Form AG-CBP-1
Rev 09/21

KWAME RAOUL
ATTORNEY GENERAL

Annual Non Profit Hospital Community Benefits Plan Report

Name of Hospital Reporting: RIVERSIDE MEDICAL CENTER

Mailing Address: 350 N. WALL STREET (Street Address/P.O. Box) KANKAKEE, IL 60901 (City, State, Zip)

Physical Address (if different than mailing address):

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

Reporting Period: 01 / 01 / 2024 (Month Day Year) **through** 12 / 31 / 2024 (Month Day Year) **Taxpayer Number:** 36-2414944

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 #

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. $1,771,585

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		$ 136,835
Financial Assistance		$ 1,927,000
Government Sponsored		$ 3,429,363
Donations		$ 175,290
Volunteer Services		
a) Employee Volunteer Services	$ -	
b) Non-Employee Volunteer Services	$ 240,772	
c) Total (add lines a and b)		$ 240,772
Education		$ 140,250
Government-sponsored program services		$ -
Research		$ -
Subsidized health services		$ 48,213,914
Bad debts		$ 12,618,680
Other Community Benefits		$ 1,507

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.

PATRICIA K. VILT, CFO
Name/ Title (Please Print)

Signature

(815) 935-7542
Phone: Area Code/ Telephone No.

6/27/25
Date.

PATRICIA K. VILT
Name of Person Completing Form

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