18-022

[ORIGINAL]

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
AUG 3 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Advocate South Suburban Hospital – Surgical, Procedural & Cardiovascular Modernization
Street Address:	17800 South Kedzie Avenue
City and Zip Code:	Hazel Crest 60429
County: Cook	Health Service Area: 7 Health Planning Area: A-04

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

Exact Legal Name:	Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital
Street Address:	17800 South Kedzie Avenue
City and Zip Code:	Hazel Crest, IL 60429
Name of Registered Agent:	Michael Kerns
Registered Agent Street Address:	3075 Highland Parkway
Registered Agent City and Zip Code:	Downers Grove, IL 60515
Name of President:	Richard Heim
President Street Address:	4440 W. 95th Street
President City and Zip Code:	Oak Lawn, IL 60453
President Telephone Number:	(708) 684-5010

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Daniel Doherty
Title:	Vice President, Operations
Company Name:	Advocate South Suburban Hospital
Address:	17800 S. Kedzie Avenue, Hazel Crest, IL 60429
Telephone Number:	(773) 967-5155
E-mail Address:	Daniel.Doherty@advocatehealth.com
Fax Number:	(708) 213-0100

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

Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health Care
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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City and Zip Code:	Hazel Crest, IL 60429
County: Cook	Health Service Area: 7 Health Planning Area: A-04

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

Exact Legal Name: Advocate Health Care Network
Street Address: 3075 Highland Parkway, Suite 600
City and Zip Code: Downers Grove, IL 60515
Name of Registered Agent: Michael Kerns
Registered Agent Street Address: 3075 Highland Parkway
Registered Agent City and Zip Code: Downers Grove, IL 60515
Name of Chief Executive Officer: James H. Skogsbergh
Chief Executive Officer Street Address: 3075 Highland Parkway, Suite 600
Chief Executive Officer City and Zip Code: Downers Grove, IL 60515
Chief Executive Officer Telephone Number: (630) 572-9393

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
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Facility/Project Identification

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City and Zip Code:	Hazel Crest, IL 60429
County: Cook	Health Service Area: 7 Health Planning Area: A-04

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

Exact Legal Name: Advocate Aurora Health, Inc.
Street Address: 750 W. Virginia
City and Zip Code: Milwaukee, WI 53204
Name of Registered Agent: The Corporation Trust Company
Registered Agent Street Address: Corporation Trust Center 1209 Orange Street
Registered Agent City and Zip Code: Wilmington, DE 19801
Name of Co-Chief Executive Officer: James H. Skogsbergh
Chief Executive Officer Street Address: 3075 Highland Parkway, Suite 600
Chief Executive Officer City and Zip Code: Downers Grove, IL 60515
Chief Executive Officer Telephone Number: (630) 572-9393
Name of Co-Chief Executive Officer: Nick Turkal, MD
Chief Executive Officer Street Address: 750 W. Virginia
Chief Executive Officer City and Zip Code: Milwaukee, WI 53204
Chief Executive Officer Telephone Number: (414) 299-1763

Type of Ownership of Applicants

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

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E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Post Permit Contact

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

Name:	Scott Nelson
Title:	Vice President, Planning, Design & Construction
Company Name:	Advocate Health Care
Address:	3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Telephone Number:	(630) 929-5575
E-mail Address:	Scott.Nelson@advocatehealth.com
Fax Number:	(630) 990-4798

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital

Address of Site Owner: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

Street Address or Legal Description of the Site: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital

Address of Site Owner: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☐ Substantive

☒ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital (South Suburban, Hospital), Advocate Health Care Network, and Advocate Aurora Health, Inc., the applicants, propose a Modernization Project for the Hospital located at 17800 South Kedzie Avenue, Hazel Crest, IL, 60429.

The number of key rooms will only increase by two, from fifteen to seventeen. The number of Surgery operating rooms will not increase. Cardiac Catheterization will increase from two to three rooms and Endoscopy will increase from four to five rooms. The supporting Phase I and Phase 2 recovery rooms for surgery and cardiac catheterization will increase from thirteen, significantly under the code, to fifty. Endoscopy Phase 2 recovery will increase from seventeen to eighteen.

The Project will include relocating the following into a two-story addition:

- Surgery with nine operating rooms,
- Cardiac Catheterization with three procedure rooms,
- Recovery Suite with eleven Post Anesthesia Care stations and thirty-nine Phase II stations with shared recovery support space for the suite,
- Central Sterile Processing Department.

Modernization will involve the following clinical areas:

- Endoscopy Department with five procedure rooms
- Endoscopy Phase II Prep and Recovery with eighteen stations

Various non-clinical areas will be modernized including:

- Medical Staff and Surgery Offices
- Staff Facilities and On Call Rooms
- Education
- Building System, Support and Air Handling Units
- Administrative Offices
- Lobby, Waiting, Registration and Security Areas
- Corridors, Stairs, Elevators and the Loading Dock
- Materials Management

The Project is expected to cost $97,630,432 with 90,842 square feet of new construction and 36,962 square feet that will be modernized. The building is designed for high efficiency in delivery of patient care as well as energy efficiency and long-term durability of infrastructure. The anticipated completion date is December 31, 2021.

The Project is classified non-substantive. The Project does not meet the criteria to be substantive because it is not building or replacing the facility. It does not offer a new category of care. It does not change the bed capacity.

Project Costs and Sources of Funds

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

PROJECT COSTS AND SOURCES OF FUNDS

COST	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	$ 491,904	$ 386,496	$ 878,400
Site Survey and Soil Investigation	$ 64,736	$ 50,864	$ 115,600
Site Preparation	$ 1,145,518	$ 900,050	$ 2,045,568
Off Site Work	0	0	0
New Construction Contracts	$ 25,919,027	$ 18,277,465	$ 44,196,492
Modernization Contracts	$ 1,679,210	$ 5,880,210	$ 7,559,420
Contingencies	$ 1,701,073	$ 731,536	$ 2,432,609
Architectural/Engineering Fees	$ 1,555,142	$ 1,249,684	$ 2,804,826
Consulting and Other Fees	$ 2,856,967	$ 2,214,894	$ 5,071,861
Movable or Other Equipment (not in construction contracts)	$ 23,095,644	$ 854,439	$ 23,950,083
Bond Issuance Expense (project related)	$ 400,400	$ 314,600	$ 715,000
Net Interest Expense During Construction (project related)	$ 2,247,562	$ 1,765,942	$ 4,013,504
Fair Market Value, Leased Space, Equipment	0	0	0
Other Costs to Be Capitalized	$ 2,769,484	$ 1,077,585	$ 3,847,069
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL COST	$ 63,926,667	$ 33,703,765	$ 97,630,432
SOURCE	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	$ 32,710,792	$ 17,245,961	$ 49,956,753
Bond Issues (project related)	$ 31,215,875	$ 16,457,804	$ 47,673,679
TOTAL SOURCES	$ 63,926,667	$ 33,703,765	$ 97,630,432

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): 12/31/2021

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

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

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

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

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Advocate South Suburban Hospital		**CITY: Hazel Crest, IL**			
REPORTING PERIOD DATES:		**From: 01/01/17**		**to: 12/31/17**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	197	7,599	36,173	0	197
Obstetrics	16	889	2,036	0	16
Pediatrics	0	0	0	0	0
Intensive Care	20	1,382	5,519	0	20
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
49431 Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	474	5,703	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	233	10,344	49,431	0	233

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

James H Skogsbergh
SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1 day of August 2018

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

SIGNATURE

William Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1 day of August 2018

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

11

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

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Richard Heim
SIGNATURE

SIGNATURE

Richard Heim
PRINTED NAME

William P. Santulli
PRINTED NAME

Primary Service Area President
PRINTED TITLE

Executive Vice President/COO
PRINTED TITLE

Janet M. Hood
Signature of Notary

Seal

JANET M. HOOD
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 10, 2018

Signature of Notary

Seal

Subscribed and sworn before me
this 4th day of June, 2018.

*Insert the EXACT legal name of the applicant

CERTIFICATION

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SIGNATURE	SIGNATURE
Richard Heim PRINTED NAME	William Santulli PRINTED NAME
Primary Service Area President South Chicagoland and Central Illinois PRINTED TITLE	Chief Operating Officer PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 30 day of May 2018
Signature of Notary	Signature of Notary
Seal	Seal OFFICIAL SEAL CRISTIN G FOSTER NOTARY PUBLIC, STATE OF ILLINOIS My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

CERTIFICATION

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James H. Skogsbergh
SIGNATURE

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PRINTED NAME

President and CEO
PRINTED TITLE

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Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
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NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 1 day of August 2018

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report. APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

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

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

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

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

E. Criterion 1110.225 - Cardiac Catheterization

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Cardiac Catheterization		

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

1. Criterion 1110.225(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110. 225(b), Establishment or Expansion of Cardiac Catheterization Service

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.225(c), Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within 90 minutes travel time that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.225(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 1110.225(e), Support Services

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not near, explain why.

7. Criterion 1110.225(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. Criterion 1110.225(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.225(l), Multi-institutional Variance

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 23 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
		1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
		2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
		3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
		4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
		5) For any option to lease, a copy of the option, including all

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

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information

regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

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

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

SECTION XI. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

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

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

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	30-40
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17	Assurances	83-84
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~~19~~	~~Medical Surgical Pediatrics, Obstetrics, ICU~~	-
~~20~~	~~Comprehensive Physical Rehabilitation~~	-
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~~24~~	~~In-Center Hemodialysis~~	-
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~~26~~	~~Selected Organ Transplantation~~	-
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	Financial and Economic Feasibility:	
34	Availability of Funds	125-149
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See Appendix for audited financials.

Type of Ownership of Applicants

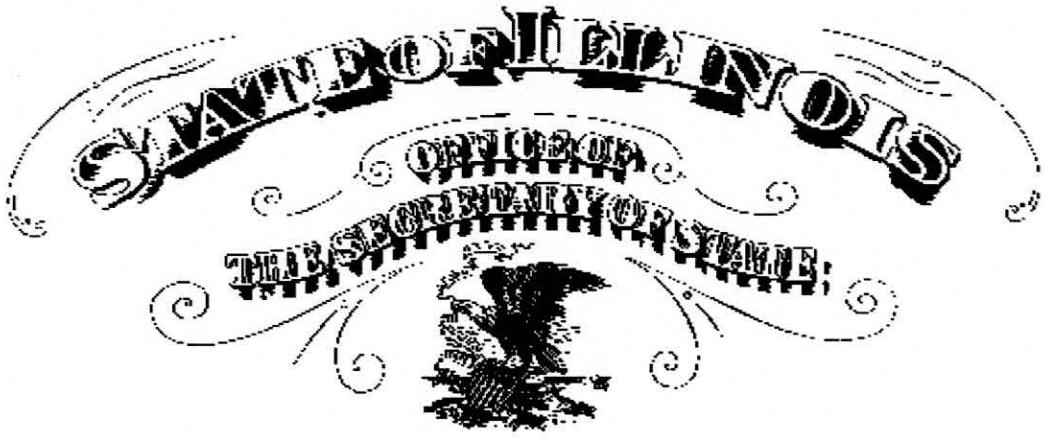
☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment #1, Exhibits 1, 2, and 3.

File Number 1707-692-2



To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

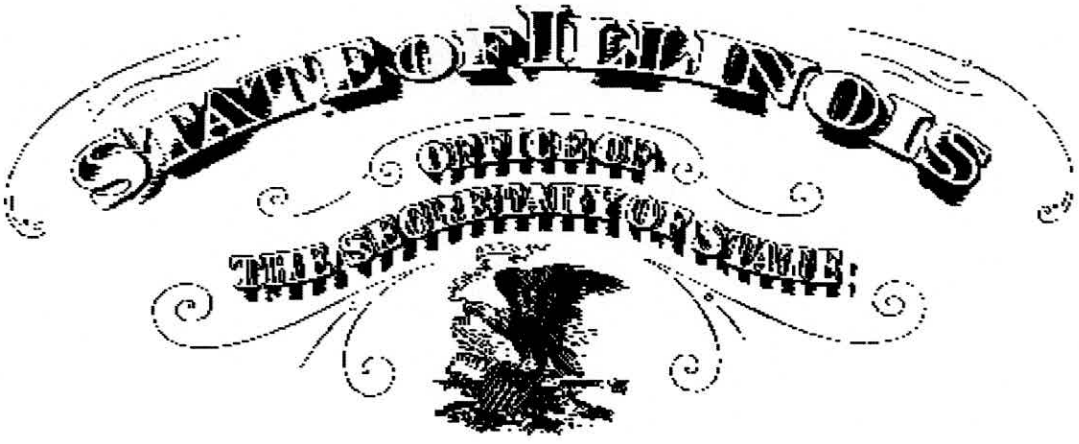
Authentication #: 1814100660 verifiable until 05/21/2019
Authenticate at: http://www.cyberdrivеillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* MAY ***A.D.*** 2018 .

Jesse White

SECRETARY OF STATE

File Number 1004-695-5



To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1812701538 verifiable until 05/07/2019
Authenticate at: http://www.cyberdrivеillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 7TH *day of* MAY *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

7/31/2018 6:24:28PM

File Number: 6645600
Incorporation Date / Formation Date: 12/4/2017
Entity Name: ADVOCATE AURORA HEALTH, INC.
Entity Kind: Corporation
Entity Type: Exempt
Residency: Domestic
State: DELAWARE
Status: Good Standing
Status Date: 12/4/2017

Registered Agent Information

Name: THE CORPORATION TRUST COMPANY
Address: CORPORATION TRUST CENTER 1209 ORANGE ST
City: WILMINGTON
Country:
State: DE
Postal Code: 19801
Phone: 302-658-7581

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

APRIL 3, 2018 **7155-851-7**

CT CORPORATION SYSTEM
118 W EDWARDS #200
SPRINGFIELD IL 62704

RE ADVOCATE AURORA HEALTH, INC.

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE AUTHORITY OF THE ABOVE NAMED CORPORATION TO CONDUCT AFFAIRS IN THIS STATE.

PAYMENT OF THE FILING FEE IS HEREBY ACKNOWLEDGED.

CERTAIN NOT FOR PROFIT CORPORATIONS ORGANIZED AS A CHARITABLE CORPORATION ARE REQUIRED TO REGISTER WITH THE OFFICE OF THE ATTORNEY GENERAL. UPON RECEIPT OF THE ENCLOSED AUTHORITY, YOU MUST CONTACT THE CHARITABLE TRUST DIVISION, OFFICE OF THE ATTORNEY GENERAL, 100 W. RANDOLPH, 3RD FLOOR, CHICAGO, ILLINOIS 60601, TELEPHONE (312) 814-2595.

SINCERELY,

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

FORM NFP 113.15 (rev. Dec. 2003)
APPLICATION FOR AUTHORITY TO CONDUCT AFFAIRS IN ILLINOIS (Foreign Corporations)
General Not For Profit Corporation Act

Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1834
www.cyberdriveillinois.com

Remit payment in the form of a cashier's check, certified check, money order or an Illinois attorney's or CPA's check payable to Secretary of State.

FILED

APR 0 3 2018

JESSE WHITE
SECRETARY OF STATE

File # 7155-8517 Filing Fee: $50 Approved: BC

----- Submit in duplicate ----- Type or Print clearly in black ink ----- Do not write above this line -----

1. a. Corporate Name: Advocate Aurora Health, Inc.

   b. Assumed Corporate Name (Complete only if the new corporate name is not available in this state.):

   By electing this assumed name, the Corporation hereby agrees NOT to use its corporate name in the transaction of business in Illinois. Form NFP 104.15 is attached.

2. a. State or Country of Incorporation: Delaware

   b. Date of Incorporation: December 4, 2017

   c. Period of Duration: Permanent

3. a. Address of Principal Office, wherever located: 3075 Highland Pkwy.,
   Downers Grove, IL 60515-1206

   b. Address of Principal Office in Illinois: 3075 Highland Pkwy.,
   Downers Grove, IL 60515-1206

4. Name and Address of Registered Agent and Registered Office in Illinois:

   Registered Agent: Earl J. Barnes II
   (First Name / Middle Name / Last Name)

   Registered Office: 3075 Highland Pkwy Suite 600
   (Number / Street / Suite # (P.O. Box alone is unacceptable))

   Downers Grove 60515 DuPage County
   (City / ZIP Code / County)

5. States and Countries in which Corporation is admitted or qualified to conduct affairs: Wisconsin (application pending)

6. Names and respective addresses of Corporation's officers and directors:

	Street Address	City State ZIP
President See attached		
Secretary		
Director		
Director		
Director		

If there are additional officers or more than three directors, please attach list.

Printed by authority of the State of Illinois. January 2015 - 1 - C 160.15

7. Purpose(s) for which the Corporation is organized and proposes to pursue in the conduct of affairs in this State:
For more space, attach additional sheets of this size.

See attached.

8. This application must be accompanied by an originally certified copy of the Articles of Incorporation and any amendments or mergers, duly authenticated within the last 90 days by the proper officer of the state or country wherein the corporation is incorporated.

9. The undersigned Corporation has caused this statement to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct. All signatures must be in **BLACK INK.**

Dated April 1, 2018 (Month, Day), 2018 (Year)

Advocate Aurora Health, Inc.
Exact Name of Corporation

Any Authorized Officer's Signature

Michael Lappin, Secretary
Name and Title (type or print)

Legal

A Corporation that is to function as a club, as defined in Section 1-3.24 of the Liquor Control Act of 1934, must insert in its purpose clause a statement that it will comply with the State and local laws and ordinances relating to alcoholic liquors.

7155-8517

ATTACHMENT TO APPLICATION FOR AUTHORITY TO CONDUCT BUSINESS IN ILLINOIS (FORM NFP 113.15) FOR ADVOCATE AURORA HEALTH, INC.

Section 6: NAMES AND ADDRESSES OF DIRECTORS AND OFFICERS

Officers:

Office/Name	Address
Co-CEO - James H. Skogsbergh	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Co-CEO - Nick W. Turkal, M.D.	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Treasurer – Dominic Nakis	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Secretary – Michael Lappin	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Chair – Joanna Disch	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Chair Elect – Michele Baker Richardson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515

4835-2888-4064.2

7155 8517

Directors:

Name	Address
Michele Baker Richardson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
John F. Timmer	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Lynn Y. Crump-Caine	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
K. Richard Jakle	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Mark M. Harris	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
David B. Anderson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
James H. Skogsbergh	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Joanne Disch	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
John W. Daniels, Jr.	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Joanne B. Bauer	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Charles Harvey	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Rick Weiss	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Thomas Bolger	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Nick W. Turkal	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515

4835-2888-4064.2

7155-8517

Section 7: PURPOSE(S) FOR WHICH THE CORPORATION IS ORGANIZED AND PROPOSES TO PURSUE IN THE CONDUCT OF AFFAIRS IN THIS STATE:

The Corporation is organized and shall be operated exclusively for charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provisions of any future United States Internal Revenue Law) (hereinafter the "**Code**"); and limited as further provided in its Certificate of Incorporation. Specifically, the Corporation is organized and shall be operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of its supported organizations, as listed below (the "**Supported Organizations**"). The Corporation is organized and operated as a Type III functionally integrated supporting organization as defined in section 509(a)(3) of the Code and Treas. Reg. Section 1.509(a)-4(i). The Corporation is organized for the purpose of serving as the parent organization of the Supported Organizations and shall exercise direction over the policies, programs and activities of the Supported Organizations. The Corporation shall engage in activities relating to the purposes described above, and invest in, receive, hold, use, and dispose of all property, real or personal, as may be necessary or desirable to carry into effect such purposes. The Corporation is formed as a result of the affiliation of Advocate Health Care Network, an Illinois nonprofit corporation ("**Advocate**") and Aurora Health Care, Inc., a Wisconsin nonstock corporation ("**Aurora**"), in accordance with the terms and conditions of that certain Affiliation Agreement between Advocate and Aurora dated December 4, 2017 (the "**Affiliation Agreement**").

The Corporation's Supported Organizations, which are described in Section 509(a)(1) or Section 509(a)(2) of the Code, are as follows:

- Advocate Health and Hospitals Corporation
- EHS Home Health Care Services, Inc.
- Advocate Charitable Foundation
- Advocate North Side Health Network
- Meridian Hospice
- Advocate Condell Medical Center
- Advocate Sherman Hospital
- Sherman West Court
- Visiting Nurse Association of Wisconsin, Inc.
- Aurora UW Academic Medical Group
- Aurora Health Care Central, Inc.
- Aurora Psychiatric Hospital, Inc.
- Aurora Medical Center of Washington County, Inc.
- Aurora Health Care North, Inc.
- West Allis Memorial Hospital, Inc.
- Aurora Family Service, Inc.
- Aurora Medical Center of Oshkosh, Inc.
- Aurora Medical Group, Inc.
- Kradwell School, Inc.
- Aurora Advanced Healthcare, Inc.

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7155-8517

- Aurora Health Care Metro, Inc.
- Aurora Health Care Southern Lakes, Inc.
- AMG Illinois, Ltd.
- Aurora Medical Center Grafton

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital
Address of Site Owner: 17800 South Kedzie Avenue, Hazel Crest, IL 60429
Street Address or Legal Description of the Site: 17800 South Kedzie Avenue, Hazel Crest, IL 60429 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment #2, Exhibit 1.

Advocate Health Care

3075 Highland Parkway, Suite 600 || Downers Grove, Illinois 60515 || T 630.572.9393|| advocatehealth.com

June 4, 2018

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

RE: Advocate South Suburban Hospital
Surgical, Procedural, and Cardiovascular Modernization

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate Health and Hospitals Corporation owns the Advocate South Suburban Hospital site.

We trust this attestation complies with the State Agency Proof of Ownership requirement indicated in the Application for Permit – March 2018 edition.

Respectfully,

Bill Santulli
Chief Operating Officer
Advocate Health & Hospitals Corporation

Notarization:

Subscribed and sworn to before me
This 30 day of May, 2018.

(Seal of Notary)

Cristin G. Foster
Signature of Notary Public

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

Operating Identity/Licensee

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

Exact Legal Name of Site Owner: Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital

Address of Site Owner: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Certificates of Good Standing for Advocate Health and Hospital Corporation d/b/a Advocate South Suburban Hospital, Advocate Health Care Network and Advocate Aurora Health, Inc. are appended as Attachment #3, Exhibits 1, 2, and 3.

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* MAY ***A.D.*** 2018 .

Authentication #: 1814100660 verifiable until 05/21/2019
Authenticate at: http://www.cyberdrivelllinois.com

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 7TH *day of* MAY ***A.D.*** 2018 .

Authentication #: 1812701538 verifiable until 05/07/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

7/31/2018 6:24:28PM

File Number:	6645600	Incorporation Date / Formation Date:	12/4/2017
Entity Name:	ADVOCATE AURORA HEALTH, INC.		
Entity Kind:	Corporation	Entity Type:	Exempt
Residency:	Domestic	State:	DELAWARE
Status:	Good Standing	Status Date:	12/4/2017

Registered Agent Information

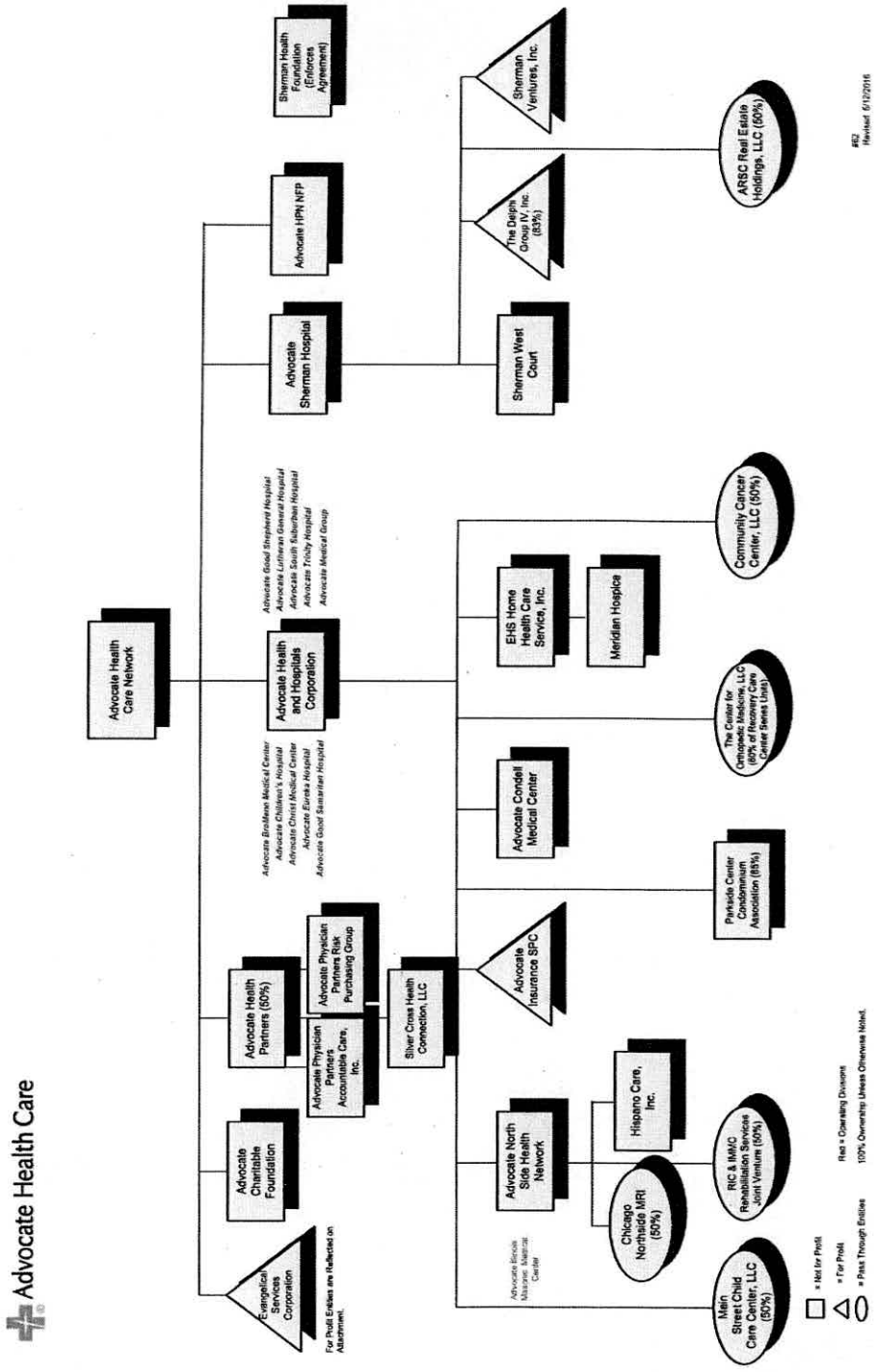
Name:	THE CORPORATION TRUST COMPANY		
Address:	CORPORATION TRUST CENTER 1209 ORANGE ST		
City:	WILMINGTON	Country:	
State:	DE	Postal Code:	19801
Phone:	302-658-7581		

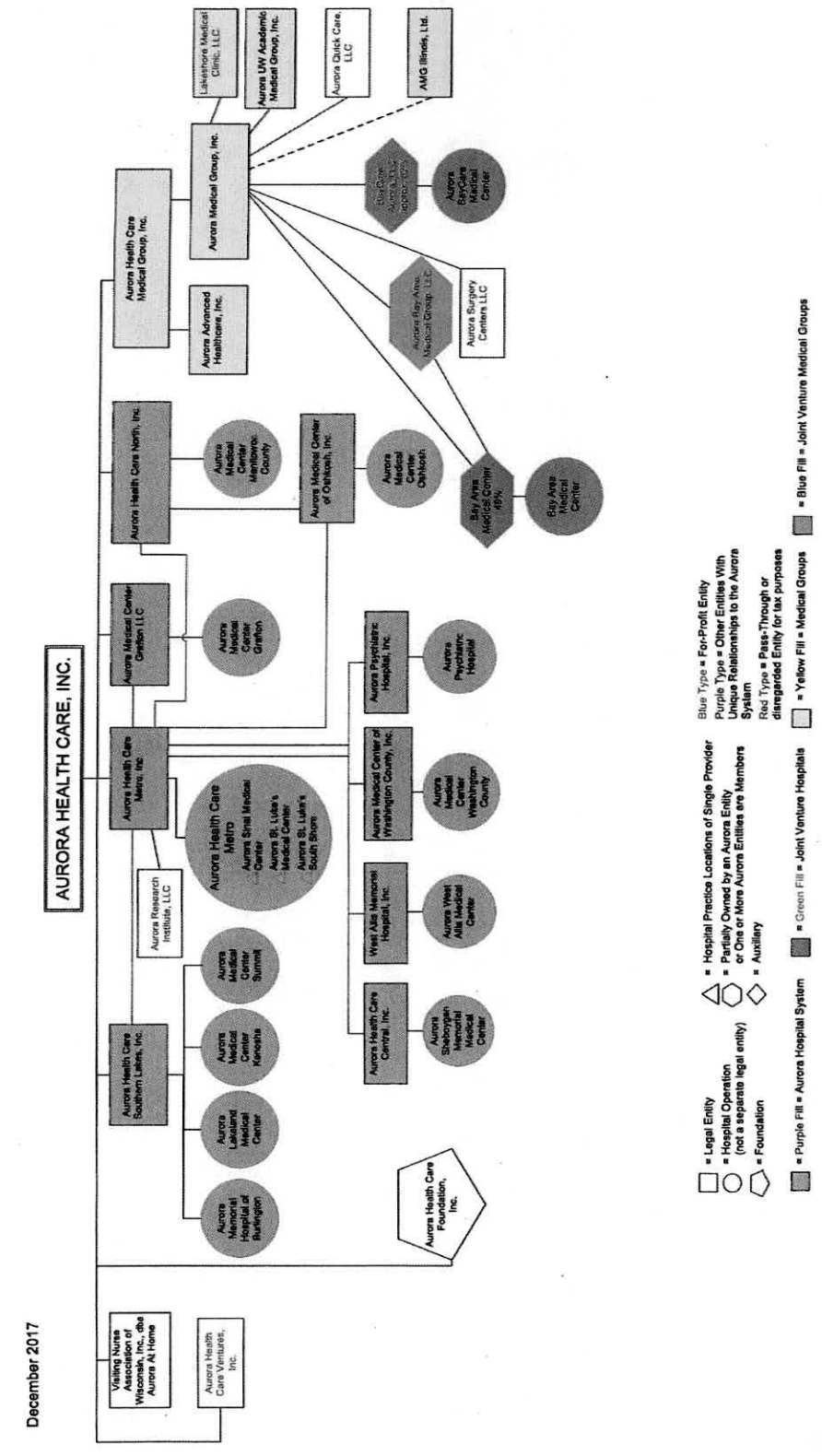
Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

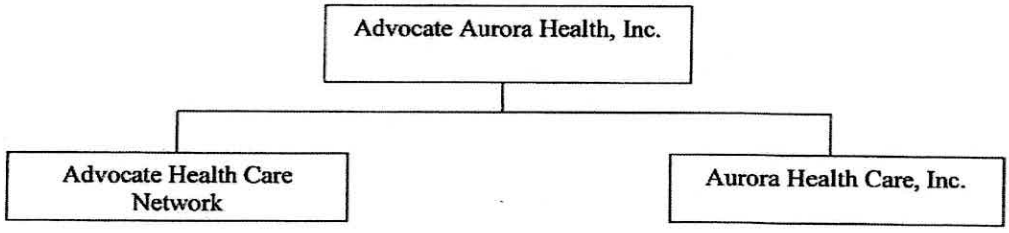
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment # 4, Exhibits 1, 2, and 3 show the legacy organizations Advocate Health Care Network and Aurora Health Care, Inc. that came together as Advocate Aurora Health, Inc.


Advocate Health Care
Advocate Health Care Network
Advocate Health and Hospitals Corporation
Advocate Sherman Hospital
Advocate HPN NFP
Sherman Health Foundation (Enforces Agreement)
Sherman West Court
The Depm Group IV, Inc. (83%)
Sherman Ventures, Inc.
ARSC Real Estate Holdings, LLC (50%)
Community Cancer Center, LLC (50%)
EHS Home Health Care Service, Inc.
Meridian Hospice
The Center for Cardiovascular Medicine, LLC (50% of Income/Loss) (Center Owns 1 Unit)
Advocate Condell Medical Center
Parkside Center Condominium Association (85%)
Advocate Insurance SPC
Silver Cross Health Connection, LLC
Advocate Physician Partners Risk Purchasing Group
Advocate Health Partners (50%)
Advocate Physician Partners Accountable Care, Inc.
Advocate Charitable Foundation
Evangelical Services Corporation
For Profit Entities are Reflected on Attachment.
Advocate North Side Health Network
Hispano Care, Inc.
Chicago Northside MRI (50%)
RIC & IMIC Rehabilitation Services Joint Venture (50%)
Main Street Child Care Center, LLC (50%)
Advocate BroMenn Medical Center
Advocate Children's Hospital
Advocate Christ Medical Center
Advocate Eureka Hospital
Advocate Good Samaritan Hospital
Advocate Good Shepherd Hospital
Advocate Lutheran General Hospital
Advocate South Suburban Hospital
Advocate Trinity Hospital
Advocate Medical Group
Advocate Bethany Maternal Center
Not for Profit
For Profit
Pass Through Entities
Red = Operating Divisions
100% Ownership Unless Otherwise Noted.
#82
Revised 6/12/2018


AURORA HEALTH CARE, INC.
December 2017
Visiting Nurse Association of Wisconsin, Inc., dba Aurora At Home
Aurora Health Care Ventures, Inc.
Aurora Health Care Foundation, Inc.
Aurora Health Care Southern Lakes, Inc.
Aurora Memorial Hospital of Burlington
Aurora Lakeland Medical Center
Aurora Medical Center Kenosha
Aurora Medical Center Summit
Aurora Research Institute, LLC
Aurora Health Care Metro, Inc.
Aurora Health Care Metro
Aurora Sinai Medical Center
Aurora St. Luke's Medical Center
Aurora St. Luke's South Shore
Aurora Health Care Central, Inc.
Aurora Sheboygan Memorial Medical Center
West Allis Memorial Hospital, Inc.
Aurora West Allis Medical Center
Aurora Medical Center of Washington County, Inc.
Aurora Medical Center Washington County
Aurora Psychiatric Hospital, Inc.
Aurora Psychiatric Hospital
Aurora Medical Center Grafton, LLC
Aurora Medical Center Grafton
Aurora Health Care North, Inc.
Aurora Medical Center Manitowoc County
Aurora Medical Center of Oshkosh, Inc.
Aurora Medical Center Oshkosh
Bay Area Medical Center 49%
Bay Area Medical Center
Aurora Health Care Medical Group, Inc.
Aurora Advanced Healthcare, Inc.
Aurora Medical Group, Inc.
Lakeshore Medical Clinic, LLC
Aurora UW Academic Medical Group, Inc.
Aurora Quick Care, LLC
AMG Illinois, Ltd.
Bay Ridge Aurora, LLC (60%)
Aurora Bayshore Medical Center
Aurora Bay Area Medical Group, LLC
Aurora Surgery Centers LLC
= Legal Entity
= Hospital Operation (not a separate legal entity)
= Foundation
= Hospital Practice Locations of Single Provider
= Partially Owned by an Aurora Entity or One or More Aurora Entities are Members
= Auxiliary
Blue Type = For-Profit Entity
Purple Type = Other Entities With Unique Relationships to the Aurora System
Red Type = Pass-Through or disregarded Entity for tax purposes
= Purple Fill = Aurora Hospital System
= Green Fill = Joint Venture Hospitals
= Yellow Fill = Medical Groups
= Blue Fill = Joint Venture Medical Groups

POST-CLOSING ORGANIZATIONAL CHART



All of the Advocate Health Care Network ("Advocate") entities will remain under the Advocate corporate structure and all of the Aurora Health Care, Inc. ("Aurora") entities will remain under the Aurora corporate structure, shown on the previously included organizational charts for each of Advocate and Aurora.

Flood Plain Requirements

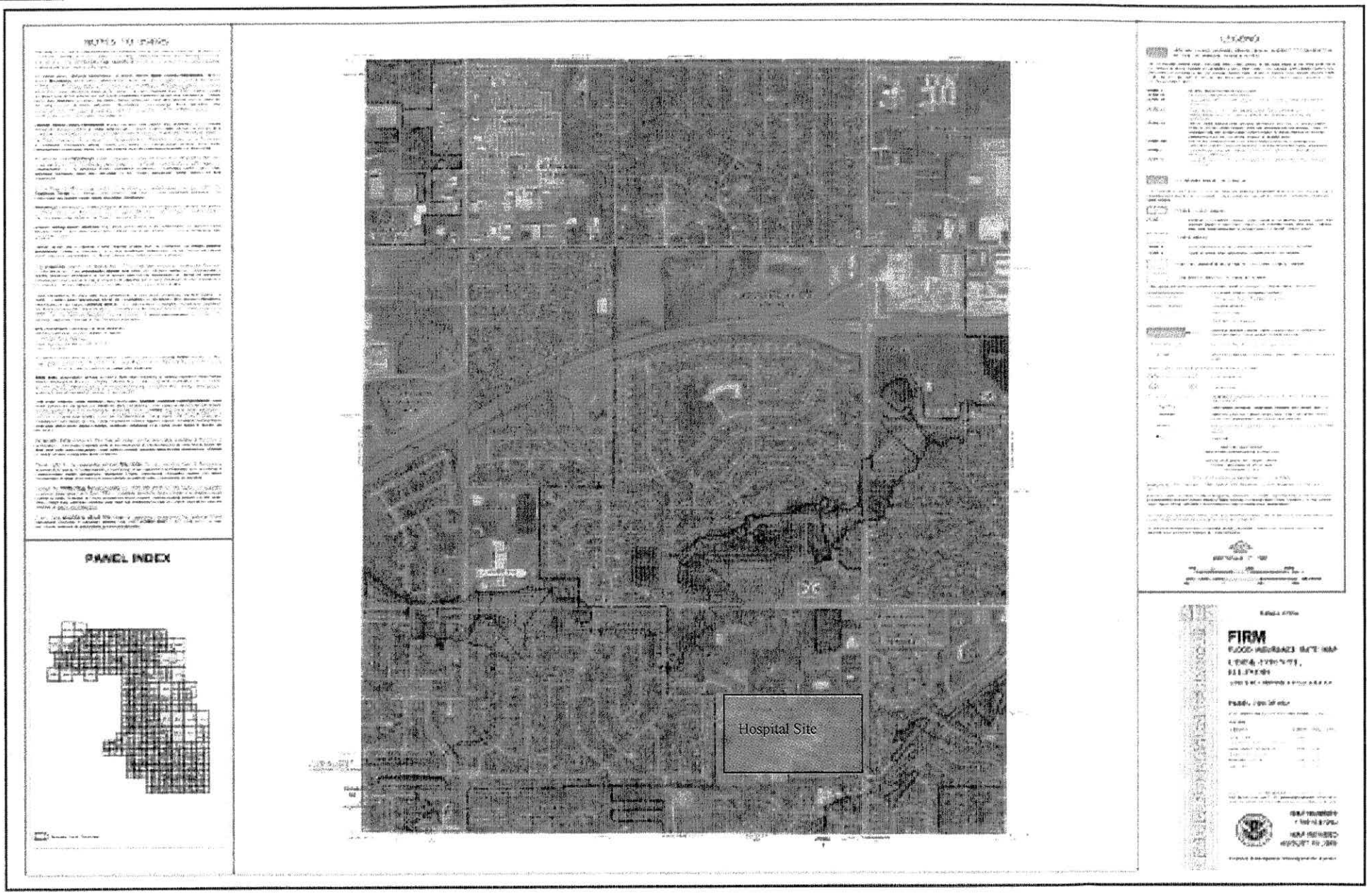
[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org. This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 5, Exhibit 1, is a map of the proposed location showing any identified flood plain areas.

Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital attests that the project is not in a flood plain and that the modernization related to the proposed surgical, procedural, and cardiovascular modernization categories of service complies with Flood Plain Rule under Illinois Order # 2005-5.


PANEL INDEX
Hospital Site
FIRM

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.
APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 6, Exhibit 1, is a letter from the Illinois Department of Natural Resources that demonstrates that no historic, architectural, or archaeological sites exist within the project area.

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of
Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor
Wayne A. Rosenthal, Director

FAX (217) 524-7525

Cook County
Hazel Crest
New Construction of 2 Story Addition and Modernization, Advocate South Suburban Hospital
17800 S. Kedzie Ave.
SHPO Log #014061318

July 9, 2018

Janet Hood
Advocate BroMenn Medical Center
P.O. Box 2850
Bloomington, IL 61702-2850

Dear Ms. Hood:

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

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

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

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

Project Costs and Sources of Funds

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

PROJECT COSTS

Cost Items	Clinical	Non-Clinical	PERMIT TOTAL
Pre-Planning	$ 491,904	$ 386,496	$ 878,400
Site and Facility Planning	$ 491,904	$ 386,496	
Site survey	$ 64,736	$ 50,864	$ 115,600
Soils Investigation	$ 29,288	$ 23,012	
Site Survey & Title	$ 4,480	$ 3,520	
Traffic / Parking Studies	$ 30,968	$ 24,332	
Site Preparation	$ 1,145,518	$ 900,050	$ 2,045,568
Prep Work (Demo, clearing, grading, shoring)	$ 145,000	$ 119,760	
Earthwork, drainage, stone, foundation prep	$ 210,000	$ 167,600	
Excavation, retention, backfill areas, ComEd dig	$ 490,000	$ 354,400	
Entry drop-off/pickup/drive/walkways/concrete	$ 300,518	$ 258,290	
Off-Site Work	$ 0-	$ 0-	$ 0-
New Construction (Various)	$ 25,919,027	$ 18,277,465	$ 44,196,492
Construction: Shell & Core	$ 10,367,611	$ 7,310,686	$ -
Construction: interior build-out	$ 15,551,416	$ 10,966,779	$ -
Modernization	$ 1,679,210	$ 5,880,210	$ 7,559,420
Construction: Modernization	$ 1,679,210	$ 5,880,210	$ -
Contingenies	$ 1,701,073	$ 731,536	$ 2,432,609
New construction - clinical	$ 1,565,984	$ -	$ -
New construction – non-clinical		$ 628,122	$ -
Mod construction - clinical	$ 135,089		$ -
Mod construction – non-clinical		$ 103,414	$ -
Architect/Eng Fees	$ 1,555,142	$ 1,249,684	$ 2,804,826
Consulting and Other Fees	$ 2,856,967	$ 2,214,894	$ 5,071,861
A/E CA work,	$ 814,900	$ 640,282	
LEED Arch /MEP Consultant	$ 13,400	$ 9,100	
CON Legal fees / Consultant	$ 4,880	$ 3,120	
CON Architect/Engineer Assistance	$ 68,000	$ 8,000	
Civil Engineering	$ 15,680	$ 12,320	
Third party code review / Village / IEPA / MWRD	$ 73,280	$ 64,720	
Interior Design	$ 125,328	$ 98,472	
Equipment Planner	$ 262,080	$ 205,920	
Parking consultant	$ 26,880	$ 21,120	

CON Fee	$ 106,400	$ 83,600	
IDPH Fee	$ 67,200	$ 52,800	
Misc. consults - Odell Hicks Audit	$ 24,640	$ 19,360	
Landscaping design	$ 25,760	$ 20,240	
Technology consultant	$ 72,184	$ 56,716	
Traffic Engineer	$ 36,400	$ 28,600	
Elevator consultant	$ 18,995	$ 14,924	
Wayfinding consultant	$ 49,280	$ 49,280	
Progress photos, virtual database	$ 42,560	$ 33,440	
Shielding Consultant	$ 43,120	$ 33,880	
IPD - ETIPS	$ 840,000	$ 660,000	
Vibration Consultant	$ 14,000	$ 11,000	
Other	$ 112,000	$ 88,000	
Movable / Equipment	$ 23,095,644	$ 854,439	$ 23,950,083
Sterile Processing	$ 2,002,557		
Loading dock		$ 64,439	
Endoscopy	$ 465,046		
Interventional Department	$ 8,542,298	$ -	
PACU	$ 1,086,047		
Prep Recovery	$ 3,015,209		
Surgical equipment	$ 7,027,032		
Other / equipment	$ 10,573	$ 790,000	
Installation / Freight/ Cont	$ 946,882		
Bond Issuance / Finance Expense	$ 400,400	$ 314,600	$ 715,000
Net Interest	$ 2,247,562	$ 1,765,942	$ 4,013,504
Fair Market Value of Lease	$ - 0	$ - 0	$ - 0
Other Costs to be Capitalized	$ 2,769,484	$ 1,077,585	$ 3,847,069
Contract project management	$ 229,400	$ 150,800	
Nurse stations	$ 140,000	$ -	
Infrastructure - Emergency Generator's Switch gear	$ 48,400	$ 21,600	
Utilities: ComEd, Gas, + Taps	$ 87,000	$ 71,000	
Exterior Signage	$ 84,000	$ 46,000	
Interior Signage	$ 148,900	$ 8,760	
Telecom Infrastructure / Core	$ 103,000	$ 12,300	
Telecom rm HVAC / UPS	$ 25,000	$ 1,850	
Telecom / Data Cabling / Misc	$ 164,000	$ 24,000	
IS Infrastructure / Core / Equipt	$ 98,000	$ 18,000	
Cabling Pac's & Imaging	$ 34,500	$ -	
PACS Hardware / Server / Station Equipment	$ 205,000	$ -	
Security System / Access control	$ 122,080	$ 95,920	
Landscaping	$ 110,000	$ 60,500	
Material testing	$ 64,000	$ 4,000	
Vibration Testing - STS	$ 87,000		
Copiers / Printers	$ 141,280	$ 16,000	
EVS Equipment	$ 98,000	$ 6,520	

Window treatments	$ 79,000	$ 8,700	
Art work	$ 40,000	$ 12,400	
Permit/Government Fees	$ 426,440	$ 335,060	
Winter Conditions	$ 234,484	$ 184,175	
Acquisition	0	0	0
TOTAL	**$ 63,926,667**	**$ 33,703,765**	**$ 97,630,432**
Sources of Funds	**Clinical**	**Non-Clinical**	**PERMIT Total**
Cash and Securities	$ 32,710,792	$ 17,245,961	$ 49,956,753
Debt Financing	$ 31,215,875	$ 16,457,804	$ 47,673,679
TOTAL	**$ 63,926,667**	**$ 33,703,765**	**$ 97,630,432**

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): 12/31/2021
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☒ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

No documentation needed.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

COST SPACE								
			Dept. Gross Square Feet		Proposed Total Gross Square Feet			
	Cost		Existing	Proposed	New Const.	Modern.	As is	Vacated
Reviewable								
Cardiac Catheterization	$	12,618,185	4,393	5,311	5,311	0	0	4,393
Surgical Operating Rooms	$	24,285,595	12,154	24,721	24,721	0	0	12,154
Recovery Suite (PACU and Phase 2)	$	14,520,244	7,406	17,370	17,370	0	0	7,406
Central Sterile Processing	$	9,210,870	2,494	13,865	12,008	0	1,857	637
Endoscopy	$	2,793,146	5,489	5,489	0	4,550	939	0
Endoscopy Prep/Recovery	$	498,627	7,187	7,187	0	983	6,204	0
Total Clinical	$	63,926,667	39,123	73,943	59,410	5,533	9,000	24,590
Non-Reviewable								
Med Staff & Surgery Offices, Support	$	3,078,107	868	9,312	0	9,312	0	0
Staff Facilities, On Call	$	421,704	2,351	3,553		1,202	2,351	0
Education	$	4,136,416	842	13,212	691	11,679	842	0
Building System/Support/AHUs	$	10,536,169	248	7,446	7,198	248	0	0
Administrative Offices / Support	$	1,133,444	4,857	8,232	0	3,375	4,857	0
Lobby, Waiting, Registration, Security	$	3,947,312	2,065	7,875	5,870	2,005	0	2,065
Corridors, Stairs, Elevators, Dock	$	9,947,276	5,190	20,099	16,491	3,608	0	2,800
Material Management	$	503,337	4,321	5,503	1,182	0	4,321	0
Total Non-Clinical	$	33,703,765	20,742	75,232	31,432	31,429	12,371	4,865
TOTAL	$	97,630,432	59,865	149,175	90,842	36,962	21,371	29,455

The vacated space will become:

Uses:	Gross Square Feet
Public Corridors	4,093
Education	10,840
Admin Offices / Support	3,375
Surgery Offices	2,296
On Call	1,202
Demo of Loading Dock	2,650
Existing entry	80
Medical staff offices/support	4,919
TOTAL	29,455

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

1. Health Care Facilities Owned and Operated by Advocate Health and Hospitals Corporation.

Attachment 11, Exhibit 1 is the listing of all the facilities owned by Advocate Health Care Network. Exhibit 2 is the current state hospital license for Advocate Health and Hospitals, d/b/a Advocate South Suburban Hospital. There are no other Illinois hospitals owned by Advocate Aurora Health, Inc. The most recent DNV accreditation certificate for the Hospital is included as Attachment 11, Exhibit 3.

2.Certified Listing of Any Adverse Action Against Any Facility Owned or Operated by the Applicant

By the signatures on the Certification pages, the applicants attest there have been no adverse actions against any facility owned and/or operated by Advocate Health Care Network, Advocate Health and Hospitals Corporation, and Advocate Aurora Health, Inc. as demonstrated by compliance with the CMS Conditions of Participation with Medicare and Medicaid, during the three years prior to the filing of this application.

3.**Authorization Permitting HFPB and DPH to Access Necessary Documentation**

Advocate Health and Hospitals Corporation, Advocate Health Care Network, and Advocate Aurora Health, Inc. hereby authorize the Health Facilities and Services Review Board and the Department of Public Health to access information in order to verify any documentation or

information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

4. **for Filing Multiple Certificates of Need in One Year**

Not applicable. This is the first certificate of need filed by Advocate Health and Hospitals in 2018.

Facility	Location	License No.	DNV Accreditation No.
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	0004697	195597-2016-AQ-USA-RvA

Additional hospitals owned and operated as a part of Advocate Health Care Network.

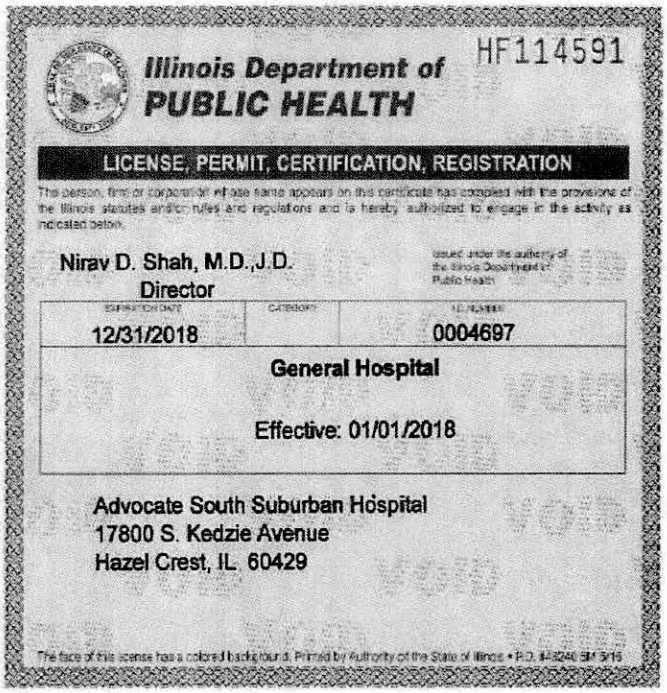
Facility	Location	License No.	DNV Accreditation No.
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	0005645	195600-2016-AQ-USA-RvA
Advocate Christ Medical Center	4440 W. 95th St. Oak Lawn, IL	0000315	197946-2016-AHC-USA-NIAHO
Advocate Condell Medical Center	801 S. Milwaukee Ave. Libertyville, IL	0005579	211487-2016-AHC-USA-NIAHO
Advocate Eureka Hospital	101 S. Major Eureka, IL	0005652	195598-2016-AQ-USA-RvA
Advocate Good Samaritan Hospital	3815 Highland Ave. Downers Grove, IL	0003384	176404-2018-AHC-USA-NIAHO
Advocate Good Shepherd Hospital	450 W. Highway, #22 Barrington, IL	0003475	261250-2018-AHC-USA-NIAHO
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	0005165	192082-2015-AHC-USA-NIAHO
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	004796	178979-2018-AHC-USA-NIAHO
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	0004697	195597- 2016- AQ-USA-RvA
Advocate Sherman Hospital	1425 N. Randall Rd Elgin, IL	0005884	246588-2017-AHC-USA-NIAHO
Advocate Trinity Hospital	2320 E. 93rd St. Chicago, IL	0004176	193041-2015-AHC-US-NIAHO

Additionally, AHHC has an ownership interest of fifty percent (50%) or more in the following licensed healthcare facilities:

Facility	Location	License No.	Joint Commission Accreditation No./ Accreditation Association for Ambulatory Health Care, Inc.
BroMenn Comfort & Care Suites	2502-B East Empire Bloomington, IL	4000025	AAAHC
Dreyer Ambulatory Surgery Center	1221 N. Highland Ave Aurora, IL	7001779	AAAHC
RML Specialty Hospital Chicago	3435 W. Van Buren St. Chicago, IL	0005678	JCAHO

RML Specialty Hospital Hinsdale	5601 S. County Line Rd Hinsdale, IL	0004804	JCAHO
Sherman West Court	1950 Larkin Ave Elgin, IL	NA	*

*Licensed under the Nursing Home Act.



HF114591

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2018		0004697

General Hospital

Effective: 01/01/2018

Advocate South Suburban Hospital
17800 S. Kedzie Avenue
Hazel Crest, IL 60429

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #3246 SM 3/16

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2018

Lic Number 0004697

Date Printed 11/21/2017

Advocate South Suburban Hospital

17800 S. Kedzie Avenue
Hazel Crest, IL 60429

FEE RECEIPT NO.

DNV·GL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
190161-2015-AHC-USA-NIAHO	12/13/2015	12/13/2018

This is to certify that:

Advocate South Suburban Hospital

17800 S. Kedzie Avenue, Hazel Crest, IL 60429

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

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

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

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

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

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

Advocate South Suburban Hospital is proposing a modernization project focusing on continuing to provide high quality surgical services to the South Suburban communities. The Project will modernize a 45-year-old hospital focusing on the surgical, procedural, and cardiovascular services which are essential to the operation of a modern community hospital.

In 2014, a master plan was developed with the assistance of the consulting firm Kurt Salmon. The plan was a basis for many of the significant needs that are being addressed in this project which include:

- Enhance surgical operating suite to **right size the operating rooms to current standards and improve the layout of the suite** to be more efficient.
- Provide appropriate **preparation/recovery bed capacity, configuration and adjacency**
- Optimize the **central sterile processing location** and **work flow**
- Design the **cardiovascular suite** to provide **flexibility** to support growing demand for interventional procedures
- Ensure surgical services are **equipped with technical capacity** to accommodate new procedures
- Modernize the surgical procedural suite for **endoscopy** patients to increase **efficiency** and **patient comfort**.

The plan identified several general parameters/guidelines for the hospital to address:

- Quantity of space: The quantity of space is undersized

- Quality of space: The layout of various areas, for example improvement in the interventional platform.
- Circulation: Minimize the crossover between patients, staff/visitors, and material flows.
- Logistics: Maintain direct vertical movement of materials

The Master Plan listed the Procedural Services (OR, cardiovascular, and endoscopy) as the priority, followed by the Emergency Department, Outpatient Services, and the conversion to private beds. The design of this project will address many of the needs identified in 2014.

The proposed plan will replace the original operating room suites which are 45+ years old. Seven of the 9 existing ORs range in size from 357 to 515 square feet. The current minimum standard for an OR is 600 square feet.

The current smaller room size inhibits the ability to schedule cases that require a larger room such as Robotic cases and ortho/spine cases. Cases are delayed, waiting for the appropriate room. The schedule problems become patient, family and physician dissatisfiers.

Fragmented patient prep and recovery locations result in staff inefficiencies, as well as logistic issues for the patient, family, and physician.

With the current cleaning and sterilizing of surgical supplies in separate locations, that results in extra transport time and communications.

Providing the most up to date facilities for technologies and procedures will lead to faster diagnosis, treatment and recovery. The Project will also increase operational efficiencies by aligning the services to maximize the support needed, such Phase I and Phase II prep and recovery. These improvements proposed in this Project align with the Hospital's goal to provide patients with the highest quality outcomes, in a value-conscious environment, aligned with population health initiatives.

2. Define the planning area or market area, or other, per the applicant's definition.
Advocate South Suburban Hospital is a major provider of health care to the residents of the Village of Hazel Crest, and surrounding communities. The Hospital was the first built in 1946 and opened as Hazel Crest General Hospital. In 1971, the hospital opened at its current location to support the families living in this geography.

The Hospital's primary service area (PSA) includes twenty-two zip codes in southern Cook County with parts of Park Forest and Frankfort in Will County. With a population of 490,000, the PSA is a diverse community with 13% of its residents of Hispanic ethnicity and a racial distribution that is 37% White, 46% Black, 13% Hispanic, 2% Asian and 2% Other. The median age of residents in the PSA is 38 years old and seniors age 65 and older represent 15% of the population. This geography has a larger number of adults 65 older compared with the US.

The demographic population information is provided in the table below. Although the total population in the service area is projected to remain stable, the 65-84 population is projected to grow by almost 20%, expecting over 12,000 additional older residents. The Hospital is preparing for the increased demand for healthcare that accompanies that change.

South Suburban PSA Demographics				
Age Group	2018 Population	2023 Population	2018 % of Total	Population Change
0-17	112,399	107,240	23%	-5%
18-64	303,231	294,701	62%	-3%
65-84	65,620	77,667	13%	18%
85+	9,004	8,713	2%	-3%
TOTAL	490,254	488,321	100%	0%

Source: Hospital records

The race and ethnicity is also reflective of this community and differs significantly from the National percentages. It is notable that there are slight increases in some of the ethnic populations. As the multicultural aspects of the community change, the Hospital is preparing to meet the social and medical needs of the population.

South Suburban PSA Demographics					
Ethnicity/Race	2018 Population	2023 Population	2018 % of Total	Population Change	National 2018 % of Total
Asian & Pacific Is. Non-Hispanic	9,041	10,420	1.8%	15.3%	5.8%
Black Non-Hispanic	224,726	222,711	45.8%	(0.9) %	12.4%
Hispanic	63,338	71,135	12.9%	12.3%	18.3%
White Non-Hispanic	182,715	171,984	37.3%	(5.9) %	60.4%
All Others	10,434	12,071	2.1%	15.7%	3.2%
Total	29,246	33,609	100.0%	(0.4) %	100.0%

Source: Hospital records

There are disparities that exist in the communities in the PSA in relation to education and income. The percent of the population with no high school diploma in the PSA is 9.5%. This ranges from 3.5% in Flossmoor to 19.4% in Harvey. While the PSA has 9.7% of residents insured by Medicaid, that percentage ranges from 16.7% in Harvey to 4.6% in Tinley Park. The median household income ranges from $107,247 in Frankfort to $38,611 in Markham and $27,306 in Harvey.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

This project addresses the need for larger, modern operating and procedure rooms including sufficient recovery beds to provide for patients during prep and recovery. The current facility includes 9 operating rooms that are smaller than needed to accommodate current procedures and technology. The configuration of the ORs is limiting the throughput and access of patients.

The community assessment outlined a growing need for health care services due to prevalent health care needs and significant health care disparities. The demographic composition of the service area projects an increased demand for interventional procedures. As the acuity of patients

increase, so does the demand for more surgical and cardiac catheterization procedures. The increased incidence of cardiovascular and digestive procedures has caused patient to leave the service area for care. This is likely to increase as the population.

There is an increasing need to provide health care services in a cost-conscious manner. This project will provide efficiencies to share space, technology, equipment, and staff not possible with the current configuration and location of services.

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

- Advocate South Suburban Hospital Modernization Feasibility Study
- Illinois Department of Public Health Hospital Licensing Code
- Illinois Health Facilities and Services Review Board (HFSRB) Administrative Rules
- IHA COMPdata
- AIA/FGI Guidelines for Design and Construction of Health Care Facilities
- Advocate South Suburban Hospital Financial Data
- Claritas Pop Facts 2018 and the US Census Bureau
- Sg2
- Advocate Medical Group
- HFSRB Hospital Profiles
- HFSRB Inventories and Data
- HFSRB State Agency Reports
- Health care literature regarding current trends re patient needs
- Advocate South Suburban Hospital Public Relations archives
- The City of Hazel Crest building codes
- Community Health Needs Assessment document
- Master Plan ASSH, Kurt Salmon

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

At the completion of this project the Hospital will have modern operating rooms, cardiac catheterization room, with separate rooms for interventional angiography and electrophysiology. In addition, there will be modernized endoscopy rooms. By standardizing the operating and procedure rooms, physicians will be able to provide increased access to address the changing needs of the population, providing innovative surgical techniques for patients in their community.

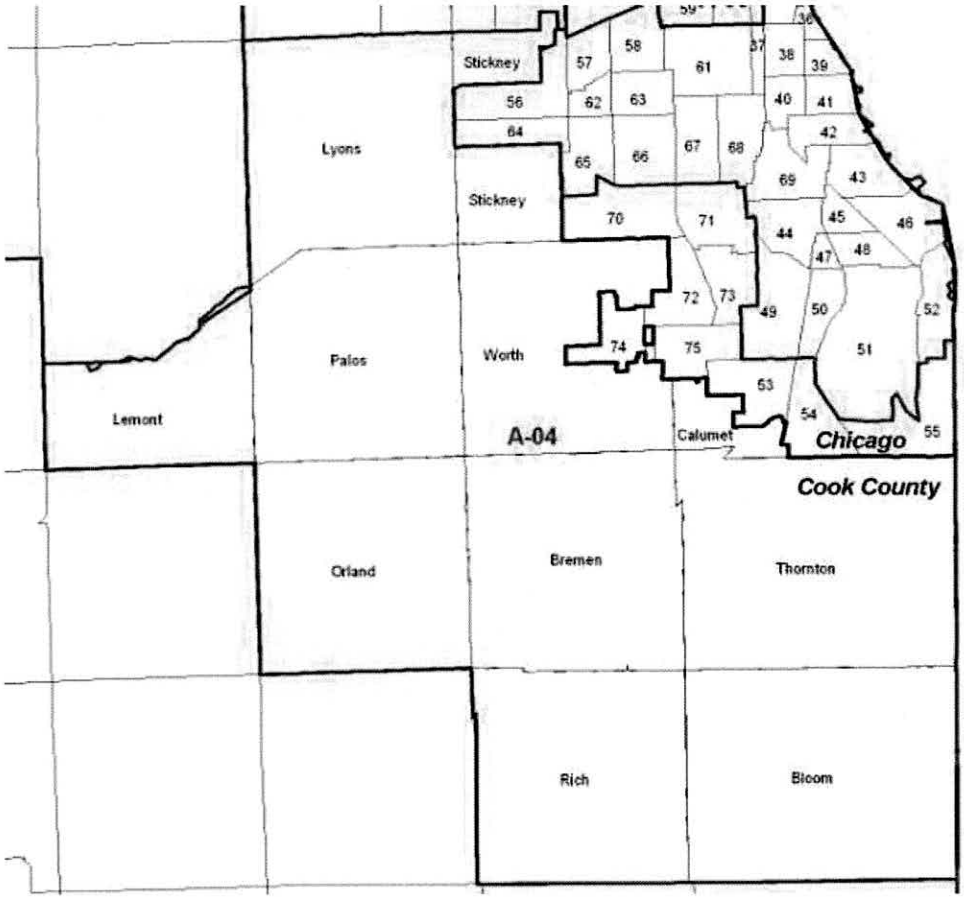
The modernization of the surgical intervention platform will greatly enhance the surgery schedule, allowing cases to be done in a timely manner. By providing an adequate number of prep and recovery bays, outpatients will come back to their original location after a procedure, increasing patient and family satisfaction. Patients that need additional time to recover will now remain in recovery area until they can be moved.

Improved family-visitor space is part of the project, recognizing the patient's need for personal support.

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

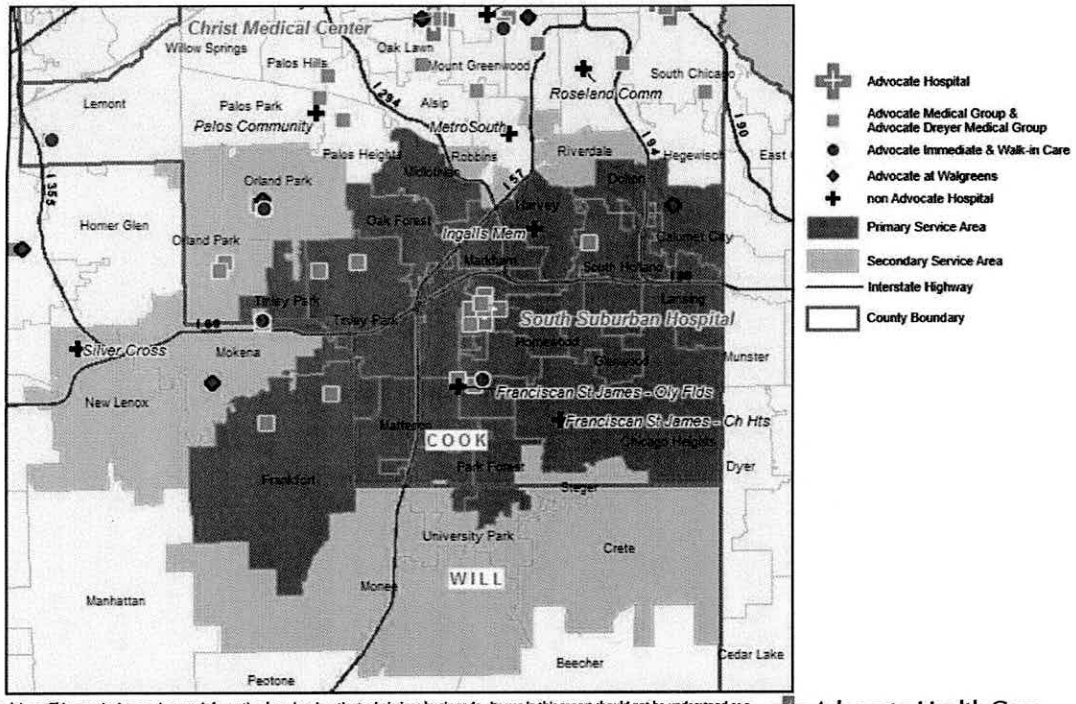
The principal goal is to create surgical and procedural spaces in one location, that are modern and designed to accommodate newer technologies. The construction of the two-story addition for the surgery and cardiology areas is expected to be completed and operational in mid-2020. The modernization of the existing endoscopy space will be completed in late 2021.

IHFSRB Planning Area A-04



Planning Area A-4: City of Chicago Community Areas of West Pullman (53), Riverdale (54), Hegewisch (55), Ashburn (70), Auburn Gresham (71), Beverly (72), Washington Heights (73), Mount Greenwood (74), and Morgan Park (75); Cook County Townships of Lemont, Stickney, Worth, Lyons, Palos, Calumet, Thornton, **Bremen**, Orland, Rich and Bloom.

Advocate South Suburban Hospital – Service Area Map



Disclaimer: This map depicts service area information based on inpatient admissions by zip code. Its use in this report should not be understood as a representation concerning a relevant geographic area of competition or concerning the actual extent of competition between or among providers in any given zip code or area.

Advocate Health Care

Source: Hospital records

ALTERNATIVES

1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

In 2014, Advocate South Suburban Hospital completed an update of the Strategic Facility Master Plan completed in 2011. This plan addressed the future volume projections responding to the recent changes in the market. This included identifying future space and programming to incorporate projects completed over the last 3 years and identified streamlined solutions to continue to provide high quality health care services to the service area. Consultants were engaged to assist with the assessment. The conclusions of administration were as follows:

- The surgical operating rooms, GI and cardiac cath rooms require development of an interventional platform with new capacity that meets physician needs and operational efficiencies. Cardiovascular service line enhancements cannot be achieved in the current outdated and undersized cardiac catherization rooms.
- There was an immediate need to right size current undersized operating rooms and procedural areas and improve functionality and connectivity. This transition out of the aging building infrastructure would allow all procedural spaces to be co-located.
- A dedicated procedural area would increase operational efficiencies and increase physician and patient satisfaction.
- Investments in the facility were needed to support the incremental growth forecasted.
- The current space does not address appropriate prep and recovery configuration
- As a result, Advocate Health Care has approved a capital budget allocated to this project, which is proposed to develop and modernize the procedural platform to include operating rooms, cardiac cath rooms and the endoscopy suite. Specific components of this Project and their related costs have been incorporated to assure the feasibility of future phases.

1. Over the course of time, there were several alternatives considered.

Alternative One – Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes

A possible option was to build or purchase surgical clinical space in other locations in a joint venture with physicians that use the service. An analysis of this option revealed the inefficiencies that would occur if clinical services were divided among various remote sites such as freestanding ambulatory surgical treatment centers and/or independent centers. The surgical cases included in the project are those that need to remain in the hospital location due the patient's condition or co-morbidities. The physicians using the procedural center would not be efficient performing procedures at multiple locations and would find it harder to confer on challenging cases. Overhead costs would increase as staff, support services, equipment, supplies, records, and common public areas would not be shared. They could not maximize use of specialty staff and testing equipment.

Cost: The cost was not explored because the option was not viable.

Alternative Two — Utilize other health care resources that are available to serve all or a portion of the population proposed to be served by the Project

The option to refer ambulatory surgery, endoscopy, and cardiovascular cases to another hospital in the service area was not feasible. The physicians seeing these patients are principally located near and on staff at Advocate South Suburban Hospital. They are significant providers of procedural cases for people that live in this community and would need to send those patients a distance to find comparable service. The patients have a long-established pattern of coming to the Advocate South Suburban for their comprehensive care and this would disrupt continuity of care.

Cost: No construction cost, but would experience a significant challenge for patients seeking a new site and thus the lack of continuity of care.

Alternative Three — Proposing a Project of greater scope and cost

The option to build a new addition that includes all the procedural areas by vacating all those departments in the existing hospital. As good financial stewards, this would be an excessive undertaking and the plan was abandoned for a scaled down project.

Cost: ~$268,000,000

Alternative Four — Proposing a Project of lesser scope and cost

This option would involve modernizing only one of the procedural areas at time and would not address the efficiencies of having all programs in the same area. It would be costlier and more disruptive to complete this project addressing one clinical area at a time and would not be provide the advantage of integrated care that is so important to progressive programs.

Cost: ~$44,000,000

Alternative Five – Construct a new procedural area

This option was selected as it will allow the organization to focus its resources to create a procedural area co-locating all procedural services instead of throughout the hospital. This space will be designed to right size the procedure rooms; achieving contemporary standards and accommodating the needed perioperative services. This setting will provide for easier patient access, adequate space for newer treatment and procedures, and operationally enhance economies of scale. The location selected is highly visible, and accessible to patients and physicians.

Cost: ~$ 97, 630,432

Alternative	Description	Patient Access	Quality	Cost	Financial Benefit, Short Range	Financial Benefit, Long Range	Conclusion
1	Develop a joint venture to build or purchase surgical clinical space in other locations	The surgical cases identified in this project include those that need to remain in the hospital location due to the patient's condition or co-morbidities.	The quality of care would not be improved for the majority of cases. Patients would need to forgo the advantage of physicians conferring with colleagues and having cases in one location.	The additional overhead cost would increase due to duplication of staff, support services and equipment costs. Cost is not provided as this is not a viable option.	This option would still incur the cost to modernize the existing ORs and would not address the pre and post surgical needs.	This would be more costly to operate in multiple locations and lose the advantages of shared staff and support systems. This would delay the modernization needed while inflation would effect future projects.	Rejected
2	Refer patients to another facility in the service area for surgical and procedural services	Patients would not have continuity of care as their providers are on staff at Advocate South Suburban Hospital. Many would need to travel outside of the community to receive comparable services.	The quality of care would not be improved as physicians would not be able to follow their patients and provide continuity of care. Patients may be challenged to find services in the community.	There would be no construction cost, but the hospital would have a significant loss of patients that would affect the ability to provide quality services. Patients may experience increased cost.	This option would forgo the construction cost.	This option would see a significant loss of patients.	Rejected
3	Build new addition to the hospital to include all procedural areas	This would improve patient access.	This option would improve quality of clinical services.	$268,000,000.00	This option would include a significant financial investment.	This option would not expect greater access or clinical quality and would be a challenge to forecast the return on such a large investment.	Rejected
4	Phased, smaller approach by dividing into several projects by modernizing one procedural area at a time	Problems with access to each area would continue for an extended timeframe. Improvement would be limited to sections as they are completed and other areas would see access compromised until the end of the project.	The quality of care would not be improved as the advantages of co-locating services would not be achieved in the short term if at all.	$44,000,000.00	There would be lower cost in the short term and may not see the project through to completion.	The longer range time would see more disruption to patients and be more costly. This plan would postpone the inevitable expenses to complete the project; during a growing need. Inflation could affect the future project.	Rejected
5	Construct new procedural area to include modernized OR suites, cardiology procedural areas and endoscopy suites	This would improve patient access by co-locating all procedural areas; improving access for patients and their families and enhanced clinical staff access.	Quality of care would be improved due to all surgical areas integrated and right sizing the procedure rooms. Co-location of services provides increased efficiencies and quality.	$97,630,432.00	This option will build on synergy by having all procedural services in one location; sharing clinical and support staff and equipment.	Clinical areas will be properly designed and built for both immediate and long term hospital needs. This will provide more efficient operations, address patient needs with growing acuity and address physicians need to provide up to date technology.	✓ Accepted

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

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

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

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

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Size of the Project

In the process of planning this project, consideration was given to the current age of the structure, configuration, adjacency, technical support. It was determined that retrofitting the existing building was not feasible so the plan was developed to build a new addition expressly for the surgical operating rooms and the cardiovascular department.

Another major factor was to locate directly below the surgery a new central sterile processing to maximize the efficiency of that work and movement of sterile supplies.

By developing the plans independent from the older building, it was possible to make the best use of the space within the standards set by the state. The table below demonstrates the proposed project has met the State Standards for physical space for the departments that are regulated regarding size.

Size of Clinical Departments

Department/Service	Proposed DGSF	State Standard	Difference	Met Standard?
Surgical Operating Rooms	24,721 per 9 ORs	(2,750 x 9) = 24,750	-29	Yes
Recovery Suite	17,370 per 50 stations	((11 x 180) + (39 x 400)) = 17,580 per 50 stations	-210	Yes
Cardiac Cath. Labs	5,311 for 3 Labs	(1,800 x 3) = 5,400	-89	Yes
Surgical Procedure Rooms	5,489 for 5 rooms =	(1,100 x 5) = 5,500	-11	Yes
Phase II Prep & Recovery for Procedure Stations	7,187 for 18 stations	(400 x 18) = 7,200	-13	Yes

Source: HFSRB and Project plans

Central Sterile Processing

In the absence of IDPH standards, the Central Sterile Processing department has been configured along the Veterans Administration and Department of Defense guidelines. (See *DoD Space Planning Criteria Chapter 450: Sterile Processing July 1, 2017)* They are based on calculations of each of the workload-driven room types and workload parameters including

- Number of projected transport carts.
- Number of projected daily instrument sets reprocessed.
- Number of projected daily carts / container racks reprocessed.
- Number of ORs supported.
- Number of projected daily surgical procedures.
- Other departments supported, in addition to Surgery (E.g., Obstetrics, Emergency, Endoscopy and more)
- Number of people using offices and staff support spaces

Additional input comes from the Facility Guidelines Institute, American Institute of Architects Academy of Architecture for Health, and the Advocate Healthcare models.

Size of Non-Clinical Departments/Areas

Medical Staff & Surgery Offices, Support,	9,312 GSF Modernized
Staff Facilities and On Call	1,202 GSF Modernized and 2,351 GSF As Is
Education	691 GSF Const, 11,679 Modernized, 842 GSF As Is
Building Systems/Support/AHUs	7,198 GSF Construction, 248 GSF Modernized
Administration	3,375 Modernized, 4,857 GSF As Is
Lobby Waiting, Registration Security	5,870 GSF Construction, 2,055 GSF Modernized
Corridors, Stairs, Elevators, Dock	16,491 GSF Construction, 3,608 GSF Modernized
Materials Management	1,182 GSF Construction, 4,321 GSF As Is

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

	UTILIZATION				
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

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

	UTILIZATION				
	DEPT./ SERVICE	HISTORICAL UTILIZATION 2017	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1 2022	Cardiac Catheterization Labs	4,654 procedures	4,654 Procedures/ 1,500 Procedures per room = 3.1 rounded to 4 rooms	1,500 procedures/room	Yes
YEAR 2 2023	Cardiac Catheterization Labs		4,654 Procedures/ 1,500 Procedures per room = 3.1 rounded to 4 rooms (only requesting 3 rooms)	1,500 procedures/room	Yes
YEAR 1 2022	Surgical Operating Suite, Class C	12,065 hrs.	12,715 hrs./1,500 hours per room = 8.5 rooms rounded to 9 rooms	1,500 hours/room	Yes
YEAR 2 2022	Surgical Operating Suite, Class C		12,701 hrs./1,500 hours per room = 8.5 rooms rounded to 9 rooms (requesting 9 rooms)	1,500 hours/room	Yes
YEAR 1 2022	Surgical Procedure Rooms, Class B	7,555 hrs.	9,020 hrs./1,500 hours per room = 6.0 rooms	1,500 hours/room	Yes
YEAR 2 2023	Surgical Procedure Rooms, Class B		9,346 hrs./1,500 hours per room = 6.2 rooms rounded to 7 rooms (only requesting 5 rooms)	1,500 hours/room	Yes

Source: Hospital records

Cardiac Catheterization

The Cardiac Catheterization Labs currently have two rooms that are extremely busy. In addition to all the reported cardiology procedures (diagnostic, interventional, and electrophysiology) there are many more done in those rooms. For example, there were 80 cardioversions done in 2017 as well as numerous pacemaker implantations and adjustment procedures that are not in the criteria to be reported but take time in the rooms.

In addition to the work related to the heart, all the Radiology Department angiography work that is not related to the heart is also done in the Cath Labs. They are reported under the category of angiography diagnostic and interventional procedures. In addition to the reported cases, there are many more such as ultrasound-guided vascular access, central vein insertions, insertion and removal of chest ports, studies on abscesses and such.

The volume of work compressed into those two rooms has forced the physicians and staff to frequently relocate equipment and extend the schedule. A third room is clearly needed and justified by the current utilization.

Surgical Operating Rooms

The surgical operating suite is currently in rooms designed in 1970 which don't meet the need 48 years later. They are too small and lack the technology required in this era. There are new pieces of equipment such as the da Vinci robot that must have more space than available.

In addition to the historical volume of cases, several surgeons are ready to bring new procedures that are needed by the patients in the service area. This will allow these patients to stay in the primary service area, near their homes, and take advantage of newer life-enhancing procedures. These surgeons are encouraged by the prospects of a modern facility that can accommodate these newer procedures.

The historic and new volume of work justifies the need to continue to provide nine operating rooms.

Surgical Procedure Rooms

The endoscopy work is continuing to increase as more new procedures are using methods that rely on visualization of the problems inside the body without making large incisions. While historically thought of as focused on colon symptoms, the technique is expanding to allow many more exams and corrective procedures with newer equipment and methods. That is increasing the demand for the service.

One of those procedures is directed at lung function. Bronchoscopy has been successfully performed at the Hospital for several years. It needs to be done in a room with negative pressure and that has been in one surgical operating room. However, that precludes that room from being used for most other surgical procedures that need positive pressure. Therefore, the bronchoscopy work and other procedures related to lung patients is proposed to go to the Surgical Procedure suite.

The Hospital is requesting to modernize the department to continue to offer four procedure rooms plus one negative pressure room for the bronchoscopy cases. The volume of work projected by this growth suggests seven rooms may be needed. However, the Hospital is requesting only five rooms.

UNFINISHED OR SHELL SPACE:

Provide the following information:

4. Total gross square footage (GSF) of the proposed shell space.

5. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

6. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   c. Historical utilization for the area for the latest five-year period for which data is available; and
   d. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

There is no shell space in the project.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

See Attachment #17, Exhibit 1.

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

June 4, 2018

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

RE: Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital
Surgical, Procedural, Cardiovascular Modernization

Dear Ms. Olson:

This letter is to provide the Illinois Health Facilities and Services Review Board the assurance required with the Certificate of Need application for a modernization project at Advocate South Suburban Hospital.

Based on the information available, it is my understanding that by the second year of operations after project completion, Advocate South Suburban Hospital reasonably expects to achieve and maintain the utilization standards for the Cardiac Catheterization services, as specified in 77 Ill. Administrative Code 1100.620. The Hospital is expected to achieve the utilization standards for the Surgical Operating Suite (Class C) and Surgical Procedure Suite (Class B) as specified in Administrative Code 1110 Appendix B.

Sincerely,

Richard Heim

Richard Heim
Primary Service Area President
South Chicago and South Suburbs
Advocate Health & Hospitals Corporation

Criterion 1110.225 - Cardiac Catheterization

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
Cardiac Catheterization	2	3

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

1. Criterion 1110.225(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110. 225(b), Establishment or Expansion of Cardiac Catheterization Service

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.225(c), Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within 90 minutes travel time that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.225(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 1110.225(e), Support Services

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not near, explain why.

7. Criterion 1110.225(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. Criterion 1110.225(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.225(I), Multi-institutional Variance

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 23 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

1. Criterion 1110.225(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

Cardiovascular Services Peer Review Committee is a representative physician group that meets quarterly for case review as outlined by Advocate policy in the Advocate South Suburban Committee Manual. Membership includes cardiologists, internists, interventional radiologists and electrophysiologists.

Cases are referred for review based on patient safety reporting, guideline non-compliance, CMS Quality Measures non-compliance, National Cardiovascular Data Registry (NCDR) definition or nurse/physician referral. Case review information is electronically stored and becomes part of the hospital's focused and ongoing Physician Practice Evaluation reporting for physician privileging. This group also regularly reviews data to identify troublesome trends needing more intense evaluation.

2. Criterion 1110. 225(b), Establishment or Expansion of Cardiac Catheterization Service

This category of service offering diagnostic catheterizations, interventional angiography, and electrophysiology is established and is not expanding any new services so the criterion does not apply.

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.225(c), Unnecessary Duplication of Services

This category of service is established so the criterion does not apply.

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within 90 minutes travel time that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.225(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

This category of service is an essential patient care component at Advocate South Suburban Hospital. Two rooms are used for <u>all</u> the diagnostic, interventional, and electrophysiology procedures. The complexity and diversity of procedures has been growing and it is

increasingly complicated to manage the schedules and also to move equipment between the two rooms. For example, the limited number of rooms forced the staff to frequently move the electrophysiology equipment which is not good on this highly technical equipment and time consuming for the staff.

The data reported in the Annual Hospital Questionnaire under the heading of Cardiac Catheterization only includes a portion of all the work that is done in the cardiology labs. A narrow definition of cardiology procedures was applied and does not include all the cardiovascular work.

For example, there were 80 cardioversions done in the catheterization labs that were not reported as procedures. Many pacemaker patients are routinely seen for implants, adjustment of the leads, or removal.

The Radiology department does NOT have an angiography suite so all the non-heart angiography reported with the Diagnostic/Imaging section of the Annual Hospital Questionnaire is also done in the cardiology labs. Again, a narrow definition of what to report was applied in the Annual Hospital Questionnaire.

A summary of the procedures done in 2017 are shown in the tables below. See the tables detailing all the 2017 cardiology procedures and the non-heart procedures as Exhibits 1 and 2.

2017		Inpatient	Outpatient	Total
Cardiology Procedures (heart related)				
	Diagnostic, reported	447	237	684
	Interventional Angiography, reported	177	50	227
	Electrophysiology, reported	41	74	115
	Subtotal			**1,026**
	Other Electrophysiology, not reported	122	216	338
	Other Cardiology, not reported	101	19	120
	Total			**1,484**
Diagnostic/Imaging Procedures (non-heart but done in cardiac cath labs)				
	Diagnostic, reported	362	337	699
	Interventional, reported	227	249	476
	Subtotal			**1,175**
	Other procedures, not reported	1,285	710	1,995
	Total			**3,170**
	Grand Total			**4,654**

Source: Hospital records

Based on the criteria of having over 1,500 procedures done in a year to support additional rooms, the 2017 volume will support 3 procedure rooms.

4,654 procedures ÷ 1,500 procedures per room = 3.1 rooms, rounded to 4 rooms

Advocate South Suburban Hospital is planning to have only **3 rooms** which are justified.

5. Criterion 1110.225(e), Support Services

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

This is an established service and all the required support services are available as shown below.

A) Nuclear medicine laboratory – Open Mon-Saturday 7am-5pm. On Call Mon-Fri 5pm-7am, On Call for Weekends starting Saturday from 3:30pm – 7am on Monday
B) Echocardiography Services - Open daily from 7am-5pm then covered by on call the remaining hours
C) Electrocardiography lab and services, including stress testing and continuous cardiogram monitoring. Cardiology Stress testing Mon-Saturday 7:30 am-5pm. EKG testing coverage 24/7. Continuous cardiac monitoring for ICU; ER; & Inpt telemetry beds 24/7 with Central Telemetry Monitoring Center.
D) Pulmonary Function unit. Mon-Fri 7-3:30 pm by appointment. Walk in's accepted if open appt.
E) Blood bank. 24/7
F) Hematology laboratory - coagulation laboratory. Both 24/7
G) Microbiology laboratory 24/7 but limited to certain testing after 4pm
H) Blood Gas laboratory 24/7
I) Clinical pathology laboratory 7:00-4:30 No weekends or holidays
J) Blood chemistry. 24/7

6. Criterion 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not near, explain why.

One of the central features of the Project is the development of a procedural center co-locating surgery and the cardiac catheterization laboratories. Cardiac catheterization integrates diagnostic procedures, electrophysiology and interventional angiography. These services will share Phase I Recovery (PACU), Phase II preparation and recovery, and support spaces, including family waiting.

This patient care redesign was developed to allow for shared resources to improve patient care and staff efficiency. This approach enhances the range of support services available for patients and families and makes effective utilization of the equipment and facilities. A broader scope of staff is better able to accommodate the peaks in volumes as well as emergency and unexpected situations. The shared equipment and resources also provide backup in case of failure of equipment or systems. The plan is developed to be flexible to meet the changing needs of patients and the industry.

The new procedure rooms will be designed to current industry standards and will be larger and thus better able to accommodate new larger equipment.

7. Criterion 1110.225(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

Advocate South Suburban Hospital has a progressive program for heart patients that has been in operation for more than ten years. For the past eight years diagnostic cardiac catheterizations, interventional angiography, and electrophysiology has been performed. The service includes a minimally-invasive endovascular procedure to improve peripheral circulation and electrophysiology procedures including device implants. A fully accredited, three-phase cardiac rehabilitation program gives patients a fresh start at heart health. There are 15 interventionalists (radiologists & cardiologists), 3 electrophysiologists, and 43 cardiologists on the staff. The Hospital has three medical directors for Cardiology, Cardiac Cath Lab, and Interventional Radiology. Also, the medical cardiologists are present daily to round on all inpatients that they are consulting on.

This is an established service and the following required personnel are available as shown:

1) Lab director board-certified in internal medicine, pediatrics or radiology with subspecialty training in cardiology or cardiovascular radiology.
   There are two physicians board-certified in Internal Medicine with subspecialties in cardiology over the Cardiology Service and the Cardiac Catheterization Labs. A physician board-certified in Radiology and a subspecialty in interventional care is over the Interventional Radiology service. Currently, filling those positions are:

Cardiology:	Ajay Parikh, MD
Cardiac Cath:	Abdul Ghani, MD
Interventional Radiology:	Paul Guzzetta, MD

2) A physician with training in cardiology and/or radiology present during examination with extra physician backup personnel available.
   Yes
3) Nurse specially trained in critical care of cardiac patients, knowledge of cardiovascular medication, and understanding of catheterization equipment.
   Yes
4) Radiologic technologist highly skilled in conventional radiographic techniques and angiographic principles, knowledgeable in every aspect of catheterization instrumentation, and with thorough knowledge of the anatomy and physiology of the cardiovascular system.
   Yes
5) Cardiopulmonary technician for patient observation, handling blood samples and performing blood gas evaluation calculations.
   The nurses and radiologic technologists carry out these functions
6) Monitoring and recording technician for monitoring physiologic data and alerting physician to any changes.
   The nurses and radiologic technologists carry out these functions
7) Electronic radiologic repair technician to perform systematic tests and routine maintenance; must be immediately available in the event of equipment failure during a procedure.
   Clinical engineering is available around the clock, on call evenings and weekends.

8) Darkroom technician well trained in photographic processing and in the operation of automatic processors used for both sheet and cine film.
This position is no longer needed as all the images are recorded electronically

8. Criterion 1110.225(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s).

Any applicant proposing the establishment, expansion or modernization of a cardiac catheterization service must document that written transfer agreements have been established with facilities with open-heart surgery capabilities for the transfer of seriously ill patients for continuity of care.

The Hospital does not provide open heart surgery. The transfer agreement is attached as Attachment #23, Exhibit 4, pages 89-91.

9. Criterion 1110.225(l), Multi-institutional Variance

This criterion is not applicable. This is an established stand-alone service

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

Cardiac Catheterization Performed in Cath Lab			
Reported as Diagnostic Catheterization	**2017-IP-Qty**	**2017-OP-Qty**	**Total**
LHC/CORONARIES WO/W LVGRAM	320	161	481
CATH PLACE FOR COR ANGIOS	43	16	59
LHC/CORS/GRAFTS WO/W LVGRAM	25	16	41
R/LHC/CORONARIES WO/W LVGRAM	25	15	40
INTRAVASC DOPP FLOW STUDY INIT	10	19	29
RHC WO/W O2 SAT AND CARD OUTPUT	7	1	8
CATH PLACE FOR COR/GRAFTS ANGIOS	6	0	6
RHC/CORONARIES WO/W O2 AND CO	3	3	6
INTRAVASC DOPP FLOW STUDY ADD	1	4	5
R/LHC/CORS/GRAFTS WO/W LVGRAM	4	0	4
LHC WO/W LVGRAM	1	1	2
R/LHC WO/W LVGRAM	1	1	2
AORTOGRAM INJECTION/IMAGING	1	0	1
Subtotal of Diagnostic Cardiac Cath Reported	447	237	684
Reported as Interventional Catheterization	**2017-IP-Qty**	**2017-OP-Qty**	**Total**
STENT/PTCA DE MAJ ART SNG LD	48	19	67
STENT/PTCA DE MAJ ART SNG RC	40	11	51
STENT/PTCA DE MAJ ART SNG LC	27	9	36
PTCA EA ADD BRANCH LD	7	2	9
REVASC ACUTE DE MAJ ART SNG LD	8	1	9
PTCA MAJOR ARTERY SINGLE LC	7	0	7
STENT/PTCA DE ADD BRANCH RC	4	1	5
REVASC ACUTE DE MAJ ART SNG RC	5	0	5
STENT/PTCA DE MAJ ART SNG RI	3	1	4
PTCA MAJOR ARTERY SINGLE RC	2	1	3
PTCA MAJOR ARTERY SINGLE LD	3	0	3
PTCA EA ADD BRANCH RC	3	0	3
STENT/PTCA MAJOR ART SINGLE LD	1	2	3
REVASC VIA GRF DE MAJ ART SNG LC	2	1	3
REVASC ACUTE MI MAJ ART SNG LD	3	0	3
REVASC ACUTE MI MAJ ART SNG RC	3	0	3
PTCA EA ADD BRANCH LC	2	0	2
STENT/PTCA MAJOR ART SINGLE RC	2	0	2
STENT/PTCA DE ADD BRANCH LC	2	0	2
REVASC VIA GRF DE MAJ ART SNG LD	1	1	2
STENT/PTCA MAJOR ART SINGLE LC	0	1	1

STENT/PTCA DE ADD BRANCH LD	1	0	1
REVASC VIA GRAFT MAJ ART SNG RC	1	0	1
REVASC VIA GRF DE MAJ ART SNG RC	1	0	1
REVASC ACUTE DE MAJ ART SNG LC	1	0	1
Subtotal of Interventional Cardiac Cath Reported	**177**	**50**	**227**
Reported as Electrophysiology	**2017-IP-Qty**	**2017-OP-Qty**	**Total**
COMP EVAL W/ABLATION SVT	11	22	33
COMP EVAL LT ATRIAL PACING	11	21	32
INTRA-CARDIAC 3D MAPPING	9	18	27
PROG STIM & PACING POST IV INF	7	8	15
COMP EVAL W INDUCTION ARRHYTHMIA	2	4	6
COMP EVAL WO INDUCT ARRHYTHMIA	0	1	1
ABLATION ADDITIONAL ARRHYTHMIA	1	0	1
Subtotal of Electrophysiology Reported	**41**	**74**	**115**
TOTAL CARDIAC CATHETERIZATION PROCEDURES REPORTED			**1,026**
Additional Electrocardiology Procedures Not Reported	**2017-IP-Qty**	**2017-OP-Qty**	**Total**
CARDIOVERSION EXTERNAL	20	60	80
INS/RPL PACEMAKER ATR/VENT + LEAD(S)	30	17	47
IMPLANT EVENT RECORDER	22	14	36
INS LV PACE LEAD WITH NEW GEN	9	23	32
INS/RPL ICD DUAL GEN + LEAD(S)	9	22	31
REM/RPL PMKR GEN/DUAL SYSTEM	1	15	16
REMOVAL EVENT RECORDER	2	10	12
INS/RPL ICD SNG GEN + LEAD(S)	2	9	11
PERICARDIOCENTESIS INITIAL	9	0	9
REM/RPL ICD GEN/DUAL SYSTEM	0	9	9
REM/RPL ICD GEN/MULT SYSTEM	0	9	9
REMOVAL PMKR GEN ONLY	3	5	8
MAPPING TACHYCARDIA	1	6	7
INS/RPL PMKR VENT + LEAD(S)	3	2	5
INS/RPL TEMP PMKR LEAD SNG CHMB	4	1	5
REM/RPL PMKR GEN/MULT SYSTEM	1	3	4
I&D HEMATOMA PACER POCKET	1	2	3
ABLATION AV NODAL	2	1	3
REM/RPL PMKR GEN/SINGLE SYSTEM	0	2	2
REMOVAL ICD GEN ONLY	0	2	2
DEBRIDEMENT SUBQ TISSUE <= 20CM2	0	1	1
PERICARDIOCENTESIS SUBSEQUENT	1	0	1

REPOSITION PREV PLACED LEAD	0	1	1
ATTEMPT INS LV LEAD W/NEW GEN	0	1	1
REMOVAL PMKR LEAD(S) DUAL SYSTEM	1	0	1
INS/RPL SUBQ GEN + LEAD W/EVAL	1	0	1
TEMPORARY TRANSCUTANEOUS PACING	0	1	1
Additional Electrophysiology Not Reported	**122**	**216**	**338**
Additional Cardiology Procedures Not Reported	**2017-IP-Qty**	**2017-OP-Qty**	**Total**
ACTIVATED COAGULATION TIME	65	10	75
INSERT IABP	14	4	18
ENDOLUMINAL IMG CORS INIT VESSEL	10	4	14
FLUORO GUIDE NEEDLE PLACEMENT	9	0	9
US GUIDE VASCULAR ACCESS	1	1	2
AORTOGRAM ABDOMINAL S&I	1	0	1
CINERADIOGRAPHY	1	0	1
Additional Cardiology Procedures Not Reported	101	19	120
TOTAL CARDIOLOGY PROCEDURES PERFORMED	888	596	**1,484**

Source: Hospital records.

Diagnostic/Imaging Angiography Procedures (Non-Heart) Performed in Cath Lab

Reported as Diagnostic Angiography	2017-IP-Qty	2017-OP-Qty	Total
IRSC CATH ART 3RD ORD ABD/PEL/UE	26	43	69
IR REMOVAL TUNNELED CENTRAL CATH	38	28	66
IR DIALYSIS CIRCUIT ANGIO	6	52	58
IR SELECTIVE EA ADD VESSEL SI	25	19	44
IRSC CATH ART 2ND ORD ABD/PEL/LE	26	15	41
IR PLACEMENT FILTER IVC W IMAGE	34	7	41
IR ABDOMINAL AORTOGRAM SI	14	23	37
IR PELVIC ANGIOGRAM SI	2	35	37
IRSC CATH ART 1ST ORD ABD/PEL/LE	29	7	36
IR EXTREM LOWER ANGIO BIL SI	14	19	33
IR EXTREM LOWER ANGIO LT SI	20	11	31
IR EXTREM LOWER ANGIO RT SI	19	9	28
IRSC INTRO CATH AORTA NON-SELECT	17	4	21
IR CELIAC ANGIOGRAM SI	20	1	21
IR SMA ANGIOGRAM SI	14	1	15
IRSC VENOUS CATH 2ND ORDER	2	7	9
IR INFERIOR VENACAVAGRAM SI	5	4	9
IRSC INJ VENOGRAM EXTREMITY	3	5	8
IRSC CATH ART ADD ORD ABD/PEL/LE	8	0	8
IR EXTREM LOWER VENOGRAM LT SI	2	6	8
IR INJECT PORT A CATH EVAL W IMG	1	6	7
IR IMA ANGIOGRAM SI	7	0	7
IRSC VENOUS CATH 1ST ORDER	2	4	6
IR EXTREM UPPER VENOGRAM RT SI	1	5	6
IRSC INTRO CATH SVC/IVC	2	2	4
IRSC CATH PULMONARY SELECT UNI	4	0	4
IR EXTREM LOWER VENOGRAM RT SI	3	1	4
IRSC INTRO NEEDLE EXTREMITY ART	0	3	3
IR ABD BIL FEM AORTOGRAM SI	1	2	3
IR EXTREM UPPER VENOGRAM LT SI	1	2	3
IR EXTREM UPPER VENOGRAM BIL SI	1	2	3
IRSC CATH EA 1ST ORD THOR/BRACH	1	1	2
IR ANGIO THORACIC ARCH NON-SEL	1	1	2
IR INJECT PICC EVAL W IMAGE	2	0	2
IR TIPS REVISION W IMAGING	1	1	2
IR EXTREM UPPER ANGIO LT SI	1	1	2

IR PULMONARY ANGIO BIL SI	2	0	2
IR RENAL VENOGRAM LT SI	1	1	2
IRSC CATH INIT 2ND ORD THOR/BRAC	0	1	1
IR CAROTCOM SEL XTRACRA ANGIO LT	0	1	1
IR VERTEBRAL SEL ANGIO RT	0	1	1
IR ANGIOGRAM RENAL SELECT RT	0	1	1
IR ANGIOGRAM RENAL SELECT LT	1	0	1
IR ANGIOGRAM RENAL SELECT BIL	0	1	1
IR ANGIO RENAL SUPERSELECT LT	1	0	1
IR ANGIO RENAL SUPERSELECT RT	1	0	1
IR INJECT PERM CATH EVAL W IMAGE	0	1	1
IR DIALYS CIRC ANGIO EXIST ACCESS	0	1	1
IR LOOPOGRAM	1	0	1
IR EXTREM LOWER VENOGRAM BIL SI	0	1	1
IR SUPERIOR VENACAVAGRAM SI	1	0	1
IR JUGULAR VENOGRAM RT SI	1	0	1
IR HEPATIC VENOGRAM W HEMO SI	0	1	1
Subtotal of Diagnostic Angiography	**362**	**337**	**699**
Reported as Interventional Angiography			
IR DIALYSIS CIRCUIT ANGIO W PTA	4	103	107
IR DIALY CIRC ANGIO PTA/MECH/INF	18	17	35
IRSC PTA THRU DIALYSIS CIRCUIT	4	31	35
IR INFUS TRANSCATH ART THROM INI	27	1	28
IR EMBOLIZATION UTERINE FIBROID	1	19	20
IR PTA VENOUS INIT	9	10	19
IR PTA FEM/POP ATHERECTOMY LT	10	5	15
IRSC ENDO AAA REP BIF PROS 1LIMB	12	0	12
IR EMBO/OCCLUDE HEM LYMPH/ART/VN	12	0	12
IR ENDOVASC AAA REPAIR SI	12	0	12
IRSC ENDO AAA REP ILIAC INIT VES	11	0	11
IR ENDOVASC AAA ILIAC EXTEN SI	11	0	11
IR PTA TIBIOPER ATHER INIT LT	4	6	10
IR THROMBECTOMY MECH VEIN(S)	6	2	8
IR INFUS TRANSCATH VEN THROM INI	5	2	7
IR PTA FEM/POP ATHERECTOMY RT	3	4	7
IR PTA TIBIOPER ATHER INIT RT	4	3	7
IR STENT VENOUS INITIAL	4	3	7
IR DIALY ANGIO PTA/STNT/MECH/INF	2	4	6
IR INF TRANSCATH VEN THROM DISC	4	2	6
IR PTA ILIAC W STENT INIT RT	3	3	6
IR PTA FEM/POP RT	5	1	6

IR PTA TIBIOPER INIT LT	4	2	6
IR ENDOVASC VISC/ABD AOR GRFT +2	5	0	5
IR THROMB MECH ART/BP GRAFT INIT	4	1	5
IR INF TRANSCATH ART THROM DISC	4	1	5
IR PTA FEM/POP LT	1	4	5
IR ABD/VISC/UE STENT ARTERY INIT	1	4	5
IR DIALYS CIRC ANGIO W PTA/STENT	0	4	4
IR PTA VENOUS EA ADD	2	2	4
IRSC ENDO PROS OPEN FEM ART BIL	3	0	3
IRSC ENDO AAA REP ILIAC EA ADD	3	0	3
IRSC VASC EMBO/OCLUSN DIALY CIRC	0	3	3
IR PTA TIBIOPER EA ADD LT	1	2	3
IR EMBO/OCCLUDE NON-HEM/TUMR ART	3	0	3
IRSC PTA THRU DIALYS CIRC	1	1	2
IRSC PTA/STENT THRU DIALY CIRC	0	2	2
IR THROMBECT MECH VEIN(S) REPEAT	1	1	2
IR INFUS TRANSCATH ART THROM SUB	2	0	2
IR PTA ILIAC W STENT INIT LT	1	1	2
IR PTA FEM/POP W STENT LT	1	1	2
IR PTA FEM/POP W STENT RT	2	0	2
IR PTA TIBIOPER INIT RT	2	0	2
IRSC ENDO PROS OPEN FEMOR ART LT	1	0	1
IRSC ENDO PROS OPEN FEMOR ART RT	1	0	1
IRSC ENDO GRAFT REPAIR ILIAC RT	1	0	1
IRSC REP BLD VES GRAFT LOW EXTR	1	0	1
IR BYPASS POP-TIB-PERON-OTHER	1	0	1
IR EXPLOR EXTRM HEM/THRM/INFEC	1	0	1
IRSC INJ PSEUDOANEURYSM EXTREM	0	1	1
IRSC REVISION AV FIST WO THROMB	0	1	1
IR DIALY CIRC ANG MECH THROM/INF	1	0	1
IR THROMB MECH ART/GRFT SECONDRY	1	0	1
IR INFUS TRANSCATH VEN THROM SUB	1	0	1
IR PTA ILIAC INIT RT	1	0	1
IR PTA FEM/POP ATHER W STENT RT	0	1	1
IR PTA FEM/POP ATHER W STENT LT	1	0	1
IR PTA TIBIOPER EA ADD RT	1	0	1
IR PTA TIBIOPER ATHER EA ADD RT	1	0	1
IR EMBO/OCCLUDE NON-HEMORR VEN	0	1	1
IR ENDO GRAFT REPAIR ILIAC LT SI	1	0	1
IR ENDO GRAFT REPAIR ILIAC RT SI	1	0	1
Subtotal of Interventional Angiography Reported	**227**	**249**	**476**

Total Non-Heart Angiography Procedures Reported	**589**	**586**	**1,175**
Additional Non-Heart Angiography Procedures Performed			
IR US GUIDE VASCULAR ACCESS	425	300	725
IR FLUORO GUIDE CENTRL VEN INSRT	245	62	307
IRSC INS TUNNEL CV CATH >=AGE 5	146	13	159
IRS ACTIVATED CLOTTING TIME	87	42	129
IRSC INS N-TUNNEL CV CATH >=AGE5	95	3	98
IRSC INSERTION PORT CHEST >=AGE5	7	43	50
IRSC INSERTION PICC >=AGE 5	39	6	45
IR FLUORO GUIDE CENTRL VEN REPLC	23	17	40
IRSC REPLACE TUNNELED CV CATH	18	17	35
IR ABSCESSOGRAM SI	5	25	30
IRSC INJ ABS/CYST VIA EXIST TUBE	5	24	29
IR REMOVAL TUNNELED PORT CHEST	3	14	17
IR ABSCESS TUBE CHANGE SI	4	13	17
IR CHOLECYSTOSTOMY W IMAGE	16	0	16
IR PLACE NEPHROSTOMY CATH LT	11	5	16
IR INSERTION GASTROSTOMY TUBE	11	2	13
IVUS NON-CORONARY EA ADD/IMAGING	9	3	12
IRSC EXCHG ABSCSS/CYST DRN CATH	3	9	12
IRSC INSRT TUNNELED PLEURAL CATH	9	2	11
IVUS NON-CORONARY INIT/IMAGING	7	4	11
IR FLUORO GUIDE PERCUT DRNAGE SI	9	2	11
IR NEPHROSTOMY CATH EXCHANGE BIL	1	9	10
IRSC URETEROSTOMY TUBE CHANGE	1	9	10
IR PLACE NEPHROSTOMY CATH RT	8	1	9
IR FIBRIN SHEATH MECH REMOVAL SI	4	5	9
IRSC REMOVAL FIBRIN SHEATH MECH	4	4	8
IR RETRIEVAL FILTER IVC W IMAGE	0	8	8
IR NEPHROSTOMY CATH EXCHANGE RT	4	4	8
IR INSERT CATHETER PLEURA W IMG	5	1	6
IR PARACENTESIS W IMAGING	3	3	6
IR INSRT PERITN CATH TUNLD W IMG	5	1	6
IR REPLACE GASTROSTOMY TUBE	4	2	6
IR REPLACE GASTRO-JEJUNOST TUBE	5	1	6
IR NEPHROSTOMY CATH EXCHANGE LT	5	1	6
RHC WO/W O2 SAT AND CARD OUTPUT	6	0	6
IR DRN PERITONEAL ABSCESS W IMG	5	0	5
IR FLUORO GUIDE BIOPSY	3	2	5
IR DECOMPRESS FASCIO LEG ANT/LAT	4	0	4
IR XCHG BILIARY DRAIN CATH	3	1	4

IR REMOVE BILIARY DRAINAGE CATH	1	3	4
IRSC ILEAL CONDUIT INJ	2	2	4
IR FLUORO GUIDE CENTRL VEN REMOV	1	3	4
IR SOFT TISSUE CATH DRAIN W IMG	3	0	3
IRSC BIOPSY BONE DEEP	2	1	3
IR KYPHO THORACIC 1 BODY W IMAGE	1	2	3
IR KYPHO THORACIC EA ADD BODY	0	3	3
IR REMOVAL PLEURAL CATHETER	1	2	3
IR THORACENTESIS W IMAGING	1	2	3
IRSC REPLACE NON-TUNNEL CV CATH	3	0	3
IRSC BIOPSY TRANSCATHETER	2	1	3
IRSC BIOPSY BONE MARROW	2	1	3
IR NEPHRO-NEPHROURET CONVRSN LT	1	2	3
IR TRANSCATHETER BIOPSY SI	2	1	3
IRSC REPLACE PICC W/O PORT/PUMP	1	1	2
IR INJ CHOLANGIO EXISTING ACCESS	0	2	2
IR REPLACE JEJUNOSTOMY TUBE	0	2	2
IR REMOVAL NEPHROSTOMY TUBE	0	2	2
IR NEPHROSTOGRM INJ RT EXIST ACC	1	1	2
IR URETERAL STENT PLACE TRACT LT	0	2	2
IR URETERAL BALLOON DILATION LT	0	2	2
IR URETERAL BALLOON DILATION RT	1	1	2
IRSC LUMBAR PUNCTURE DIAGNOSTIC	1	1	2
IR UROSTOMY TUBE CHANGE BIL SI	0	2	2
IR FLUORO FIRST HOUR	2	0	2
IR US GUIDE ASPIRATION SI	2	0	2
IRSC FNA W IMAGE	1	0	1
IR ABLATION BONE TUMOR RF W IMG	1	0	1
IR REMOVAL TUNNELED PORT ARM	0	1	1
IRSC REPOSTION VAD PREV PLACED	0	1	1
IR PLACE BILIARY DRN CATH XTERNL	0	1	1
IRSC ABDOMINAL/RETROPERITONL BX	0	1	1
IR CONVERSION G TO G-J TUBE	1	0	1
IR REMOVE URETERL STENT INTERNAL	0	1	1
IR REM/REPL URETERL STENT EXTERN	0	1	1
NEPHROURETERAL CATH EXCHANGE BIL	0	1	1
IR NEPHROSTOGRAM INJ LT NEW ACC	1	0	1
IR NEPHROSTOGRM INJ LT EXIST ACC	0	1	1
IR PLACE NEPHROURETR CATH RT NEW	0	1	1
IR PLACE NEPHROURETR CATH LT NEW	1	0	1
IR URETERAL STENT W CATH RT	1	0	1

IRSC SUPERIOR HYPOGAS PLEXUS INJ	0	1	1
IR BILIARY TUBE CHANGE SI	0	1	1
IR SINOGRAM SI	0	1	1
IR US GUIDE BIOPSY SI	0	1	1
IR FLUORO GUIDE ASPIRATION	1	0	1
IR FLUORO GUIDE SPINE INJECTION	1	0	1
ADDITIONAL NON-HEART ANGIOGRAPHY PERFORMED	**1285**	**710**	**1,995**
TOTAL NON-HEART ANGIOGRAPHY PROCEDURES PERFORMED			**3,170**

Source: Hospital records.

Advocate Heart Institute
17850 S. Kedzie Avenue, Suite 3250 || Hazel Crest, Illinois 60429 || P 708.799.8700 ||

Date: May 31, 2018

Kathryn J Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson,

I am writing this letter in support of the proposed modernization project at Advocate South Suburban Hospital. I am on medical staff here, as a Cardiac Electrophysiologist specializing in Heart Rhythm disorders.

Electrophysiology is one of the growing specialties of cardiology where the volumes of patients and procedures have been on a rapid rise. Dedicated EP labs have become a necessity. The numbers of device implants, including pacemakers and defibrillators have been increasing with our aging population. Cases can take several hours with additional time required to maintain effective sterile environment for these implants.

In addition, with the increasing prevalence of arrhythmias, catheter ablation as a curative procedure has become an important first line therapy. We also anticipate starting complex ablations for atrial fibrillation. This in addition would definitely require a dedicated EP lab with additional time and equipment for these cases. We hope to help our patients better with providing them the availability of such procedures at our hospital in their familiar and convenient environment.

I am encouraged by the prospect of having the new surgical suite and Interventional suite (including the EP lab) in the next few years and humbly request you to support this project.

Sincerely,

Adarsh Bhan, MD FHRS

Signed before me this 31st day of May 2018 in Cook County, IL.

Cynthia N. Tolliver

"OFFICIAL SEAL"
CYNTHIA N TOLLIVER
Notary Public, State of Illinois
My Commission Expires 5/10/2022

TRANSFER AGREEMENT
BETWEEN
ADVOCATE HEALTH AND HOSPITALS CORPORATION,
d/b/a Advocate South Suburban Hospital
AND
ADVOCATE HEALTH AND HOSPITALS CORPORATION,
d/b/a Advocate Christ Medical Center

THIS TRANSFER AGREEMENT ("Agreement") is entered into this 24th day of July, 2018 ("Effective Date") between and among Advocate South Suburban Hospital (ASSH) and Advocate Christ Medical Center (ACMC), both operating units of ADVOCATE HEALTH AND HOSPITALS CORPORATION.

WHEREAS, ASSH plans to open another cardiac catheterization laboratory on its premises, 17800 Kedzie, Hazel Crest, Illinois 60429;

WHEREAS, to open a cardiac catheterization laboratory, ASSH must have a transfer plan to ensure that patients requiring a higher level of care than provided at ASSH, including an open heart program are transferred to a facility with such capabilities; and

WHEREAS, ACMC, located at 4440 W. 95th Street, Oak Lawn, Illinois 60453, is a Level I trauma center with a comprehensive cardiac program, including but not limited to open heart surgery, which will accept the medically necessary transfer of cardiac patients from ASSH pursuant to the terms of this Agreement

NOW, THEREFORE, BE IT RESOLVED, that in consideration of the mutual covenants, obligations and agreements set forth herein, ASSH and ACMC agree as follows:

I. TERM AND TERMINATION

1.1 This Agreement shall be effective from the Effective Date, and shall remain in full force and effect until terminated by either ASSH or ACMC. This Agreement can be terminated by either ASSH or ACMC on six (6) months written notice.

II. OBLIGATIONS OF THE PARTIES

2.1 ASSH agrees:

a. That ASSH shall refer and transfer patients to ACMC for medical treatment only when such transfer and referral has been determined to be medically appropriate by the patient's attending physician or, in the case of an emergency, the Medical Director for ASSH, hereinafter referred to as the "Transferring Physician";

b. That the Transferring Physician shall contact ACMC's Emergency Department Nursing Coordinator, prior to transport, to verify the transport and acceptance of the emergency patient by ACMC. The decision to accept the transfer of the emergency patient shall be made by ACMC's Emergency Department physician, hereinafter referred to as the "Emergency Physician", based on consultation with the member of ACMC's Medical Staff who will serve as the accepting attending physician, hereinafter referred to as the "Accepting Physician". In the case of the non-emergency patient, the Medical Staff attending physician will act as the Accepting Physician and must indicate acceptance of the patient. ASSH agrees

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that ACMC shall have the sole discretion to accept the transfer of patients pursuant to this Agreement subject to the availability of equipment and personnel at ACMC. The Transferring Physician shall report all patient medical information which is necessary and pertinent for transport and acceptance of the patient by ACMC to the Emergency Physician and Accepting Physician;

c. That ASSH shall be responsible for effecting the transfer of all patients referred to ACMC under the terms of this Agreement, including arranging for appropriate transportation, financial responsibility for the transfer in the event the patient fails or is unable to pay, and care for the patient during the transfer. The Transferring Physician shall determine the appropriate level of patient care during transport in consultation with the Emergency Physician and the Accepting Physician;

d. That pre-transfer treatment guidelines, if any, will be augmented by orders obtained from the Emergency Physician and/or Accepting Physician;

e. That, prior to patient transfer, the Transferring Physician is responsible for insuring that written, informed consent to transfer is obtained from the patient, the parent or legal guardian of a minor patient, or from the legal guardian or next-of-kin of a patient who is determined by the Transferring Physician to be unable to give informed consent to transfer; and

f. To inform its patient of their responsibility to pay for all inpatient and outpatient services provided by ACMC.

2.2 ACMC agrees:

a. To accept and admit in a timely manner, subject to bed availability, ASSH patients referred for medical treatment, as more fully described in Section 3.1, Subparagraphs a through g;

b. To accept patients from ASSH in need of inpatient hospital care, when such transfer and referral has been determined to be medically appropriate by the patient's attending physician and/or emergency physician at ASSH;

c. That ACMC will seek to facilitate referral of transfer patients to specific Accepting Physicians when this is requested by Transferring Physicians and/or transfer patients; and

d. That ACMC shall provide ASSH patients with medically appropriate and available treatment provided that Accepting Physician and/or Emergency Physician writes appropriate orders for such services.

III. GENERAL COVENANTS AND CONDITIONS

3.1 Release of Medical Information. In all cases of patients transferred for the purpose of receiving medical treatment under the terms of this Agreement, ASSH shall insure that copies of the patient's medical records, including X-rays and reports of all diagnostic tests, accompany the patient to ACMC, subject to the provisions of applicable State and Federal laws governing the confidentiality of such information. Information to be exchanged shall include any completed transfer and referral forms mutually agreed upon for the purpose of providing the medical and administrative information necessary to determine the appropriateness of treatment or placement, and to enable continuing care to be provided to the patient. The medical records in the care and custody of ACMC and ASSH shall remain the property of each respective institution.

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3.2 Personal Effects. ASSH shall be responsible for the security, accountability and appropriate disposition of the personal effects of patients prior to and during transfer to ACMC. ACMC shall be responsible for the security, accountability and appropriate disposition of the personal effects of transferred patients upon arrival of the patient at ACMC.

3.3 Cooperative Efforts. ASSH and ACMC agree to devote their best efforts to promoting cooperation and effective communication between the parties in the performance of services hereunder, to foster the prompt and effective evaluation, treatment and continuing care of recipients of these services. They each shall each designate a representative who shall meet as often as necessary to discuss quality improvement measures related to patient stabilization and/or treatment prior to and subsequent to transfer and patient outcome. ASSH and ACMC each agree to reasonably cooperate with each other to oversee performance improvement and patient safety applicable to the activities under this Agreement to the extent permissible under applicable laws. All information obtained and any materials prepared pursuant to this section and used in the course of internal quality control or for the purpose of reducing morbidity and mortality, or for improving patient care, shall be privileged and strictly confidential for use in the evaluation and improvement of patient, as may be amended from time to time.

3.4 Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed, national origin, age or handicap, under any program or activity receiving Federal financial assistance.

IN WITNESS WHEREOF, this Agreement has been executed by ACMC and ASSH on the date first above written.

ADVOCATE HEALTH AND HOSPITALS CORPORATION d/b/a ADVOCATE CHRIST MEDICAL CENTER

BY: _____
NAME: Matthew Primack
TITLE: President

ADVOCATE HEALTH AND HOSPITALS CORPORATION, d/b/a ADVOCATE SOUTH SUBURBAN HOSPITAL

BY: _____
NAME: Richard Heim
TITLE: EVP South Chicago

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Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

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

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

Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ **Surgical Operating Suite, Class C**	**9**	**9**
☒ **Recovery Suite**	**13**	**50**
Phase 1 Recovery - PACU = 11		
Phase 2 Recovery - Prep & Recovery for OR, Cardio = 39		
☒**Surgical Procedure Suite Class B**	**4**	**5**
☒**Phase 2 Recovery -Prep & Recovery for Procedural Suite**	**17**	**18**
☒**Central Sterile Processing**		

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

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

SECTION 1110.270 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Surgical Operating Suite, Class C

c) Service Modernization

The applicant shall document that the proposed Project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed Project will address a variety of issues experienced in the 45-year old surgery suite. Examples include the following:

The HVAC system is very old and will not take the temperature lower than 68 degrees, presenting issues for gowned surgeons and staff that need a lower temperature to function well.

The electrical booms, essential in all the ORs, are obsolete and parts to repair them are no longer available.

The costs to address these and many other issues are not a wise investment in an area where the ORs are significantly undersized. The new, modernized systems in the proposed Project will correct these and other issues, and help prepare the Hospital for future system needs.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

The current surgical suite was built in 1972 and no longer meets the needs for a modern department. Larger-sized operating rooms are needed to meet current industry standards, to accommodate the latest equipment that is both more abundant in number and larger in size than when the surgical suite was originally built.

For example, the da Vinci robot and intraoperative radiation therapy offer many benefits to patients but are pieces of equipment that require large operating rooms in which to maneuver. The current rooms are not designed for the technology used today. For example, there is not enough space to put in the booms needed to get the many cords and cables off the floor, which creates a hazard for the staff. The operating tables are larger today which consumes the space for staff around the patient. Larger rooms will support an increased number of staff within each operating room to manage the more complex procedures and equipment. Larger operating rooms are quickly becoming the industry standard with a minimum of 600 sf per room. Only 2 of the 9 rooms meet today's

standard for square feet. The remaining general rooms range in size from 350-450 sf, far below today's industry standard,

With only two of the rooms sized to meet the needs of many of today's procedures. The demand for these two large-sized rooms far exceeds capacity.

Growing demand for larger-sized operating rooms is created by many disciplines. For example, new surgical robotic equipment must be accommodated. Presently, the robotic assisted procedures are performed for urologic, gynecologic and bariatric procedures. The Hospital is seeing evidence of a growing demand for robotic procedures.

Sometimes the procedures with the smallest incision involve the largest equipment as in the case of the new minimally invasive valve cases. Laparoscopic equipment with large lights and cameras require more space in the ORs.

Orthopedics and other surgical specialties are also using larger and more abundant equipment.

The new operating rooms will integrate state-of-art technology such as video/audio routing and overhead booms for equipment and gases. By having the equipment on the booms, it will assist in reducing all the wires on the floors which promotes staff and patient safety. The new technologies and equipment in the operating room will assist in performing simple to complex surgeries using minimally invasive techniques, which will shorten the recovery time so that the patient can return to their normal life much more quickly.

One of the central features of the Project is the development of an interventional platform co-locating surgery and other interventional procedures including cardiac catheterization, electrophysiology, and interventional angiography. These interventional services will share Phase I recovery (PACU), Phase II prep and recovery, and support spaces (family waiting, consult rooms, management offices, employee lockers, physician dictation and conference rooms).

This patient care redesign was developed to allow for cross-trained staff and shared resources to improve patient care and staff efficiency. The novel design enhances the range of support services available for patients and families and effective utilization of equipment and facilities. A broader scope of staff is better able to accommodate the peaks in volume as well as emergency and unexpected situations. The shared equipment and resources also provide backup in case of failure of equipment or systems. The plan has been developed to be flexible to meet the changing needs of patients and the industry.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

Not applicable. There is no equipment in this component of the Project that meets or exceeds the major medical threshold.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

In calculating the need for ORs, it was important to consider the history without the bronchoscopy hours as it has been planned for those services to go to the surgical procedure suite.

	Historical Utilization						
Surgery without Bronch	Base Year 2013 from earlier correction	2014 from earlier correction	2015	2016	2017	% change 2013-2017	Annual Change Projected
Surgery Hours, all cases	12,306	12,712	13,183	12,568	12,340	0.28%	0.07%
Less Bronchoscopy hours	184	249	240	243	275		
Surgery Hours remaining	12,122	12,463	12,943	12,325	12,065	-0.47%	-0.12%
Historical	12,122						
Standard hours per room	1,500						
Rooms needed	8.1						

Source: Annual Hospital Questionnaires and Hospital records

While the history is important, the picture for future surgery demand is changing significantly. As an example, the following physicians are bringing new procedures and new patients to the Advocate South Suburban Hospital. Their energy and forward vision is adding to the story of need for a new surgical platform.

- Dr. Ruby has introduced uterus sparing removal of uterine fibroids using radiofrequency ablation which is important for younger women with uterine fibroids who would like to save their uterus.
- Dr. Song is relocating his practice from a site outside the ASSH primary service area. He is noted as a neuro-spine surgeon and will attract patients that had to go outside the community to get treated.
- Dr. Finkelstein is a urogynecologist who is introducing a new procedure successful with older patients.
- Dr. Tanquilut, a vascular/endovascular surgeon, is bringing a new procedure: Trans Carotid Artery Revascularization to address the risk of stroke. He is also doing endovascular abdominal aortic aneurysm repairs which are seen more often in the aging population around the service area. His group is recruiting another associate to assist in their growing practice doing procedures to implant dialysis catheters.

By looking at four of these physicians' new volume, it shows the impact of this utilization as defined in the projected volume using the Compound Annual Growth Rate (CAGR) to 2023, two years after the Project's completed. Letters attesting to this volume follow as Exhibits #1-4, pages 93-96.

Dr. Ruby expects to do 32 uterine sparing cases/year at 3 hours/case = 96 new hours

Dr. Song expects to do 100 neuro-spine cases/year, averaging 2.5 hours/case = 250 hours

Dr. Finkelstein expects to do 50 new urogynecology cases/year, averaging 3 hours/case = 150 hours

Dr. Tanquilut expects to do 75 vascular cases/year averaging 3 hours/case = 225 hours

			CAGR Projected Utilization					
			Planning	Construction	Construction	Modernization	Year 1 Post	Year 2 Post
Surgery	% change 2013-2017	Annual Change Projected	2018	2019	2020	2021	2022	2023
Surgery Hours without bronchoscopy	-0.47%	-0.12%	12,051	12,037	12,022	12,008	11,994	11,980
New procedure hours								
Dr. Ruby			96	96	96	96	96	96
Dr. Song			250	250	250	250	250	250
Dr. Finkelstein			150	150	150	150	150	150
Dr. Tanquilut			225	225	225	225	225	225
Total with new cases projected							12,715	12,701
Standard hours per room							1.500	1,500
Rooms needed							8.5	8.5

Source: Hospital Records

The data shows that 9 ORs will be needed:

12,701 hours ÷ 1,500 hours per OR = 8.5 ORs, rounded to 9 ORs.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

There are utilization standards and the Hospital meets them.

Advocate South Suburban Hospital has justified the need for 9 Surgical Operating Rooms (Class C). This standard has been met.

Advocate Medical Group

17850 S. Kedzie Avenue, Suite 3500 || Hazel Crest, Illinois 60429 || P 708.575.4415 ||

Allan Ruby, MD FACOG
Advocate Medical Group
Suite 3500
17850 S. Kedzie Ave.
Hazel Crest, IL 60429

May 31, 2018

Kathyrn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson,

I am a physician specializing in Obstetrics and Gynecology. I am writing in support of the proposed modernization project at Advocate South Suburban Hospital where I am on the medical; staff.

In addition to the work I have done there for several years, starting in the month of July, I will be starting to perform a minimal invasive procedure to remove uterine fibroids with the use of radio frequency energy and intraoperative ultrasound while keeping the uterus intact. This procedure will take about 3 hours including set up and clean up time. I am expecting to do at least 8 cases per quarter which would result in 96 additional hours per year in OR time and anticipate the demand for this new treatment to increase.

I am encouraged by the prospect of having a new surgical suite in the next few years and urge you to support this project.

Sincerely,

Allan Ruby, MD

Signed before me this 31st day of May 2018 in Cook County, IL.

Cynthia N. Tolliver

"OFFICIAL SEAL"
CYNTHIA N TOLLIVER
Notary Public, State of Illinois
My Commission Expires 5/10/2022

NEUROLOGICAL SURGERY & SPINE SURGERY, S.C.
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Board Certified Neurosurgeon

SEAN A. SALEHI, M.D., FAANS
Former Assistant Professor of Neurosurgery
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TIBOR BOCO, M.D., FAANS
Assistant Professor of Neurosurgery
Rush University Medical Center
Board Certified Neurosurgeon

JOHN K. SONG, MD, FACS, FAANS, CIME

KIMBERLY J. MERCURIO, MD
Physical Medicine and Rehabilitation
Board Certified Physiatrist

Date: 05/24/18

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson,

I am a physician specializing in neurosurgery. I am writing in support of the proposed modernization project at Advocate South Suburban Hospital.

I have been practicing for 14 years. I am now moving my practice from a hospital not in this service area and will be practicing at Advocate South Suburban Hospital.

Some of my procedures are not currently offered in the South Suburban service area. A representative list of the types of cases I will be doing include:

Cervical fusions and disc replacements
Lumbar fusions
Lumbar disc replacement
Minimally Invasive spine surgery

Based on the demand in this area, I expect to do 100 cases a year. My cases take an average of 2-3 hours to complete, including set up and clean up. That would likely result in 200-300 additional hours of surgery per year at Advocate South Suburban Hospital.

I am encouraged by the prospect of having a new surgical suite in the next few years and urge you to support this project.

Sincerely,

John K Song, MD
Board Certified Neurosurgeon

OFFICIAL SEAL
DONNA P SVOBODA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/21/20

Donna P Svoboda 5-24-18

Women's Healthcare of Illinois

a division of Providea Health Partners, LLC

Obstetrics, Gynecology & Urogynecology

www.whcillinois.com

June 1, 2018

Kathryn J. Olson, Chair

Illinois Health Facilities and Services Review Board

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

Dear Ms. Olson,

I am a physician specializing in Urogynecology. I am writing in support of the proposed modernization project at Advocate South Suburban Hospital where I am on the medical staff.

In addition to the work I have done there for several years. I have recently begun performing a new procedure that is especially targeted at the older patients. I anticipate the demand for this new treatment to increase.

Based on the higher incidence of older people in the Advocate South Suburban Hospital service area, I expect to do 50 additional cases a year. My cases take an average of 3 hours to complete, including set up and clean up. That would likely result in 150 additional hours of surgery per year.

I am delighted by the prospect of having a new surgical suite in the next few years and urge you to support this project.

Sincerely,

"OFFICIAL SEAL"
CYNTHIA N TOLLIVER
Notary Public, State of Illinois
My Commission Expires 5/10/2022

Dr. Kenneth Finkelstein DO

Signed before me this 1st day of June 2018 in Cook County IL
Cynthia N Tolliver

Evergreen Park
9730 South Western, Suite 100
Evergreen Park, IL 60805
(708) 425 – 1907

Mokena
10260 W. 191st Street, Suite 100
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Vascular Specialists

20060 Governors Drive Suite 102
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Fax: (708) 856-0567

Eugene Tanquilut, D.O.
Sanjeev Pradhan, M.D.
Saadi Alhalbouni, M.D.

May 29, 2018

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson,

I am a physician specializing in Vascular and Endovascular services. I am writing in support of the proposed modernization project at Advocate South Suburban Hospital where I am on the medical staff.

In addition to the work I have done there for several years, I am looking to bring new procedures called Trans Carotid Artery Revascularization to decrease risk of stroke. We also perform endovascular abdominal aortic aneurysm repairs in addition to treatment for peripheral vascular disease. Based on the aging population in this area, there will be an increased demand to perform interventions on these patients. I expect to do 75 cases a year. My cases take an average of 3 hours to complete, including set up and clean up. That would result in 225 additional hours of surgery per year and in the interventional suites.

I am encouraged by the prospect of having a new surgical and interventional suites in the next few years and urge you to support this project.

Sincerely,

Eugene M. Tanquilut, D.O., FACOS
Vascular/Endovascular Surgery

Signed before me this 29th day of May 2018 in Cook County IL.

Cynthia N. Tolliver

"OFFICIAL SEAL"
CYNTHIA N TOLLIVER
Notary Public, State of Illinois
My Commission Expires 5/10/2022

SECTION 1110.270 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Recovery Suite: PACU and Phase II

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

Not applicable. This project will not result in replacement of deteriorated facilities.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate South Suburban's proposed surgery and cardiovascular services will be located into one new building with the intent of integrating the support spaces and services. The Recovery Suite will contain the Post Anesthesia Care Unit and the Phase II Recovery stations and share common support space. Consolidating the separate areas into one larger area leverages the use of valuable resources, reducing redundant costs.

This project is proposing 11 Post Anesthesia Care Unit (PACU) stations and 39 Phase II prep and recovery stations. They will support the 9 Surgery Operating Rooms (Class C), and, as needed, the Cardiovascular Service. The new recovery suite will provide updated monitoring technology and facilities, critical to care for post-surgical patients.

The new area will correct the current inadequate number of Phase II stations for surgery patients. Due to the lack of available stations, patients are at times held in an operating room after surgery waiting for a Phase II recovery station.

The recovery stations are designed to the Advocate Corporate standard, developed by 45 clinical and facility experts across the Advocate system to enhance patient safety, the patient experience and staff efficiency. With all the stations designed to the same layout standard, that results in improved efficiency and safety. In case of an emergency when urgent response is needed, the clinician will immediately know location of the critical technology and facility components.

The Recovery Suite will provide more space for visitors, now allowed under the amended Illinois code, and accommodate the additional staff required by code to manage those visitors.

The combined unit will provide more support space for each patient, as well as making it quiet and private, important in a healing environment. The new design provides an improved line of sight with workstations, enhancing patient safety and more space for staff support.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

Not applicable. There is no equipment in this component of the Project that meets or exceeds the major medical threshold.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

There are no utilization standards for recovery stations.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

IDPH Hospital Licensing Code 250, Section 250.2440, i) 4) B) defines "A minimum of one (PACU) recovery room bed shall be provided for each operating room".

IDPH Hospital Licensing Code 250, Section 250.2440, i) 5) A) defines "A minimum of four recovery stations per operating room shall be provided for each operating room".

Advocate South Suburban Hospital is proposing 9 general operating rooms to be supported by 11 post anesthesia stations and 39 Phase II stations with capacity to support the cardiovascular services, as needed.

Advocate South Suburban Hospital has justified the need for 11 Phase I Recovery (PACU) Stations and 39 Phase II Recovery stations. This standard has been met.

Section 1110.270 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Surgical Procedure Rooms (Class B)

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1. Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not replace facilities or equipment that has deteriorated.

2. Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate South Suburban Hospital is proposing to modernize the surgical procedure suite to provide endoscopy which will include gastrointestinal studies, endoscopic retrograde cholangiopancreatography, referred to as ERCPs, and bronchoscopy in one department. This is planned to be in the area currently used for endoscopy and will only require some minor modernization.

Healthcare consultant Sg2, that tracks trends and forecasts demand, reports: "Outpatient GI procedures growth is expected due to aging population, expanded insurance coverage, including access to timely OP services and improvements in diagnostic and therapeutic endoscopy."

Cases seen in the surgical procedure rooms are expanding beyond the traditional colonoscopy. The list below shows some of the procedures done in this department.

- Endoscopic Ultrasound (EUS)
- Spyglass for cholangioscopy and pancreatoscopy via ERCP
- Pseudocyst drainages (via EUS guidance)
- Fiducial placements via EUS
- Large colon polyp removal
- Single balloon enteroscopy
- Barrett's therapy with HALO/RFA and endoscopic mucosal resection
- Endoscopic mucosal resection for both upper GI esophagus stomach and duodenal lesions as well as colon lesions
- Enteral stenting - esophagus, pyloric, duodenal and colonic
- Dilation of complex structures such as esophageal
- Transoral incisionless fundoplication
- Endoscopic obesity treatment – E.g., intragastric balloons for weight loss

Two additional gastroenterologists, Drs. Julka and Ballard, joined the medical staff in the past 12 months. Considering that most of these cases are scheduled, that allows for better management of the utilization. For the foreseeable future, the modernization of the rooms with adjacent prep and recovery rooms is expected to meet the need for this important service.

Currently, bronchoscopies are done in the general surgery suite, in the one operating room with negative pressure. Because of the negative pressure, the room has not been available for all the other surgical cases that essentially require positive pressure. That is prompting the need to relocate the bronchoscopy service to be done in the procedural suite in a negative pressure room, and thus restoring the availability of all the general operating rooms.

While the bronchoscopy volume has been small in the past, these are critical services to patients with pulmonary disease and a valuable service for the Oncology Department. Oncology started low dose lung screening in August 2017 and have already completed 138 screening, and identified five suspicious and one positive case. These lung studies are a significant component for the expected expansion of the Oncology Services and the accompanying utilization of bronchoscopy studies.

In addition to the bronchoscopies, isolation cases and inpatient gastroenterology cases will be done in that room. That allows the other 4 rooms to be more available for outpatients, usually seen in a predictable schedule.

3. Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

N/A There is no endoscopy equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

Current Utilization

To project the future demand, utilization trends were prepared using the past 5 years utilization.

	Historical Utilization						
Procedural Suite Hours	**Base Year 2013 from earlier correction**	**2014 from earlier correction**	**2015**	**2016**	**2017**	**% change 2013-2017**	**Annual Change Projected**
GI & ERCP	6,372	5,154	5,807	6,081	7,280	14.25%	3.39%
Bronchoscopy	184	249	240	243	275		
Total Hours	6,556	5,403	6,047	6,324	7,555	15.24%	3.61%
Historical vs Projected	6,372				7,555		
Standard hours per room	1,500				1,500		
Rooms needed	4.2				5.0		

Source: Hospital records

Projected Utilization

The trend was then projected to 2023 using the CAGR trend lines. That resulted in the following:

			CAGR Projected Utilization					
			Planning	Construction	Construction	Modernization	Year 1 Post	Year 2 Post
Procedural Suite Hours	% change 2013-2017	Annual Change Projected	2018	2019	2020	2021	2022	2023
Total Procedural Hours	15.24%	3.61%	7,828	8,110	8,403	8,706	9,020	9,346
Projected							9,020	9,346
Standard hours per room							1,500	1,500
Rooms needed							6.0	6.2

Source: Hospital records

9,346 hours in 2023 ÷ 1,500 = 6.2 = 7 rooms

The Hospital is planning to have **five** rooms and clearly meets the standards.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

There is a State Standard for Surgical Procedure Rooms (Class B). The projections show Advocate South Suburban Hospital volume meets the need for **five** rooms.

SECTION 1110.270 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Phase II Prep & Recovery – Surgical Procedure Suite

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities
The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

Not applicable. This project will not result in replacement of deteriorated facilities.

2) Necessary Expansion
The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate South Suburban Hospital has justified the need for 5 surgical procedure rooms. There will be comparatively minor modification to the existing suite. There are currently 17 rooms used for Phase II Prep and Recovery. An office will be converted to provide one more Phase II Prep & Recovery room.

A) Major Medical Equipment
Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

Not applicable. There is no equipment in this component of the Project that meets or exceeds the major medical threshold.

B) Service or Facility
Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

There is no State Standard for utilization of Phase II Prep and Recovery rooms. Instead, the minimum number of rooms required is dictated by the number and type of surgical procedure rooms.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

The State has indicated it requires a minimum of 3 recovery stations for every Surgical Procedure Room where outpatients are treated. There are five procedure rooms in the Surgical Procedure Suite being modernized in the proposed Project.

5 surgical procedure rooms x 3 recovery rooms/procedure room = 15 recovery rooms

The throughput of incoming patients for preparation, and into the Procedure Rooms can be slowed if the recovering patients are not ready to be discharged. Three additional prep and recovery stations are needed to accommodate timely throughput of patients to ensure department and physician productivity and decrease the current bottlenecks that exist today.

Additionally, Endoscopy has seen an increase in the acuity of the patients being treated and therefore additional prep and recovery bays are needed due to the variation in procedure and recovery times.

All prep and recovery rooms will be in separate rooms to provide privacy to ensure compliance with HIPAA standards, minimize the spread of infection, and provide patients, families and physicians a quiet space to explain procedures and discuss the outcomes and follow-up needed.

Advocate South Suburban Hospital has justified the need for 18 Phase II Prep & Recovery Rooms for the Surgical Procedure Suite.

SECTION 1110.270 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Central Sterile Processing

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

4) Deteriorated Equipment or Facilities
The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

Not applicable. This project will not result in replacement of deteriorated facilities.

5) Necessary Expansion
The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate South Suburban Hospital has justified the need for 9 surgical operating rooms, 5 surgical procedure rooms, and 3 cardiovascular rooms. Central Sterile Processing will be used to support these operating and procedure rooms. Central Sterile Processing also supports labor and delivery, emergency department, wound clinic, and mammography.

The current 2,494 GSF facility is too small to even allow for the proper cleaning, decontamination, assembly and wrapping of instrument trays so currently all that work is done in the departments before they are sent to the central sterile department for sterilization. This process is inefficient and creates more work the staff. In addition, the department faces a daily challenge over space to store equipment and carts to keep them out of hallways.

The proposed department will have 13,865 GSF with well-planned storage. The location will be in the lower level of the same building as the surgical operating rooms and the cardiovascular rooms with easy access via a dedicated elevator.

6) Utilization
D) Major Medical Equipment
Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

Not applicable. There is no equipment in this component of the Project that meets or exceeds the major medical threshold.

E) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

There are no utilization standards for Central Sterile Processing.

F) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

IDPH Hospital Licensing Code 250, Section 250.2440, i) 7) requires a central sterilizing and supply room, to be either within the surgical suite or provided as a separate department within the hospital. The service, as planned, will be a separate department located directly below the surgery and cardiovascular department.

Advocate South Suburban Hospital has justified the need for a Central Sterile Processing department.

Non-Clinical Service Areas
While this information is not required, it is included to provide a better understanding of the non- clinical areas in the project.

Medical Staff and Surgery Offices and Support 9,312 GSF Modernized
These offices will be in space that currently houses the cardiology support. In addition to the specific offices for the medical staff department heads, the medical staff credentialing staff and meeting space will also be here. This is the location for the surgery director, managers, staff education, and clerical support to have their offices and be in close communication

Staff Facilities and On Call 1,202 Modernized and 2,351 GSF As Is
The area is where the surgery lockers are located. They will remain "as is" and the lockers will be used by other hospital support staff. In today's around the clock delivery of specialized care, it is necessary to always have some physicians and staff available in the hospital. These sleeping rooms allow certain "on call" staff to be there and available regardless of distance or weather.

Education 691 GSF Construction, 11,679 Modernized, 842 GSF As Is
The area is a combination of new, modernized and "as is" space. Community education classrooms and a resource center are included. The proposed resource center will be a location where patients, family members, and the public can find materials related to health and life style, a health library of sorts.

Building Systems/Support/AHUs 7,198 GSF Construction, 248 GSF Modernized
The mechanical support for the whole building will come from areas designated as building systems. That includes the heating, ventilation, and cooling systems as well as vacuum. The electrical and plumbing fixtures are also located in various sites throughout the building including the roof top. The efficiency of operating the building is linked to the quality of mechanical, electrical, and plumbing systems including how they are installed, operated and maintained.

Administration 3,375 Modernized, 4,857 GSF As Is
These administrative offices will be in modernized and "as is" space currently used for other administrative purposes. The work entails directing staffing, process management, budgeting and strategic planning. Included in this definition are offices, conference rooms and training sites for such functions as health information management, finance and accounting, quality management, marketing, public relations, risk management, patient relations, human resources, employee health and business development. The conference rooms will be used by physicians, staff, researchers, and students, as well as the community.

Lobby Waiting, Registration Security 5,870 GSF Construction, 2,055 GSF Modernized
These locations are both in new construction and modernized space. They include the patient reception and registration areas and toilets as well as visitor designated spaces for persons waiting for someone in surgery. Their strategic locations make it easier for patients and those accompanying them to enter and find accommodations. By specifically designating visitor space close to the operating rooms, the patients are more comfortable knowing they have a friend or family member close, and the visitors know they are not in the way of the clinical team. The security department will vacate its space and relocate to a compact site that is more accessible to a critical entry point and with better visibility.

Corridors, Stairs, Elevators, Dock 16,491 GSF Construction, 3,608 GSF Modernized
Sections of the building are passageways and corridors that help move people through the Hospital to get to various departments. The stairs and elevators are part of the circulation area. They have been carefully designed to assure unimpeded movement for wheelchairs, gurneys, and supply carts. Equally important is a good line of sight and appropriate lighting to help patients, visitors, and staff locate their destination. The current dock will be demolished to make way for the new building and this will replace that dock. A new loading dock will expedite the delivery and better manage the truck traffic around the hospital.

Materials Management 1,182 GSF Construction, 4,321 GSF As Is
This department provides a core of supply support. The supply chain function includes receiving, storage, and delivery of virtually all the supplies needed. Technology is changing the way materials are tracked, ordered, and accessed so the new department will take full advantage of that.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

This section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, Moody's as Aa2, and Standard and Poor's as A-1+, which qualifies the applicants for the waiver. See Attachment 34, Exhibits 1-3.

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

_____	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts
_____	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

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

FitchRatings

FITCH AFFIRMS ADVOCATE HEALTH CARE'S (IL) REV BONDS AT 'AA'; OUTLOOK STABLE

Fitch Ratings-Austin-02 October 2017: Fitch Ratings affirms the 'AA' rating on approximately $1.4 billion of rated revenue bonds issued by the Illinois Health Facilities Authority and the Illinois Finance Authority on behalf of Advocate Health Care (Advocate).

Fitch also affirms the 'F1+' short-term ratings on the applicable Illinois Health Facilities Authority and Illinois Finance Authority bonds based upon self-liquidity provided by Advocate.

The Rating Outlook is Stable.

SECURITY
The bonds are unsecured obligations of the obligated group.

KEY RATING DRIVERS
AMPLE LIQUIDITY: Advocate's robust operating cash flow continues to bolster its substantial balance sheet strength and support any necessary capital investments. At fiscal 2016, Advocate's unrestricted cash and investments totaled $5 billion, equal to a very strong 361 days cash on hand (DCOH). In addition, Advocate's strong unrestricted reserves are equal to almost 3x long-term debt. Both key metrics exceed Fitch's respective 'AA' category medians of 254 DCOH and 2x cash to debt.

LIGHT DEBT BURDEN: The affirmation of Advocate's 'AA' rating is partly based on Advocate's relatively low debt burden. Advocate's maximum annual debt service (MADS) of $97.3 million equates to a light 1.7% of fiscal 2016 (audited results through Dec. 31, 2016) revenues which, when combined with solid cash flow, generated strong coverage of 7.9x for the same time period.

SOLID MARKET POSITION: Advocate maintains a leading position within its six-county Chicago metropolitan service area that is nearly double its nearest competitors, and remains the largest provider in the state. Fitch continues to note the service area is highly competitive, and the operating environment in Illinois remains challenging.

STRONG CLINICAL INTEGRATION: The 'AA' rating also reflects Advocate's high level of integration with its clinicians, which has produced better care coordination, operating efficiencies, effective contracting, physician engagement, and should continue to position it well to navigate an ongoing shift toward value-based reimbursement.

RATING SENSITIVITIES
CREDIT STABILITY: Given Advocate's strong market position, advanced stance on population health management, sound liquidity position and very good debt service coverage metrics, Fitch does not see any downward rating pressure on Advocate over the outlook period. Similarly, with slightly softer operating margins in 2016, and the high degree of uncertainty in the sector as a whole, Fitch is also of the opinion that upward rating movement is limited over the outlook period.

CREDIT PROFILE
Advocate is an integrated health care system serving the Chicago metropolitan area and central Illinois. The system includes 12 acute care hospitals and an integrated children's hospital (totaling approximately 3,600 licensed beds), a large physician group offering primary and extensive specialty physician services, home health, hospice care, and outpatient centers serving the Chicago

metropolitan area and central Illinois. Total revenues in fiscal 2016 (Dec. 31 fiscal year end) were $5.6 billion.

Advocate and NorthShore University Health System dropped their merger plans after a March 2017 court ruling in favor of the FTC blocking the merger.

Fitch's analysis is based on the consolidated system. The obligated group consists of Advocate Health Care Network Corp, Advocate Health and Hospitals, Advocate North Side Health Network, Advocate Condell Medical Center, and Advocate Sherman Hospital. As of Dec. 31, 2016, the obligated group represented approximately 87% of consolidated assets and 90% of total operating revenues of the consolidated system.

VERY STRONG UNRESTRICED RESERVES: As previously mentioned, Advocate's solid operating cash flow continues to support unrestricted reserve growth and Advocate's capital needs. At fiscal 2016, Advocate's unrestricted cash and investments totaled $5 billion, equal to a very strong 361 DCOH, and almost 3x long-term debt.

This has continued through the second quarter of fiscal 2017 (unaudited six month figures through June 30, 2017) with unrestricted reserves increasing to $5.2 billion, equal to 337 DCOH, and over 3x long-term debt. In addition, Advocate has a very light leverage position, with a debt to capitalization ratio of under 22%.

Advocate has a defined pension plan, which is now (as of fiscal 2017 year to date, fully funded. Fitch views Advocate's investment asset allocation as slightly aggressive, with 22% in equities, 20% in fixed income, and 38% in hedge funds and real estate. Advocate has $326 million in swaps, currently with a negative mark to market of $81 million, however no collateral is posted. Based on discussions with management, Advocate's future capital expenditures appear routine in nature, and there are no new money debt issuances expected at this time, or factored into this rating affirmation.

SOFTER OPERATIONS: As of fiscal 2016, Advocate produced an operating income of $264 million, equal to a 4.7% operating margin, comparing slightly less favorably to fiscal 2015's $331 million operating income, or a 6.1% operating margin. The differential between fiscal 2016 and 2015 is largely due to some minor deterioration of operating revenues (e.g., decreased Medicaid expansion funds, increase in net bad debt and charity) and some slight increases in the expense base, including pharma costs, and increased depreciation and interest expense. However, it remains Fitch's opinion that Advocate will be able to produce consistent positive operating returns over the long term, albeit at perhaps lower levels than historical. It is this ability to continually demonstrate positive margins that remains a hallmark of Advocate's operational strength.

SERVICE AREA: Advocate maintains a leading position (approximately 18% market share) within its six-county Chicago metropolitan service area, nearly double its nearest competitor, but the service area continues to be competitive with sizeable and well respected competitors such as Northwestern Medicine, Presence Health, and Amita Health System.

SELF-LIQUIDITY RATING
The 'F1+' rating reflects Advocate's availability of highly liquid resources to cover the mandatory tender on $212 million of debt that is subject to unremarketed puts. At June 30, 2017, Advocate's eligible cash and investment position available for same-day settlement would cover the maximum mandatory tender on any given date well in excess of Fitch's criteria of 1.25x.

Advocate provided Fitch with an internal procedures letter outlining the procedures to meet any unremarketed puts. In addition, Advocate provides monthly liquidity reports to Fitch to monitor the sufficiency of Advocate's cash and investment position relative to its mandatory put exposure.

DEBT PROFILE

Advocate has approximately $1.6 billion in long-term debt outstanding. Approximately $921 million is fixed rate, $321 million is variable rate demand debt supported by standby bond purchase agreements with three different banks (Wells Fargo, JPMorgan and Northern Trust), $142 million is multi-annual tender bonds with long term interest rates (tender dates are staggered in 2018, 2019 and 2020), $100 million is variable rate direct placement debt, and $70 million is variable rate bonds in windows mode.

Advocate is party to $326 million notional in swap agreements, which had an aggregate negative $81 million mark-to-market as of June 30, 2017. No collateral was required to be posted as of the same time period.

DISCLOSURE

Advocate's disclosure includes annual audited financial statements as well as quarterly unaudited balance sheet, income statement, cash flow statement, an extensive MD&A, and utilization statistics. The information is posted to the Municipal Securities Rulemaking Board's EMMA system. In addition, management holds routine calls with rating agencies and with investors. Fitch considers Advocate's disclosure standards to be best practice.

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Applicable Criteria
Rating Criteria for Public Sector Revenue-Supported Debt (pub. 05 Jun 2017)
https://www.fitchratings.com/site/re/898969
U.S. Nonprofit Hospitals and Health Systems Rating Criteria (pub. 09 Jun 2015)
https://www.fitchratings.com/site/re/866807

U.S. PUBLIC FINANCE

MOODY'S
INVESTORS SERVICE

CREDIT OPINION
27 September 2017

Update

Rate this Research

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Advocate Health Care Network, IL

Update - Moody's affirms Advocate Health Care Network's (IL) Aa2, Aa2/VMIG 1 & Aa2/P-1; Outlook stable

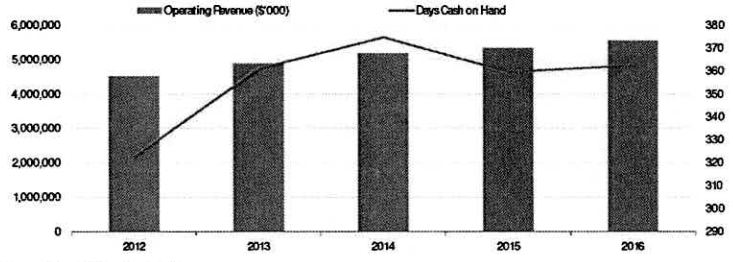
Summary Rating Rationale

Moody's Investors Service affirms Advocate Health Care Network's (Advocate) Aa2, Aa2/VMIG 1 and Aa2/P-1 ratings, affecting approximately $1.5 billion of debt. The outlook is stable.

Affirmation of Aa2 long-term rating is based on Advocate's status as the largest health system in the greater Chicago area as well as statewide with good geographic diversity and well positioned individual hospitals, very strong liquidity that allows absorption of delays in state Medicaid payments, moderate leverage and very good debt metrics even during lower performance, fully funded pension plan, and manageable capital. The system's margins, as reflected year-to-date 2017, are likely to be lower than the historical average given growing competition, pricing pressure from governmental and commercial payers, and shifts of business to lower revenue settings. However, the strengths above along with a history of quickly and effectively responding to challenges provide credit strength to mitigate challenges.

The VMIG 1 rating reflects the availability of bank standby bond purchase agreements or internal liquidity for unremarketed tenders of variable rate bonds. The P-1 rating for bonds in the Windows mode reflects the system's ample liquidity and notice to pay unremarketed tenders.

Exhibit 1
Strong liquidity maintained during growth



Source: Moody's Investors Service

Credit Strengths

» Leading market position in greater Chicagoland

» Moderate leverage with favorably low total debt-to-cashflow of 2.0 times and strong 8 times maximum annual debt service, even with lower operating performance

» Very strong liquidity of 338 days cash on hand, providing cushion to absorb delays in state Medicaid payments

» Fully funded pension plan

» Consistent investment in facilities and manageable near-term capital plans

» Strong management evidenced by historical ability to absorb operating challenges and adjust mid-year; commitment to very good disclosure practices

Credit Challenges

» Lower margins in year-to-date 2017 likely to persist given growing pricing pressure and unfavorable payer mix shift in the region

» Increasing competition and major consolidation among long-standing hospitals, new market entrants, and competition to recruit physicians

» Investment allocation drives comparatively low 49% of investments liquid on a monthly basis

Rating Outlook

The stable outlook is based on expectations that the system will maintain strong liquidity given manageable near-term capital needs, moderate leverage and good metrics, and stabilize operating margins even if at currently lower levels. The system has already executed numerous strategies to cut costs and grow revenue to compensate for operating headwinds. Further decline in margins or worsening of payer or competitive pressures could drive a negative outlook.

Factors that Could Lead to an Upgrade

» Greater geographic and cash flow diversity and material enterprise growth

» Sustained significant improvement in operating margins

Factors that Could Lead to a Downgrade

» Further decline in operating margins from current levels

» Material reduction in liquidity

» Increase in leverage resulting in significant weakening of debt metrics

» Notably dilutive acquisition or merger

Key Indicators

Exhibit 2
Advocate Health Care Network, IL

	2012	2013	2014	2015	2016
Operating Revenue ($'000)	4,520,826	4,889,729	5,184,505	5,350,795	5,547,601
3 Year Operating Revenue CAGR(%)	5.1	4.9	5.8	5.8	4.3
Operating Cash Flow Margin (%)	10.1	10.6	11.2	11.0	9.9
PM: Medicare (%)	37.0	37.0	37.0	37.0	37.0
PM: Medicaid (%)	16.0	15.0	17.0	19.0	19.0
Days Cash on Hand	322	361	375	360	362
Unrestricted Cash and Investments to Total Debt (%)	270.0	272.8	297.4	280.9	300.5
Total Debt to Cash Flow (x)	1.9	1.9	1.8	2.0	2.0

Based on audits for Advocate Health Care Network and Subsidiaries, fiscal years ended December 31
Investment returns normalized at 6% prior to FY 2015 and 5% in FY 2015 and beyond
Investment income excluded from other operating revenue all years.
Source: Moody's Investors Service

Recent Developments

Recent developments are included in Detailed Rating Considerations.

Detailed Rating Considerations

Market Position: Leading market position, but region increasingly competitive

Advocate has pursued an effective strategy to develop an integrated and full service system that has resulted in the system achieving broad geographic coverage and the leading market position in the greater Chicago area. Advocate controls 11 inpatient acute care hospitals, an integrated children's hospital, a large home health care operation, and is clinically aligned with more than 5,000 physicians. Advocate is the largest health system in the greater Chicago area as well as the state. However, rapid consolidation continues in the state and several large academic medical systems maintain prominent positions, including Northwestern Medicine, Rush University Medical Center and The University of Chicago Health System. Competition for physicians is intensifying, including from a large independent medical group with private investors. Most recently, Presence Health announced plans to divest Chicago-area hospitals to AMITA, which is a joint operating company formed by Ascension Health and Adventist Health System Sunbelt, Inc. which would make the combined system the second largest in the region.

Advocate partners with payers under value-based strategies, increasingly shifting to risk-based models of care from fee-for-service models. Medicare shared savings and commercial risk arrangements represent approximately one million members. The system reports receiving sizable incentive payments under these arrangements. The system continues to invest in ambulatory capabilities to increase patient access, including adding 56 Walgreens clinics to its service capabilities.

Operating Performance, Balance Sheet and Capital Plans: Strong liquidity & manageable capital plans mitigate margin pressure

Following a long and consistent trend of 10-11% operating cashflow margins, Advocate's margin declined to 8.2% year-to-date June 2017. The system was affected by volume softness, shifts from higher to lower paying commercial business, higher bad debt in part from more high deductible insurance plans, pharmaceutical cost increases, and a loss under a public exchange product. Advocate participates in a narrow network exchange product, which required a large risk transfer payment in FY 2016; premium increases are expected to notably improve performance under this product in FY 2017. The margin was also suppressed by the assumption of 100% (previously 50%) control of Advocate Physician Partners.

While the system is still developing a FY 2018 budget, competitive and payer pressures suggest margins may remain at lower FY 2017 levels. Volumes will be challenged from declining use rates and population declines. Growing pricing pressures include those mentioned above related to bad debt and shifts in commercial business and minimal increases in governmental rates. While the state

passed a budget and no Medicaid cuts were included, state fiscal pressures are likely to stress Medicaid funding. Additionally, the state's migration of about half of Medicaid patients into managed care plans increases the risk of claim denials and payment delays from administrative complexities. Advocate has approximately $200 million in revenue enhancements and cost reductions targeted in FY 2017 to offset revenue pressures.

Advocate completed several large projects in 2016 and capital spending will decline to manageable levels relative to expected operating cashflow. The system recently completed construction of an inpatient tower at Advocate Christ Medical Center, modernization projects at Advocate Good Shepherd Hospital and Good Samaritan Hospital, and various ambulatory projects. Given lower operating performance, the system is reducing capital spending to about 1.2-1.3 times depreciation, which is well below expected operating cashflow. Advocate is evaluating IT needs including clinical and revenue cycle systems; the system currently has two platforms.

LIQUIDITY

Advocate has maintained very strong liquidity with 338 days cash on hand at June 30, 2017, providing cushion to absorb delays in state Medicaid payments. Advocate's accounts receivable increased to 56 days at June 30, 2017 from 47 days at FYE 2015, largely due to Medicaid receivables. Advocate's investment allocation has resulted in less overall liquidity with a comparatively low 49% of investments that can be liquidated monthly. Based on management data, at FYE 2016 24% was allocated to cash and fixed income, 22% to equities, and 50% to hedge funds and private equity.

Debt Structure and Legal Covenants: Moderate leverage drives good metrics

Advocate's moderate leverage drives favorable debt metrics, even based on lower operating performance, providing financial flexibility during a period of margin pressures. Based on FY 2016 results, total debt-to-cashflow is favorably low at 2.0 times, maximum annual debt service coverage is high at 8.8 times and total debt-to-revenue is 30%. Based on annualized six months year-to-date FY 2017 total debt-to-cashflow is 2.1 times and MADs coverage is over 8 times. There are no plans for material incremental leverage in the near term.

DEBT STRUCTURE

Debt structure risks are manageable with diversified bank counterparties and staggered demand risk. Approximately 38% of debt is in demand debt, including VRDOs supported by SBPAs, annual put debt and Windows bonds supported by self-liquidity, and variable rate private placement debt.

DEBT-RELATED DERIVATIVES

Advocate's derivative program has minimal credit risk. Advocate has three floating-to-fixed rate swaps with a notional amount $326 million associated with the Series 2008C bonds. The system pays a fixed rate of 3.6% and receives 61.7% of LIBOR plus 26 basis points. The swaps mature in 2038 and the counterparties are Wells Fargo and PNC. Based on management data, as of June 30, 2017, the net termination value of the swaps was a negative $81 million to Advocate and no collateral was posted.

PENSIONS AND OPEB

The system has a cash balance defined benefit pension plan, which has been almost fully funded or overfunded for many consecutive years. One of Advocate's plans is a church plan and has been subject to litigation regarding its status. Given Advocate's funding position and liquidity, we don't view this issue as a credit risk.

Management and Governance

Advocate has demonstrated strong management capabilities evidenced by the system's historical ability to absorb operating challenges, make mid-year adjustments, and typically meet or exceed operating budgets. These capabilities in part support the stable outlook as Advocate faces growing competitive and reimbursement challenges. The system consistently invested in capital, which allows the flexibility to scale back on spending if operations weaken. The system has very good disclosure practices.

Legal Security

The obligated group includes the Advocate Health Care Network (system parent), Advocate Health and Hospitals Corporation (operates most of the system's hospitals), Advocate North Side Health Network, and Advocate Condell Medical Center. Security is a general, unsecured obligation of the obligated group. No additional indebtedness tests.

Use of Proceeds

Not applicable.

Obligor Profile

Advocate is an integrated health system with 11 acute care hospitals, 10 of which are in the Chicago metro area (the 11th hospital is in Bloomington-Normal, IL). The system is integrated with more than 5,000 physicians. Advocate is the largest health system in Illinois and is the market share leader in the Chicago area.

Methodology

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in November 2015. An additional methodology used in the VMIG 1 ratings supported by bank SBPAs was Variable Rate Instruments Supported by Conditional Liquidity Facilities published in March 2017. Additional methodology used in the P-1 rating and VMIG 1 ratings supported by self-liquidity was Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. Please see the Rating Methodologies page on www.moodys.com for a copy of these methodologies.

REPORT NUMBER 1093067

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Illinois Finance Authority
Advocate Health Care Network; System

Credit Profile		
US$21.975 mil rev bnds (rmktd 7/25/2017) (Advocate Hlth Care) ser 2008C-3B dtd 07/25/2017 due 11/01/2038		
Short Term Rating	A-1+	New
Illinois Finance Authority, Illinois		
Advocate Hlth Care, Illinois		
series 2011B windows		
Long Term Rating	AA+/A-1+/Negative	Outlook Revised
Series 2008C-1, 2008C-2B		
Long Term Rating	AA+/A-1/Negative	Outlook Revised
Series 2008C-3A		
Long Term Rating	AA+/A-1+/Negative	Outlook Revised

Rationale

S&P Global Ratings revised its outlook to negative from stable and affirmed its 'AA+' long-term rating on the Illinois Finance Authority's various series of fixed-rate tax-exempt bonds, issued for Advocate Health Care Network (AHCN). At the same time, S&P Global Ratings affirmed its long-term component of its dual ratings ('AA+/A-1+' and 'AA+/A-1'), where applicable, on the authority's various series of variable-rate demand bonds (VRDBs).

In addition, S&P Global Ratings assigned its 'A-1+' short-term rating to the authority's series 2008C-3B (remarketed last July with a one year tender), which reflects AHCN's own self-liquidity. All bonds are issued for AHCN.

The negative outlook reflects our assessment of the AHCN's pending consolidation with Aurora Health Care (in Wisconsin). In December 2017, AHCN and Aurora Health Care (Aurora) signed a definitive agreement to consolidate into one system (Advocate Aurora Health, or AAH). In our opinion, the post-consolidation financial profile would be a combination of both accretive and dilutive elements, while the enterprise profile would be stronger if the consolidation went smoothly. We don't rate Aurora, but we have reviewed publicly available information and high-level information provided by AHCN management. Combined operating income would likely improve post-merger, as Aurora's recent operating margins are stronger than those of AHCN, which has experienced slight declines in recent years. However, overall maximum annual debt service (MADS) coverage, which would remain very strong, in our opinion, could drop from current extremely strong levels as Aurora has a higher debt burden compared with that of AHCN. Similarly, the combined balance sheet, while still very strong, in our view, would be meaningfully weaker than current metrics shown by AHCN.

While management has provided a high-level overview of opportunities and benefits for the combined organization (AAH) and the consolidation plan, we expect to meet with management over the next year to discuss more specifics as

it relates to those plans. In our view, the success on any merger depends on the cultural fit between the two organizations and we would expect to have a stronger understanding of the success of the new organization as it moves forward.

In our view, one potential challenge is the co-CEO model with an evenly divided board structure for the first four years of the merger. We believe it could result in a long-term rating risk, as we believe clearly defined roles and accountability are important for the long-term success of any organization.

The two organizations have received their final approvals and ACHN anticipates closing the transaction on April 1. Together, AAH will have considerable size and scale with more than $10 billion in revenues and more than $16 billion in assets (approximately double Advocate's operating revenues and 1.5x its assets). There will be one management team (recently announced) and one board (with equal representation from the two entities, for at least the first four years). We expect to view Aurora and AHCN as both core to the overall system, as each will contribute approximately equal revenues to AAH.

The 'AA+' rating reflects our expectation that AHCN will continue to build on its already solid enterprise profile and leading market position in the broad Chicagoland area, with what we believe could be a much stronger enterprise profile as Aurora provides diversification across Wisconsin due to its large revenue and patient base and a more favorable payor mix. In addition, we believe AAH can benefit from both systems' individual strengths, including AHCN's national reputation for developing a strong clinically integrated physician network model that has allowed it to manage increasing value-based reimbursement. We expect AHCN's financial operating profile and MADS coverage to remain healthy due to the organization's significant cost restructuring and expense management over the past year, and that AHCN's balance sheet will remain sound. Aurora's operations are likely to be accretive to AAH, in our view, although we understand Aurora's debt levels are higher and unrestricted reserves are lower in comparison to what we consider Advocate's extremely robust balance sheet.

The 'AA+' long-term rating reflects our view of AHCN's:

- Position as Chicagoland's and Illinois' largest and most successfully integrated health care delivery system, which has developed Advocate Physician Partners (APP) as the clinically integrated network to help provide cost effective care, and a system that is able to manage risk for the communities it serves;
- Healthy balance-sheet measures, as demonstrated by light leverage of 19%, solid unrestricted reserves of 354 days' cash on hand (and more than 400 when including self-insurance reserves) and unrestricted reserves to long-term debt of 349% (and just over 390% when including self-insurance reserves) as of Dec. 31, 2017;
- Leading and incrementally increasing market share through 2016 of 18% in a competitive market that should further benefit from Aurora's solid market position; and
- Consistently strong MADS coverage (smoothed) generally more than 7x for the past couple of years.

Partially offsetting these strengths, in our view, are AHCN's:

- Strong competition in the greater Chicago market--from other systems and large academic medical centers--coupled with broader volume pressures related to both the health care industry and the economy;

- Lighter operating margins over the past few years, but that are generally consistent with industry trends and fiscal 2017 incorporated one-time expenses of $42.75 million; and
- Slightly high government-oriented payor mix with approximately 45% of net patient revenue coming from Medicaid and Medicare, and some increased exposure to provider-fee funds in recent years.

We believe the larger system's strategic benefits, sustained operating performance, and healthy coverage support the 'AA+' rating on the combined AAH organization. However, we recognize there are certain risks to executing the strategies and we will continue to monitor how plans unfold.

The 'A-1+' short-term component of the rating on the series 2008C-3B mandatory tender bonds and 2011B windows bonds reflects our view of the credit strength inherent in the 'AA+' long-term rating on AHCN's debt and the sufficiency of AHCN's unrestricted reserves to provide liquidity support for the bonds. Our Fund Ratings and Evaluations Group assesses the liquidity of AHCN's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. We monitor the liquidity and sufficiency of AHCN's investment portfolio monthly.

The 'A-1+' short-term component of the rating on the issuer's series 2008C-2A and 2008C-3A bonds, and the 'A-1' short-term component of the rating on the series 2008C-1 and 2008C-2B bonds reflect our view of the standby bond purchase agreements (SBPAs) in effect from various financial institutions. They further reflect our view of the likelihood of payment of tenders, and our view of liquidity facilities that cover all of the bond series. (For more information, see the Financial Profile section.)

Outlook

The negative outlook reflects our view that there is a one-in-three chance in the next two years that our long-term rating on AHCN could decline one notch to 'AA' due primarily to meaningful balance-sheet dilution, including higher debt levels, related to the affiliation with Aurora. While we do view significant opportunities and strengths related to the affiliation, there could be some stress to the rating if we don't see that that the combined entity can achieve meaningful benefits--both strategic and operational--in the next couple years.

Downside scenario

We could lower the rating if we believe that the operating synergies of the combined organization will take longer than expected; performance and coverage levels dip below 3% and 5x, respectively; or we don't believe the balance sheet will show enough incremental improvement in the next couple of years.

Upside scenario

We could return the outlook to stable if management demonstrates the benefits of the larger organization, including benefits from possible refunding and debt restructuring, and continues to sustain operating performance consistent with recent trends in order to compensate for the lighter combined balance sheet.

Given the high rating and overall industry risks, we don't expect to raise the rating over the outlook period.

Enterprise Profile: Very Strong

AHCN's very strong enterprise profile reflects our view of its leading market share in a competitive service area and across a diverse number of settings and access points, but with less favorable demographics and economics as well as a higher governmental payor mix. In addition, the enterprise profile reflects our assessment of AHCN's pioneering efforts as a clinically integrated network, its very capable management team that has a history of consistent strategies and solid execution. We believe that the combined entity could benefit from Aurora as it contributes a large revenue base, provides diversification across multiple markets in Wisconsin, and has a more favorable payor mix than that of AHCN. In addition, we understand that Aurora maintains competitive positions in most of the markets it serves with good physician integration through employment.

Strong market position a result of clinically integrated network and expansive access points

AHCN continues to have a solid position in the market place and has a full complement of tertiary and community services across the Chicagoland region. Advocate remains a market and national leader in establishing a clinically integrated network (APP) for its employed (Advocate Medical Group) and independent physicians and accepts full and partial risk on certain commercial and Medicare advantage contracts as well as the exchange's narrow network product, BlueCare Direct powered by Advocate. Membership declined for the BlueCare product in 2018, but that was partially planned as AHNC increased premiums and offered only a silver plan on the exchange. AHCN has also managed risk through shared savings programs, including the Medicare accountable care organization demonstration project. APP was fully consolidated in fiscal 2017 (from a 50/50 joint venture), which had minimal operating impact. In our view, AHCN maintains strength in its physician integration activities, including aligning its physician base on both quality and clinical metrics that are key to certain aspects of reimbursement as well as to managing overall patient care through limited-risk contracts. We anticipate AHCN will continue to expand its patient base under risk contracts (although incrementally) while further positioning AHCN and its network with clinical and value-based strengths.

In addition, the geographic reach of both AHCN's acute-care and non-acute-care services help support its strong business position in the very competitive Chicagoland market. Outside the Chicago metropolitan statistical area (MSA), AHCN has established a limited presence in the Central Illinois market. We believe that overall competition in the Chicago MSA is increasing due partially to recent consolidations. Key competitors include AMITA Health (a joint venture between Adventist Midwest Health, part of Adventist Health System in Florida and Alexian Brothers Health System, a subsidiary of Ascension Health, which recently acquired Presence Health), Northwestern Medicine, Rush University Medical Center, the University of Chicago Medical Center, and other providers in the service area.

AHCN continued to experience some inpatient volume growth due to slight market-share increases and some capacity coming on line in recent years, as well as a focus on key service lines and the continued growth of Advocate Medical Group (AMG). While AMG will continue to grow, management plans to focus on optimizing and running the group more efficiently. Outpatient volume was mixed in fiscal 2017, but has historically shown growth in recent years. Management aims to modestly increase inpatient volume (including observation visits) and outpatient volume over the next couple years. AHCN continues to expand its ambulatory network, but market and industry dynamics lead us to believe that growth will likely depend on AHCN's ability to capture additional market share and lives under risk-based contracts, including Medicare Advantage--although certainly AAH may provide new opportunities.

Combined AAH could show additional market and operating strengths

We believe that while there is likely weakening around the combined balance sheet profile, Advocate and Aurora's merger could yield strengths for the enterprise profile as well as financial operations. Key factors supporting AHCN's decision to merge with Aurora include:

- Diversification benefits from Aurora, including a better payor mix, broad revenue base, and market diversification within Wisconsin;
- Ability to capitalize on individual system strengths to broaden the enterprise profile (including AHCN's ability to manage risk and Aurora's favorable physician employment model); and
- Potential growth opportunities in two broad markets that remain competitive.

The combined organization would cover a contiguous market from Green Bay south through the Chicagoland market (and into Central Illinois), with Aurora contributing 15 hospitals, 150 clinics, and a large physician and patient base to the system. In addition, Aurora has a joint venture health plan with Anthem that could be something AAH can expand. From public disclosure, we understand that Aurora has meaningful market share across much of the eastern part of Wisconsin, including in key markets such as Green Bay and Milwaukee among other regions, and it has historically maintained solid operations, albeit with a leveraged balance sheet, and lighter MADS coverage and operational liquidity. While each organization will initially continue to maintain separate headquarters in their respective states and maintain their individual brand, there could be opportunities to develop AAH branded initiatives where appropriate, although these are still being reviewed and analyzed. AHCN management also believes that as a larger organization, AAH would also have the opportunity to invest in pilot projects and strategies that could yield benefits as the industry experiences entry from non-traditional, and often much larger participants.

AHCN maintains stable management with operating and strategic focus

We believe AHCN has a very strong, capable, and stable management team with considerable bench strength throughout the organization. We view favorably AHCN's ability to operate its entities from a position of strength particularly in a challenging state and payor environment, and the organization maintains excellent disclosure and transparency of information. CEO Jim Skogsbergh has been with the organization 14 years, and many of the other key senior management positions have had limited turnover. One key management change has been Dr. Barbara Byrne, chief information officer, who joined Advocate from Edward-Elmhurst in fall 2017, and has experience with the Epic information technology system and will be leading Advocate's Epic implementation.

We believe management is forward-looking as relates to physician employment and integration through both employed AMG physicians and AHCN's relationship with its independent physicians. Many of these independent physicians, along with AMG physicians, are part of APP. We further believe AHCN's participation in both capitated contracts and some risk-sharing programs with certain payers will likely position AHCN well, given a continued focus by payers on reducing health care costs. Along with providing care in a high quality and cost effective manner through APP, AHCN management team will focus on becoming much more consumer oriented. Management is analyzing key strategies and we believe that the larger AAH organization may help AHCN to try various pilot projects.

In addition, we believe management and AHCN's board will engage and focus on the changing health care landscape. The affiliation with Aurora is one example of how management has considered the increasingly competitive

environment as well as how the combined organization could be in a better position to develop key strategies and initiatives around consumer initiatives while focusing on strong quality and cost metrics.

We view favorably that many AHCN management team members were appointed to the new AAH management team. Outside of the two Co-CEOs, there is generally one member of the team for each role. While health care organizations have had co-CEOs, we believe that can be a challenging leadership structure as it could hinder decision-making and execution.

Advocate Health Care Network And Subsidiaries, IL				
	--Fiscal year ended Dec. 31--			
	2017	2016	2015	2014
Enterprise profile				
PSA population, six-county Chicagoland area	N.A.	8,426,488	N.A.	N.A.
PSA market share %	N.A.	18.0	N.A.	N.A.
Inpatient admissions	165,540	162,558	161,962	159,640
Equivalent inpatient admissions	290,391	300,995	296,210	290,729
Emergency visits	393,294	403,408	399,372	393,984
Inpatient surgeries	41,277	42,130	40,596	40,458
Outpatient surgeries	73,852	74,958	73,237	71,010
Medicare case mix index	1.8021	1.7814	1.7259	1.6979
FTE employees	31,400	31,500	29,600	28,700
Active physicians	N.A.	6,300	6,300	6,400
Based on net/gross revenues	Net	Net	Net	Net
Medicare %	30.0	29.0	30.0	24.0
Medicaid %	15.0	14.0	14.0	11.0
Commercial/Blues %	47.0	50.0	49.0	57.0

Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. PSA--Primary service area. FTE--Full-time equivalent. N.A.--Not available.

Financial Profile: Extremely Strong

Advocate Health's extremely strong financial profile, in our view, reflects a healthy balance sheet, very solid MADS coverage and adequate operations. We expect that post-merger, the combined organization's operating profile could actually improve slightly (compared to that of AHCN), but debt and liquidity related ratios will likely decline as Aurora has limited unrestricted reserves and higher debt levels (and debt burden) than AHCN.

Healthy cash flow and coverage supported by robust investment income and adequate operations

Like many providers, AHCN's operating margin softened in fiscal 2017 to just under 3% (just under operating budget targets) compared with a slightly stronger margin in fiscal 2016 and much stronger margins in fiscal years 2014 and 2015. The decline from 2016 was partially due to some one-time expenses. Despite lighter operating margins, cash flow was still healthy and aided by solid investment income returns with MADS (smoothed) coverage continuing to be healthy at more than 7x and lease adjusted coverage at 5x. In fiscal 2017, AHCN experienced certain one-time

expenses ($42.75 million) related to restructuring as well as the write-off of its information technology (IT) system, as it begins to implement Epic. However, AHCN also improved certain areas including better performance on its payor contracts (including its exchange product that was weaker in fiscal 2016) as well as maintaining more care within the Advocate Health Care system and APP. (We adjust AHCN operating income to exclude joint venture income, investment income on self-insurance trust assets, and unrestricted contributions--all of which we include in non-operating income.)

Management expects AHCN's fiscal year 2018 operating margins to be less than 3%, which we view as consistent with AHCN's recent history but adequate for the rating level. We understand that last year's restructuring efforts (along with some volume increases) will offer support to income as the system continues to experience reimbursement stresses (including increasing governmental payors), increased expenses related to the Epic implementation, and manages other expense pressures related to the industry (for example, labor, pharmaceuticals, physician investment). We believe AHCN's focus on increasing the number of covered lives through its managed care and risk-based contracts, managing expenses, and backfilling volumes that may be lost due to lower utilization (which are in turn linked to both better care management and fewer readmissions) will remain important to maintaining healthy cash flow and coverage.

From public disclosure, the incorporation of Aurora's operating profile would likely be accretive as the organization has experienced solid operating results, albeit with a slightly declining trend in recent years. Aurora's MADS coverage is lighter than that of AHCN and estimated at between 3x and 5x on an annual basis, given the higher debt burden and less investment income supporting cash flow. Management indicates there are significant operating synergies that it could collect in the next five years and likely more details around those plans and timing will be provided after the transaction closes.

Very healthy liquidity and debt related ratios likely to be diluted by potential merger

Despite increased capital expenditures in recent years, AHCN's unrestricted reserves remain quite healthy, in our view, and have increased to $5.6 billion, or about 360 days' cash on hand, at Dec. 31, 2017 or almost 3.5x unrestricted reserves to long-term debt. AHCN's unrestricted reserves excludes self-insurance reserves and, including those amounts, days' cash on hand would improve to just above 400 (and 4x unrestricted reserves to long-term debt). AHCN forecasts cash on hand to exceed 300 days for the next few years, despite ongoing increased capital spending through fiscal years 2018 and 2019 (although we note this excludes Aurora). Management continues to evaluate projects through its normal capital planning process and we will continue to monitor how any new projects may affect balance-sheet ratios. We note that the pro-forma AAH balance sheet will likely be weaker than Advocate's current profile, as a review of publicly available information indicates Aurora maintains higher debt levels and less unrestricted reserves. However, on a combined basis, we believe that the pro-forma balance sheet would remain healthy, but we have not received additional details regarding Aurora's full capital spending plans and projections. We believe more information will likely be forthcoming after the transaction closes. Estimates of pro-forma days' cash on hand would be around 270 days' (296 including the self-insurance reserves) and unrestricted reserves to long-term debt would be between 230%-260% depending on debt assumptions.

Given recent capital spending, average age of plant remains around 10.2 years for AHCN. We expect AHCN's capital spending to remain at higher levels as it embarks on a large systemwide Epic implementation (approximately 2x

annual depreciation expense over the next couple of years) and some ongoing spending at Advocate Illinois Masonic Medical Center. Recently completed projects include Advocate Good Shepherd's and Advocate Good Samaritan's renovations (2016 and 2017), and Advocate Christ's patient tower (2016). Management indicates AHCN will fund most capital spending through cash flow.

AHCN's target investment portfolio is reasonable, in our opinion, given AHCN's healthy unrestricted reserves, with an allocation of about 29% equities, 45% of hedge funds, real assets, and private equity, and 22% fixed income. AHCN had unfunded commitments of about $877 million for its private equity and real estate partnership investments as of Dec. 31, 2017 (over the next seven years), which we view as manageable given its more than $5 billion in unrestricted reserves. In addition, we expect that this allocation could also aid investment returns for the combined entity's portfolio.

AHCN's debt levels remain quite modest, in our view, with leverage at 19% and a low debt burden of 1.6% at Dec. 31, 2017 with no plans (by Advocate) for any new debt over the next two years. AHCN advance refunded a portion of its series 2010 bonds with a $115 million direct purchase taxable loan in fall 2017. The fixed rate debt is held by Bank of America and has a maturity in 2024 (with a $69.9 million maturity in 2024) and we view it as contingent debt. Key rating and financial covenants are maintenance of a credit rating at 'BBB' or higher and coverage of 1.10 or higher.

We believe AHCN's debt structure is reasonable, given its solid unrestricted reserves and investment allocation of its unrestricted reserves. We anticipate that when the AAH transaction is finalized, the overall system will increase its overall debt levels, but with the mix of contingent and variable rate at similar levels. We anticipate pro-forma system leverage for AAH will increase to around 25%, with a slightly higher pro-forma debt burden of over 2%.

About 60% of AHCN's debt is fixed, with the remainder in some type of variable-rate mode. The split of the variable-rate debt is:

- $22 million in long-term interest rate mode with a mandatory tender within one year (2008C-3B);
- $120.3 million in long-term interest rate mode with mandatory tenders within two years (2008A-1, 2008A-2, and 2008A-3);
- $70 million in windows mode that provides seven months' notice before a mandatory tender would occur (2011B);
- $100 million in direct placement bonds (2011C, 2011D); and
- $321.3 million in weekly variable-rate demand mode backed by various liquidity facilities (see below).

Specifically, the providers of the liquidity facilities of the $321.3 million of other VRDBs are:

- JPMorgan Chase Bank (series 2008C-1; 'A-1'), Aug 31, 2020;
- Wells Fargo Bank N.A. (series 2008C-2A: 'A-1+'), Aug. 1, 2019;
- JPMorgan Chase Bank (series 2008C-2B; 'A-1'), Aug 15, 2021; and
- Northern Trust (series 2008C-3A; 'A-1+'), Aug 15, 2021.

AHCN provides liquidity support for the series 2011B windows mode variable-rate debt and the series 2008C-3B

variable-rate debt that has a tender within a year. Based on AHCN's liquidity analysis provided to our funds group, the system can amply cover its total $92 million of its self-liquidity-backed VRDBs, in our view. (As of February 2018, AHCN had unrestricted reserves of $1.3 billion based on the funds group analysis and $854 billion based on discounted analysis.) In addition, management maintains $325 million of available lines of credit for added flexibility, on which there were no draws as of Dec. 31, 2017.

AHCN maintains three floating- to fixed-rate swaps with a total notional amount of $326.3 million as of Dec. 31, 2017. The counterparties are Wells Fargo Bank and PNC Bank N.A. As of Dec 31, 2017, the liability on the swaps was lower than in previous years at $74 million with no collateral posting required.

AHCN also maintains two defined benefit pension plans, one an ERISA plan that is frozen and the other is active and has been granted church plan status. Together they were more than 100% funded at Dec. 31, 2017. We understand Aurora also maintains a defined benefit plan that is fairly well funded (per Aurora's 2016 audit).

Advocate Health Care Network And Subsidiaries, IL--Financial Statistics

	–Fiscal year ended Dec. 31–			–Medians reported for 'AA+' rated healthcare systems–
	2017	2016	2015	2016
Financial profile				
Net patient revenue ($000s)	5,833,068	5,280,667	5,075,946	3,705,900
Total operating revenue ($000s)	6,173,858	5,537,628	5,328,330	MNR
Total operating expenses ($000s)	6,013,714	5,323,816	5,062,027	MNR
Operating income ($000s)*	160,144	213,812	266,303	MNR
Operating margin (%)	2.6	3.9	5.0	4.0
Net nonoperating income ($000s)	313,342	229,950	53,713	MNR
Excess income ($000s)	473,486	443,762	320,016	MNR
Excess margin (%)	7.3	7.7	6.0	6.5
Operating EBIDA margin (%)	8.3	9.7	10.7	11.6
EBIDA margin (%)	12.7	13.3	11.6	13.3
Net available for debt service ($000s)	826,666	767,329	622,190	661,416
Maximum annual debt service ($000s)	106,596	106,596	106,596	MNR
Maximum annual debt service coverage (x)	7.8	7.2	5.8	6.4
Operating lease-adjusted coverage (x)	5.0	4.7	3.9	5.0
Liquidity and financial flexibility				
Unrestricted reserves ($000s)	5,649,845	5,019,803	4,661,452	4,510,478
Unrestricted days' cash on hand	360.6	362.5	354.1	398.8
Unrestricted reserves/total long-term debt (%)	349.0	305.2	279.9	314.2
Unrestricted reserves/contingent liabilities (%)	702.9	757.1	698.2	856.7
Average age of plant (years)	10.2	10.3	9.9	8.3
Capital expenditures/depreciation and amortization (%)	116.8	149.5	196.5	110.3
Debt and liabilities				
Total long-term debt ($000s)	1,618,991	1,644,894	1,665,417	MNR
Long-term debt/capitalization (%)	19.1	21.6	23.7	21.9

Advocate Health Care Network And Subsidiaries, IL--Financial Statistics (cont.)

	—Fiscal year ended Dec. 31—			—Medians reported for 'AA+' rated healthcare systems—
	2017	2016	2015	2016
Contingent liabilities ($000s)	803,758	662,990	667,670	MNR
Contingent liabilities/total long-term debt (%)	49.6	40.3	40.1	36.7
Debt burden (%)	1.6	1.9	2.0	1.7
Defined benefit plan funded status (%)	104.8	98.0	96.9	89.3

*Fiscal year 2017 includes $42.75 million of non-recurring operating losses. MNR--Median not reported.

Credit Snapshot

- Security: ACHN's rated bonds are the general, unsecured joint, and several obligations of the obligated group, which consists of the parent, AHCN; Advocate Health and Hospitals Corp., which includes most of AHCN's acute-care facilities, Advocate North Side Health Network, which includes Advocate Illinois Masonic Center, Advocate Condell Medical Center, and Advocate Sherman.
- Group rating methodology status: The rating reflects our view of AHCN's group credit profile (GCP) and the obligated group's core status in that the obligated group accounts for the vast majority of total operating income and assets. Accordingly, we rate the AHCN obligated group at the level of the GCP and we used AHCN's consolidated financial results.
- Credit overview: AHCN has 11 acute-care hospitals (including an integrated children's hospital operating mainly on two campuses) mostly in the greater Chicagoland market, 1,350 employed full-time equivalent physicians as of Dec. 31, 2017 through its two wholly owned medical groups, Advocate Medical Group (AMG) and Dreyer Medical Group (with a total of 6,500 active physicians, of which about 5,000 are part of APP); six home health offices, pharmacies, clinic, and outpatient sites; and several joint venture operations. AHCN also has long-term teaching affiliations with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University, and Midwestern University. As part of these affiliations, AHCN trains about 600 residents in 31 AHCN residency programs.

Ratings Detail (As Of March 28, 2018)

Illinois Finance Authority, Illinois

Advocate Hlth Care, Illinois

Illinois Finance Authority (Advocate Hlth Care) rev bnds (rmktd 7/25/2017) (Advocate Hlth Care) ser 2008C-3B dtd 07/25/2017 due 11/01/2038

Short Term Rating	A-1+	Affirmed
series 2008A-1/A-2/A-3		
Long Term Rating	AA+/Negative	Outlook Revised
ser 2008C-2A		
Long Term Rating	AA+/A-1/Negative	Outlook Revised
Series 2008D, 2010A-D, 2011A, 2012, and 2013A		
Long Term Rating	AA+/Negative	Outlook Revised

Illinois Finance Authority Advocate Health Care Network; System

Ratings Detail (As Of March 28, 2018) (cont.)		
Illinois Hlth Fac Auth, Illinois		
Advocate Hlth Care, Illinois		
Illinois Hlth Fac Auth (Advocate Hlth Care Network) sys		
Long Term Rating	AA+/Negative	Outlook Revised
Illinois Hlth Fac Auth (Advocate Hlth Care Network) sys		
Long Term Rating	AA+/Negative	Outlook Revised

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

This section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, Moody's as Aa2, and Standard and Poor's as A-1+, which qualifies the applicants for the waiver. See Attachment 34, Exhibits 1-3.

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

5. "A" Bond rating or better
6. All of the projects capital expenditures are completely funded through internal sources
7. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
8. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

This section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, Moody's as Aa2, and Standard and Poor's as A-1+, which qualifies the applicants for the waiver. See Attachment 34, Exhibits 1-3.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE FORM.

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

A. Reasonableness of Financing Arrangements

This section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, Moody's as Aa2, and Standard and Poor's as A-1+, which qualifies the applicants for the waiver. See Attachment 34, Exhibits 1-3.

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
   A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

F. Total Effect of the Project on Capital Costs

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

A letter attesting to the conditions of debt financing follows as Attachment 37, Exhibit #1.

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

June 4, 2018

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital
Surgical, Procedural & Cardiovascular Modernization

Dear Ms. Olson:

This letter is to attest to the fact that the selected form of debt financing for the proposed Advocate South Suburban Hospital project will be at the lowest net cost available, or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs, and other factors.

Sincerely,

Richard Heim

Richard Heim
Primary Service Area President
South Chicago and South Suburbs
Advocate Health & Hospitals Corporation

Subscribed and sworn before me this 4th day of June, 2018.

JANET M. HOOD
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 10, 2018

(SEAL)

Janet M. Hood

Signature of Notary Public

Cost & Gross Square Feet by Department

	A	B	C	D	E	F	G	H	
Dept. / Area	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. $	Mod. $	Total Cost
	New	Mod	New	Circ	Mod.	Circ.	A x C	B x E	G + H
Reviewable									
Cardiac Catheterization	$ 494.12		5,311	15%			$ 2,624,271		$ 2,624,271
Surgical Operating Rooms	$ 482.08		24,721	15%			$ 11,917,500		$ 11,917,500
Recovery Suite	$ 385.85		17,370	15%			$ 6,702,301		$ 6,702,301
Central Sterile Processing	$ 389.32		12,008	15%			$ 4,674,955		$ 4,674,955
Endoscopy		$ 303.49			4,550	15%		$ 1,380,880	$ 1,380,880
Endoscopy Prep/Recovery		$ 303.49			983	15%		$ 298,331	$ 298,331
Total Clinical							$ 25,919,027	$ 1,679,210	$ 27,598,237
Clinical Contingency									$ 1,701,073
Total Clinical Reviewable + Contingency									$ 29,299,310
Non-Reviewable									
Medical Staff Offices and Support		$ 179.72			9,312	15%		$ 1,673,530	$ 1,673,530
Staff Facilities, On Call		$ 200.00			1,202	15%		$ 240,400	$ 240,400
Education	$ 280.00	$ 177.85	691	15%	11,679	15%	$ 193,480	$ 2,077,105	$ 2,270,585
Building System/Support/AHUs	$1,275.00	$ 950.00	7,198	15%	248	15%	$ 9,177,450	$ 235,600	$ 9,413,050
Admin. Offices, Support		$ 185.00			3,375	15%		$ 624,375	$ 624,375
Lobby, Waiting, Registration, Security	$ 386.97	$ 243.39	5,870	15%	2,005	15%	$ 2,271,485	$ 488,000	$ 2,759,485
Corridors, Stairs, Elevators, Dock	$ 382.63	$ 150.00	16,491	95%	3,608	95%	$ 6,310,000	$ 541,200	$ 6,851,200
Material Management	$ 275.00		1,182	15%			$ 325,050		$ 325,050
Total Non-Reviewable							$18,277,465	$ 5,880,210	$ 24,157,675
Non-reviewable Contingency									$ 731,536
Total Non-Reviewable + Contingency									$ 24,889,211
Total									$ 51,755,912
Contingency									$ 2,432,609
Total + Contingency									$ 54,188,521

Complexity of Construction Impact on Cost	Premium
1. The new ASSH Procedural Center foundation requires several design enhancements to allow for future vertical expansion capability of up to 3 additional floors including the following: Oversized spread foot foundations to support the future expansion. The steel columns, girders and beams need to be oversized to accommodate the future building and associated increase of seismic/wind loads. Elevator shaft space will be required to accommodate three (3) future elevators. The mechanical and electrical piping enclosed in building shafts will be oversized to accommodate the future vertical expansion.	$1,025,000
2. Cost escalation is rising rapidly with recent material pricing increases greatly affected by recent tariffs. Prices are already up ~5% from last year and anticipate continued escalation of at least 5-7% for the next few years.	$825,000
3. The existing hospital campus does not have the electrical service capacity to serve the new building. The local electrical utility will need to extend service from two different locations along major roadways all the way to the farthest corner of the hospital campus.	$780,000
4. The Cath Lab, EP Lab, IR room, and new state-of-the-art ORs have large amounts of technology incorporated in the rooms which adds a significant cost premium for structural supports and infrastructure to support the technology components.	$1,515,000
5. The new facility will be bordered by existing building structures and underground utilities requiring potential underpinning and tie-ins to the existing building and systems.	$240,000
6. The work required to connect the new building to the existing hospital involves saw-cutting and penetrating the exterior wall, frame-in exterior wall openings (lintels & expansion joints), and relocate mechanical, electrical, plumbing, and fire protection utilities. This involves various steps to implement phasing and control of interim life safety measures and infection control.	$325,000
7. The addition is being constructed adjacent to an existing building with critical care patient rooms that will remain occupied during construction. There is nowhere else on campus that the patients can be relocated. The existing building must remain water-tight and vibrations and noise due to construction have to be minimized to not affect patient care. This involves various steps to implement phasing and control of interim life safety measures and infection control.	$315,000
8. The logistics of constructing an addition at the crossroads of major entrances for patients, employees, and service vehicles is very complicated. The parking lots and driveways must remain operational and access to the existing building must remain unencumbered during construction.	$625,000
9. The project has a goal for a Healthy Space Roadmap certification (Similar to LEED), which requires additional administrative costs as well as an initial cost premium for energy efficient and other sustainable materials/equipment.	$235,000
Total impact	**$5,885,000**

Projected Operating Costs

	2021	Cost Per Equivalent Patient Day
Operating Cost	$233,897,918	$2,442

Impact of Project on Capital Costs

	2021	Cost Per Equivalent Patient Day
Capital Costs	$12,247,047	$ 159

SECTION X. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

This project will strengthen the essential safety net services that ASSH provides to residents in the community by continuing to offer current, state of the art facilities that will attract and retain physicians and other providers, thereby reducing the need for patients to travel out of the service area.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

Modernization of the procedural center is not expected to adversely impact the ability of other providers to cross-subsidize safety net services, as it will not draw on the patient base from other area hospitals. This project is expected to continue to provide surgical, cardiovascular and endoscopy procedures for patients already receiving care at Advocate South Suburban Hospital.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant. **N/A**

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

1. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

The Hospital has been designated by the Illinois Department of Public Health as a Stroke Center and earned the American Heart Association's Get with the Guidelines - Stroke Gold-Plus Quality Achievement Award. The hospital's Nurses Improving Care for Healthcare Elders (NICHE) program is one of only three in the state to have earned Exemplar status, the highest level of recognition for efforts to improve care and service to older adults.

Advocate South Suburban also features a sexual assault nurse examiner program. This program was recognized by the Metropolitan Chicago Healthcare Council as a benchmark and model for other hospitals.

Recently a Pediatric Asthma Initiative was developed to reduce the trips to the Emergency Department for kids with asthma. This is so important that Asthma was selected as the top health need to address in the primary service area.

The Hospital was recognized by Practice Greenhealth with the Environmental Stewardship Excellence award in 2017 and 2018.

Physician/Nursing Practice Health outcomes performance is in the top quartile of the country for heart failure, heart attack, pneumonia and surgical site infections

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2014**	**2015**	**2016**
Inpatient	165	106	140
Outpatient	5,252	4,796	4,747
Total	5,417	4,902	4,887
Charity (cost in dollars)			
Inpatient	$1,568,000	1029000	878000
Outpatient	$2,203,000	2027000	1318000
Total	$3,771,000	$3,056,000	$2,196,000
MEDICAID			
Medicaid (# of patients)	**2014**	**2015**	**2016**
Inpatient	1,654	2,411	2,047
Outpatient	38,403	44,003	41,188
Total	40,057	46,414	43,235
Medicaid (revenue)			
Inpatient	$11,058,545	$11,834,689	$10,710,905
Outpatient	$4,610,931	$8,279,587	$9,086,428
Total	$15,669,476	$20,114,276	$19,797,333

Source: Hospital Records

SECTION XI. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

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

Advocate South Suburban Hospital Charity Care			
	2014	2015	2016
Net Patient Revenue	$213,874,760	$222,131,931	$214,234,086
Amount of Charity Care (charges)	$16,098,883	$14,168,945	$10,428,561
Cost of Charity Care	$3,771,000	$3,056,000	$2,196,000

Source: Hospital Records

Consolidated Financial Statements and Supplementary Information

Advocate Health Care Network and Subsidiaries
Years Ended December 31, 2017 and 2016 With
Reports of Independent Auditors

Advocate Health Care Network and Subsidiaries

Consolidated Financial Statements and Supplementary Information

Years Ended December 31, 2017 and 2016

Contents

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Building a better working world

Report of Independent Auditors

The Board of Directors
Advocate Health Care Network and Subsidiaries

We have audited the accompanying consolidated financial statements of Advocate Health Care Network and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, 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.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

Building a better working world

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Advocate Health Care Network and Subsidiaries at December 31, 2017 and 2016, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

March 9, 2018

Advocate Health Care Network and Subsidiaries

Consolidated Balance Sheets
(Dollars in Thousands)

	December 31 2017	2016
Assets		
Current assets:		
Cash and cash equivalents	$ **411,133**	$ 151,588
Short-term investments	**27,748**	22,837
Assets limited as to use	**94,224**	83,524
Patient accounts receivable, less allowances for uncollectible accounts of $216,555 in 2017 and $242,973 in 2016	**746,392**	680,979
Amounts due from primary third-party payors	**32,301**	25,898
Prepaid expenses, inventories and other current assets	**295,369**	319,803
Collateral proceeds received under securities lending program	**19,577**	19,953
Total current assets	**1,626,744**	1,304,582
Assets limited as to use:		
Internally and externally designated investments limited as to use	**5,973,730**	5,543,823
Investments under securities lending program	**18,975**	19,564
	5,992,705	5,563,387
Prepaid pension expense and other noncurrent assets	**276,277**	210,027
Interest in health care and related entities	**151,968**	144,282
Reinsurance receivable	**76,376**	97,603
	6,497,326	6,015,299
Property and equipment – at cost:		
Land and land improvements	**301,964**	291,894
Buildings	**3,727,467**	3,415,558
Movable equipment	**1,808,122**	1,720,602
Construction-in-progress	**137,072**	283,515
	5,974,625	5,711,569
Less allowances for depreciation	**2,992,201**	2,766,283
	2,982,424	2,945,286
Total assets	**$ 11,106,494**	$ 10,265,167

	December 31	
	2017	**2016**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 28,120**	$ 25,892
Long-term debt subject to short-term remarketing arrangements	**91,975**	91,975
Accounts payable and accrued expenses	**540,786**	508,413
Accrued salaries and employee benefits	**459,774**	431,333
Amounts due to primary third-party payors	**319,020**	320,711
Current portion of accrued insurance and claims costs	**104,593**	100,225
Obligations to return collateral under securities lending program	**19,577**	19,953
Total current liabilities	**1,563,845**	1,498,502
Noncurrent liabilities:		
Long-term debt, less current portion	**1,527,016**	1,552,919
Pension plan liability	**4,345**	20,202
Accrued insurance and claims cost, less current portion	**617,735**	666,496
Accrued losses subject to reinsurance recovery	**76,376**	97,603
Obligations under swap agreements, net of collateral posted	**73,875**	79,622
Other noncurrent liabilities	**213,240**	221,574
	2,512,587	2,638,416
Total liabilities	**4,076,432**	4,136,918
Net assets:		
Unrestricted	**6,860,328**	5,964,762
Temporarily restricted	**115,114**	109,014
Permanently restricted	**53,446**	52,975
	7,028,888	6,126,751
Noncontrolling interest	**1,174**	1,498
Total net assets	**7,030,062**	6,128,249
Total liabilities and net assets	**$ 11,106,494**	$ 10,265,167

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended December 31	
	2017	**2016**
Unrestricted revenues, gains and other support		
Net patient service revenue	**$ 4,752,539**	$ 5,062,334
Provision for uncollectible accounts	**(237,310)**	(269,463)
	4,515,229	4,792,871
Capitation revenue	**1,317,839**	487,796
Other revenue	**400,345**	306,753
	6,233,413	5,587,420
Expenses		
Salaries, wages and employee benefits	**3,125,883**	2,963,613
Purchased services and operating supplies	**1,414,485**	1,395,329
Contracted medical services	**606,922**	209,265
Other	**470,494**	432,042
Depreciation and amortization	**294,280**	268,846
Interest	**58,900**	54,721
	5,970,964	5,323,816
Operating income before nonrecurring losses	**262,449**	263,604
Nonrecurring losses	**42,750**	–
Operating income	**219,699**	263,604
Nonoperating income (loss)		
Investment income	**621,236**	329,119
Change in fair value of interest rate swaps	**5,748**	9,221
Loss on refinancing of debt	**(5,971)**	–
Other nonoperating items, net	**(29,369)**	
	(4,340) **591,644**	
	334,000	
Revenues in excess of expenses	**811,343**	597,604

Advocate Health Care Network and Subsidiaries

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

	Year Ended December 31	
	2017	**2016**
Unrestricted net assets		
Revenues in excess of expenses	**$ 811,343**	$ 597,604
Net assets released from restrictions and used for capital purchases	**6,450**	9,430
Postretirement benefit plan adjustments	**77,773**	6,044
Increase in unrestricted net assets	**895,566**	613,078
Temporarily restricted net assets		
Contributions for medical education programs, capital purchases and other purposes	**17,001**	14,633
Realized gains on investments	**3,586**	1,031
Unrealized gains on investments	**7,239**	3,837
Net assets released from restrictions and used for operations, medical education programs, capital purchases and other purposes	**(21,726)**	(22,070)
Increase (decrease) in temporarily restricted net assets	**6,100**	(2,569)
Permanently restricted net assets		
Contributions for medical education programs, capital purchases and other purposes	**471**	4,358
Increase in permanently restricted net assets	**471**	4,358
Increase in net assets	**902,137**	614,867
Change in noncontrolling interest	**(324)**	136
Net assets at beginning of year	**6,128,249**	5,513,246
Net assets at end of year	**$ 7,030,062**	$ 6,128,249

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Year Ended December 31	
	2017	2016
Operating activities		
Increase in net assets	$ 901,813	$ 615,003
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation, amortization and accretion	288,932	263,387
Provision for uncollectible accounts	237,310	269,463
Change in deferred income taxes	(823)	(13,685)
Losses on disposal of property and equipment	20,390	942
Loss on refinancing of debt	5,971	–
Change in fair value of interest rate swaps	(5,748)	(9,221)
Postretirement benefit plan adjustments	(77,773)	(6,044)
Restricted contributions and gains on investments, net of assets released from restrictions used for operations	(15,276)	(12,640)
Changes in operating assets and liabilities:		
Trading securities	(457,919)	(437,653)
Patient accounts receivable	(302,691)	(346,819)
Amounts due to/from primary third-party payors	(8,094)	(8,703)
Accounts payable, accrued salaries and employee benefits, accrued expenses and other noncurrent liabilities	(69,946)	137,150
Other assets	55,370	(57,948)
Accrued insurance and claims cost	(44,393)	(49,859)
Net cash provided by operating activities	527,123	343,373
Investing activities		
Purchases of property and equipment	(343,626)	(401,868)
Proceeds from sale of property and equipment	7,063	8,273
Cash and investments acquired in the acquistion of Advocate Physician Partners	157,286	–
Purchases of investments designated as non-trading	(69,867)	(70,493)
Sales of investments designated as non-trading	69,835	102,419
Other	(90,321)	(33,387)
Net cash used in investing activities	(269,630)	(395,056)
Financing activities		
Proceeds from issuance of debt	115,000	–
Payments of long-term debt	(140,894)	(25,210)
Collateral returned under swap agreements	–	830
Proceeds from restricted contributions and gains on investments	28,297	23,859
Other	(351)	–
Net cash provided by (used in) financing activities	2,052	(521)
Increase (decrease) in cash and cash equivalents	259,545	(52,204)
Cash and cash equivalents at beginning of year	151,588	203,792
Cash and cash equivalents at end of year	$ 411,133	$ 151,588

See accompanying notes to consolidated financial statements.

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1. Organization and Summary of Significant Accounting Policies

Organization

Advocate Health Care Network (the System) is a nonprofit, faith-based health care organization dedicated to providing comprehensive health care services, including inpatient acute and non-acute care, primary and specialty physician services and various outpatient services to communities in northern and central Illinois. Additionally, through long-term academic and teaching affiliations, the System trains resident physicians. The System is affiliated with the United Church of Christ and the Evangelical Lutheran Church of America. Substantially all expenses of the System are related to providing health care services.

To better align the System's and Advocate Health Partner's (d/b/a Advocate Physician Partners) (APP) resources related to capitated and other risk arrangements, the APP bylaws were amended effective January 1, 2017. The amendment resulted in the System obtaining a majority of voting board seats and certain reserve powers. Accordingly, APP's results are included in the System's consolidated financial statements beginning January 1, 2017.

Mission and Community Benefit

As a faith-based health care organization, the mission, values and philosophy of the System form the foundation for its strategic priorities. The System's mission is to serve the health care needs of individuals, families and communities through a holistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. The System's core values of compassion, equality, excellence, partnership and stewardship guide its actions to provide health care services to sustain and improve the health of the individuals and communities it serves.

Consistent with the values of compassion and stewardship, the System makes a major commitment to patients in need, regardless of their ability to pay. Charity care is provided to patients who meet the criteria established under the System's financial assistance policy. Patients eligible for consideration can earn up to 600% of the federal poverty level. Qualifying patients can receive up to 100% discounts from charges and extended payment plans. Charity care services are not reported as net patient service revenue because payment is not anticipated while the related costs to provide the health care are included in operating expenses. The System's cost of providing charity care in 2017 and 2016, as determined using the 2016 Medicare cost-to-charge ratio, was $56,296 and $56,996, respectively.

1. Organization and Summary of Significant Accounting Policies (continued)

The System files the Annual Non-Profit Hospital Community Benefits Plan Report with the Illinois Attorney General. The total community benefit amount reported on this report for the year ended December 31, 2016, the latest filed, was $612,786 (including $56,996 of charity care at cost) (unaudited). The information needed to prepare the 2017 report, which is anticipated to be filed in June 2018, is being compiled. This report summarizes the significant financial support that the System provides to its communities to sustain and improve health care services. In addition to the charity care provided, this report includes:

- The unreimbursed cost of providing care to patients covered by the Medicare and Medicaid programs.

- The cost of providing services which are not self-sustaining, for which net patient service revenues are less than the costs required to provide the services. Such services benefit uninsured and low-income patients, as well as the broader community, but are not expected to be financially self-supporting.

- Other community benefits include the unreimbursed costs of community benefits programs and services for the general community, not solely for those demonstrating financial need, including the unreimbursed cost of medical education, health education, immunizations for children, support groups, health screenings and fairs.

Principles of Consolidation

Included in the System's consolidated financial statements are all of its wholly owned or controlled subsidiaries. All significant intercompany transactions 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 requires management to make estimates, assumptions and judgments that affect the reported amounts of assets and liabilities and amounts disclosed in the notes to the consolidated financial statements at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period.

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1. Organization and Summary of Significant Accounting Policies (continued)

Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Cash Equivalents

The System considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

Investments

The System has designated substantially all of its investments as trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices or other observable inputs. Certain debt-related investments are designated as non-trading. The non-trading portfolio consists mainly of cash equivalents, money market and commercial paper. Investments in limited partnerships that invest in marketable securities and derivative products (hedge funds) are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships with ownership percentages of 5% or greater are recorded on the equity method of accounting, while those with ownership percentages of 5% or less are recorded on the cost method of accounting. Commingled funds are carried at fair value based on other observable inputs. Investment income or loss (including realized gains and losses, interest, dividends, changes in equity of limited partnerships and unrealized gains and losses) is included in investment income unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue. Unrealized gains and losses that are restricted by donor or law are reported as a change in temporarily restricted net assets.

Assets Limited as to Use

Assets limited as to use consist of investments set aside by the Board of Directors for future capital improvements and certain medical education and other health care programs. The Board of Directors retains control of these investments and may, at its discretion, subsequently use them for other purposes. Additionally, assets limited as to use include investments held by trustees under debt agreements and self-insurance trusts.

(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Patient Service Revenue and Accounts Receivable

Patient accounts receivable are stated at net realizable value. The System evaluates the collectability of its accounts receivable based on the length of time the receivable is outstanding, major payor sources of revenue, historical collection experience and trends in health care insurance programs to estimate the appropriate allowance and provision for uncollectible accounts. For receivables associated with self-pay patients, the System records an allowance for uncollectible accounts in the period of service on the basis of its past experience. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

The allowance for uncollectible accounts as a percentage of accounts receivable decreased from 26% in 2016 to 22% in 2017 primarily due to improved collection experience.

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for service rendered, including estimated adjustments under reimbursement agreements with third-party payors, certain of which are subject to audit by administering agencies. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

Net patient service revenue recognized in the period from these major payor sources is as follows for the years ended December 31:

	2017	2016
Third-party payors	**$ 4,481,872**	$ 4,794,914
Self-pay	**270,667**	267,420
Total all payors	**$ 4,752,539**	$ 5,062,334

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market value.

1. Organization and Summary of Significant Accounting Policies (continued)

Reinsurance Receivables

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Goodwill and Intangible Assets

Goodwill of $55,093 and $49,304 and intangible assets of $2,609 and $2,996 at December 31, 2017 and 2016, respectively, are included in other noncurrent assets on the consolidated balance sheets. Goodwill is not amortized and is evaluated for impairment at least annually. Intangible assets with expected useful lives are amortized over that period.

Asset Impairment

The System considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs, except for those related to investments, are recognized in operating income at the time the impairment is identified.

Property and Equipment

Provisions for depreciation of property and equipment are based on the estimated useful lives of the assets ranging from 3 to 80 years using the straight-line method.

Asset Retirement Obligations

The System recognizes its legal obligations associated with the retirement of long-lived assets that result from the acquisition, construction, development or normal operations of long-lived assets when these obligations are incurred. The obligations are recorded as a noncurrent liability and are accreted to present value at the end of each period. When the obligation is incurred, an amount equal to the present value of the liability is added to the cost of the related asset and is accreted over the life of the related asset. The obligations at December 31, 2017 and 2016, were $22,855 and $24,704, respectively.

1. Organization and Summary of Significant Accounting Policies (continued)

Derivative Financial Instruments

The System has entered into transactions to manage its interest rate, credit risks, and market risks. Derivative instruments, including exchange-traded and over-the counter derivative contracts and interest rate swaps, are recorded as either assets or liabilities at fair value. Subsequent changes in a derivative's fair value are recognized in nonoperating income (loss).

Bond Issuance Costs, Discounts and Premiums

Bond issuance costs, discounts and premiums are amortized over the term of the bonds using the effective interest method.

General and Professional Liability Risks

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity. Temporarily restricted net assets and earnings on permanently restricted net assets are used in accordance with the donor's wishes primarily to purchase property and equipment, and to fund medical education or other health care programs.

Assets released from restrictions to fund purchases of property and equipment are reported in the consolidated statements of operations and changes in net assets as increases to unrestricted net assets. Those assets released from restriction for operating purposes are reported in the consolidated statements of operations and changes in net assets as other revenue. When restricted, earnings are recorded as temporarily restricted net assets until amounts are expended in accordance with the donor's specifications.

1. Organization and Summary of Significant Accounting Policies (continued)

Capitation Revenue

The System has agreements with various managed care organizations under which the System provides or arranges for medical care to members of the organizations in return for a monthly payment per member. Revenue is earned each month as a result of agreeing to provide or arrange for their medical care.

Other Nonoperating Items, Net

Other nonoperating items, net primarily consist of the net expenses of the Advocate Charitable Foundation, contributions to charitable organizations, valuation adjustments for investments on the equity method of accounting and income taxes.

Revenues in Excess of Expenses and Changes in Net Assets

The consolidated statements of operations and changes in net assets include revenues in excess of expenses as the performance indicator. Changes in unrestricted net assets, which are excluded from revenues in excess of expenses, primarily include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets) and postretirement benefit adjustments.

Nonrecurring Losses

The System incurred salary, purchased services and other expenses associated with developing an information technology system. This project was abandoned late in 2017; therefore, expenses of $24,092 related to this project are recorded as nonrecurring expenses.

The System undertook initiatives to reduce operating expenses during 2017 and, as part of the process, offered an early retirement incentive and eliminated other positions. The System recorded nonrecurring expenses of $18,658 related to these initiatives.

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1. Organization and Summary of Significant Accounting Policies (continued)

Other Revenue

Other revenue primarily consist of nonpatient service revenues, clinical integration funds and investment income in operations.

Accounting Pronouncements Not Yet Adopted

In March 2017, the Financial Accounting Standards Board (FASB) issued guidance related to the presentation of net periodic pension cost. This new guidance requires that the service cost component be reported in the same line item as compensation costs arising from services rendered by the pertinent employees during the period. The other components of net pension benefit costs are required to be presented separately from the service cost component and outside a subtotal of income from operations. This new guidance is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. The System has evaluated the effect of this guidance on the consolidated financial statements and has determined that this guidance will reduce operating income but will have no effect on revenues in excess of expenses. This guidance will not have an effect on the measurement of pension cost nor presentation of prepaid pension expense or pension plan liabilities on the consolidated balance sheets. The System is early adopting the standard effective January 1, 2018.

In November 2016, the FASB issued guidance related to the statements of cash flow. The guidance will require restricted cash and restricted cash equivalents to be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. This guidance is effective for the fiscal years and interim periods within those fiscal years beginning after December 15, 2018.

In August 2016, the FASB issued guidance related to the presentation of financial statements of not-for-profit entities. The guidance will require net assets to be categorized either as net assets with donor restrictions or net assets without donor restrictions rather than the currently required three classes of net assets. The guidance also requires additional quantitative and qualitative disclosures and expenses to be disclosed by both their natural and functional classifications. This guidance is effective for fiscal years beginning after December 15, 2017, but for interim periods beginning after December 15, 2018. The System is evaluating the effect this guidance will have on its consolidated financial statements; however, the guidance is not expected to have an effect on revenues in excess of expenses on the consolidated statements of operations and changes in net assets.

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1. Organization and Summary of Significant Accounting Policies (continued)

In February 2016, the FASB issued guidance related to lease accounting. The guidance will require leases that are currently classified as operating leases under current guidance to be recognized on the balance sheet as lease assets and liabilities by lessees. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2018. The System is evaluating the effect this guidance will have on its consolidated financial statements.

In January 2016, the FASB issued guidance requiring financial instruments accounted for on the equity method to be measured at fair value, with changes in fair value recognized in net income. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2018. As of January 1, 2018, the System will elect to measure its investments in private equity limited partnerships, currently carried at cost, at fair value. The System will record a cumulative-effect adjustment of approximately $110,000 due to this election.

In May 2014, the FASB issued guidance related to recognizing revenue from contracts with customers. The guidance outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance, and requires significantly expanded disclosures about revenue recognition. The core principle of the revenue model is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The requirements of the guidance will result in changes to the presentation and disclosure of revenue from services to patients. Currently, a significant portion of the System's provision for doubtful accounts relates to uninsured patients as well as deductibles and co-pays due from patients with insurance. Under the new guidance, the uncollectible amounts due from patients will generally be reported as a direct reduction to net patient service revenue and will result in a significant reduction in the amounts presented separately as provision for doubtful accounts.

Although the adoption of the new guidance will have a significant impact on the amounts presented in certain categories of the System's consolidated statements of operations and changes in net assets, it is not expected to materially impact the System's financial position, results of operations or cash flows. The System adopted this guidance using the full retrospective method, as of January 1, 2018, there was no material cumulative adjustment recorded.

(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Reclassifications in the Consolidated Financial Statements

Certain reclassifications were made to the 2016 consolidated financial statements to conform to the classifications used in 2017. There was no impact on previously reported 2016 net assets or revenues in excess of expenses.

2. Contractual Arrangements With Third-Party Payors

The System provides care to certain patients under payment arrangements with Medicare, Medicaid, Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois (Blue Cross) and various other health maintenance and preferred provider organizations. Services provided under these arrangements are paid at predetermined rates and/or reimbursable costs, as defined. Reported costs and/or services provided under certain of the arrangements are subject to audit by the administering agencies. Changes in Medicare and Medicaid programs and reduction of funding levels could have a material adverse effect on the future amounts recognized as net patient service revenue.

Amounts earned from the above payment arrangements accounted for 95% and 96% of the System's net patient service revenue, net of the provision for uncollectible accounts, in 2017 and 2016, respectively. The System's net patient service revenue net of the provision for uncollectible accounts by payor for the years ended December 31 is as follows:

	2017	2016
Blue Cross	**22%**	31%
Medicare and Medicare Managed Care	**29**	29
Medicaid and Medicaid Managed Care	**16**	15
Other	**33**	25
	100%	100%

The reduction in the percentage of net patient service revenues related to Blue Cross is due to the consolidation of APP and the increase in patients covered under capitated risk contracts.

(Dollars in Thousands)

2. Contractual Arrangements With Third-Party Payors (continued)

Provision has been made in the consolidated financial statements for contractual adjustments, representing the difference between the established charges for services and actual or estimated payment. The extreme complexity of laws and regulations governing the Medicare and Medicaid programs renders at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Changes in the estimates that relate to prior years' third-party payment arrangements resulted in decreases in net patient service revenue of $2,445 and an increase of $12,886 for the years ended December 31, 2017 and 2016, respectively.

In connection with the State of Illinois' Hospital Assessment Program, including the enhanced Medicaid assessment system, the System recognized $280,024 and $275,740 of net patient service revenue and $162,457 and $149,609 of program assessment expense in other expense in 2017 and 2016, respectively.

The System's concentration of credit risk related to accounts receivable is limited due to the diversity of patients and payors. The System grants credit, without collateral, to its patients, most of whom are local residents and insured under third-party payor arrangements. The System has established guidelines for placing patient balances with collection agencies, subject to terms of certain restrictions on collection efforts as determined by the System. Significant concentrations of accounts receivable, less allowance for uncollectible accounts at December 31 is as follows:

	2017	2016
Blue Cross	**15%**	13%
Medicare and Medicare Managed Care	**17**	18
Medicaid and Medicaid Managed Care	**25**	27
Other	**43**	42
	100%	100%

(Dollars in Thousands)

2. Contractual Arrangements With Third-Party Payors (continued)

The System has entered into various capitated provider agreements. Capitation revenue by payor for the years ended December 31 is as follows:

	2017	2016
Humana Health Plan, Inc. and Humana Insurance Company and their affiliates	**19%**	37%
Blue Cross	**66**	37
Cigna-HealthSpring	**4**	12
WellCare Health Plans, Inc.	**4**	10
Other	7	4
	100%	100%

Provision has been made in the consolidated financial statements for the estimated cost of providing certain medical services under the aforementioned capitated arrangements. The System accrues a liability for reported, as well as an estimate for incurred but not reported (IBNR), contracted medical services. The liability represents the expected ultimate cost of all reported and unreported claims unpaid at year-end. The System uses the services of a consulting actuary to determine the estimated cost of the IBNR claims. Adjustments to the estimates are reflected in current year operations. At December 31, 2017 and 2016, the liabilities for unpaid medical claims amounted to $26,039 and $22,353, respectively, and are included in accounts payable and accrued expenses in the consolidated balance sheets.

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(Dollars in Thousands)

3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use)

Investments (including assets limited as to use) and other financial instruments at December 31 are summarized as follows:

	2017	2016
Assets limited as to use:		
Designated for self-insurance programs	**$ 785,912**	$ 717,988
Internally and externally designated for capital improvements, medical education and health care programs	**5,275,958**	4,903,306
Externally designated under debt agreements	**6,084**	6,053
Investments under securities lending program	**18,975**	19,564
	6,086,929	5,646,911
Other financial instruments:		
Cash and cash equivalents and short-term investments	**438,881**	174,425
	$ 6,525,810	$ 5,821,336

The composition and carrying value of assets limited as to use, short-term investments and cash and cash equivalents at December 31 are set forth in the following table:

	2017	2016
Cash and short-term investments	**$ 753,399**	$ 322,650
Corporate bonds and other debt securities	**347,290**	489,400
United States government obligations	**378,051**	489,937
Non-government fixed-income obligations	**21,145**	–
Bond and other debt security funds	**430,581**	272,136
Hedge funds	**1,958,788**	1,961,320
Private equity limited partnerships	**826,278**	651,587
Equity securities	**962,123**	933,478
Equity funds	**848,155**	700,828
	$ 6,525,810	$ 5,821,336

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(Dollars in Thousands)

3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use) (continued)

For private equity limited partnership investments carried at cost, the System regularly compares the net asset value (NAV), which is a proxy for the fair value, to the recorded cost of these investments for potential other-than-temporary impairment. The cost of these investments is $610,525 and $523,328, and the NAV of these based on estimates determined by the investments' management was $719,645 and $603,795 at December 31, 2017 and 2016, respectively. In 2017 and 2016, the System identified and recorded $2,551 and $1,313, respectively, of impairment losses that are included in investment income in the consolidated statements of operations and changes in net assets.

At December 31, 2017, the System had additional commitments to fund private equity limited partnership investments, including recallable distributions, an additional $877,451 over the next seven years.

Receivables and payables for investment trades not settled are presented with prepaid expenses, inventories and other current assets and accounts payable and accrued expenses. Unsettled sales resulted in receivables due from brokers of $29,465 and $16,740 at December 31, 2017 and 2016, respectively. Unsettled purchases resulted in payables of $76,784 and $94,088 at December 31, 2017 and 2016, respectively.

Investment returns for assets limited as to use, cash and cash equivalents and short-term investments are composed of the following for the years ended December 31:

	2017	2016
Interest and dividend income	**$ 51,142**	$ 56,703
Equity income from alternative investments	**179,441**	189,615
Net realized gains (losses)	**103,030**	(20,969)
Net unrealized gains	**345,319**	148,457
	$ 678,932	$ 373,806

(Dollars in Thousands)

3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use) (continued)

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

	2017	2016
Other revenue	**$ 46,871**	$ 39,819
Investment income	**621,236**	329,119
Realized and unrealized gains on investments – temporarily restricted net assets	**10,825**	4,868
	$ 678,932	$ 373,806

As part of the management of the investment portfolio, the System has entered into an arrangement whereby securities owned by the System are loaned primarily to brokers and investment banks. The loans are arranged through a bank. Borrowers are required to post collateral for securities borrowed equal to no less than 102% in 2017 and 2016 of the value of the security on a daily basis, at a minimum. The bank is responsible for reviewing the creditworthiness of the borrowers. The System has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At December 31, 2017 and 2016, the System loaned $18,975 and $19,564, respectively, in securities and accepted collateral for these loans in the amount of $19,577 and $19,953, respectively, which represents cash and government securities and are included in current liabilities and current assets, respectively, in the accompanying consolidated balance sheets.

4. Fair Value Measurements

The System accounts for certain assets and liabilities at fair value. The hierarchy below lists three levels of fair value based on the extent to which inputs used in measuring fair value are observable in active markets. The System categorizes each of its fair value measurements in one of the three levels based on the highest level of input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices in active markets for identified assets or liabilities.

Level 2: Inputs, other than quoted prices in active markets that are observable either directly or indirectly.

Level 3: Unobservable inputs in which there is little or no market data, which then requires the reporting entity to develop its own assumptions about what market participants would use in pricing the asset or liability.

The following section describes the valuation methodologies the System uses to measure financial assets and liabilities at fair value. In general, where applicable, the System uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments, such as domestic and international equities, United States Treasuries, exchange-traded mutual funds and agency securities. If quoted prices in active markets for identical assets and liabilities are not available to determine fair value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, commercial paper and certain agency securities. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include fair value adjustments related to the System's credit risk.

4. Fair Value Measurements (continued)

The System's investments are exposed to various kinds and levels of risk. Equity securities and equity mutual funds expose the System to market risk, performance risk and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is the risk associated with a company's operating performance. Fixed-income securities and fixed-income mutual funds expose the System to interest rate risk, credit risk and liquidity risk. As interest rates change, the value of many fixed-income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value resulting in additional gains and losses in the near term.

In the normal course of operations and within established investment policy guidelines, the System may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the System's strategic asset allocation, adjust the portfolio duration, modify term structure exposure, change sector exposure and arbitrage market inefficiencies. These instruments require the System to deposit cash collateral with the broker or custodian. At December 31, 2017 and 2016, the collateral provided was $11,328 and $13,143, respectively.

At December 31, 2017 and 2016, the notional value of the derivatives in long positions was $160,072 and $37,562, respectively, and those in a short position was $(2,851) and $(4,009), respectively.

By using derivative financial instruments, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in the underlying reference security. The market risk associated with market changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

(Dollars in Thousands)

4. Fair Value Measurements (continued)

The following are assets and liabilities measured at fair value on a recurring basis at December 31, 2017:

		Fair Value Measurements at Reporting Date Using		
Description	2017	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 753,399	$ 685,370	$ 68,029	$ –
Corporate bonds and other debt securities	347,290	–	347,290	–
United States government obligations	378,051	–	378,051	–
Bond and other debt security funds	430,581	99,974	330,607	–
Non-government fixed-income obligations	21,145	–	21,145	–
Equity securities	962,123	962,123	–	–
Equity funds	848,155	92,452	755,703	–
Assets at equity method or cost:				
Hedge funds	1,958,788			
Private equity limited partnerships	826,278			
Total investments	$ 6,525,810			
Collateral proceeds received under securities lending program	$ 19,577		$ 19,577	
Liabilities				
Obligations under swap agreements *(see Note 7)*	$ (73,875)		$ (73,875)	
Obligations to return collateral under securities lending program	$ (19,577)		$ (19,577)	

(Dollars in Thousands)

4. Fair Value Measurements (continued)

The following are assets and liabilities measured at fair value on a recurring basis at December 31, 2016:

Description	2016	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 322,650	$ 306,598	$ 16,052	$ –
Corporate bonds and other debt securities	489,400	–	489,400	–
United States government obligations	489,937	–	489,937	–
Bond and other debt security funds	272,136	115,207	156,929	–
Equity securities	933,478	933,478	–	–
Equity funds	700,828	73,138	627,690	–
Assets at equity method or cost:				
Hedge funds	1,961,320			
Private equity limited partnerships	651,587			
Total investments	$ 5,821,336			
Collateral proceeds received under securities lending program	$ 19,953		$ 19,953	
Liabilities				
Obligations under swap agreements *(see Note 7)*	$ (79,622)		$ (79,622)	
Obligations to return collateral under securities lending program	$ (19,953)		$ (19,953)	

4. Fair Value Measurements (continued)

The carrying values of cash and cash equivalents, accounts receivable and payable, accrued expenses and short-term borrowings are reasonable estimates of their fair values due to the short-term nature of these financial instruments.

5. Interest in Health Care and Related Entities

During 2000, in connection with the acquisition of a medical center, the System acquired an interest in the net assets of the Masonic Family Health Foundation (the Foundation), an independent organization, under the terms of an asset purchase agreement (the Agreement). The use of substantially all of the Foundation's net assets is designated to support the operations and/or capital needs of one of the System's medical facilities. Additionally, 90% of the Foundation's investment yield, net of expenses, on substantially all of the Foundation's investments is designated for the support of one of the System's medical facilities. The Foundation must pay the System, annually, 90% of the investment yield or an agreed-upon percentage of the beginning-of-the-year net assets.

The interest in the net assets of this organization amounted to $88,394 and $84,554 as of December 31, 2017 and 2016, respectively, which is reflected in interest in health care and related entities in the consolidated balance sheets. The System's interest in the investment yield is reflected in the consolidated statements of operations and changes in net assets and amounted to $11,606 and $4,268 for the years ended December 31, 2017 and 2016, respectively. Cash distributions received by the System from the Foundation under terms of the Agreement amounted to $3,218 and $3,812 during the years ended December 31, 2017 and 2016, respectively. In addition to the amounts distributed under the Agreement, the Foundation contributed $562 and $454 to the System for program support of one of its medical facilities during the years ended December 31, 2017 and 2016, respectively.

At December 31, 2017 and 2016, the System has a 49.5% ownership interest in RML Health Providers, L.P. (RML) that is accounted for on an equity basis. RML is an Illinois not-for-profit limited partnership that operates a 115-bed licensed long-term acute care hospital in Hinsdale, IL and an 86-bed licensed long-term acute care hospital in Chicago, IL. The System's carrying value of this interest was $29,032 and $25,036 at December 31, 2017 and 2016, respectively.

RML leases the Chicago, IL facility from the System. The lease has a fixed term through June 30, 2020 with four five-year renewal terms remaining executable at the option of RML. The System recorded rental income of $1,091 and $1,059 at December 31, 2017 and 2016, respectively.

(Dollars in Thousands)

5. Interest in Health Care and Related Entities (continued)

In December 2016, in order to better align the System and APP resources related to capitated and other risk arrangements, the APP bylaws were amended effective January 1, 2017. The amendment resulted in the System obtaining a majority of voting board seats and certain reserve powers. At December 31, 2017, the System has a 50% membership interest in APP. Accordingly, APP's financial results are consolidated in the System's financial statements in 2017.

Prior to the amendment, the interest in APP was accounted for on an equity basis. The System's carrying value, which approximated the fair value in this interest was $0 at December 31, 2016. APP's carrying value of assets and liabilities were reasonable estimates of their fair value due to the short-term nature of these items.

Financial information relating to this interest as of and for the year ended December 31, 2016, was as follows:

	2016
Assets	$ 182,506
Liabilities	183,907
Revenues in excess of expenses	–

The System contracted with APP for certain operational and administrative services. Total expenses incurred for these services were $29,281 in 2016, which was included in purchased services and operating supplies and other in the consolidated statements of operations and changes in net assets. At December 31, 2016, the System had an accrued liability to APP for those services for $250, which was included in accounts payable and accrued expenses in the consolidated balance sheets.

(Dollars in Thousands)

5. Interest in Health Care and Related Entities (continued)

APP purchased claims processing and certain management services from the System in the amount of $9,436 in 2016, which is included in other revenue in the consolidated statements of operations and changes in net assets. Under the terms of an agreement with the System, APP reimburses the System for salaries, benefits and other expenses that are incurred by the System on APP's behalf. The amount billed for these services in 2016 was $30,988, which is included in other revenue in the consolidated statements of operations and changes in net assets. The System had a receivable from APP at December 31, 2016, for claims processing and management services of $4,776, which is included in prepaid expenses, inventories and other current assets in the consolidated balance sheets.

6. Long-Term Debt

Long-term debt, net of unamortized original issue discount or premium and unamortized deferred bond issuance costs, consisted of the following at December 31:

	2017	2016
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series:		
1993C, 6.00%, principal payable in varying annual installments through April 2018	$ **8,462**	$ 11,547
2003A (weighted average rate of 1.38% and 0.81% during 2017 and 2016, respectively), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	**12,551**	14,911
2003C (weighted average rate of 1.60% and 1.15% during 2017 and 2016, respectively), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	**12,589**	14,225
2008A (weighted average rate of 5.00% during 2017 and 2016), principal payable in varying annual installments through November 2030; interest based on prevailing market conditions at time of remarketing	**126,562**	130,047

(Dollars in Thousands)

6. Long-Term Debt (continued)

	2017	2016
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series (continued):		
2008C (weighted average rate of 0.85% and 0.43% during 2017 and 2016, respectively), principal payable in varying annual installments through November 2038; interest based on prevailing market conditions at time of remarketing	**$ 342,614**	$ 342,574
2008D, 5.50%, principal payable in varying annual installments through November 2038	**4,892**	9,529
2010A, 5.50%, principal payable in varying annual installments through April 2044	–	19,502
2010B, 5.38%, principal payable in varying annual installments through April 2044	–	27,334
2010C, 5.38%, principal payable in varying annual installments through April 2044	–	13,379
2010D, 4.00% to 5.00%, principal payable in varying annual installments through April 2038	**17,485**	73,045
2011A, 4.00% to 5.00%, principal payable in varying annual installments through April 2041	**35,861**	36,750
2011B (weighted average rate of 1.14% and 0.67% during 2017 and 2016, respectively), principal payable in varying annual installments through April 2051, subject to a put provision that provides for a cumulative seven-month notice and remarketing period; interest tied to a market index plus a spread	**69,251**	69,228
2011C (weighted average rate of 1.37% and 1.04% during 2017 and 2016, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 3, 2024; interest tied to a market index plus a spread	**49,689**	49,861

(Dollars in Thousands)

6. Long-Term Debt (continued)

	2017	2016
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series (continued):		
2011D (weighted average rate of 1.44% and 1.14% during 2017 and 2016, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 3, 2024; interest tied to a market index plus a spread	**$ 49,689**	$ 49,861
2012, 4.00% to 5.00%, principal payable in varying annual installments through June 2047	**147,913**	148,000
2013A, 5.00%, principal payable in varying annual installments through June 2031	**95,095**	96,775
2014, 4.00% to 5.00%, principal payable in varying annual installments through August 2038	**332,727**	334,768
2015, 4.13% to 5.00%, principal payable in varying annual installments through May 2045	**102,819**	102,935
2015B, 4.00% to 5.00%, principal payable in varying annual installments through May 2044	**72,469**	72,511
Taxable Term Loan, 2.58%, principal payable in varying annual installments through September 2024	**114,813**	–
Capital lease obligations	**50,880**	53,124
Other	**750**	880
	1,646,111	1,670,786
Less current portion of long-term debt	**28,120**	25,892
Less long-term debt subject to short-term remarketing arrangements	**91,975**	91,975
	$ 1,526,016	$ 1,552,919

Maturities of long-term debt, capital leases, and sinking fund requirements, assuming remarketing of the variable rate demand revenue refunding bonds, for the five years ending December 31, 2022, are as follows: 2018 – $28,120; 2019 – $33,691; 2020 – $36,352; 2021 – $37,456; and 2022 – $39,337.

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6. Long-Term Debt (continued)

The System's outstanding bonds are secured by obligations issued under the Amended and Restated Master Trust Indenture dated as of September 1, 2011 and subsequently amended, with Advocate Health Care Network, Advocate Health and Hospitals Corporation, Advocate Condell, Advocate North Side and Advocate Sherman (the Obligated Group or Restricted Affiliates) and U.S. Bank National Association, as master trustee (the System Master Indenture). Under the terms of the bond indentures and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The System Master Indenture and other debt agreements, including a bank credit agreement, also place restrictions on the System and require the System to maintain certain financial ratios.

The System's unsecured variable rate revenue bonds, Series 2008C-3B of $21,975, and Series 2011B of $70,000, while subject to a long-term amortization period, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within a maximum of 12 months after December 31, 2017, the principal amount of such bonds has been classified as a current obligation in the accompanying consolidated balance sheets. Management believes the likelihood of a material amount of bonds being put to the System is remote. However, to address this possibility, the System has taken steps to provide various sources of liquidity, including assessing alternate sources of financing, including lines of credit and/or unrestricted assets as a source of self-liquidity.

The System has standby bond purchase agreements with banks to provide liquidity support for substantially all of the Series 2008C Bonds. In the event of a failed remarketing of the supported Series 2008C Bonds upon its tender by an existing holder and subject to compliance with the terms of the standby bond purchase agreement, the standby bank would provide the funds for the purchase of such tendered bonds, and the System would be obligated to repay the bank for the funds it provided for such bond purchase (if such bond is not subsequently remarketed), with the first installment of such repayment commencing on the date one year and one day after the bank purchases the bond. As of December 31, 2017 and 2016, there were no bank-purchased bonds outstanding. The agreements expire as follows: $49,829 in August 2019; $129,456 in August 2020; and $145,919 in August 2021.

6. Long-Term Debt (continued)

In September 2017, the System entered into a taxable term loan in the amount of $115,000. The proceeds of the loan were used to advance refund a portion of the Series 2010 Bonds and to pay certain financing costs.

The System maintains an interest rate swap program on certain of its variable rate debt as described in Note 7.

Interest paid, net of capitalized interest, amounted to $62,536 and $57,514 in 2017 and 2016, respectively. The System capitalized interest of $2,676 and $7,325 in 2017 and 2016, respectively.

At December 31, 2017, the System had lines of credit with banks aggregating to $325,000. These lines of credit provide for various interest rates and payment terms and expire as follows: $100,000 in March 2018, $100,000 in August 2018, $100,000 in December 2019 and $25,000 in August 2020. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures, or for general working capital purposes. At December 31, 2017, no amounts were outstanding on these lines of credit.

7. Interest Rate Swap Program

The System has interest rate-related derivative instruments to manage exposure of its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The System also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

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(Dollars in Thousands)

7. Interest Rate Swap Program (continued)

At December 31, 2017, the System maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose the System to variability in interest payments due to changes in interest rates. The System believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, the System entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps convert the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in the principal outstanding under various bond series. The following is a summary of the outstanding positions under these interest rate swap agreements at December 31, 2017 and 2016:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	$ 129,900	November 1, 2038	61.7% of LIBOR + 26 bps	3.60%
2008C-2	108,425	November 1, 2038	61.7% of LIBOR + 26 bps	3.60
2008C-3	88,000	November 1, 2038	61.7% of LIBOR + 26 bps	3.60

The swaps are not designated as hedging instruments, and therefore, hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are included as a component of nonoperating income (loss) in the consolidated statements of operations and changes in net assets as changes in the fair value of interest rate swaps. The net cash settlement payments, representing the realized changes in fair value of the swaps, are included as interest expense in the consolidated statements of operations and changes in net assets.

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(Dollars in Thousands)

7. Interest Rate Swap Program (continued)

The fair value of derivative instruments is as follows:

	December 31 2017	2016
Consolidated balance sheet location		
Obligations under swap agreements	**$ (73,875)**	$ (79,622)
Collateral posted under swap agreements	**–**	–
Obligations under swap agreements, net	**$ (73,875)**	$ (79,622)

Amounts recorded in the consolidated statements of operations and changes in net assets for the derivatives are as follows:

	Year Ended December 31 2017	2016
Consolidated statement of operations and changes in net assets location		
Net cash payments on interest rate swap agreements (interest expense)	**$ 8,613**	$ 9,831
Change in the fair value of interest rate swaps (nonoperating)	**$ 5,748**	$ 9,221

The swap instruments contain provisions that require the System's debt to maintain an investment grade credit rating from certain major credit rating agencies. If the System's debt were to fall below investment grade on the valuation date, it would be in violation of these provisions and the counterparty to the derivative instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on derivative instruments in net liability positions. If the credit risk-related contingent features underlying these swap agreeents were triggered on December 31, 2017, the System would be required to post $73,875 in collateral with the counterparties.

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(Dollars in Thousands)

8. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31:

	2017	2016
Purchases of property and equipment	$ **23,723**	$ 22,702
Medical education and other health care programs	**91,391**	86,312
	$ **115,114**	$ 109,014

Permanently restricted net assets generate investment income, which is used to benefit the following purposes at December 31:

	2017	2016
Purchases of property and equipment	$ **1,000**	$ 1,000
Medical education and other health care programs	**52,446**	51,975
	$ **53,446**	$ 52,975

9. Retirement Plans

The System maintains defined benefit pension plans, the Advocate Health Care Network Pension Plan (Advocate Plan) and Condell Health Network Retirement Plan (Condell Plan) (collectively, the Plans), which cover a majority of its employees (associates). The Condell Plan was frozen effective January 1, 2008, to new participants and participants ceased to accrue additional pension benefits. The System may elect to terminate the Condell Plan in the future subject to the provisions set forth in Employee Retirement Income Security Act of 1974.

(Dollars in Thousands)

9. Retirement Plans (continued)

A summary of changes in the plan assets, projected benefit obligation, and the resulting funded status of the Advocate Plan is as follows:

	2017	2016
Change in plan assets:		
Plan assets at fair value at beginning of year	**$ 917,901**	$ 857,529
Actual return on plan assets	**122,799**	70,999
Employer contributions	**24,375**	31,200
Benefits paid	**(54,338)**	(41,827)
Plan assets at fair value at end of year	**$ 1,010,737**	$ 917,901
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 932,032**	$ 878,083
Service cost	**54,107**	49,413
Interest cost	**38,737**	38,649
Actuarial (gain) loss	**(13,618)**	7,714
Benefits paid	**(54,338)**	(41,827)
Projected benefit obligation at end of year	**$ 956,920**	$ 932,032
Plan assets greater (less) than projected benefit obligation	**$ 53,817**	$ (14,131)
Accumulated benefit obligation at end of year	**$ 878,477**	$ 850,736

(Dollars in Thousands)

9. Retirement Plans (continued)

A summary of changes in the plan assets, projected benefit obligation, and the resulting funded status of the Condell Plan is as follows:

	2017	2016
Change in plan assets:		
Plan assets at fair value at beginning of year	$ **60,784**	$ 58,548
Actual return on plan assets	**8,334**	2,549
Employer contributions	**3,400**	4,400
Benefits paid	**(5,640)**	(4,713)
Plan assets at fair value at end of year	$ **66,878**	$ 60,784
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	$ **66,855**	$ 67,348
Interest cost	**2,604**	2,792
Actuarial loss	**7,404**	1,428
Benefits paid	**(5,640)**	(4,713)
Projected benefit obligation at end of year	$ **71,223**	$ 66,855
Plan assets less than projected benefit obligation	$ **(4,345)**	$ (6,071)
Accumulated benefit obligation at end of year	$ **71,223**	$ 66,855

(Dollars in Thousands)

9. Retirement Plans (continued)

The Condell Plan paid lump sums totaling $4,085 and $2,891 in 2017 and 2016, respectively. The amount in 2017 was greater than the sum of the Condell Plan's service cost and interest cost resulting in a settlement charge in the amount of $1,010.

Plans' net pension expense consists of the following for the years ended December 31:	2017	2016
Service cost	**$ 54,108**	$ 49,413
Interest cost	**41,341**	41,440
Expected return on plan assets	**(68,177)**	(66,388)
Amortization of:		
Prior service credit	**(4,823)**	(4,823)
Recognized actuarial loss	**10,639**	11,690
Settlement/curtailment	**1,010**	852
Plans' net pension expense	**$ 34,098**	$ 32,184

The amounts of actuarial loss and prior service cost (credit) included in other changes in unrestricted net assets expected to be recognized in net periodic pension cost during the year ending December 31, 2018, are $6,978 and $(3,983), respectively.

For the defined benefit plans previously described, changes in plans' assets and benefit obligations recognized in unrestricted net assets during 2017 and 2016 include an actuarial gain of $80,820 and $10,309, respectively, and net prior service credit of $4,823 in both years.

Included in unrestricted net assets at December 31 are the following amounts that have not yet been recognized in net pension expense:

	2017	2016
Unrecognized prior credit	**$ (4,126)**	$ (8,949)
Unrecognized actuarial loss	**147,982**	228,802
	$ 143,856	$ 219,853

(Dollars in Thousands)

9. Retirement Plans (continued)

Employer contributions were paid from employer assets. No plan assets are expected to be returned to the employer. All benefits paid under the Plans were paid from the Plans' assets. The System anticipates making no contributions to the Plans' assets during 2018. Expected associate benefit payments are 2018 – $77,510; 2019 – $67,960; 2020 – $73,510; 2021 – $77,540; 2022 – $79,720; and 2023 through 2027 – $416,270.

The Plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors and manager style to minimize the risk of loss. The System uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. The System regularly monitors manager performance and compliance with investment guidelines.

The System's target and actual pension asset allocations for the Plans are as follows:

Asset Category – Advocate Plan	Target	2017 Actual	2016 Actual
Domestic and international equity securities	35%	35%	36%
Alternative investments	45	45	46
Cash and fixed-income securities	20	20	18
	100%	100%	100%

Asset Category – Condell Plan	Target	2017 Actual	2016 Actual
Domestic and international equity securities	15%	15%	31%
Cash and fixed-income securities	85	85	69
	100%	100%	100%

9. Retirement Plans (continued)

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 4. Real estate commingled funds for which an active market exists are included in Level 2. The System opted to use the NAV per share, or its equivalent, as a practical expedient for fair value of the Plans' interest in hedge funds, private equity limited partnerships and real estate commingled funds. There is inherent uncertainty in such valuations and the estimated fair values may differ from the values that would have been used had a ready market for these investments existed. Private equity limited partnerships and real estate commingled funds typically have finite lives ranging from five to ten years, at the end of which all invested capital is returned. For hedge funds, the typical lockup period is one year, after which invested capital can be redeemed on a quarterly basis with at least 30 days' but no more than 90 days' notice. The Plans' investment assets are exposed to the same kinds and levels of risk as described in Note 4.

At December 31, 2017, the Advocate Plan had commitments to fund private equity limited partnerships, including recallable distributions, an additional $137,972 over the next seven years.

In the normal course of operations and within established investment policy guidelines, the Plan may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the Plan's strategic asset allocation, adjust the portfolio duration, modify term structure exposure, change sector exposure and arbitrage market inefficiencies. These instruments require the Plan to deposit cash collateral with the broker or custodian. At December 31, 2017 and 2016, the collateral provided was $5,454 and $3,739, respectively.

At December 31, 2017 and 2016, the notional value of the derivatives in long positions was $48,822 and $30,499, respectively, and those in a short position was $(22,618) and $(271), respectively.

9. Retirement Plans (continued)

By using derivative financial instruments, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in the underlying reference security. The market risk associated with market changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Receivables and payables for investment trades not settled are presented within Plan assets. Unsettled sales resulted in receivables due from brokers of $11,976 and $10,012 at December 31, 2017 and 2016, respectively. Unsettled purchases resulted in payables of $32,163 and $17,284 at December 31, 2017 and 2016, respectively.

(Dollars in Thousands)

9. Retirement Plans (continued)

The following are the Plans' financial instruments at December 31, 2017, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

	Fair Value Measurements at Reporting Date Using			
Description	**Total**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Cash and short-term investments	$ 35,504	$ 33,067	$ 2,437	$ –
Corporate bonds and other debt securities	38,837	–	38,837	–
United States government obligations	55,107	–	55,107	–
Non-government fixed-income obligations	517	–	517	–
Bond and other debt security mutual funds	130,444	43,885	86,559	–
Equity securities	142,509	142,509	–	–
Equity funds	216,367	42,047	174,320	–
Real estate funds	15,606	–	15,606	–
Assets at net asset value:				
Hedge funds	270,823			
Private equity limited partnerships and real estate funds	171,901			
Total	$ 1,077,615			

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(Dollars in Thousands)

9. Retirement Plans (continued)

The following are the Plans' financial instruments at December 31, 2016, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

	Fair Value Measurements at Reporting Date Using			
Description	**Total**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Cash and short-term investments	$ 13,126	$ 11,694	$ 1,432	$ –
Corporate bonds and other debt securities	15,600	–	15,600	–
United States government obligations	62,790	–	62,790	–
Government mutual funds	14,825	–	14,825	–
Bond and other debt security funds	99,281	30,145	69,136	–
Equity securities	124,862	124,862	–	–
Equity funds	218,001	35,202	182,799	–
Real estate funds	14,558	–	14,558	–
Assets at net asset value:				
Hedge funds	261,288			
Private equity limited partnerships and real estate funds	154,354			
Total	$ 978,685			

(Dollars in Thousands)

9. Retirement Plans (continued)

Assumptions used to determine benefit obligations at the measurement date are as follows:

	2017	2016
Discount rate – both plans	**3.60%**	4.05%
Assumed rate of return on assets – Advocate Plan	**7.00**	7.25
Assumed rate of return on assets – Condell Plan	**5.00**	5.00
Weighted average rate of increase in future compensation (age-based table) – Advocate Plan	**3.61**	4.00

Assumptions used to determine net pension expense for the fiscal years are as follows:

	2017	2016
Discount rate – both plans	**4.05%**	4.30%
Assumed rate of return on assets – Advocate Plan	**7.00**	7.25
Assumed rate of return on assets – Condell Plan	**5.00**	5.00
Weighted average rate of increase in future compensation (age-based table) – Advocate Plan	**4.00**	4.03

The assumed rate of return on plan assets is based on historical and projected rates of return for asset classes in which the portfolio is invested. The expected return for each asset class was then weighted based on the target asset allocation to develop the overall expected rate of return on assets for the portfolio.

The 2017 mortality assumption for the Plans was the RP-2014 no-collar adjustment scale MP-2017 generational projection scale. The 2016 mortality assumption for the Plans was the RP-2014 no-collar adjustment scale MP-2016 generational projection scale.

In addition to the defined benefit pension plans, the System sponsors various defined contribution plans. The System contributed to the defined contribution plans $50,933 and $51,682 in 2017 and 2016, respectively, which are included in salaries, wages and employee benefits expense in the consolidated statements of operations and changes in net assets.

10. General and Professional Liability Risks

The System is self-insured for substantially all general and professional liability risks. The self-insurance programs combine various levels of self-insured retention with excess commercial insurance coverage. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Revocable trust funds, administered by a trustee and a captive insurance company, have been established for the self-insurance programs. Actuarial consultants have been retained to determine the estimated cost of claims, as well as to determine the amount to fund into the trust and captive insurance company.

The estimated cost of claims is actuarially determined based on past experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance liabilities and contributions to the trust were determined using a discount rate of 3.00% for 2017 and 2016. Accrued insurance liabilities for the System's captive insurance company were determined using a discount rate of 3.00% for 2017 and 2016. Total accrued insurance liabilities would have been $32,310 and $38,058 greater at December 31, 2017 and 2016, respectively, had these liabilities not been discounted.

The System is a defendant in certain litigation related to professional and general liability risks. Although the outcome of the litigation cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of this litigation will not have any material adverse effect on the System's operations or financial condition.

11. Legal, Regulatory and Other Contingencies and Commitments

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. During the last few years, as a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, exclusion from the Medicare and Medicaid programs and revocation of federal or state tax-exempt status. Moreover, the System expects that the level of review and audit to which it and other health care providers are subject will increase.

11. Legal, Regulatory and Other Contingencies and Commitments (continued)

Various federal and state agencies have initiated investigations, which are in various stages of discovery, relating to reimbursement, billing practices and other matters of the System. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have on the System. As a result, there is a reasonable possibility that recorded amounts will change by a material amount in the near term. To foster compliance with applicable laws and regulations, the System maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

In March 2014, the System and certain of its subsidiaries were named as defendants to litigation surrounding the church plan status of the Advocate Plan. In December 2014, the United States District Court for the Northern District of Illinois issued its Decision and Order denying the Defendants' Motion to Dismiss. The System filed a Motion for Interlocutory Appeal, which was granted in January 2015, and subsequently filed its Petition for Appeal with the Seventh Circuit in January 2015. In March 2016, the Seventh Circuit affirmed the Northern District of Illinois decision. In July 2016, the System filed a petition with the Supreme Court of the United States seeking review of the lower courts' ruling. In December 2016, the Supreme Court agreed to hear the System's appeal as part of a consolidated case. Oral arguments were heard in March 2017. In June 2017, the Supreme Court of the United States ruled a pension plan maintained by a principal-purpose organization qualified as a church plan, regardless of who establishes the plan, and the case was remanded to the Seventh Circuit. In August 2017, the Seventh Circuit entered an order reversing the District Court's judgment and remanding the case to the District Court for further proceedings. The System executed a non-binding settlement that was filed with the District Court in February 2018. In order for the settlement to become final, the District Court must grant approval. A final approval hearing is expected to take place in June 2018. The System does not believe that this matter will have a material adverse effect on the System's financial position or results of operations.

11. Legal, Regulatory and Other Contingencies and Commitments (continued)

The System is committed to constructing additions and renovations to its medical facilities that are expected to be completed in future years. The estimated cost of these commitments is $785,122, of which $723,536 has been incurred as of December 31, 2017.

The System entered into agreements for information technology services provided by a third party. The maximum amount of future payments that the System could be required to make under these agreements is approximately $250,000 over the next seven years. The System has also entered into various other agreements. The future commitments under these agreements is $36,624 over the next eight years.

Future minimum rental commitments at December 31, 2017, for all noncancelable leases with original terms of more than one year are $42,234, $35,621, $31,041, $26,370 and $24,093 for the years ending December 31, 2018 through 2022, respectively, and $81,534 thereafter.

Rent expense, which is included in other expenses, amounted to $73,925 and $70,745 in 2017 and 2016, respectively.

(Dollars in Thousands)

12. Income Taxes and Tax Status

Certain subsidiaries of the System are for-profit corporations. Significant components of the for-profit subsidiaries' deferred tax assets (liabilities) are as follows at December 31:

	2017	2016
Deferred tax assets		
Allowance for uncollectible accounts	$ **2,013**	$ 3,476
Other accrued expenses	**5,996**	5,214
Accrued insurance	**4,640**	4,393
Accrued compensation and employee benefits	**2,850**	2,288
Third-party settlements	**214**	226
Deferred gain on acquisition	**–**	895
Prepaid and other assets	**343**	520
Total deferred tax assets	**33,440**	36,647
Less valuation allowance	**13,551**	18,376
Net deferred tax assets	**19,889**	18,271
Deferred tax liabilities		
Property and equipment	**(2,135)**	(3,576)
Other accrued expenses	**(4,304)**	(3,348)
Total deferred tax liabilities	**(7,298)**	(7,096)
Net deferred tax asset, included in other noncurrent assets	$ **12,591**	$ 11,175

As of December 31, 2017, the for-profit corporations had $50,835 of federal and $67,995 of state net operating loss carryforwards with unutilized amounts expiring between 2019 and 2037.

In compliance with the Tax Cuts and Jobs Act of 2017, the federal components of the deferred tax assets (liabilities) were revalued from 35% to 21%. The valuation allowance related to these deferred tax assets (liabilities) was reduced accordingly. The valuation allowance at December 31, 2017, primarily consist of net operating losses that are unlikely to be

(Dollars in Thousands)

12. Income Taxes and Tax Status (continued)

Significant components of the for-profit subsidiaries' (credit) provision for income taxes are as follows for the years ended December 31:

	2017	2016
Current:		
Federal	**$ 1,072**	$ 687
State	–	176
Deferred	**(1,416)**	(13,157)
	$ (344)	$ (12,294)

Federal and state income taxes paid relating to the System's for-profit corporations were $(32) and $115 in 2017 and 2016, respectively.

The System and all other controlled or wholly owned subsidiaries are exempt from income taxes under Internal Revenue Code Section 501(c)(3). They do, however, operate certain programs that generate unrelated business income. The current tax provision recorded on this income was $884 and $911 for the years ended December 31, 2017 and 2016, respectively.

As of January 1, 2017, APP was merged into the System. APP is a nonstock organization that is taxed as a property and casualty insurance company under Internal Revenue Code Section 831, as well as Illinois State corporate income taxes. APP's tax components are not included in the above tables. At December 31, 2017, APP had a deferred asset totaling $1,003 and a deferred tax liability of $68. A valuation allowance of $934 has been recorded as of December 31, 2017. APP has no net operating loss carryforwards available to offset future taxable income. During 2017, APP paid net income taxes of $680.

13. Affiliation and Merger

In December 2017, the System and Aurora Health Care, Inc. (Aurora) entered into a definitive affiliation agreement (the Agreement) to form Advocate Aurora Health, Inc. The completion of the transaction is conditioned upon the satisfaction of certain conditions precedent, including required regulatory approval of the Federal Trade Commission (FTC). The FTC did not challenge the Agreement and the only remaining regulatory approval required is from the Wisconsin Office of the Commissioner of Insurance. Though the System can provide no assurances the transaction will, or will not, occur, the System anticipates closing the transaction on or about April 1, 2018.

(Dollars in Thousands)

13. Affiliation and Merger (continued)

Prior to January 1, 2017, the System had a 50% membership and governance interest in APP, which had been accounted for on an equity basis. The System's carrying value, which approximated the fair value in this interest was $0 at December 31, 2016. To better align the System's and APP resources related to capitated and other risk arrangements, the APP bylaws were amended effective January 1, 2017. The amendment resulted in the System obtaining a majority of voting board seats and certain reserve powers. Accordingly, APP's results were consolidated in the System's consolidated financial statements beginning January 1, 2017. There was no consideration transferred with this transaction.

The fair value of assets and liabilities of APP on January 1, 2017, consisted of the following:

Cash and cash equivalents	$ 157,286
Other current assets	28,580
Total assets	$ 185,866
Current liabilities	$ 185,866

Total operating revenue and operating loss from the date of consolidation for APP of $857,024 and $1, respectively, have been included in the accompanying consolidated statements of operations and changes in net assets.

Following are the unaudited pro forma results for the year ended December 31, 2016, as if the consolidation had occurred on January 1, 2016:

Total operating revenue	$ 6,072,672
Operating income	263,960
Revenues in excess of expenses	597,604

The pro forma information provided should not be construed to be indicative of the System's results of operations had the consolidation been consummated on January 1, 2016, and is not intended to project the System's results of operations for any future period.

14. Subsequent Events

The System evaluated events occurring between January 1, 2018 and March 9, 2018, which is the date when the consolidated financial statements were issued.

Supplementary Information

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Building a better working world

Report of Independent Auditors on Supplementary Information

The Board of Directors
Advocate Health Care Network

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying details of consolidated balance sheet and details of consolidated statement of operations and changes in net assets and shareholders' equity are presented for the purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information 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. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

March 9, 2018

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Advocate Charitable Foundation

Statements of Operations
(Dollars in Thousands)

	Year Ended December 31	
	2017	**2016**
Unrestricted revenues, gains and other support		
Other revenue	**$ 2,673**	$ 1,602
Expenses		
Salaries, wages and employee benefits	**7,891**	7,630
Purchased services and operating supplies	**774**	997
Other	**3,541**	2,752
Depreciation and amortization	**18**	35
	12,224	11,414
Operating loss	**(9,551)**	(9,812)
Nonoperating income (loss)		
Other nonoperating items, net	**(29)**	(15)
Expenses in excess of revenues	**$ (9,580)**	$ (9,827)

Advocate Health Care Network and Subsidiaries

Details of Consolidated Balance Sheet
(Dollars in Thousands)

December 31, 2017

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries	Advocate Health Partners and Subsidiary
Assets									
Current assets:									
Cash and cash equivalents	$ 411,133	$ –	$ 3,923	$ 301,027	$ (6,746)	$ 1	$ 127	$ 14,141	$ 98,660
Short-term investments	27,748	–	–	–	–	27,748	–	–	–
Assets limited as to use	94,224	–	–	82,664	–	–	11,560	–	Patient accounts
receivable, less allowances for uncollectible accounts	746,392	–	–	685,768	14,941	–	–	45,683	–
Amounts due from primary third-party payors	32,301	–	–	27,672	–	–	–	4,629	– Intercompany
receivables	–	(194,791)	7,363	94,224	64,216	271	181	12,279	16,257
Prepaid expenses, inventories and other current assets	295,369	–	–	199,477	11,958	37,253	6,007	6,367	34,307
Collateral proceeds received under securities lending program	19,577	–	–	19,577	–	–	–	–	–
Total current assets	1,626,744	(194,791)	11,286	1,410,409	84,369	65,273	17,875	83,099	149,224
Assets limited as to use:									
Internally and externally designated investments limited as to use	5,973,730	–	306,100	5,173,691	60,837	125,084	118,050	153,744	36,224
Investments under securities lending program	18,975	–	–	18,975	–	–	–	–	–
Investment in subsidiaries	–	(184,196)	184,196	–	–	–	–	–	–
Intercompany receivables	–	(239,761)	66,360	173,401	–	–	–	–	–
Prepaid pension expense and other noncurrent assets	276,277	(547)	–	235,683	30,530	7,766	–	2,845	–
Interest in health care and related entities	151,968	–	–	124,357	23,868	–	–	3,743	–
Reinsurance receivable	76,376	–	–	3,210	–	–	72,729	437	–
	6,497,326	(424,504)	556,656	5,729,317	115,235	132,850	190,779	160,769	36,224
Property and equipment – at cost:									
Land and land improvements	301,964	–	–	256,784	15,525	–	–	29,655	–
Buildings	3,727,467	–	–	3,384,505	91,404	355	–	251,203	–
Movable equipment	1,808,122	–	–	1,662,605	66,644	1,456	–	77,417	–
Construction-in-progress	137,072	–	–	124,938	1,110	–	–	11,024	–
	5,974,625	–	–	5,428,832	174,683	1,811	–	369,299	–
Less allowances for depreciation	2,992,201	–	–	2,806,714	91,929	1,795	–	91,763	–
	2,982,424	–	–	2,622,118	82,754	16	–	277,536	–
Total assets	$ 11,106,494	$ (619,295)	$ 567,942	$ 9,761,844	$ 282,358	$ 198,139	$ 208,654	$ 521,404	$ 185,448

SSUB-SPC

Advocate Health Care Network and Subsidiaries

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries	Advocate Health Partners and Subsidiary
Liabilities and net assets									
Current liabilities:									
Current portion of long-term debt	$ 28,120	$ –	$ –	$ 27,176	$ 809	$ –	$ –	$ 135	$ –
Current portion of intercompany long-term debt	–	(6,425)	–	–	–	–	–	6,425	– Long-
term debt subject to short-term remarketing arrangements	91,975	– –	91,975	–	–	–	–	–	Accounts payable
and accrued expenses	540,786	–	–	377,142	33,188	337	2,368	16,996	110,755
Accrued salaries and employee benefits	459,774	–	–	420,596	25,176	1,281	–	12,721	–
Amounts due to primary third-party payors	319,020	–	–	280,098	2,760	–	–	36,162	–
Current portion of accrued insurance and claims costs	104,593	–	–	86,486	235	–	17,567	305	–
Intercompany payables	–	(188,366)	–	72,656	15,465	5,249	853	18,131	76,012 Obligations to return
collateral under securities lending program	19,577	–	–	19,577	–	–	–	–	–
Total current liabilities		1,563,845	(194,791)	– 1,375,706	77,633		6,867	20,788	90,875 186,767
Noncurrent liabilities:									
Long-term debt, less current portion	1,527,016	–	–	1,519,987	6,414	–	–	615	–
Intercompany payables	–	(238,691)	–	–	–	–	–	238,691	–
Pension plan liability	4,345	(547)	–	4,345	547	–	– –	–	Accrued insurance and
claims cost, less current portion	617,735	–	–	579,100	4,203	–	34,432	–	–
Accrued losses subject to reinsurance recovery	76,376	–	–	3,210	–	–	72,729	437	–
Obligations under swap agreements, net of collateral posted	73,875	–	–	73,875	–	–	–	–	–
Other noncurrent liabilities	213,240	–	154	193,277	17,057	2,744	–	8	–
	2,512,587	(239,238)	154	2,373,794	28,221	2,744	107,161	239,751	–
Total liabilities	4,076,432	(434,029)	154	3,749,500	105,854	9,611	127,949	330,626	186,767
Net assets:									
Unrestricted	6,860,328	70,769	567,788	6,011,158	–	21,275	–	190,657	(1,319)
Temporarily restricted	115,114	–	–	1,186	–	113,807	–	121	–
Permanently restricted	53,446	–	–	–	–	53,446	–	–	–
Common stock	–	(1)	–	–	1	–	–	–	–
Additional paid-in capital	–	(177,163)	–	–	177,163	–	–	–	–
Noncontrolling interest	1,174	–	–	–	1,174	–	–	–	–
Retained (deficit) earnings/partnership losses	–	(78,871)	–	–	(1,834)	–	80,705	–	– Total net assets
		7,030,062	(185,266)	567,788	6,012,344	176,504	188,528	80,705 190,778	(1,319)
Total liabilities and net assets	$ 11,106,494	$ (619,295)	$ 567,942	$ 9,761,844	$ 282,358	$ 198,139	$ 208,654	$ 521,404	$ 185,448

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Advocate Health Care Network and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended December 31, 2017

				Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries	Advocate Health Partners and Subsidiary
				$ 4,587,432	$ 192,930	$ –	$ –	$ 347,622	$ –
Provision for uncollectible accounts	(237,310)	–	–	(198,194)	(5,867)	–	–	(33,249)	–
	4,515,229	(375,445)	–	4,389,238	187,063	–	–	314,373	–
Capitation revenue	1,317,839	(15,069)	–	598,450	46,356	–	–	–	688,102
Other revenue	400,345	(193,487)	2	331,621	59,443	–	29,365	4,479	168,922
	6,233,413	(584,001)	2	5,319,309	292,862	–	29,365	318,852	857,024
Expenses									
Salaries, wages and employee benefits	3,125,883	–	9	2,798,611	195,195	–	–	131,855	213
Purchased services and operating supplies	1,414,485	(145,141)	–	1,288,829	78,830	–	223	120,484	71,260
Contracted medical services	606,922	(415,384)	–	229,085	10,903	–	–	–	782,318
Other	470,494	(23,030)	(13)	435,615	19,188	–	12,327	23,173	3,234
Depreciation and amortization	294,280	(431)	–	265,668	9,255	–	–	19,788	–
Interest	58,900	(9,153)	–	58,663	204	–	–	9,186	–
	5,970,964	(593,139)	(4)	5,076,471	313,575	–	12,550	304,486	857,025
Operating income (loss) before nonrecurring losses	262,449	9,138	6	242,838	(20,713)	–	16,815	14,366	(1)
Nonrecurring losses	42,750	–	–	41,103	970	–	–	677	–
Operating income (loss)	219,699	9,138	6	201,735	(21,683)	–	16,815	13,689	(1)
Nonoperating income (loss)									
Investment income (loss)	621,236	(9,042)	54,081	536,751	12,744	–	7,210	20,810	(1,318)
Change in fair value of interest rate swaps	5,748	–	–	5,748	–	–	–	–	–
Loss on refinancing	(5,971)	–	–	(5,971)	–	–	–	–	–
Other nonoperating items, net	(29,369)	447	–	(24,496)	3,279	(9,580)	–	981	–
Revenues in excess of (less than) expenses	811,343	543	54,087	713,767	(5,660)	(9,580)	24,025	35,480	(1,319)
Unrestricted net assets									
Net assets released from restrictions and used for capital purchases	6,450	–	–	6,409	–	–	–	41	–
Transfers to/from Advocate Health Care Network and subsidiaries	–	–	(111,000)	120,000	–	11,000	(20,000)	–	–
Postretirement benefit plan adjustments	77,773	–	–	77,773	–	–	–	–	–
Increase (decrease) in unrestricted net assets	895,566	543	(56,913)	917,949	(5,660)	1,420	4,025	35,521	(1,319)

Advocate Health Care Network and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries	Advocate Health Partners and Subsidiary
Temporarily restricted net assets									
Contributions for medical education programs, capital purchases and other purposes	$ 17,001	$ –	$ –	$ –	$ –	$ 17,001	$ –	$ –	$ –
Realized gains on investments	3,586	–	–	40	–	3,546	–	–	–
Unrealized gains on investments	7,239	–	–	79	–	7,160	–	–	–
Net assets released from restrictions and used for operations, medical education programs, capital purchases and other purposes	(21,726)	–	–	(47)	–	(21,670)	–	(9)	–
Increase (decrease) in temporarily restricted net assets	6,100	–	–	72	–	6,037	–	(9)	–
Permanently restricted net assets									
Contributions for medical education programs, capital purchases and other purposes	471	–	–	–	–	471	–	–	–
Increase in permanently restricted net assets	471	–	–	–	–	471	–	–	–
Increase (decrease) in net assets	902,137	543	(56,913)	918,021	(5,660)	7,928	4,025	35,512	(1,319)
Change in noncontrolling interest	(324)	–	–	–	(324)	–	–	–	–
Net assets at beginning of year	6,128,249	(185,809)	624,701	5,094,323	182,488	180,600	76,680	155,266	–
Net assets at end of year	$ 7,030,062	$ (185,266)	$ 567,788	$ 6,012,344	$ 176,504	$ 188,528	$ 80,705	$ 190,778	$ (1,319)

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Balance Sheet
(Dollars in Thousands)

December 31, 2017

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Assets									
Current assets:									
Cash and cash equivalents	$ 301,027	$ –	$ 229,643	$ 50,687	$ 17,100	$ 3,597	$ –	$ 1,992	$ 1,605
Assets limited as to use	82,664	–	82,664	–	–	–	–	–	–
Patient accounts receivable, less allowances for uncollectible accounts	685,768	–	572,253	60,714	46,231	6,570	–	2,198	4,372
Amounts due from primary third-party payors	27,672	–	17,789	5,283	4,600	–	–	–	–
Accounts receivable from Advocate Health Care Network and subsidiaries	94,224	–	82,778	7,902	2,090	1,454	–	1,448	6
Intercompany receivables	–	(49,378)	23,729	15,541	7,553	2,555	(297)	2,770	82
Prepaid expenses, inventories and other current assets	199,477	–	171,882	19,710	7,465	420	–	414	6
Collateral proceeds received under securities lending program	19,577	–	19,577	–	–	–	–	–	–
Total current assets	1,410,409	(49,378)	1,200,315	159,837	85,039	14,596	(297)	8,822	6,071
Assets limited as to use:									
Internally and externally designated investments limited as to use	5,173,691	–	4,810,147	213,570	102,020	47,954	–	34,120	13,834
Investments under securities lending program	18,975	–	18,975	–	–	–	–	–	–
Accounts receivable from Advocate Health Care Network and subsidiaries	173,401	–	173,401	–	–	–	–	–	–
Prepaid pension expense and other noncurrent assets	235,683	–	233,625	49	2,009	–	–	–	–
Interest in health care and related entities	124,357	–	34,516	89,841	–	–	–	–	–
Reinsurance receivable	3,210	–	3,210	–	–	–	–	–	–
	5,729,317	–	5,273,874	303,460	104,029	47,954	–	34,120	13,834
Property and equipment – at cost:									
Land and land improvements	256,784	–	158,161	43,477	55,146	–	–	–	–
Buildings	3,384,505	–	2,869,750	252,022	261,946	787	–	740	47
Movable equipment	1,662,605	–	1,494,843	80,165	83,183	4,414	–	4,349	65
Construction-in-progress	124,938	–	112,299	11,839	800	–	–	–	–
	5,428,832	–	4,635,053	387,503	401,075	5,201	–	5,089	112
Less allowances for depreciation	2,806,714	–	2,508,470	152,122	141,129	4,993	–	4,929	64
	2,622,118	–	2,126,583	235,381	259,946	208	–	160	48
Total assets	$ 9,761,844	$ (49,378)	$ 8,600,772	$ 698,678	$ 449,014	$ 62,758	$ (297)	$ 43,102	$ 19,953

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Liabilities and net assets									
Current liabilities:									
Current portion of long-term debt	$ 27,176	$ –	$ 25,898	$ –	$ 1,278	$ –	$ –	$ –	$ –
Long-term debt subject to short-term remarketing arrangements	91,975	–	91,975	–	–	–	–	–	–
Accounts payable and accrued expenses	377,142	–	346,603	13,011	12,145	5,383	–	2,998	2,385
Accrued salaries and employee benefits	420,596	–	386,896	16,212	11,717	5,771	–	4,818	953
Amounts due to primary third-party payors	280,098	–	197,608	34,974	37,391	10,125	–	10,081	44
Current portion of accrued insurance and claims costs	86,486	–	86,486	–	–	–	–	–	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	72,656	–	63,279	4,752	3,422	1,203	–	888	315
Intercompany payables	–	(49,378)	25,549	13,284	8,780	1,765	(297)	1,165	897
Obligations to return collateral under securities lending program	19,577	–	19,577	–	–	–	–	–	–
Total current liabilities	1,375,706	(49,378)	1,243,871	82,233	74,733	24,247	(297)	19,950	4,594
Noncurrent liabilities:									
Long-term debt, less current portion	1,519,987	–	1,493,648	–	26,339	–	–	–	–
Pension plan liability	4,345	–	–	–	4,345	–	–	–	Accrued
insurance and claims cost, less current portion	579,100	–	579,100	–	–	–	–	–	–
Accrued losses subject to reinsurance recovery	3,210	–	3,210	–	–	–	–	–	–
Obligations under swap agreements, net of collateral posted	73,875	–	73,875	–	–	–	–		
Other noncurrent liabilities	193,277	–	192,585	623	69	–	–	–	–
	2,373,794	–	2,342,418	623	30,753	–	–	–	–
Total liabilities	3,749,500	(49,378)	3,586,289	82,856	105,486	24,247	(297)	19,950	4,594
Net assets:									
Unrestricted	6,011,158	–	5,013,297	615,822	343,528	38,511	–	23,152	15,359
Temporarily restricted	1,186	–	1,186	–	–	–	–	–	–
Total net assets	6,012,344	–	5,014,483	615,822	343,528	38,511	–	23,152	15,359
Total liabilities and net assets	$ 9,761,844	$ (49,378)	$ 8,600,772	$ 698,678	$ 449,014	$ 62,758	$ (297)	$ 43,102	$ 19,953

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended December 31, 2017

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Unrestricted revenues, gains and other support									
Net patient service revenue	$ 4,587,432	$ (66,242)	$ 3,679,756	$ 497,779	$ 382,944	$ 93,195	$ –	$ 66,030	$ 27,165
Provision for uncollectible accounts	(198,194)	–	(149,300)	(22,133)	(24,361)	(2,400)	–	(1,845)	(555)
	4,389,238	(66,242)	3,530,456	475,646	358,583	90,795	–	64,185	26,610
Capitation revenue	598,450	–	598,161	109	–	180	–	180	–
Other revenue	331,621	(88,295)	379,885	24,342	12,390	3,299	(2,444)	5,664	79
	5,319,309	(154,537)	4,508,502	500,097	370,973	94,274	(2,444)	70,029	26,689
Expenses									
Salaries, wages and employee benefits	2,798,611	–	2,412,983	187,818	133,085	64,725	–	51,527	13,198
Purchased services and operating supplies	1,288,829	(82,932)	1,063,388	156,742	135,656	15,975	(2,444)	8,698	9,721
Contracted medical services	229,085	(66,242)	295,327	–	–	–	–	–	–
Other	435,615	(5,363)	375,348	32,723	28,654	4,253	–	3,065	1,188
Depreciation and amortization	265,668	–	226,045	20,687	18,841	95	–	87	8
Interest	58,663	–	56,387	1	2,275	–	–	–	–
	5,076,471	(154,537)	4,429,478	397,971	318,511	85,048	(2,444)	63,377	24,115
Operating income before nonrecurring losses	242,838	–	79,024	102,126	52,462	9,226	–	6,652	2,574
Nonrecurring losses	41,103	–	40,125	557	271	150	–	150	–
Operating income	201,735	–	38,899	101,569	52,191	9,076	–	6,502	2,574
Nonoperating income (loss)									
Investment income	536,751	–	474,320	38,164	19,122	5,145	–	3,653	1,492
Change in fair value of interest rate swaps	5,748	–	5,748	–	–	–	–	–	–
Loss on refinancing	(5,971)	–	(5,971)	–	–	–	–	–	–
Other nonoperating items, net	(24,496)	–	(24,563)	(45)	50	62	–	62	–
Revenues in excess of expenses	713,767	–	488,433	139,688	71,363	14,283	–	10,217	4,066
Unrestricted net assets									
Net assets released from restrictions and used for capital purposes	6,409	–	5,289	1,065	55	–	–	–	–
Transfers to/from Advocate Health Care Network and subsidiaries	120,000	–	270,000	(75,000)	(75,000)	–	–	–	–
Postretirement benefit plan adjustments	77,773	–	77,583	–	190	–	–	–	–
Increase (decrease) in unrestricted net assets	917,949	–	841,305	65,753	(3,392)	14,283	–	10,217	4,066

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Temporarily restricted net assets									
Realized gains on investments	$ 40	$ –	$ 40	$ –	$ –	$ –	$ –	$ –	$ –
Unrealized gains on investments	79	–	79	–	–	–	–	–	–
Net assets released from restrictions and used for operations, medical education programs, capital purchases and other purposes	(47)	–	(47)	–	–	–	–	–	–
Increase in temporarily restricted net assets	72	–	72	–	–	–	–	–	–
Increase (decrease) in net assets	918,021	–	841,377	65,753	(3,392)	14,283	–	10,217	4,066
Net assets at beginning of year	5,094,323	–	4,173,106	550,069	346,920	24,228	–	12,935	11,293
Net assets at end of year	$ 6,012,344	$ –	$ 5,014,483	$ 615,822	$ 343,528	$ 38,511	$ –	$ 23,152	$ 15,359

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Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Balance Sheet

(Dollars in Thousands)

December 31, 2017

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court
Assets				
Current assets:				
Cash and cash equivalents	$ 14,141	$ –	$ 14,065	$ 76
Patient accounts receivable, less allowances for uncollectible accounts	45,683	–	43,407	2,276
Amounts due from primary third-party payors	4,629	–	4,629	–
Accounts receivable from Advocate Health Care Network and subsidiaries	12,279	–	12,172	107
Intercompany receivables	–	(797)	797	–
Prepaid expenses, inventories and other current assets	6,367	–	6,367	–
Total current assets	83,099	(797)	81,437	2,459
Assets limited as to use:				
Internally and externally designated investments limited as to use	153,744	–	153,744	–
Intercompany receivables	–	(3,785)	3,785	–
Other noncurrent assets	2,845	–	2,845	–
Interest in health care and related entities	3,743	–	3,743	–
Reinsurance receivable	437	–	437	–
	160,769	(3,785)	164,554	–
Property and equipment – at cost:				
Land and land improvements	29,655	–	28,471	1,184
Buildings	251,203	–	248,519	2,684
Movable equipment	77,417	–	77,250	167
Construction-in-progress	11,024	–	11,024	–
	369,299	–	365,264	4,035
Less allowances for depreciation	91,763	–	90,821	942
	277,536	–	274,443	3,093
Total assets	$ 521,404	$ (4,582)	$ 520,434	$ 5,552

Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Balance Sheet (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court
Liabilities and net assets				
Current liabilities:				
Current portion of long-term debt	$ 135	$ –	$ 135	$ –
Current portion of intercompany long-term debt	6,425	(294)	6,425	294
Accounts payable and accrued expenses	16,996	–	16,693	303
Accrued salaries and employee benefits	12,721	–	12,236	485
Amounts due to primary third-party payors	36,162	–	36,162	–
Current portion of accrued insurance and claims costs	305	–	305	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	18,131	–	16,208	1,923
Intercompany payables	–	(503)	–	503
Total current liabilities	90,875	(797)	88,164	3,508
Noncurrent liabilities:				
Long-term debt, less current portion	615	–	615	–
Long-term intercompany debt, less current portion	–	(3,785)	–	3,785
Notes and accounts payable to Advocate Health Care Network and subsidiaries	238,691	–	238,691	–
Accrued losses subject to reinsurance recovery	437	–	437	–
Other noncurrent liabilities	8	–	8	–
	239,751	(3,785)	239,751	3,785
Total liabilities	330,626	(4,582)	327,915	7,293
Net assets:				
Unrestricted	190,657	–	192,398	(1,741)
Temporarily restricted	121	–	121	–
Total net assets	190,778	–	192,519	(1,741)
Total liabilities and net assets	$ 521,404	$ (4,582)	$ 520,434	$ 5,552

Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets

(Dollars in Thousands)

Year Ended December 31, 2017

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court
Unrestricted revenues, gains, and other support				
Net patient service revenue	$ 347,622	$ –	$ 337,754	$ 9,868
Provision for uncollectible accounts	(33,249)	–	(31,594)	(1,655)
	314,373	–	306,160	8,213
Other revenue	4,479	(352)	4,743	88
	318,852	(352)	310,903	8,301
Expenses				
Salaries, wages and employee benefits	131,855	–	124,085	7,770
Purchased services and operating supplies	120,484	(271)	118,158	2,597
Other	23,173	–	22,803	370
Depreciation and amortization	19,788	–	19,566	222
Interest	9,186	(81)	9,186	81
	304,486	(352)	293,798	11,040
Operating income (loss) before nonrecurring losses	14,366	–	17,105	(2,739)
Nonrecurring losses	677	–	677	–
Operating income (loss)	13,689	–	16,428	(2,739)
Nonoperating income (loss)				
Investment income	20,810	–	20,810	–
Other nonoperating items, net	981	–	982	(1)
Revenues in excess of (less than) expenses	35,480	–	38,220	(2,740)
Net assets released from restrictions and used for capital purposes	41	–	41	–
Increase (decrease) in unrestricted net assets	35,521	–	38,261	(2,740)
Temporarily restricted net assets				
Net assets released from restrictions and used for operations, medical education programs, capital purchases and other purposes	(9)	–	(9)	–
Decrease in temporarily restricted net assets	(9)	–	(9)	–
Increase (decrease) in net assets	35,512	–	38,252	(2,740)
Net assets at beginning of year	155,266	–	154,267	999
Net assets at end of year	$ 190,778	$ –	$ 192,519	$ (1,741)

Advocate Northside Health System and Subsidiaries

Details of Consolidated Balance Sheet

(Dollars in Thousands)

December 31, 2017

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Assets				
Current assets:				
Cash and cash equivalents	$ 50,687	$ –	$ 50,431	$ 256
Patient accounts receivable, less allowances for uncollectible accounts	60,714	–	60,714	–
Amounts due from primary third-party payors	5,283	–	5,283	–
Accounts receivable from Advocate Health Care Network and subsidiaries	7,902	–	7,881	21
Intercompany receivables	15,541	(65)	15,606	–
Prepaid expenses, inventories and other current assets	19,710	–	19,698	12
Total current assets	159,837	(65)	159,613	289
Assets limited as to use:				
Internally and externally designated investments limited as to use	213,570	–	213,570	–
Other noncurrent assets	49	–	49	–
Interest in health care and related entities	89,841	–	89,841	–
	303,460	–	303,460	–
Property and equipment – at cost:				
Land and land improvements	43,477	–	43,477	–
Buildings	252,022	–	252,022	–
Movable equipment	80,165	–	80,158	7
Construction-in-progress	11,839	–	11,839	–
	387,503	–	387,496	7
Less allowances for depreciation	152,122	–	152,115	7
	235,381	–	235,381	–
Total assets	$ 698,678	$ (65)	$ 698,454	$ 289

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Advocate Northside Health System and Subsidiaries

Details of Consolidated Balance Sheet (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Liabilities and net assets				
Current liabilities:				
Accounts payable and accrued expenses	$ 13,011	$ –	$ 13,011	$ –
Accrued salaries and employee benefits	16,212	–	16,211	1
Amounts due to primary third-party payors	34,974	–	34,974	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	4,752	–	4,752	–
Intercompany payables	13,284	(65)	13,284	65
Total current liabilities	82,233	(65)	82,232	66
Noncurrent liabilities:				
Other noncurrent liabilities	623	–	623	–
	623	–	623	–
Total liabilities	82,856	(65)	82,855	66
Net assets:				
Unrestricted	615,822	–	615,599	223
Total net assets	615,822	–	615,599	223
Total liabilities and net assets	$ 698,678	$ (65)	$ 698,454	$ 289

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Advocate Northside Health System and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended December 31, 2017

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Unrestricted revenues, gains, and other support				
Net patient service revenue	$ 497,779	$ –	$ 497,779	$ –
Provision for uncollectible accounts	(22,133)	–	(22,133)	–
	475,646	–	475,646	–
Capitation revenue	109	–	109	–
Other revenue	24,342	(5)	24,165	182
	500,097	(5)	499,920	182
Expenses				
Salaries, wages and employee benefits	187,818	–	187,604	214
Purchased services and operating supplies	156,742	(5)	156,743	4
Other	32,723	–	32,545	178
Depreciation and amortization	20,687	–	20,687	–
Interest	1	–	1	–
	397,971	(5)	397,580	396
Operating income (loss) before nonrecurring losses	102,126	–	102,340	(214)
Nonrecurring losses	557	–	557	–
Operating income (loss)	101,569	–	101,783	(214)
Nonoperating income (loss)				
Investment income	38,164	–	38,164	–
Other nonoperating items, net	(45)	–	(45)	–
Revenues in excess of (less than) expenses	139,688	–	139,902	(214)
Unrestricted net assets				
Net assets released from restrictions and used for capital purposes	1,065	–	1,065	–
Transfers to/from Advocate Health Care Network and subsidiaries	(75,000)	–	(75,150)	150
Increase (decrease) in unrestricted net assets	65,753	–	65,817	(64)
Unrestricted net assets at beginning of year	550,069	–	549,782	287
Unrestricted net assets at end of year	$ 615,822	$ –	$ 615,599	$ 223

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Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries
Details of Consolidated Balance Sheet
(Dollars in Thousands)
December 31, 2017

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	BroMenn Medical Group
Assets							
Current assets:							
Cash and cash equivalents	$ (6,746)	$ –	$ (22,211)	$ 4,477	$ 3,472	$ 3,429	$ 4,087
Patient accounts receivable, less allowances for uncollectible accounts	14,941	–	–	1,294	1,349	12,298	–
Accounts receivable from Advocate Health Care Network and subsidiaries	64,216	–	57,610	273	1,076	5,257	–
Intercompany receivables	–	(6,646)	3,865	354	302	2,125	–
Prepaid expenses, inventories and other current assets	11,958	–	6,929	162	1,277	3,590	–
Total current assets	84,369	(6,646)	46,193	6,560	7,476	26,699	4,087
Assets limited as to use:							
Internally and externally designated investments limited as to use	60,837	–	42,696	9,265	5,842	–	3,034
Intercompany receivables	–	(49,263)	49,263	–	–	–	–
Investments in subsidiaries	–	(89,242)	89,242	–	–	–	–
Other noncurrent assets	30,530	–	7,359	–	–	23,171	–
Interest in health care and related entities	23,868	–	7,927	–	–	1,850	
	14,091 115,235	(138,505)	196,487	9,265	5,842	25,021	17,125
Property and equipment – at cost:							
Land and land improvements	15,525	–	6,138	1,004	–	8,383	–
Buildings	91,404	–	3,081	10,453	349	77,521	–
Movable equipment	66,644	–	8,243	20,096	8,779	29,526	–
Construction-in-progress	1,110	–	–	96	–	1,014	–
	174,683	–	17,462	31,649	9,128	116,444	–
Less allowances for depreciation	91,929	–	11,950	24,650	6,610	48,719	–
	82,754	–	5,512	6,999	2,518	67,725	–
Total assets	$ 282,358	$ (145,151)	$ 248,192	$ 22,824	$ 15,836	$ 119,445	$ 21,212

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Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries
Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	BroMenn Medical Group
Liabilities and shareholders' equity							
Current liabilities:							
Current portion of long-term debt	$ 809	$ –	$ –	$ –	$ –	$ 809	$ –
Current portion of intercompany long-term debt	–	(729)	–	–	–	729	–
Accounts payable and accrued expenses	33,188	–	13,583	1,610	892	17,084	
	19						
Accrued salaries and employee benefits	25,176	–	6,361	700	675	17,440	–
Amounts due to primary third-party payors	2,760	–	–	–	60	2,700	–
Current portion of accrued insurance and claims costs	235	–	–	–	–	235	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	15,465	–	10,058	521	904	3,962	20
Intercompany payables	–	(5,917)	2,748	62	362	1,247	1,498
Total current liabilities	77,633	(6,646)	32,750	2,893	2,893	44,206	1,537
Noncurrent liabilities:							
Long-term debt, less current portion	6,414	–	–	–	–	6,414	–
Long-term intercompany debt, less current portion	–	(49,263)	–	–	–	49,263	–
Pension plan liability	547	–	397	72	78	–	–
Accrued insurance and claims cost, less current portion	4,203	–	–	–	4,203	–	Other
noncurrent liabilities	17,057	–	17,057	–	–	–	–
	28,221	(49,263)	17,454	72	78	59,880	–
Total liabilities	105,854	(55,909)	50,204	2,965	2,971	104,086	1,537
Shareholders' equity:							
Common stock	1	(5,163)	1	3,250	50	1,862	1
Additional paid-in capital	177,163	(116,064)	177,163	22,294	9,098	43,581	41,091
Noncontrolling interest	1,174	–	–	–	–	1,174	–
Retained earnings (deficit)	(1,834)	31,985	20,824	(5,685)	3,717	(31,258)	(21,417)
Total shareholders' equity	176,504	(89,242)	197,988	19,859	12,865	15,359	19,675
Total liabilities and shareholders' equity	$ 282,358	$ (145,151)	$ 248,192	$ 22,824	$ 15,836	$ 119,445	$ 21,212

Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Statement of Operations and Shareholders' Equity
(Dollars in Thousands)

Year Ended December 31, 2017

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Revenues								
Net patient service revenue	$ 192,930	$ –	$ –	$ 20,716	$ 22,653	$ 149,538	$ 5	$ 18
Provision for uncollectible accounts	(5,867)	–	–	(287)	(1,989)	(3,578)	(13)	–
	187,063			20,429	20,664	145,960	(8)	18
Capitation revenue	46,356	–	–	–	1,576	44,780	–	–
Other revenue	59,443	(23)	42,946	116	3,855	9,454	3	3,092
	292,862	(23)	42,946	20,545	26,095	200,194	(5)	3,110
Expenses								
Salaries, wages and employee benefits	195,195	–	35,798	7,441	6,799	145,157	–	–
Purchased services and operating supplies	78,830	(23)	10,320	9,627	14,214	44,292	200	200
Contracted medical services	10,903	–	–	–	–	10,903	–	–
Other	19,188	–	3,940	1,157	1,596	15,048	(2,519)	(34)
Depreciation and amortization	9,255	–	211	1,456	591	6,997	–	–
Interest	204	(1,303)	16	–	–	1,491	–	–
	313,575	(1,326)	50,285	19,681	23,200	223,888	(2,319)	166
Operating (loss) income before nonrecurring losses	(20,713)	1,303	(7,339)	864	2,895	(23,694)	2,314	2,944
Nonrecurring losses	970	–	680	–	–	290	–	–
Operating (loss) income	(21,683)	1,303	(8,019)	864	2,895	(23,984)	2,314	2,944

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Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Statement of Operations and Shareholders' Equity (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Nonoperating income (loss)								
Investment income (loss)	$ 12,744	$ (1,303)	$ 6,690	$ 1,457	$ 2,221	$ 11	$ 1,977	$ 1,691
Other nonoperating items, net	3,279	–	(2,333)	(371)	(1,100)	8,779	(198)	(1,498)
Net (loss) income	(5,660)	–	(3,662)	1,950	4,016	(15,194)	4,093	3,137
Transfers to/from Advocate Health Care Network and subsidiaries	–	87,080	(46,334)	(10,000)	(10,000)	–	(12,746)	(8,000)
Change in noncontrolling interest	(324)	–	–	–	–	(324)	–	–
(Decrease) increase in noncontrolling interest	(324)	–	–	–	–	(324)	–	–
Total change in shareholders' equity (deficit)	(5,984)	87,080	(49,996)	(8,050)	(5,984)	(15,518)	(8,653)	(4,863)
Shareholders' equity (deficit) at beginning of year	182,488	(176,322)	247,984	27,909	18,849	30,877	8,653	24,538
Shareholders' equity (deficit) at end of year	$ 176,504	$ (89,242)	$ 197,988	$ 19,859	$ 12,865	$ 15,359	$ –	$ 19,675

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Details of Consolidated Balance Sheet

(Dollars in Thousands)

December 31, 2017

	Consolidated	Eliminations	Advocate Physician Partners	APP Accountable Care Org
Assets				
Current assets:				
Cash and cash equivalents	$ 98,660	$ –	$ 98,623	$ 37
Accounts receivable from Advocate Health Care Network and subsidiaries	16,257	–	16,257	–
Prepaid expenses, inventories and other current assets	34,307	–	34,307	–
Total current assets	149,224	–	149,187	37
Assets limited as to use:				
Internally and externally designated investments limited as to use	36,224	–	36,224	–
Total assets	$ 185,448	$ –	$ 185,411	$ 37
Liabilities and net assets				
Current liabilities:				
Accounts payable and accrued expenses	$ 110,755	$ –	$ 110,717	$ 38
Notes and accounts payable to Advocate Health Care Network and subsidiaries	76,012	–	76,012	–
Total current liabilities	186,767	–	186,729	38
Net assets:				
Unrestricted	(1,319)	–	(1,318)	(1)
Temporarily restricted	–	–	–	–
Total net assets	(1,319)	–	(1,318)	(1)
Total liabilities and net assets	$ 185,448	$ –	$ 185,411	$ 37

Details of Consolidated Statement of Operations and Changes in Net Assets

(Dollars in Thousands)

Year Ended December 31, 2017

	Consolidated	Eliminations	Advocate Physician Partners	APP Accountable Care Org
Unrestricted revenues, gains, and other support				
Capitation revenue	$ 688,102	$ –	$ 688,102	$ –
Other revenue	168,922	(28,924)	168,922	28,924
	857,024	(28,924)	857,024	28,924
Expenses				
Salaries, wages and employee benefits	213	–	213	–
Purchased services and operating supplies	71,260	–	71,260	–
Contracted medical service	782,318	(28,924)	782,318	28,924
Other	3,234	–	3,233	1
	857,025	(28,924)	857,024	28,925
Operating loss	(1)	–	–	(1)
Nonoperating income (loss)				
Investment loss	(1,318)	–	(1,318)	–
Revenues less than expenses	(1,319)	–	(1,318)	(1)
Net assets at beginning of year	–	–	–	–
Net assets at end of year	$ (1,319)	$ –	$ (1,318)	$ (1)