designated affiliates representing, when combined with the Obligated Group members, at least 85% of the consolidated net revenues of the Trinity Health Credit Group to grant to the master trustee security interests in their pledged property which security interests secure all obligations issued under the ARMI. There are several conditions and covenants required by the ARMI with which the Corporation must comply, including covenants that require the Corporation to maintain a minimum historical debt-service coverage and limitations on liens or security interests in property, except for certain permitted encumbrances, affecting the property of the Corporation or any material designated affiliate (a designated affiliate whose total revenues for the most recent fiscal year exceed 5% of the combined total revenues of the Corporation for the most recent fiscal year). Long-term debt outstanding as of June 30, 2023 and 2022, that has not been secured under the ARMI is generally collateralized by certain property and equipment.

Commercial Paper – The Corporation's commercial paper program is authorized for borrowings up to $600 million. As of June 30, 2023 and 2022, the total amount of commercial paper outstanding was $99.5 million and $99.7 million, respectively. Proceeds from this program are to be used for general purposes of the Corporation. The notes are payable from the proceeds of subsequently issued notes and from other funds available to the Corporation, including funds derived from the liquidation of securities held by the Corporation in its investment portfolio. The interest rate charged on borrowings outstanding during the years ended June 30, 2023 and 2022, ranged from 1.28% to 5.30% and 0.06% to 2.00%, respectively.

Liquidity Facilities – On September 29, 2022, the Corporation renewed and amended its revolving credit agreement ("RCAI"), by and among the Corporation and U.S. Bank National Association, which acts as an administrative agent for a group of lenders under RCAI. RCAI establishes a revolving credit facility for the Corporation, under which that group of lenders agree to lend to the Corporation amounts that may fluctuate from time to time. Amounts drawn under the RCAI can only be used to support the Corporation's obligation to pay the purchase price of bonds that are subject to tender and that have not been successfully remarketed, and the maturing principal of and interest on commercial paper notes. Of the $600 million available balance, the first tranche of $300 million expires on September 26, 2025 and the second tranche of $300 million expires on September 28, 2026. As of June 30, 2023 and 2022, there were no amounts outstanding under RCAI.

On September 29, 2022, the Corporation renewed its three-year general-purpose credit facility ("RCAII") of $600 million, with a maturity date of September 26, 2025. The agreement is by and among the Corporation and U.S. Bank National Association, which acts as an administrative agent for a group of lenders under RCAII and establishes a revolving credit facility for the Corporation, under which that group of lenders agree to lend to the Corporation amounts that may fluctuate from time to time. Amounts drawn under the RCAII can be used for general corporate purposes and working capital needs. As of June 30, 2023 and 2022, there were no amounts outstanding under RCAII.

Each financial institution providing liquidity support under RCAI and RCAII is secured by an obligation under the ARMI.

Standby Letters of Credit – The Corporation maintains an arrangement for multiple standby letters of credit with a financial institution with a capacity available of $90.0 million as of June 30, 2023 and 2022. The arrangement is for letters of credit that support insurance, unemployment, and other risk liabilities that have been issued in the amounts of $63.8 million and $71.9 million as of June 30, 2023 and 2022, respectively. As of June 30, 2023 and 2022, there were no draws on the letters of credit.

In addition, the Corporation maintains a two-year arrangement for standby letters of credit with an additional financial institution in the amount of $50.0 million. The arrangement is for letters of credit that can be used to support insurance, unemployment, and other risk liabilities. A letter of credit was issued as of June 30, 2022 in the amount of $0.2 million. There were no letters of credit issued under this arrangement as of June 30, 2023. As of June 30, 2023 and 2022 there were no draws on the letters of credit.

The banks providing standby letters of credit are not secured by an obligation under the ARMI.

Transactions – During January 2022, the Corporation issued $331.0 million par value tax-exempt hospital revenue and remarketing bonds at a premium of $46.4 million. A portion of the bonds was issued in the fixed rate mode and a portion in the term rate mode. Proceeds were used to remarket $75.0 million of certain tax-exempt variable-rate bonds as tax-exempt fixed-rate hospital revenue bonds to their stated maturity. The remaining bonds were used for capital project reimbursement. As a result of this transaction, the Corporation recognized a loss on extinguishment of debt of $0.3 million in other nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2022.

On June 30, 2022, the Corporation redeemed $29.7 million of tax-exempt fixed rate bonds. The Corporation recorded a net gain from early extinguishment of debt of $0.9 million in other nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2022.

In December 2022, the Corporation issued $329.7 million par value in tax-exempt fixed rate private placement bonds. Proceeds were used to retire $300 million of outstanding taxable commercial paper obligations issued in connection with the acquisition of MercyOne & MHN as described in Note 3, and to refinance $29.7 million of outstanding taxable commercial paper obligations in connection with certain tax-exempt fixed rate hospital revenue bonds refunded on a current basis in June 2022.

In January 2023, the Corporation renewed $50.0 million of direct placement bonds that were scheduled for mandatory put in February 2023. In addition, during February 2023, the Corporation renewed $54.7 million taxable fixed-rate direct placement bonds and converted them to taxable variable-rate direct placement bonds. This debt obligation was scheduled for mandatory put in February 2023.

On March 1, 2023, the acquisition of Genesis, as described in Note 3, resulted in the assumption of $125.6 million of taxable revenue fixed-rate bonds and $15.1 million of tax-exempt fixed rate bonds. On the acquisition date, Trinity Health issued replacement obligations under the ARMI in exchange for obligations securing bonds previously issued under the Genesis Master Indenture ("GMI"). The replacement obligations were accepted by banks previously holding Genesis revenue bonds. Furthermore, all obligations under the GMI were cancelled and the GMI was discharged. On June 30, 2023, the Corporation converted the $125.6 million taxable revenue bonds to tax-exempt fixed-rate bonds.

Each series of the referenced bonds is secured by an obligation issued under the ARMI.

Due to the disposition of Mercy Health System of Chicago, on August 12, 2021, the Corporation defeased $18.8 million of tax-exempt fixed rate hospital revenue and refunding bonds and the Corporation recorded a net loss from early extinguishment of debt of $0.5 million in other nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2022.

On September 30, 2021, a subsidiary of the Corporation defeased $20.0 million of bonds and recorded a net gain from the early extinguishment of debt of $0.2 million in other nonoperating items in the consolidated statement of operations and changes in net assets for the year ended June 30, 2022.

7. PROFESSIONAL AND GENERAL LIABILITY PROGRAMS

The Corporation operates a wholly owned insurance company, Trinity Assurance, Ltd. ("TAL"). TAL qualifies as a captive insurance company and provides certain insurance coverage to the Corporation's Health Ministries under a centralized program. The Corporation is self-insured for certain levels of general and professional liability, workers' compensation, and certain other claims. The Corporation has limited its liability by purchasing other coverages from unrelated third-party commercial insurers. TAL has also limited its liability through commercial reinsurance arrangements.

The Corporation's current self-insurance program includes $20 million per occurrence for professional liability and $15 million per occurrence for general liability as well as $10 million per occurrence for hospital government liability, $5 million per occurrence for miscellaneous errors and omissions liability and network security and privacy liability, and $1 million per occurrence for management liability (directors' and officers' and employment practices), and certain other coverages. In addition, through TAL and its various commercial reinsurers, the Corporation maintains integrated excess liability coverage with separate annual aggregate limits for professional/general liability and management liability. The Corporation self-insures $750,000 per occurrence for workers' compensation in most states, with commercial insurance providing coverage up to the statutory limits and self-insures up to $500,000 per occurrence for first-party property damage with commercial insurance providing additional coverage. Privacy and network security coverage in excess of the self-insurance is also commercially insured.

The liability for self-insurance reserves represents estimates of the ultimate net cost of all losses and loss adjustment expenses, which are incurred but unpaid at the consolidated balance sheet date. The reserves are based on the loss and loss adjustment expense factors inherent in the Corporation's premium structure. Independent consulting actuaries determined these factors from estimates of the Corporation's expenses and available industry-wide data. The Corporation discounts the reserves to their present value using a discount rate of 3.0% and 2.5% as of June 30, 2023 and 2022, respectively. The reserves include estimates of future trends in claim severity and frequency. Although considerable variability is inherent in such estimates, management believes that the liability for unpaid claims and related adjustment expenses is adequate based on the loss experience of the Corporation. The estimates are continually reviewed and adjusted as necessary. The changes to the estimated self-insurance reserves were determined based upon the annual independent actuarial analyses.

Claims in excess of certain insurance coverage and the recorded self-insurance liability have been asserted against the Corporation by various claimants. The claims are in various stages of processing, and some may ultimately be brought to trial. There are known incidents occurring through June 30, 2023, that may result in the assertion of additional claims and other claims may be asserted arising from services provided in the past. While it is possible that settlement of asserted claims and claims which may be asserted in the future could result in liabilities in excess of amounts for which the Corporation has provided, management, based upon the advice of legal counsel, believes that the excess liability, if any, should not materially affect the consolidated financial statements of the Corporation.

8. PENSION AND OTHER BENEFIT PLANS

Deferred Compensation – The Corporation has nonqualified deferred compensation plans at certain Health Ministries that permit eligible employees to defer a portion of their compensation. The deferred amounts are distributable in cash after retirement or termination of employment. As of June 30, 2023 and 2022, the assets under these plans totaled $380.2 million and $306.7 million, respectively, and liabilities totaled $385.6 million and $314.0 million, respectively, which are included in self-insurance, benefit plans and other assets and other long-term liabilities in the consolidated balance sheets.

Defined Contribution Benefits – The Corporation sponsors defined contribution pension plans covering substantially all of its employees. These programs are funded by employee voluntary contributions, subject to legal limitations. Employer contributions to the majority of these plans include a nonelective contribution of 3% for participants who satisfy certain eligibility requirements, with a minimum nonelective contribution for certain participants, and varying levels of matching contributions based on employee service. The employees direct their voluntary contributions and employer contributions among a variety of investment options. Contribution expense under the plans totaled $365.1 million and $330.9 million for the years ended June 30, 2023 and 2022, respectively, which is included in employee benefits in the consolidated statements of operations and changes in net assets.

Noncontributory Defined Benefit Pension Plans ("Pension Plans") – The Corporation maintains qualified Pension Plans that are closed to new participants, and under which benefit accruals are frozen. Certain nonqualified, supplemental plan arrangements also provide retirement benefits to specified groups of participants. Certain plans are subject to the provisions of ERISA. The majority of the plans sponsored by the Corporation are intended to be "Church Plans," as defined in the Code Section 414(e) and Section 3(33) of the ERISA, as amended, which have not made an election under Section 410(d) of the Code to be subject to ERISA. The Corporation's adopted funding policy for its qualified church plans, which is reviewed annually, is to fund the current service cost based on the accumulated benefit obligations and amortization of any under or over funding.

Plan Termination – Effective December 31, 2021 the Board approved the termination of the Trinity Health ERISA Pension Plan ("ERISA Plan"). Approval of plan termination was received from the IRS in July 2022. During fiscal year 2022, the ERISA Plan operated as normal. The ERISA Plan termination included the provision of a pension lump sum election window that ran from January to March 2023. The ERISA Plan paid $82.5 million in lump sum payments to participants who elected such payments within that voluntary lump sum window. In May 2023, the ERISA plan irrevocably transferred all future obligations to a third party insurance company through the purchase of a group annuity contract. The purchase price of the group annuity contract was $195.9 million. The plan termination process concluded in fiscal year 2023 resulting in a one-time settlement charge of $88.4 million which is included in nonoperating items in the consolidated statements of operations and changes in net assets. Additionally, a $13.0 million contribution was paid in fiscal year 2023 with an estimated additional contribution of $3.1 million to be paid in the first half of fiscal 2024 related to final plan termination costs.

Postretirement Health Care and Life Insurance Benefits ("Postretirement Plans") – The Corporation sponsors both funded and unfunded contributory plans to provide health care benefits to certain of its retirees. All of the Postretirement Plans are closed to new participants. The Postretirement Plans cover certain hourly and salaried employees who retire from certain Health Ministries. Medical benefits for these retirees are subject to deductibles and cost sharing provisions. The funded plans provide benefits to certain retirees at fixed dollar amounts in health reimbursement account arrangements for Medicare eligible participants.

The following table sets forth the changes in projected benefit obligations, accumulated postretirement obligations and changes in plan assets and funded status of the plans for both the Pension Plans and Postretirement Plans for the years ended June 30 (in thousands):

	Pension Plans		Postretirement Plans	
	2023	2022	2023	2022
Change in Benefit Obligations:				
Benefit obligation, beginning of year	$ 6,076,344	$ 7,634,001	$ 79,176	$ 106,523
Service cost	-	-	1	2
Interest cost	295,525	233,505	3,775	2,999
Actuarial gain	(373,780)	(1,278,080)	(9,814)	(23,443)
Benefits paid	(486,424)	(336,346)	(5,353)	(5,805)
Plan amendments	-	1,357	(19)	(1,122)
Settlements	(288,887)	(178,093)	-	-
Medicare Part D reimbursement	-	-	32	22
Benefit obligation, end of year	5,222,778	6,076,344	67,798	79,176
Change in Plan Assets:				
Fair value of plan assets, beginning of year	5,939,531	7,692,336	142,252	163,097
Actual return on plan assets	66,884	(1,279,514)	24,865	(16,914)
Employer contributions	40,325	41,148	1,249	1,874
Benefits paid	(486,424)	(336,346)	(5,353)	(5,805)
Settlements	(288,887)	(178,093)	-	-
Fair value of plan assets, end of year	5,271,429	5,939,531	163,013	142,252
Funded (unfunded) amount recognized June 30	$ 48,651	$ (136,813)	$ 95,215	$ 63,076
Recognized in other long-term assets	$ 125,342	$ 12,498	$ 107,383	$ 78,783
Recognized in accrued pension and retiree health costs	$ (76,691)	$ (149,311)	$ (12,168)	$ (15,707)

The benefit obligation actuarial gain in 2023 and 2022 was due primarily to increases in the discount rates to measure plan liabilities.

The accumulated benefit obligation for all defined benefit pension plans was $5,222.8 million and $6,076.3 million at June 30, 2023 and 2022, respectively.

The accumulated postretirement benefit obligation for all plans was $67.8 million and $79.2 million at June 30, 2023 and 2022, respectively.

The information for pension plans with projected and accumulated benefit obligations in excess of plan assets as of June 30, 2023 and 2022 are as follows (in thousands):

	2023	2022
Projected and accumulated benefit obligations	$ 570,140	$ 5,234,516
Fair value of plan assets	493,449	5,085,205
Funded status	$ (76,691)	$ (149,311)

The information for postretirement plans with projected and accumulated benefit obligations in excess of plan assets as of June 30, 2023 and 2022 are as follows (in thousands):

	2023	2022
Projected and accumulated benefit obligations	$ 12,168	$ 16,010
Fair value of plan assets	-	303
Funded status	$ (12,168)	$ (15,707)

Components of net periodic benefit expense (income) for the years ended June 30 consisted of the following (in thousands):

	Pension Plans		Postretirement Plans	
	2023	2022	2023	2022
Service cost	$ -	$ -	$ 1	$ 2
Interest cost	295,525	233,505	3,775	2,999
Expected return on assets	(285,027)	(296,164)	(9,071)	(10,418)
Amortization of prior service credit	(4,111)	(4,880)	(549)	(443)
Recognized net actuarial loss (gain)	77,797	59,513	(3,708)	(4,424)
Net periodic benefit expense (income) before settlements	84,184	(8,026)	(9,552)	(12,284)
Settlements	88,392	70,642	-	-
Net periodic benefit expense (income)	$ 172,576	$ 62,616	$ (9,552)	$ (12,284)

The deferred losses (gains) included in net assets without donor restrictions, including amounts arising during the year and amounts reclassified into net periodic benefit cost, are as follows (in thousands):

	Pension Plans		
	Net Loss (Gain)	Prior Service Credit	Total
Balance at July 1, 2021	$ 2,080,586	$ (101,357)	$ 1,979,229
Reclassified into net periodic benefit cost	(59,513)	4,880	(54,633)
Arising during the year	297,597	1,357	298,954
Settlements	(70,642)	-	(70,642)
Balance at June 30, 2022	2,248,028	(95,120)	2,152,908
Reclassified into net periodic benefit cost	(77,797)	4,111	(73,686)
Arising during the year	(155,634)	-	(155,634)
Settlements	(88,392)	-	(88,392)
Balance at June 30, 2023	$ 1,926,205	$ (91,009)	$ 1,835,196

	Postretirement Plans			All Plans
	Net Loss (Gain)	Prior Service Credit	Total	Grand Total
Balance at July 1, 2021	$ (62,722)	$ (1,550)	$ (64,272)	$ 1,914,957
Reclassified into net periodic benefit cost	4,424	443	4,867	(49,766)
Arising during the year	3,776	(1,122)	2,654	301,608
Settlements	-	-	-	(70,642)
Balance at June 30, 2022	(54,522)	(2,229)	(56,751)	2,096,157
Reclassified into net periodic benefit cost	3,708	549	4,257	(69,429)
Arising during the year	(25,398)	(19)	(25,417)	(181,051)
Settlements	-	-	-	(88,392)
Balance at June 30, 2023	$ (76,212)	$ (1,699)	$ (77,911)	$ 1,757,285

Assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years ended June 30 were as follows:

	Pension Plans		Postretirement Plans	
	2023	2022	2023	2022
Benefit Obligations:				
Discount rate	5.90% - 5.95%	4.20% - 5.25%	5.85% - 5.95%	4.80% - 5.10%
Weighted average interest crediting rate	4.89%	4.13%	N/A	N/A
Net Periodic Benefit Cost:				
Discount rate	4.20% - 5.25%	2.80% - 3.35%	4.80% - 5.10%	2.25% - 3.05%
Weighted average interest crediting rate	4.13%	2.67%	N/A	N/A
Expected long-term return on plan assets	2.00% - 6.25%	2.00% - 5.00%	6.50%	6.50%

Approximately 77% of the Corporation's pension plan liabilities were measured using a 5.90% discount rate as of June 30, 2023. Approximately 70% of the Corporation's pension plan liabilities were measured using a 5.15% discount rate as of June 30, 2022.

The Corporation utilizes a pension liability driven investment ("LDI") strategy in determining its asset allocation and long-term rate of return for plan assets. This risk management strategy uses a glide path methodology based on funded status, which was further refined during fiscal year 2021 to protect the funded status of the Pension Plans. The revised glidepath was developed in alignment of an improving hedging ratio, which measures the percentage of hedging assets to Pension Plan liabilities. The glidepath methodology is used to initiate asset allocation changes across the efficient frontier. Efficient frontier analysis models the risk and return trade-offs among asset classes while taking into consideration the correlation among the asset classes. Historical market returns and risks are examined as part of this process, but risk-based adjustments are made to correspond with modern portfolio theory. Long-term historical correlations between asset classes are used, consistent with widely accepted capital markets principles. Current market factors, such as inflation and interest rates, are evaluated before long-term capital market assumptions are determined. The long-term rate of return is established using the efficient frontier analysis approach with proper consideration of asset class diversification and rebalancing. Peer data and historical returns are reviewed to check for reasonableness and appropriateness.

Health Care Cost Trend Rates – Assumed health care cost trend rates have a significant effect on the amounts reported for the postretirement plans. The postretirement benefit obligation includes assumed health care cost trend rates as of June 30 as follows:

	2023	2022
Medical and drugs, pre-age 65	6.75%	6.11%
Medical and drugs, post-age 65	6.75%	6.11%
Ultimate trend rate	5.00%	5.00%
Year rate reaches the ultimate rate	2030	2026

The Corporation's investment allocations as of June 30 by investment category are as follows:

	Pension Plans		Postretirement Plans	
	2023	2022	2023	2022
Investment Category:				
Cash and cash equivalents	2%	4%	-	-
Marketable securities:				
U.S. and non-U.S. equity securities	7%	6%	-	-
Equity mutual funds	2%	1%	-	-
Debt securities	59%	58%	7%	9%
Other investments:				
Commingled funds	25%	25%	93%	91%
Hedge funds	3%	3%	-	-
Private equity funds	2%	3%	-	-
Total	100%	100%	100%	100%

The LDI investment strategy focuses on maintaining an appropriate liability hedging ratio along the glidepath. It utilizes a mix of equities, hedge funds and fixed-income investments for a prudent level of risk. Risk tolerance is established through careful consideration of plan liabilities, plan funded status and corporate financial condition. The investment portfolio contains a diversified blend of equity and fixed-income investments. Furthermore, equity investments are diversified across U.S. and non-U.S. stocks, as well as growth, value and small and large capitalizations. Other investments, such as hedge funds, interest rate swaps and private equity are used judiciously to enhance long-term returns while improving portfolio diversification. Derivatives may be used to gain market exposure in an efficient and timely manner; however, derivatives may not be used to leverage the portfolio beyond the market value of the underlying investments. Investment risk is measured and monitored on an ongoing basis through monthly investment portfolio reviews, annual liability measurements and periodic asset/liability studies. For the majority of the Corporation's pension plan investments, the combined target investment allocation as of June 30, 2023, was fixed-income obligations 78%; global and traditional equity securities 18%; hedge funds 2%; and cash 2%.

The following table summarizes the Pension Plans' and Postretirement Plans' assets measured at fair value as of June 30, 2023 (in thousands). See Note 10 for definitions of Levels 1, 2 and 3 of the fair value hierarchy.

	2023		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Total Fair Value**
Pension Plans:			
Cash and cash equivalents	$ 123,355	$ -	$ 123,355
Equity securities	347,485	36	347,521
Debt securities			
Government and government agency obligations	-	679,505	679,505
Corporate bonds	-	2,425,577	2,425,577
Exchange traded/mutual funds			
Equity funds	84,071	-	84,071
Other	4,425	-	4,425
Subtotal	$ 559,336	$ 3,105,118	$ 3,664,454
Investments measured at net asset value:			
Commingled funds			
Equity funds			680,240
Fixed-income funds			644,111
Hedge funds			142,215
Private equity			110,473
Total financial assets			5,241,493
Accrued income and other			29,936
Fair value of plan assets			$ 5,271,429
Postretirement Plans:			
Exchange traded/mutual funds			
Short-term investment funds	$ 891	$ -	$ 891
Fixed-income funds	11,150	-	11,150
Subtotal	$ 12,041	$ -	$ 12,041
Investment measured at net asset value:			
Equity commingled fund			150,972
Fair value of plan assets			$ 163,013

The following table summarizes the Pension Plans' and Postretirement Plans' assets measured at fair value as of June 30, 2022 (in thousands).

	2022		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total Fair Value
Pension Plans:			
Cash and cash equivalents	$ 199,274	$ -	$ 199,274
Equity securities	331,417	37	331,454
Debt securities			
Government and government agency obligations	-	801,999	801,999
Corporate bonds	-	2,654,075	2,654,075
Exchange traded/mutual funds			
Equity funds	64,649	-	64,649
Other	61,407	-	61,407
Subtotal	$ 656,747	$ 3,456,111	$ 4,112,858
Investments measured at net asset value:			
Commingled funds			
Equity funds			737,904
Fixed-income funds			751,224
Hedge funds			177,332
Private equity			160,213
Fair value of plan assets			$ 5,939,531
Postretirement Plans:			
Exchange traded/mutual funds			
Short-term investment funds	$ 243	$ -	$ 243
Fixed-income funds	11,996	-	11,996
Subtotal	$ 12,239	$ -	$ 12,239
Investment measured at net asset value:			
Equity commingled fund			130,013
Fair value of plan assets			$ 142,252

Unfunded capital commitments related to private equity investments totaled $20.7 million and $35.2 million as of June 30, 2023 and 2022, respectively. The private equity investments are in harvest mode and the anticipated amount of capital to be called is less than 15% of the unfunded amount.

See Note 10 for the Corporation's methods and assumptions to estimate the fair value of equity and debt securities, mutual funds, commingled funds and hedge funds.

Private Equity – These assets include several private equity funds that invest primarily in the United States, Asia, and Europe, both directly and on the secondary market, pursuing distressed opportunities and natural resources, primarily energy. These funds are valued at net asset value, which is calculated using the most recent fund financial statements.

Derivatives – The fair value of the derivatives is estimated utilizing the terms of the derivative instruments and publicly available market yield curves. The Pension Plans' investment policies specifically prohibit the use of derivatives for speculative purposes.

Other – Represents unsettled transactions relating primarily to purchases and sales of plan assets. Due to the short maturity of these assets and liabilities, the fair value approximates the carrying amounts.

There were no Level 3 assets in the Pension Plan portfolios at June 30, 2023 or 2022.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Corporation believes the valuation methodologies 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.

Expected Contributions – The Corporation expects to contribute approximately $16.5 million to its Pension Plans and $2.1 million to its Postretirement Plans during the year ended June 30, 2024, under the Corporation's stated funding policies.

Expected Benefit Payments – The Corporation expects to pay the following for pension benefits for the year ending June 30, which reflect expected future service as appropriate, and expected postretirement benefits:

	Pension Plans	Postretirement Plans
Years ending June 30:		
2024	$ 509,987	$ 7,443
2025	439,599	7,153
2026	436,707	6,892
2027	433,302	6,628
2028	430,771	6,368
Years 2029 – 2032	1,990,098	28,034

9. COMMITMENTS AND CONTINGENCIES

Litigation and Settlements – In November 2018, Mount Carmel Health System ("Mount Carmel"), the Corporation's Regional Health Ministry in Central Ohio, discovered sentinel events relating to the clinical practice by one of its physicians and the related conduct of certain of Mount Carmel's staff. The physician's employment was terminated, and this matter was reported to the authorities. Mount Carmel has been fully cooperative with the investigations. The matter has been resolved as to the criminal aspects, however, civil litigation remains pending. The Corporation believes that this matter will be resolved without material adverse effect to the Corporation's future consolidated financial position or results of operations.

The Corporation is involved, from time to time, in other litigation and regulatory investigations that may result in litigation or settlement, arising in the ordinary course of doing business. After consultation with legal counsel, management believes that these matters will be resolved without material adverse effect on the Corporation's future consolidated financial position or results of operations.

COVID-19 Pandemic Ongoing Impacts – Since March of 2020, the global COVID-19 pandemic has significantly affected the U.S. health care industry and the Corporation's patients, communities, employees, and business operations to various degrees across the Corporation's markets. The United States Federal Public Health Emergency ("PHE") expired on May 11, 2023 and the pandemic appears to have transitioned to an endemic state, with periodic surges of COVID-19 cases anticipated in the future, similar to annual influenza surges. Inpatient volumes are stabilizing to a new normal that may not return to pre-pandemic levels, which includes a shift from inpatient care to ambulatory, home health, PACE, urgent care, specialty pharmacy and digital telehealth care. On a same facility basis, COVID-19 discharges were much lower during fiscal year 2023, with a 45% decrease, when compared to fiscal year 2022.

The Corporation's service mix, revenue mix and patient volumes still endure negative impacts from broad economic factors spurred by the pandemic, such as on-going nationwide shortage of nursing staff, reduced consumer spending and rising inflation rates. Furthermore, the expiration of the PHE resulted in reduced payments from Medicare for patients diagnosed with COVID-19, as well as other revenue reductions and cost increases, and the cessation of pandemic related waivers on certain care delivery requirements and continuous enrollment of Medicaid beneficiaries, which will all put further financial strains on the U.S. health care industry and the Corporation. The Corporation's response to these new and ongoing economic factors continues to require increased premium labor rates and use of contract labor staff, although contract labor costs during fiscal year 2023, excluding acquisitions, are significantly lower by 40.6%, than the prior fiscal year. However, labor costs in total are still challenged with an increase over fiscal year 2022. Labor and supply chain disruptions, including shortages, delays, and significant price increases in medical supplies, pharmaceuticals, and personal protective equipment, have impacted, and are expected to continue to impact the Corporation's operations. Cost increases outpacing revenue growth have put strains on the Corporation's financial results and historical debt service coverage ratio. The Corporation's historical debt service coverage ratio exceeded the 1.1 minimum threshold required for the twelve-month period ended June 30, 2023. Lingering risks and uncertainties spurred by the COVID-19 pandemic continue to impact the financial condition, results of operations and cash flows of the Corporation.

The Corporation continues to take various actions to mitigate the impact on operations from the negative ongoing economic factors. The Corporation is focused on clinical optimization and access, revenue growth opportunities, labor retention, recruitment and stabilization, including utilization of the Corporation's FirstChoice internal staffing agency to augment labor stabilization, new care delivery models, and continued cost reduction plans to mitigate the lingering impacts of the COVID-19 pandemic. Furthermore, the Corporation continues to control capital and reallocate resources to support its operations and clinicians.

Health Care Regulatory Environment – The health care industry is subject to numerous and complex federal, state and local government laws and regulations. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, data privacy and security, government health care program participation requirements, government reimbursement rules for patient services, fraud and abuse prevention requirements, and requirements for tax-exempt organizations. Both the CARES Act and the PPPHCE Act include Terms and Conditions as well as attestation to accept related funding. In addition, requirements for accepting, using and reporting on use of the funds are numerous and the compliance guidance has been subject to periodic updates by the Department of Health and Human Services. Laws and regulations concerning government programs, including Medicare, Medicaid, CARES Act, PPPHCE Act and ARP Act, are subject to varying interpretation. Compliance with such laws and regulations is nuanced and can be subject to future government review and interpretation as well as significant regulatory enforcement actions, including fines, penalties, and potential exclusion from government health care programs such as Medicare and Medicaid.

The Corporation and its Health Ministries periodically receive requests for information and notices of investigations regarding potential noncompliance with those laws and regulations, billing, payment or other reimbursement matters; or indicating the existence of whistleblower litigation which, in some instances, have resulted in the Corporation entering into significant settlement agreements. There can be no assurance that regulatory authorities will not challenge the Corporation's compliance with these laws and regulations. In addition, the contracts the Corporation has with commercial payers also provide for retroactive audit and review of claims. The health care industry in general is experiencing an increase in these activities as federal and state governments increase their enforcement activities and institute new programs designed to identify potential irregularities in reimbursement or quality of patient care. Based on the information received to date, management does not believe the ultimate resolution of these matters will have a material adverse effect on the Corporation's future consolidated financial position or results of operations. Trinity Health monitors its business activities for compliance with applicable laws and regulations and operates a values-based ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards.

10. LIQUIDITY AND FAIR VALUE MEASUREMENTS

Liquidity and Availability – The following financial assets are not subject to donor or other contractual restrictions and are available for expenditure generally within one year of the balance sheet date. Board-designated funds have been established in which the Board has the objective of setting funds aside that can be drawn upon for current needs. Also, as more fully described in Note 6, the Corporation has a commercial paper program authorized for borrowings of up to $600 million and a general-purpose credit facility of $600 million as of June 30, 2023. As of both June 30, 2023 and 2022, there were no amounts outstanding under the existing general purpose credit facility.

In April 2020, the Corporation requested and received accelerated Medicare payments of $1.6 billion for its acute care hospitals, which was provided through the CARES Act. For the years ended June 30, 2023 and 2022, CMS recouped $409.5 million (including advances acquired; see MercyOne and MHN in Note 3), and $907.1 million, respectively, of the advances. As of June 30, 2023 the remaining balance was fully repaid.

The Corporation monitors liquidity position through days cash on hand, which is defined as total unrestricted cash and investments without donor or contractual restrictions, divided by total operating expenses minus depreciation and amortization, divided by the number of days in the period.

The following table depicts the liquidity position of the Corporation as of June 30, but does not include cash or securities provided to the Corporation as collateral under its securities lending program (in thousands):

	2023	2022
Cash and cash equivalents	$ 576,308	$ 643,363
Investment securities classified as current assets	5,266,635	5,717,088
Board-designated funds	4,372,991	4,704,093
Total unrestricted cash and investments	$ 10,215,934	$ 11,064,544
Days cash on hand	178	211

For the years ended June 30, 2023 and 2022, days cash on hand decreased 33 days and decreased 43 days, respectively. The decrease in fiscal year 2023 is related to capital expenditures, cash paid for the MercyOne & MHN acquisition (see Note 3), recoupment of remaining Medicare cash advances, and increase in expense per day, partially offset by investment earnings, operating cash flows and net cash acquired from the Genesis acquisition as discussed in Note 3. The decrease in fiscal year 2022 is related to investment losses and the recoupment of the majority of the Medicare cash advances, partially offset by proceeds from the disposition of GHP as discussed further in Note 3 and $140.5 million of PRF and Rural grant revenue.

Approximately 14.6% of the Board-designated funds include private equity investments that may not be as readily available depending on market conditions. The Corporation has other assets limited or restricted as to use for donor-restricted purposes, debt service and for future capital improvements. Additionally, certain other Board-designated assets are designated for future capital expenditures and operating reserves. These assets limited as to use, which are more fully described in Note 12, are not available for general expenditure within the next year. However, the Board-designated amounts could be made available, if necessary and are thus reflected in the amounts above.

In addition, as of June 30, 2023 and 2022 the Corporation had a working capital surplus of $5.8 billion and $5.3 billion, respectively.

Fair Value Measurements – The Corporation's consolidated financial statements reflect certain assets and liabilities recorded at fair value. Assets and liabilities measured at fair value on a recurring basis in the Corporation's consolidated balance sheets include cash, cash equivalents, security lending collateral, equity securities, debt securities, mutual funds, commingled funds, hedge funds and derivatives. Defined benefit retirement plan assets are measured at fair value on an annual basis; see Note 8 for further details.

Fair value is 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. The fair value should be based on assumptions that market participants would use, including a consideration of nonperformance risk.

To determine fair value, the Corporation uses various valuation methodologies based on market inputs. For many instruments, pricing inputs are readily observable in the market; the valuation methodology is widely accepted by market participants and involves little to no judgment. For other instruments, pricing inputs are less observable in the marketplace. These inputs can be subjective in nature and involve uncertainties and matters of considerable judgment. The use of different assumptions, judgments and/or estimation methodologies may have a material effect on the estimated fair value amounts.

The Corporation assesses the inputs used to measure fair value using a three-level hierarchy based on the extent to which inputs used in measuring fair value are observable in the market. The fair value hierarchy is as follows:

Level 1 – Quoted (unadjusted) prices for identical instruments in active markets

Level 2 – Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar instruments in active markets
- Quoted prices for identical or similar instruments in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.)
- Inputs other than quoted prices that are observable for the instrument (interest rates, yield curves, volatilities, default rates, etc.)
- Inputs that are derived principally from or corroborated by other observable market data

Level 3 – Unobservable inputs that cannot be corroborated by observable market data

Valuation Methodologies – Exchange-traded securities whose fair value is derived using quoted prices in active markets are classified as Level 1. In instances where quoted market prices are not readily available, fair value is estimated using quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices, discounted cash flow models and other pricing models. These models are primarily industry-standard models that consider various assumptions, including time value and yield curve as well as other relevant economic measures. The inputs to these models depend on the type of security being priced, but are typically benchmark yields, credit spreads, prepayment spreads, reported trades and broker-dealer quotes, all with reasonable levels of transparency. Generally, significant changes in any of those inputs in isolation would result in a significantly different fair value measurement. The Corporation classifies these securities as Level 2 within the fair value hierarchy. There were no Level 3 investments as of June 30, 2023 and 2022.

The Corporation maintains policies and procedures to value instruments using the best and most relevant data available. The Corporation has not adjusted the prices obtained. Third-party administrators do not provide access to their proprietary valuation models, inputs and assumptions. Accordingly, the Corporation reviews the independent reports of internal controls for these service providers. In addition, on a quarterly basis, the Corporation performs reviews of investment consultant industry peer group benchmarking and supporting relevant market data. Finally, all of the fund managers have an annual independent audit performed by an accredited accounting firm. The Corporation reviews these audited financials for ongoing validation of pricing used. Based on the information available, the Corporation believes that the fair values provided by the third-party administrators and investment fund managers are representative of prices that would be received to sell the assets.

In instances where the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Corporation's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset.

Following is a description of the valuation methodologies the Corporation used for instruments recorded at fair value, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Cash and Cash Equivalents – The carrying amounts reported in the consolidated balance sheets approximate their fair value. Certain cash and cash equivalents are included in investments and assets limited or restricted as to use in the consolidated balance sheet. Included in this category is commercial paper. The fair value of commercial paper is based on amortized cost. Commercial paper is designated as Level 2 investments with significant observable inputs, including security cost, maturity and credit rating.

Security Lending Collateral – The security lending collateral is invested in a Northern Trust sponsored commingled collateral fund, which is composed primarily of short-term securities. The fair value amounts of the commingled collateral fund are determined using the calculated net asset value per share (or its equivalent) for the fund with the underlying investments valued using techniques similar to those used for instruments noted below.

Equity Securities – Equity securities are valued at the closing price reported on the applicable exchange on which the security is traded or are estimated using quoted market prices for similar securities.

Debt Securities – Debt securities are valued using quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices, discounted cash flow models and other pricing models. These models are primarily industry-standard models that consider various assumptions, including time value and yield curve as well as other relevant economic measures.

Exchange-Traded/Mutual Funds – Exchange-traded funds are valued at the closing price reported on the applicable exchange on which the fund is traded or estimated using quoted market prices for similar securities. Mutual funds are valued using the net asset value based on the value of the underlying assets owned by the fund, minus liabilities, divided by the number of shares outstanding and multiplied by the number of shares owned.

Commingled Funds – Commingled funds are developed for investment by institutional investors only and, therefore, do not require registration with the Securities and Exchange Commission. Commingled funds are recorded at fair value based on net asset value, which is calculated using the most recent fund financial statements.

Hedge Funds – Hedge funds utilize either a direct or a "fund-of-funds" approach resulting in diversified multistrategy, multimanager investments. Underlying investments in these funds may include equity securities, debt securities, commodities, currencies and derivatives. These funds are valued at net asset value, which is calculated using the most recent fund financial statements.

The Corporation classifies its equity and debt securities, mutual funds, commingled funds and hedge funds as trading securities. The amount of holding gains included in the excess of revenue over expenses related to securities still held as of June 30, 2023 and 2022, were $1,456.3 million and $773.1 million, respectively.

Equity Method Investments – Certain other investments are accounted for using the equity method. These investments are structured as limited liability corporations and partnerships and are designed to produce stable investment returns regardless of market activity. These investments utilize a combination of "fund-of-funds" and direct fund investment strategies resulting in a diversified multistrategy, multimanager investment approach. Some of these funds are developed by investment managers specifically for the Corporation's use and are similar to mutual funds but are not traded on a public exchange. Underlying investments in these funds may include other funds, equity securities, debt securities, commodities, currencies and derivatives. Audited information is only available annually based on the limited liability corporations, partnerships or funds' year-end. Management's estimates of the fair values of these investments are based on information provided by the third-party administrators and fund managers or the general partners. Management obtains and considers the audited financial statements of these investments when evaluating the overall reasonableness of the recorded value. In addition to a review of external information provided, management's internal procedures include such things as review of returns against benchmarks and discussions with fund managers on performance, changes in personnel or process, along with evaluations of current market conditions for these investments. Because of the inherent uncertainty of valuations, values may differ materially from the values that would have been used had a ready market existed. Unfunded capital commitments related to equity method investments totaled $689.5 million and $693.7 million as of June 30, 2023 and 2022, respectively.

Interest Rate Swaps – The fair value of the Corporation's derivatives, which are mainly interest rate swaps, are estimated utilizing the terms of the swaps and publicly available market yield curves along with the Corporation's nonperformance risk as observed through the credit default swap market and bond market and based on prices for recent trades. These swap agreements are classified as Level 2 within the fair value hierarchy.

The following table presents information about the fair value of the Corporation's financial instruments measured at fair value on a recurring basis and recorded as of June 30, 2023 (in thousands):

	2023		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total Fair Value
Assets:			
Cash and cash equivalents	$ 1,093,410	$ 6,235	$ 1,099,645
Security lending collateral	-	349,985	349,985
Equity securities	3,155,639	458	3,156,097
Debt securities:			
Government and government agency obligations	-	845,135	845,135
Corporate bonds	-	1,099,702	1,099,702
Asset backed securities	-	335,547	335,547
Bank loans	-	2,494	2,494
Other	-	5,665	5,665
Exchange traded/mutual funds:			
Equity funds	620,670	-	620,670
Fixed income funds	350,679	-	350,679
Real estate investment funds	65,431	-	65,431
Other	20,747	-	20,747
Subtotal	$ 5,306,576	$ 2,645,221	$ 7,951,797
Equity method investments			2,730,957
Investments measured at net asset value:			
Commingled funds			1,037,930
Hedge funds			573,523
Total assets			$ 12,294,207
Liabilities:			
Interest rate swaps	$ -	$ 49,119	$ 49,119

The following table presents information about the fair value of the Corporation's financial instruments measured at fair value on a recurring basis and recorded as of June 30, 2022 (in thousands):

	2022		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total Fair Value
Assets:			
Cash and cash equivalents	$ 985,684	$ 10,183	$ 995,867
Security lending collateral	-	502,981	502,981
Equity securities	3,134,434	6,013	3,140,447
Debt securities:			
Government and government agency obligations	-	965,894	965,894
Corporate bonds	-	1,515,911	1,515,911
Asset backed securities	-	412,851	412,851
Bank loans	-	32	32
Other	-	5,287	5,287
Exchange traded/mutual funds:			
Equity funds	563,647	-	563,647
Fixed income funds	423,704	-	423,704
Real estate investment funds	80,473	-	80,473
Other	44,099	-	44,099
Interest rate swaps	-	2,524	2,524
Subtotal	$ 5,232,041	$ 3,421,676	$ 8,653,717
Equity method investments			2,637,270
Investments measured at net asset value:			
Commingled funds			1,215,828
Hedge funds			603,976
Total assets			$ 13,110,791
Liabilities:			
Interest rate swaps	$ -	$ 88,980	$ 88,980

The following table reconciles the information about the fair value of the Corporation's financial instruments measured at fair value on a recurring basis presented in the table above to amounts presented in the consolidated balance sheets as of June 30 (in thousands):

	2023	2022
Assets:		
Cash and cash equivalents	$ 576,308	$ 643,363
Investments	5,266,635	5,717,088
Security lending collateral	349,985	502,981
Assets limited or restricted as to use - current portion	430,985	475,836
Assets limited or restricted as to use - noncurrent portion:		
Self-insurance, benefit plans and other	1,052,049	912,032
By Board	4,160,166	4,494,293
By donor	598,003	503,742
Interest rate swaps in other long-term assets	-	2,524
Less items not recorded at fair value:		
Unconditional promises to give - net	(43,232)	(54,026)
Reinsurance recovery receivable	(85,329)	(80,268)
Other, primarily beneficial interests in trusts	(11,363)	(6,774)
Total assets	$ 12,294,207	$ 13,110,791

Investments in Entities that Calculate Net Asset Value per Share – The Corporation holds shares or interests in investment companies at year-end, included in commingled funds and hedge funds, where the fair value of the investment held is estimated based on the net asset value per share (or its equivalent) of the investment company. There were no unfunded commitments as of June 30, 2023 and 2022. The fair value and redemption rules of these investments are as follows as of June 30 (in thousands):

	2023		
	Fair Value	Redemption Frequency	Redemption Notice Period
Commingled funds	$ 1,037,930	Daily, thrice-monthly, monthly	2 - 10 days
Hedge funds	573,523	Monthly, quarterly, semi-monthly, semi-annually	30 - 90 days
Total	$ 1,611,453		

	2022		
	Fair Value	Redemption Frequency	Redemption Notice Period
Commingled funds	$ 1,215,828	Daily, thrice-monthly, monthly	2 - 10 days
Hedge funds	603,976	Daily, monthly, quarterly, semi-annually, annually	15 - 95 days
Total	$ 1,819,804		

The hedge fund category includes equity long/short hedge funds, multistrategy hedge funds and relative value hedge funds. Equity long/short hedge funds invest both long and short, primarily in U.S. common stocks. Management of the fund has the ability to shift investments from value to growth strategies, from small to large capitalization stocks and from a net long position to a net short position. Multistrategy hedge funds pursue multiple strategies to diversify risks and reduce volatility.

The relative value hedge fund strategy is to exploit structural and technical inefficiencies in the market by investing in financial instruments that are perceived to be inefficiently priced as a result of business, financial or legal uncertainties. Investments representing approximately 0.6% and 0.4% of the value of the investments in this category as of June 30, 2023 and 2022, respectively, can only be redeemed semi-annually, bi-annually, or annually subsequent to the initial investment date. Investments representing 61.5% and 65.0% of the investments in this category as of June 30, 2023 and 2022, respectively, can only be redeemed at the rate of 25% per quarter.

The commingled fund category primarily includes investments in funds that invest in financial instruments of U.S. and non-U.S. entities, primarily bonds, notes, bills, debentures, currencies and interest rate and derivative products.

The composition of investment returns included in the consolidated statements of operations and changes in net assets for the years ended June 30 is as follows (in thousands):

	2023	2022
Dividend, interest income and other	$ 208,213	$ 226,813
Realized gain - net	129,253	262,498
Realized equity earnings, other investments	38,834	142,868
Change in net unrealized (loss) gain on investments	461,624	(1,699,351)
Total investment return	$ 837,924	$ (1,067,172)
Included in:		
Operating income	$ 94,903	$ (17,554)
Nonoperating items	715,572	(1,015,043)
Changes in net assets with donor restrictions	27,449	(34,575)
Total investment return	$ 837,924	$ (1,067,172)

In addition to investments, assets restricted as to use include receivables for unconditional promises to give cash and other assets, net of allowances for uncollectible promises to give. Unconditional promises to give consist of the following as of June 30 (in thousands):

	2023	2022
Amounts expected to be collected in:		
Less than one year	$ 16,372	$ 40,897
One to five years	26,613	17,562
More than five years	6,867	3,077
	49,852	61,536
Discount to present value of future cash flows	(3,927)	(3,793)
Allowance for uncollectible amounts	(2,693)	(3,717)
Total unconditional promises to give - net	$ 43,232	$ 54,026

11. DERIVATIVE FINANCIAL INSTRUMENTS

Derivative Financial Instruments – In the normal course of business, the Corporation is exposed to market risks, including the effect of changes in interest rates and equity market volatility. To manage these risks, the Corporation enters into various derivative contracts, primarily interest rate swaps. Interest rate swaps are used to manage the effect of interest rate fluctuations.

Management reviews the Corporation's hedging program, derivative position and overall risk management on a regular basis. The Corporation only enters into transactions it believes will be highly effective at offsetting the underlying risk.

Interest Rate Swaps – The Corporation utilizes interest rate swaps to manage interest rate risk related to the Corporation's variable interest rate debt. Cash payments on interest rate swaps totaled $7.9 million and $23.2 million for the years ended June 30, 2023 and 2022, respectively, and are included in nonoperating income.

Certain of the Corporation's interest rate swaps contain provisions that give certain counterparties the right to terminate the interest rate swap if a rating is downgraded below specified thresholds. If a ratings downgrade threshold is breached, the counterparties to the derivative instruments could demand immediate termination of the swaps. Such termination could result in a payment from the Corporation or a payment to the Corporation depending on the market value of the interest rate swap.

Effect of Derivative Instruments on Excess (Deficiency) of Revenue over Expenses – The Corporation has interest rate swaps not designated as hedging instruments which are included in the excess (deficiency) of revenue over expenses in the statement of operations. Net gains included in the change in market value and cash payments of interest rate swaps totaled $29.8 million and $63.4 million for the years ended June 30, 2023 and 2022, respectively.

Balance Sheet Effect of Derivative Instruments – The following table summarizes the estimated fair value of the Corporation's derivative financial instruments as of June 30 (in thousands):

Derivatives Not Designated as Hedging Instruments	Consolidated Balance Sheet Location	Fair Value 2023	Fair Value 2022
Asset Derivatives:			
Interest rate swaps	Other assets	$ -	$ 2,524
Liability Derivatives:			
Interest rate swaps	Other long-term liabilities	$ 49,119	$ 88,980

The counterparties to the interest rate swaps expose the Corporation to credit loss in the event of nonperformance. As of June 30, 2023 and 2022, an adjustment for nonperformance risk reduced derivative assets by $0 million and $0.1 million, respectively, and derivative liabilities by $2.1 million and $3.4 million, respectively.

12. NET ASSETS WITHOUT DONOR RESTRICTIONS AND WITH DONOR RESTRICTIONS

Net assets with donor restrictions are those whose use by the Corporation has been limited by donors to a specific program or time period. In addition, certain restricted assets have been restricted by donors to be maintained by the Corporation in perpetuity. Net assets with donor restrictions as of June 30 are restricted for the following programs or periods (in thousands):

	2023	2022
Subject to expenditure for specified program		
Education and research	$ 50,364	$ 41,754
Building and equipment	82,107	66,384
Patient care	68,237	50,284
Cancer center/research	17,539	19,206
Services for elderly care	43,865	40,704
Other	107,688	95,712
Total subject to expenditure for specified program	369,800	314,044
Subject to the passage of time		
For periods after June 30	43,232	54,026
Total subject to expenditure for specified program and passage of time	$ 413,032	$ 368,070
Subject to organization spending policy and appropriation		
Investment in perpetuity, which, once appropriated, is expendable to support:		
Hospital operations	134,260	122,929
Medical programs	14,391	14,353
Scholarship funds	15,256	10,783
Research funds	13,636	12,826
Community service funds	21,581	15,662
Other	43,858	41,929
Total subject to organization spending policy and appropriation	242,982	218,482
Total net assets with donor restrictions	$ 656,014	$ 586,552

The Corporation's endowments consist of funds established for a variety of purposes. Endowments include both donor-restricted endowment funds and funds designated by the Board to function as endowments. Net assets associated with endowment funds, including funds designated by the Board to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions. The Corporation considers various factors in making a determination to appropriate or accumulate donor-restricted endowment funds.

The Corporation employs a total return investment approach whereby a mix of equities and fixed-income investments are used to maximize the long-term return of endowment funds for a prudent level of risk. The Corporation targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. The Corporation can appropriate each year all available earnings in accordance with donor restrictions. The endowment corpus is to be maintained in perpetuity. Certain donor-restricted endowments require a portion of annual earnings to be maintained in perpetuity along with the corpus. Only amounts exceeding the amounts required to be maintained in perpetuity are expended.

The changes in endowment net assets and composition by type of fund for the years ended June 30 are as follows (in thousands):

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total
Endowment net assets, July 1, 2021	$ 100,367	$ 309,812	$ 410,179
Investment return:			
Investment income	-	3,696	3,696
Change in net realized and unrealized gains (losses)	(9,363)	(31,078)	(40,441)
Total investment return	(9,363)	(27,382)	(36,745)
Contributions	3,755	6,170	9,925
Appropriation of endowment assets for expenditures	(2,184)	(1,833)	(4,017)
Other	(915)	(10,478)	(11,393)
Endowment net assets, June 30, 2022	91,660	276,289	367,949
Investment return:			
Investment income	2,744	4,390	7,134
Change in net realized and unrealized gains (losses)	5,869	9,967	15,836
Total investment return	8,613	14,357	22,970
Contributions	716	2,909	3,625
Appropriation of endowment assets for expenditures	(1,763)	(2,115)	(3,878)
Acquistions	1,228	21,590	22,818
Other	976	(12,751)	(11,775)
Endowment net assets, June 30, 2023	$ 101,430	$ 300,279	$ 401,709

The table below describes the restrictions for endowment amounts classified as net assets with donor restrictions as of June 30 (in thousands):

	2023	2022
Net assets with donor restrictions:		
Endowments requiring income to be added to the original gift	$ 10,868	$ 10,110
Term endowment funds	10,253	8,115
Accumulated investment gains on endowment funds:		
Without purpose restrictions	190,569	168,835
With purpose restrictions	88,589	89,229
Total endowment funds classified as net assets with donor restrictions	$ 300,279	$ 276,289

Underwater Endowments – Periodically, the fair value of assets associated with the individual donor-restricted endowment funds may fall below the level that the donor or the Uniform Prudent Management of Institutional Funds Act (UPMIFA) requires the Corporation to retain as a fund of perpetual duration. The Corporation has a policy that permits spending from underwater endowment funds depending on the degree to which the fund is underwater, unless otherwise precluded by donor intent or relevant laws and regulations. However, the Corporation's policy for all endowments is the investment returns released into income during the year may not exceed 5% of the total investment pool balance. This policy also applies to underwater endowments.

Governing Board Designations – At times, the Corporation's governing Board may make designations or appropriations that result in self-imposed limits on the use of resources without donor restrictions, known as Board-designated net assets. The Corporation's governing Board has designated, from net assets without donor restrictions amounts for the following purposes as of June 30 (in thousands):

	2023	2022
Quasi-endowment funds	$ 101,430	$ 91,660
Future capital improvements	1,046,782	812,482
System development fund	330,755	690,442
Insurance and retirement programs	1,012,875	849,593
Retirement of debt/intercompany loan program	1,478,302	1,763,924
Program/mission	288,068	283,740
Liquidity reserve	-	30,886
Other	114,779	181,366
Total governing Board designations	4,372,991	4,704,093
Less current portion	(212,825)	(209,800)
Total governing Board designations - net of current portion	$ 4,160,166	$ 4,494,293

13. RELATED PARTY TRANSACTIONS

The Corporation provides information services, insurance coverage, lab services, management services, and other administrative support services to certain equity investees and other non-consolidated affiliates. For the years ended, June 30, 2023 and 2022, respectively, revenue for these services totaled $50.6 million and $43.9 million which is included in other revenue in the consolidated statement of operations and changes in net assets. As of June 30, 2023 and 2022, respectively, accounts receivable for services provided totaled $8.6 million and $4.2 million which is included in other receivables in the consolidated balance sheets. In addition, the Corporation receives lab services, imaging services, radiology and other clinical services, laundry services, and other administrative support services from certain equity investees and other non-consolidated affiliates. For the years ended, June 30, 2023 and 2022, respectively, expenses for these services totaled $58.8 million and $26.7 million which is included in purchased services and medical claims expense in the consolidated statement of operations and changes in net assets. As of June 30, 2023, accounts payable for services received totaled $8.7 million which is included in accounts payable and accrued expenses in the consolidated balance sheets. As of June 30, 2022, there were no outstanding payables for these services.

14. RESTRUCTURING CHARGES

For the year ended June 30, 2023, $82.3 million of restructuring charges, primarily related to loss on sale, asset retirement obligations and transition benefits for colleagues were recorded in the consolidated statement of operations and changes in net assets as a result of the SFMC divestiture as described further in Note 3.

In addition, during fiscal years 2023 and 2022, the Corporation undertook actions to reduce administrative costs in response to financial challenges spurred by the COVID-19 pandemic, as further described in Note 9. As a result of these actions, restructuring charges, primarily for severance and termination benefits, of $40.0 million and $72.6 million, respectively, for the years ended June 30, 2023 and 2022, were recorded in the consolidated statement of operations and changes in net assets.

15. SUBSEQUENT EVENTS

Management has evaluated subsequent events through September 20, 2023, the date the consolidated financial statements were issued. There were no subsequent events requiring adjustment to or disclosure in the consolidated financial statements.

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INDEPENDENT AUDITOR'S REPORT ON CONSOLIDATING SCHEDULES

To the Board of Directors of
Trinity Health Corporation
Livonia, Michigan

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules (the "schedules") listed in the table of contents are presented for the purpose of additional analysis of the financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements. These schedules are the responsibility of Trinity Health Corporation's management and were derived from and relate directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Deloitte + Touche LLP

September 20, 2023

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Saint Agnes Medical Center, Fresno, California	Saint Alphonsus Health System, Oregon-Idaho	Trinity Health Iowa Region	Loyola University Health System, Maywood, Illinois	Saint Joseph Regional Medical Center, South Bend, Indiana
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 137,622	$ 544,148	$ 475,538	$ 188,131	$ 46,878
Assets limited as to use - current portion	59	496	3,366	1,150	16
Patient and other receivables	283,559	189,498	505,261	348,868	68,404
Other current assets	13,189	23,258	127,364	45,845	11,779
Total current assets	434,429	757,400	1,111,529	583,994	127,077
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	303	17,173	89,899	63,666	9,253
By Board	792	19,241	382,262	2,264	-
By donors	13,458	7,950	84,277	64,820	8,755
Total assets limited or restricted as to use - Noncurrent portion	14,553	44,364	556,438	130,750	18,008
PROPERTY AND EQUIPMENT - Net	264,359	520,870	945,997	679,510	286,472
OTHER ASSETS	146,465	198,593	544,535	316,358	56,490
TOTAL ASSETS	$ 859,806	$ 1,521,227	$ 3,158,499	$ 1,710,612	$ 488,047
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 152,703	$ 152,001	$ 478,675	$ 296,545	$ 88,187
LONG-TERM DEBT - Net of current portion	146,095	238,166	963,959	733,559	362,732
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	5,537	26,825	132,843	13,087	8,951
OTHER LIABILITIES	2,910	19,115	102,559	78,773	9,359
NET ASSETS:					
Net assets without donor restrictions	539,047	1,076,673	1,393,107	522,678	10,047
Net assets with donor restrictions	13,514	8,447	87,356	65,970	8,771
TOTAL LIABILITIES AND NET ASSETS	$ 859,806	$ 1,521,227	$ 3,158,499	$ 1,710,612	$ 488,047

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Trinity Health Michigan Region	Mount Carmel Health System, Columbus, Ohio	Holy Cross Health, Inc., Maryland	Trinity Health New York Region	Trinity Health Of New England Corporation, Inc.
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 2,188,888	$ 710,929	$ 429,197	$ 211,682	$ 42,207
Assets limited as to use - current portion	2,007	351	814	6,685	2,978
Patient and other receivables	646,139	272,020	88,685	273,734	252,847
Other current assets	76,104	33,770	15,413	35,924	57,701
Total current assets	2,913,138	1,017,070	534,109	528,025	355,733
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	91,920	27,545	1,945	40,891	13,073
By Board	466,553	81,516	2,000	236,148	32,561
By donors	84,867	14,949	6,738	106,700	133,964
Total assets limited or restricted as to use - Noncurrent portion	643,340	124,010	10,683	383,739	179,598
PROPERTY AND EQUIPMENT - Net	1,588,047	978,395	412,433	795,706	542,615
OTHER ASSETS	478,455	473,689	124,586	230,384	244,897
TOTAL ASSETS	$ 5,622,980	$ 2,593,164	$ 1,081,811	$ 1,937,854	$ 1,322,843
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 659,304	$ 423,427	$ 133,538	$ 434,375	$ 297,146
LONG-TERM DEBT - Net of current portion	920,272	610,830	359,871	567,467	385,424
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	101,200	20,162	10,149	37,795	24,135
OTHER LIABILITIES	102,101	23,903	5,637	112,616	167,900
NET ASSETS:					
Net assets without donor restrictions	3,754,014	1,499,542	565,063	672,123	311,296
Net assets with donor restrictions	86,089	15,300	7,553	113,478	136,942
TOTAL LIABILITIES AND NET ASSETS	$ 5,622,980	$ 2,593,164	$ 1,081,811	$ 1,937,854	$ 1,322,843

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Trinity Health Mid-Atlantic	St. Francis Medical Center, Trenton, New Jersey	St. Mary's Hospital, Inc., Athens, Georgia	Holy Cross Hospital, Inc., Ft. Lauderdale, Florida	Premier Health, National Urgent Care
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 462,981	$ 20	$ 43,638	$ 9,837	$ -
Assets limited as to use - current portion	743	-	3,633	13,537	-
Patient and other receivables	158,104	-	53,440	87,857	9,955
Other current assets	22,827	-	10,399	12,575	1,676
Total current assets	644,655	20	111,110	123,806	11,631
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	3,589	-	3,364	16,872	-
By Board	9,861	-	25,845	21,919	-
By donors	10,642	-	2,311	31,213	-
Total assets limited or restricted as to use - Noncurrent portion	24,092	-	31,520	70,004	-
PROPERTY AND EQUIPMENT - Net	311,763	-	102,787	218,823	4,694
OTHER ASSETS	102,260	-	45,064	70,583	85,011
TOTAL ASSETS	$ 1,082,770	$ 20	$ 290,481	$ 483,216	$ 101,336
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 144,776	$ -	$ 62,013	$ 83,647	$ 19,494
LONG-TERM DEBT - Net of current portion	1,611	-	59,941	145,690	3
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	18,478	-	19,950	12,419	10,742
OTHER LIABILITIES	9,325	-	3,515	49,260	-
NET ASSETS:					
Net assets without donor restrictions	897,188	20	142,446	160,563	71,097
Net assets with donor restrictions	11,392	-	2,616	31,637	-
TOTAL LIABILITIES AND NET ASSETS	$ 1,082,770	$ 20	$ 290,481	$ 483,216	$ 101,336

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Trinity Continuing Care Services	Trinity Home Health Services	Trinity Health PACE	Pittsburgh Mercy Health System Inc., Pittsburgh, Pennsylvania	Mercy Primary Care Center, Detroit, Michigan
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 26,298	$ 41,267	$ 121,145	$ 14,220	$ 16,022
Assets limited as to use - current portion	953	-	-	-	-
Patient and other receivables	20,853	44,624	7,307	20,278	405
Other current assets	1,651	829	429	2,189	80
Total current assets	49,755	86,720	128,881	36,687	16,507
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	6,245	290	183	526	-
By Board	1,245	-	-	89,131	-
By donors	5,852	747	1,929	2,768	419
Total assets limited or restricted as to use - Noncurrent portion	13,342	1,037	2,112	92,425	419
PROPERTY AND EQUIPMENT - Net	174,170	484	26,726	25,467	17
OTHER ASSETS	24,390	37,948	34,639	41,975	956
TOTAL ASSETS	$ 261,657	$ 126,189	$ 192,358	$ 196,554	$ 17,899
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 42,207	$ 42,475	$ 72,336	$ 12,668	$ 767
LONG-TERM DEBT - Net of current portion	247,360	24,502	8,382	2,078	-
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	44	3,849	16,546	20,779	777
OTHER LIABILITIES	91,994	291	184	534	-
NET ASSETS:					
Net assets without donor restrictions	(125,802)	54,325	92,981	157,726	15,882
Net assets with donor restrictions	5,854	747	1,929	2,769	473
TOTAL LIABILITIES AND NET ASSETS	$ 261,657	$ 126,189	$ 192,358	$ 196,554	$ 17,899

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Trinity Health Consolidated Labs	Trinity Health Warde Lab LLC	Trinity Specialty Pharmacy	Global Health Ministry	St. Joseph's Health System, Inc., Atlanta, Georgia
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 4,998	$ 7,079	$ 6,689	$ 7,132	$ 194,031
Assets limited as to use - current portion	-	-	-	-	224
Patient and other receivables	5,553	-	4,278	2	4,049
Other current assets	3,631	-	1,535	3	223
Total current assets	14,182	7,079	12,502	7,137	198,527
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	-	-	-	-	35
By Board	-	-	-	-	39,224
By donors	-	-	-	309	12,109
Total assets limited or restricted as to use - Noncurrent portion	-	-	-	309	51,368
PROPERTY AND EQUIPMENT - Net	4,046	5,466	728	-	46,154
OTHER ASSETS	466	-	-	-	234,690
TOTAL ASSETS	$ 18,694	$ 12,545	$ 13,230	$ 7,446	$ 530,739
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 10,837	$ -	$ 6,107	$ 626	$ 5,319
LONG-TERM DEBT - Net of current portion	2,002	-	-	-	21,440
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	-	-	-	-	-
OTHER LIABILITIES	6	-	-	1,379	561
NET ASSETS:					
Net assets without donor restrictions	5,849	12,545	7,123	5,205	489,448
Net assets with donor restrictions	-	-	-	236	13,971
TOTAL LIABILITIES AND NET ASSETS	$ 18,694	$ 12,545	$ 13,230	$ 7,446	$ 530,739

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Mercy Care Center Chicago, Illinois	Trinity Health ACO, Inc.	Allegany Franciscan Ministries	Cadillac Foundation	Trinity Assurance, Ltd.
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ 409	$ 2,494	$ 111,432	$ -	$ 10
Assets limited as to use - current portion	-	-	1,946	-	105,385
Patient and other receivables	339	-	13	-	11,616
Other current assets	41	-	14	-	27
Total current assets	789	2,494	113,405	-	117,038
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	-	-	-	-	614,131
By Board	-	-	-	11,263	-
By donors	-	-	-	-	-
Total assets limited or restricted as to use - Noncurrent portion	-	-	-	11,263	614,131
PROPERTY AND EQUIPMENT - Net	5,594	-	34	-	-
OTHER ASSETS	-	-	5	-	1
TOTAL ASSETS	$ 6,383	$ 2,494	$ 113,444	$ 11,263	$ 731,170
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ 1,913	$ 4,828	$ 2,611	$ 1,732	$ 118,652
LONG-TERM DEBT - Net of current portion	-	-	-	-	-
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	1,784	-	-	-	-
OTHER LIABILITIES	-	-	1	-	589,729
NET ASSETS:					
Net assets without donor restrictions	2,686	(2,334)	110,832	9,531	22,789
Net assets with donor restrictions	-	-	-	-	-
TOTAL LIABILITIES AND NET ASSETS	$ 6,383	$ 2,494	$ 113,444	$ 11,263	$ 731,170

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2023
(In thousands)

	Investment in Baycare Health System	Other Subsidiaries	System Office	Eliminations	TRINITY HEALTH
ASSETS					
CURRENT ASSETS:					
Cash, cash equivalents and investments	$ -	$ 9,278	$ 583,090	$ (444,362)	**$ 6,192,928**
Assets limited as to use - current portion	-	2,365	284,275	2	**430,985**
Patient and other receivables	-	23,450	557,576	(741,522)	**3,197,192**
Other current assets	-	-	160,395	(24,214)	**634,657**
Total current assets	-	35,093	1,585,336	(1,210,096)	**10,455,762**
ASSETS LIMITED OR RESTRICTED AS TO USE -					
Noncurrent portion:					
Self-insurance, benefit plans and other	-	1,259	49,887	-	**1,052,049**
By Board	-	-	2,738,341	-	**4,160,166**
By donors	-	3,226	-	-	**598,003**
Total assets limited or restricted as to use - Noncurrent portion	-	4,485	2,788,228	-	**5,810,218**
PROPERTY AND EQUIPMENT - Net	-	146	904,994	-	**8,846,497**
OTHER ASSETS	4,401,908	4,156	6,253,756	(6,984,530)	**7,167,730**
TOTAL ASSETS	$ 4,401,908	$ 43,880	$ 11,532,314	$ (8,194,626)	**$ 32,280,207**
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES	$ -	$ 255,346	$ 1,820,199	$ (1,155,118)	**$ 4,669,336**
LONG-TERM DEBT - Net of current portion	-	37	6,610,698	(5,654,960)	**6,757,159**
LONG-TERM PORTION OF OPERATING LEASE LIABILITIES	-	7	49,830	(1)	**535,888**
OTHER LIABILITIES	-	40,200	1,902,327	(1,322,357)	**1,991,822**
NET ASSETS:					
Net assets without donor restrictions	4,370,441	(257,304)	1,149,138	(65,977)	**17,669,988**
Net assets with donor restrictions	31,467	5,594	122	3,787	**656,014**
TOTAL LIABILITIES AND NET ASSETS	$ 4,401,908	$ 43,880	$ 11,532,314	$ (8,194,626)	**$ 32,280,207**

TRINITY HEALTH

Supplemental Condensed Consolidating Statements of Operations and Changes in Net Assets - Information
June 30, 2023
(In thousands)

	Saint Agnes Medical Center, Fresno, California	Saint Alphonsus Health System, Oregon-Idaho	Trinity Health Iowa Region	Loyola University Health System, Maywood, Illinois	Saint Joseph Regional Medical Center, South Bend, Indiana
Operating revenue:					
Net patient service revenue	$ 732,136	$ 1,095,882	$ 2,305,527	$ 1,789,737	$ 449,453
Other	39,063	69,840	322,023	231,464	19,159
Total operating revenue	771,199	1,165,722	2,627,550	2,021,201	468,612
Expenses:					
Labor costs	383,218	624,188	1,429,967	999,456	252,502
Purchased services and medical claims	189,286	171,722	463,148	243,289	77,474
Depreciation, amortization and interest	35,411	64,039	117,718	109,572	38,329
Other	240,362	289,082	808,400	650,753	144,463
Total expenses	848,277	1,149,031	2,819,233	2,003,070	512,768
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	(77,078)	16,691	(191,683)	18,131	(44,156)
Other items	(6,961)	(940)	(49,738)	-	-
OPERATING INCOME (LOSS)	(84,039)	15,751	(241,421)	18,131	(44,156)
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	10,737	39,544	54,943	22,605	2,317
Loss from early extinguishment of debt	-	-	-	-	-
Other	(2,764)	(2,370)	461,920	(10,492)	(1,835)
Total nonoperating items	7,973	37,174	516,863	12,113	482
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	(76,066)	52,925	275,442	30,244	(43,674)
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(7,057)	(137)	(35,311)	-	-
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ (83,123)	$ 52,788	$ 240,131	$ 30,244	$ (43,674)
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ (82,694)	$ 46,637	$ 565,332	$ 19,611	$ (47,071)
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	1,771	(93)	75,377	428	(138)
INCREASE (DECREASE) NET ASSETS	(80,923)	46,544	640,709	20,039	(47,209)
NET ASSETS, Beginning of year	633,484	1,038,576	839,754	568,609	66,027
NET ASSETS, End of year	$ 552,561	$ 1,085,120	$ 1,480,463	$ 588,648	$ 18,818

TRINITY HEALTH

Supplemental Condensed Consolidating Statements of Operations and Changes in Net Assets - Information
June 30, 2023
(In thousands)

	Trinity Health Michigan Region	Mount Carmel Health System, Columbus, Ohio	Holy Cross Health, Inc., Maryland	Trinity Health New York Region	Trinity Health Of New England Corporation, Inc.
Operating revenue:					
Net patient service revenue	$ 3,917,938	$ 1,303,730	$ 620,321	$ 2,109,590	$ 1,830,315
Other	431,756	683,669	34,360	225,372	132,139
Total operating revenue	4,349,694	1,987,399	654,681	2,334,962	1,962,454
Expenses:					
Labor costs	2,318,271	792,646	378,998	1,384,123	1,024,550
Purchased services and medical claims	530,093	697,466	108,159	305,691	307,160
Depreciation, amortization and interest	212,653	114,069	47,265	120,547	81,611
Other	1,190,712	392,065	132,012	569,641	606,612
Total expenses	4,251,729	1,996,246	666,434	2,380,002	2,019,933
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	97,965	(8,847)	(11,753)	(45,040)	(57,479)
Other items	(3,482)	(2,050)	(692)	-	(4,842)
OPERATING INCOME (LOSS)	94,483	(10,897)	(12,445)	(45,040)	(62,321)
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	194,980	22,721	31,597	26,021	9,655
Loss from early extinguishment of debt	-	-	-	-	-
Other	(10,704)	(10,668)	(2,011)	(6,759)	(5,384)
Total nonoperating items	184,276	12,053	29,586	19,262	4,271
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	278,759	1,156	17,141	(25,778)	(58,050)
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(6,427)	(23,073)	-	(2,071)	(517)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ 272,332	$ (21,917)	$ 17,141	$ (27,849)	$ (58,567)
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ 261,565	$ (40,957)	$ 13,686	$ (40,687)	$ (32,333)
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	(8,823)	211	413	7,031	(2,463)
INCREASE (DECREASE) NET ASSETS	252,742	(40,746)	14,099	(33,656)	(34,796)
NET ASSETS, Beginning of year	3,587,361	1,555,588	558,517	819,257	483,034
NET ASSETS, End of year	$ 3,840,103	$ 1,514,842	$ 572,616	$ 785,601	$ 448,238

TRINITY HEALTH

Supplemental Condensed Consolidating Statements of Operations and Changes in Net Assets - Information
June 30, 2023
(In thousands)

	Trinity Health Mid-Atlantic	St. Francis Medical Center, Trenton, New Jersey	St. Mary's Hospital, Inc., Athens, Georgia	Holy Cross Hospital, Inc., Ft. Lauderdale, Florida	Premier Health, National Urgent Care
Operating revenue:					
Net patient service revenue	$ 966,726	$ 48,312	$ 362,627	$ 575,920	$ 24,739
Other	82,131	15,594	11,093	19,550	69,402
Total operating revenue	1,048,857	63,906	373,720	595,470	94,141
Expenses:					
Labor costs	630,446	36,154	200,418	304,449	87,400
Purchased services and medical claims	183,228	21,920	67,628	86,152	4,456
Depreciation, amortization and interest	51,366	1,970	18,287	33,737	1,083
Other	269,798	15,750	99,486	159,115	9,274
Total expenses	1,134,838	75,794	385,819	583,453	102,213
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	(85,981)	(11,888)	(12,099)	12,017	(8,072)
Other items	6,213	(82,257)	(4,252)	(4,711)	(876)
OPERATING INCOME (LOSS)	(79,768)	(94,145)	(16,351)	7,306	(8,948)
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	37,534	(2,689)	3,566	3,052	137
Loss from early extinguishment of debt	-	-	-	-	-
Other	(4,387)	(360)	(481)	(2,657)	-
Total nonoperating items	33,147	(3,049)	3,085	395	137
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	(46,621)	(97,194)	(13,266)	7,701	(8,811)
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(4,633)	(966)	-	(87)	2,670
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ (51,254)	$ (98,160)	$ (13,266)	$ 7,614	$ (6,141)
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ (54,386)	$ 196,037	$ (15,071)	$ 6,349	$ (5,237)
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	(904)	(1,459)	(371)	105	(1)
INCREASE (DECREASE) NET ASSETS	(55,290)	194,578	(15,442)	6,454	(5,238)
NET ASSETS, Beginning of year	963,870	(194,558)	160,504	185,746	76,335
NET ASSETS, End of year	$ 908,580	$ 20	$ 145,062	$ 192,200	$ 71,097

TRINITY HEALTH

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(In thousands)

	Trinity Continuing Care Services	Trinity Home Health Services	Trinity Health PACE	Pittsburgh Mercy Health System Inc., Pittsburgh, Pennsylvania	Mercy Primary Care Center, Detroit, Michigan
Operating revenue:					
Net patient service revenue	$ 87,533	$ 229,746	$ -	$ 67,775	$ 863
Other	124,695	1,125	297,457	47,703	3,909
Total operating revenue	212,228	230,871	297,457	115,478	4,772
Expenses:					
Labor costs	123,237	190,446	93,262	68,391	2,115
Purchased services and medical claims	30,247	17,288	155,178	10,223	178
Depreciation, amortization and interest	25,772	1,423	5,001	1,933	-
Other	43,019	20,677	18,525	31,609	2,248
Total expenses	222,275	229,834	271,966	112,156	4,541
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	(10,047)	1,037	25,491	3,322	231
Other items	1,062	(429)	(239)	(157)	-
OPERATING INCOME (LOSS)	(8,985)	608	25,252	3,165	231
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	2,395	1,527	9,479	1,668	1,177
Loss from early extinguishment of debt	(355)	-	-	-	-
Other	904	9,742	-	(531)	-
Total nonoperating items	2,944	11,269	9,479	1,137	1,177
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	(6,041)	11,877	34,731	4,302	1,408
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	-	-	-	-	-
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ (6,041)	$ 11,877	$ 34,731	$ 4,302	$ 1,408
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ (7,529)	$ 27,003	$ 33,479	$ 6,169	$ 1,970
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	152	145	50	(2,385)	37
INCREASE (DECREASE) NET ASSETS	(7,377)	27,148	33,529	3,784	2,007
NET ASSETS, Beginning of year	(112,571)	27,924	61,381	156,711	14,348
NET ASSETS, End of year	$ (119,948)	$ 55,072	$ 94,910	$ 160,495	$ 16,355

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(In thousands)

	Trinity Health Consolidated Labs	Trinity Health Warde Lab LLC	Trinity Specialty Pharmacy	Global Health Ministry	St. Joseph's Health System, Inc., Atlanta, Georgia
Operating revenue:					
Net patient service revenue	$ -	$ -	$ -	$ -	$ 3,408
Other	58,394	779	78,713	3,390	26,433
Total operating revenue	58,394	779	78,713	3,390	29,841
Expenses:					
Labor costs	10,624	-	1,790	1,531	23,628
Purchased services and medical claims	25,396	-	162	97	3,851
Depreciation, amortization and interest	1,362	318	324	-	1,803
Other	21,094	1	75,479	1,551	4,214
Total expenses	58,476	319	77,755	3,179	33,496
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	(82)	460	958	211	(3,655)
Other items	-	-	-	-	(106)
OPERATING INCOME (LOSS)	(82)	460	958	211	(3,761)
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	461	529	419	544	24,723
Loss from early extinguishment of debt	-	-	-	-	-
Other	-	-	-	(8)	(165)
Total nonoperating items	461	529	419	536	24,558
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	379	989	1,377	747	20,797
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	-	-	-	-	-
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ 379	$ 989	$ 1,377	$ 747	$ 20,797
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ 30	$ 989	$ 1,377	$ 751	$ 20,952
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	-	-	(1)	1	612
INCREASE (DECREASE) NET ASSETS	30	989	1,376	752	21,564
NET ASSETS, Beginning of year	5,819	11,556	5,747	4,689	481,855
NET ASSETS, End of year	$ 5,849	$ 12,545	$ 7,123	$ 5,441	$ 503,419

TRINITY HEALTH

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(In thousands)

	Mercy Care Center Chicago, Illinois	Trinity Health ACO, Inc.	Allegany Franciscan Ministries	Cadillac Foundation	Trinity Assurance, Ltd.
Operating revenue:					
Net patient service revenue	$ 265	$ -	$ -	$ -	$ -
Other	1,297	18,761	8,022	997	145,455
Total operating revenue	1,562	18,761	8,022	997	145,455
Expenses:					
Labor costs	2,225	-	1,051	-	-
Purchased services and medical claims	446	19,038	1,168	-	808
Depreciation, amortization and interest	806	-	10	-	-
Other	460	2	5,793	997	144,647
Total expenses	3,937	19,040	8,022	997	145,455
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	(2,375)	(279)	-	-	-
Other items	-	-	-	-	-
OPERATING INCOME (LOSS)	(2,375)	(279)	-	-	-
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	450	259	2,511	-	-
Loss from early extinguishment of debt	-	-	-	-	-
Other	-	-	-	-	-
Total nonoperating items	450	259	2,511	-	-
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	(1,925)	(20)	2,511	-	-
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	-	-	-	-	-
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ (1,925)	$ (20)	$ 2,511	$ -	$ -
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ 6,709	$ (20)	$ 2,491	$ -	$ -
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	1	-	20	-	-
INCREASE (DECREASE) NET ASSETS	6,710	(20)	2,511	-	-
NET ASSETS, Beginning of year	(4,024)	(2,314)	108,321	9,531	22,789
NET ASSETS, End of year	$ 2,686	$ (2,334)	$ 110,832	$ 9,531	$ 22,789

TRINITY HEALTH

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(In thousands)

	Investment in Baycare Health System	Other Subsidiaries	System Office	Eliminations	**TRINITY HEALTH**
Operating revenue:					
Net patient service revenue	$ -	$ -	$ 8,036	$ (8,885)	**$ 18,521,694**
Other	-	8,136	2,346,860	(2,493,717)	**3,065,024**
Total operating revenue	-	8,136	2,354,896	(2,502,602)	**21,586,718**
Expenses:					
Labor costs	-	(1)	924,658	(297,350)	**11,992,393**
Purchased services and medical claims	-	24	472,527	(1,267,657)	**2,925,846**
Depreciation, amortization and interest	-	2	422,403	(388,133)	**1,120,681**
Other	-	(909)	421,064	(532,238)	**5,835,758**
Total expenses	-	(884)	2,240,652	(2,485,378)	**21,874,678**
OPERATING INCOME (LOSS) BEFORE OTHER ITEMS	-	9,020	114,244	(17,224)	**(287,960)**
Other items	-	-	10,757	(2)	**(143,702)**
OPERATING INCOME (LOSS)	-	9,020	125,001	(17,226)	**(431,662)**
NONOPERATING ITEMS:					
Investment earnings (losses) and interest rate swaps	409,428	(3,718)	241,586	17,062	**1,167,220**
Loss from early extinguishment of debt	-	-	177	-	**(178)**
Other	-	-	(108,920)	(9)	**302,061**
Total nonoperating items	409,428	(3,718)	132,843	17,053	**1,469,103**
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	409,428	5,302	257,844	(173)	**1,037,441**
LESS EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	-	-	-	(112)	**(77,721)**
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES - Net of noncontrolling interest	$ 409,428	$ 5,302	$ 257,844	$ (285)	**$ 959,720**
CHANGES IN NET ASSETS					
INCREASE (DECREASE) NET ASSETS WITHOUT DONOR RESTRICTIONS	$ 424,976	$ (159,694)	$ 206,385	$ 2,413	**$ 1,359,232**
INCREASE (DECREASE) NET ASSETS WITH DONOR RESTRICTIONS	2,020	136	(5)	(2,405)	**69,462**
INCREASE (DECREASE) NET ASSETS	426,996	(159,558)	206,380	8	**1,428,694**
NET ASSETS, Beginning of year	3,974,912	(92,152)	942,880	(62,198)	**16,897,308**
NET ASSETS, End of year	$ 4,401,908	$ (251,710)	$ 1,149,260	$ (62,190)	**$ 18,326,002**