ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	The University of Chicago Medical Center – New Cancer Hospital
Street Address:	5654 South Drexel Avenue
City and Zip Code:	Chicago, IL 60637
County: Cook	Health Service Area: 6 Health Planning Area: A-03

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

Exact Legal Name:	The University of Chicago Medical Center
Street Address:	5841 S. Maryland Avenue
City and Zip Code:	Chicago 60637
Name of Registered Agent:	John Satalic
Registered Agent Street Address:	5841 S. Maryland Avenue
Registered Agent City and Zip Code:	Chicago 60637
Name of Chief Executive Officer:	Thomas Jackiewicz
CEO Street Address:	5841 S. Maryland Avenue
CEO City and Zip Code:	Chicago 60637
CEO Telephone Number:	(773) 702-6240

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:	Joe Ourth
Title:	Partner
Company Name:	Saul Ewing Arnstein & Lehr LLP
Address:	161 N. Clark Street, Site 4200, Chicago, IL 60601
Telephone Number:	(312) 876-7815
E-mail Address:	joe.ourth@saul.com
Fax Number:	(312) 8766215

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

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

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

Name:	Phillip L. Kaufman, CPA
Title:	Vice President – Finance Shared Services
Company Name:	The University of Chicago Medical Center
Address:	5841 S. Maryland Avenue, Chicago, IL 60637
Telephone Number:	(773) 702-8184
E-mail Address:	phillipkaufman@uchospitals.edu
Fax Number:	(773) 702-8184

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: The University of Chicago Medical Center

Address of Site Owner: 5841 S. Maryland Avenue, Chicago, IL 60637

Street Address or Legal Description of the Site:

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

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

Operating Identity/Licensee

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

Exact Legal Name: The University of Chicago Medical Center

Address: 5841 S. Maryland Avenue, Chicago, IL 60637

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (**http://www.hfsrb.illinois.gov**). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification :

☐ Substantive

☒ Non-substantive

2. Narrative Description

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

The University of Chicago Medical Center ("UCMC") seeks authority from the Board for approval of a Master Design Permit to expend funds in excess of the capital cost review threshold for architectural services that are required to develop a free-standing, dedicated cancer hospital for the future on UCMC's Hyde Park Campus on the South Side of Chicago. In addition to architectural fees, this application is requesting permission to complete underground utility system improvements needed to ensure that the UCM Adult Level 1 Trauma ED can operate without interruption as part of the site preparation.

Since 2014, UCMC has been engaged in a strategic planning process to enhance the delivery of cancer-related services to the communities it serves, where the incidence and mortality from cancer is high and the availability of resources is disproportionately low. The purpose of the dedicated cancer hospital would be to consolidate inpatient, outpatient and clinical trials research services that are currently dispersed throughout campus in a single tower, to expand access to high-quality cancer services to underserved residents on the South Side of Chicago, and to facilitate the coordinated delivery of the entire spectrum of cancer care.

The Master Design Project includes the following key components:

- Development of a 128-bed inpatient hospital with all private rooms.
- Development of space for a comprehensive program of ambulatory cancer care services including exam rooms, an infusion center, radiation oncology, imaging, lab, interventional radiology and rehabilitation therapy services.
- Development of dedicated space for clinical trials research and care.
- Construction of underground utility system improvements and site preparation.

The total GSF of the proposed inpatient and outpatient tower would be approximately 544,000 GSF and the cost will be approximately $633,300,000. It is estimated the building will be seven (7) floors, and planning will review various options to connect the new building by tunnels and/or bridges to existing structures on the UCMC campus. The design costs, including initial A&E and related expenses, along with site preparation and off-site utility work, is estimated to be $37,569,000, which exceeds the current capital expenditure threshold.

UCMC has engaged Cannon Design for architecture and engineering services, and Turner Construction for logistics and budgeting services. Contracts for both services will include a contingency with respect to CON approval.

UCMC anticipates the completion date of the Master Design Permit to be December 31, 2023. It is anticipated that the dedicated cancer hospital would open in 2026, contingent upon receipt of a CON permit, and any other required regulatory approvals for same.

Pursuant to 77 Ill. Adm. Code 1120.20(b), the Project is classified as "Non-Substantive" because it is for a Master Design Permit and will not establish a new facility on a new site, establish or discontinue a category of service, effectuate a change in 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			
USE OF FUNDS	**REVIEWABLE**	**NONREVIEWABLE**	**TOTAL**
Preplanning Costs		$2,400,000	$2,400,000
Site Survey and Soil Investigation		$215,000	$215,000
Site Preparation		$500,000	$500,000
Off Site Work		$10,500,000	$10,500,000
New Construction Contracts			
Modernization Contracts			
Contingencies		$1,800,000	$1,800,000
Architectural/Engineering Fees	$7,300,000	$7,200,000	$14,500,000
Consulting and Other Fees	2,800,000	$1,870,000	$4,670,000
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)		$1,800,000	$1,800,000
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	2,450,000	$2,534,000	
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$12,550,000	$26,819,000	$37,569,000
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$12,550,000	$26,819,000	$37,569,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$12,550,000	$26,819,000	$37,569,000

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

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

Land acquisition is related to project ☐ Yes ☐ No
Purchase Price: $ N/A
Fair Market Value: $ N/A

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 $ N/A .

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): December 31, 2023

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.**

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

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: The University of Chicago Medical Center		**CITY:** Chicago			
REPORTING PERIOD DATES:		**From: 1/1/2021**		**to: 12/31/2021**	
Category of Service	**Authorized Beds***	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	481	19,313	151,118	-	481
Obstetrics	46	2,942	5,852	-	46
Pediatrics	60	3,156	16,320	-	60
Intensive Care	142	6,431	40,169	-	142
Comprehensive Physical Rehabilitation	-	-	-	-	-
Acute/Chronic Mental Illness	-	-	-	-	-
Neonatal Intensive Care	53	845	15,902	-	53
General Long-Term Care	-	-	-	-	-
Specialized Long-Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other ((identify)	-	-	-	-	-
TOTALS:	782	32,687	229,361	-	782
* Authorized bed information based on Alteration of Project #16-008 The University of Chicago Medical Center, approved on September 16, 2021					

CERTIFICATE

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

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

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

SIGNATURE	SIGNATURE
Thomas Jackiewicz PRINTED NAME	Jennifer Hill PRINTED NAME
President PRINTED TITLE	Secretary PRINTED TITLE
Notarization: Subscribed and sworn to before me this 28th day of January, 2022	Notarization: Subscribed and sworn to before me this 28th day of January, 2022
Signature of Notary	Signature of Notary
Seal BONITA ESCOBEDO ALCANTAR OFFICIAL SEAL Notary Public - State of Illinois My Commission Expires Oct 30, 2023	Seal BONITA ESCOBEDO ALCANTAR OFFICIAL SEAL Notary Public - State of Illinois My Commission Expires Oct 30, 2023

*Indicate EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

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.

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)**

VI. 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]:**

$37,569,000	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$37,569,000	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. - MASTER DESIGN AND RELATED PROJECTS

This Section is applicable only to proposed master design and related projects.

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities.

2. How the services proposed in future projects will improve access to planning area residents.

3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed.

4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b)-Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed and document the improvement in access for each service proposed. Provide thefollowing:

1. The anticipated completion date(s) for the future construction or modernization projects; and

2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:

   a. limitation on government funded or charity patients that are expected to continue.

   b. restrictive admission policies of existing planning area health care facilities that areexpected to continue.

   c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.

3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:

   a. historical service/beds utilization levels.
   b. projected trends in utilization (include the rationale and projection assumptions used in such projections).
   c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and anticipated changes in delivery of the service due to changes in technology, care delivery techniques or p hysician availability that would support the p r ojected utilization levels.

Criterion 1110.235(c) - Relationship to Previously Approved Master Design Projects

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit.

2. The estimated project cost for the proposed projects and also for the totalconstruction/modification projects approved in the master design permit.

3. An item-by-item comparison of the construction elements (i.e., site, number of buildings, numberof floors, etc.) in the proposed project to the approved master design project.

4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY - NOT APPLICABLE

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 34, 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 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.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 in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

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

B. Conditions of Debt Financing

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

SECTION IX. SAFETY NET IMPACT STATEMENT

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

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

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

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

Safety Net Impact Statements shall also include all of the following:

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

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

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 37.

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

Outpatient			
Total			

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

SECTION X. CHARITY CARE INFORMATION

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

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

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

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

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

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

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

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

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

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

1. Applicant: University of Chicago Medical Center, 5841 S. Maryland Avenue
   (Name) (Address)
   Chicago IL 60637
   (City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 5654 South Drexel Ave Chicago, IL 60637
   (Address) (City) (State)
   Cook
   (County) (Township) (Section)

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

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

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No _X_

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

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

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

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

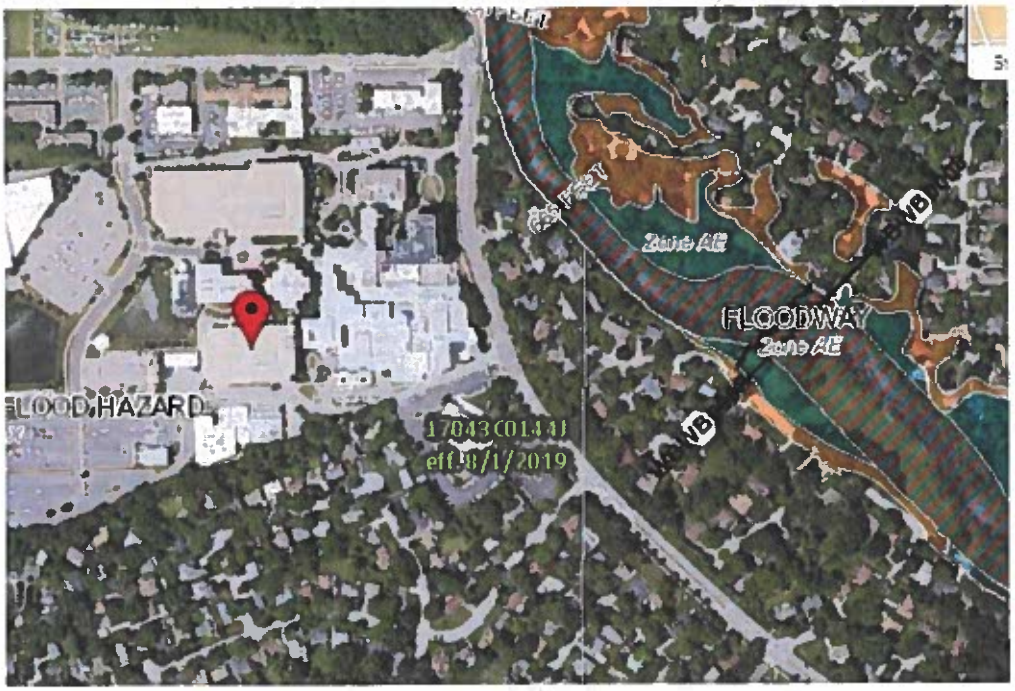
Signature:_____ Date: _____

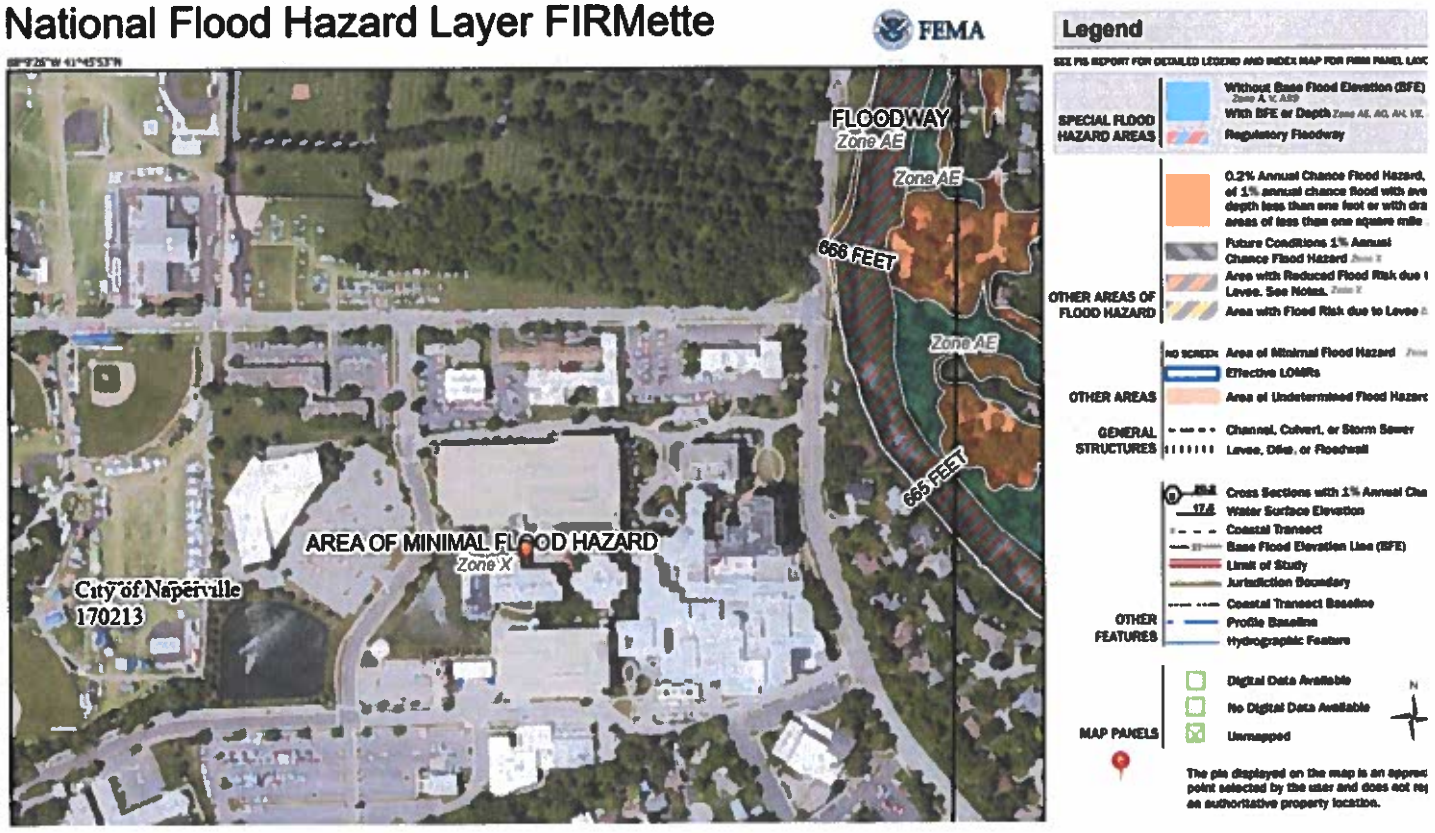
NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

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

Floodplain Map Example

The image below is an example of the floodplain mapping required as part of the IDPH swimming facility construction permit showing that the swimming pool, to undergo a major alteration, is outside the mapped floodplain.





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

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3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36-37
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Section I, Type of Ownership of Applicant/Co-Applicant

Attachment 1

The University of Chicago Medical Center ("UCMC") is an Illinois not-for-profit corporation. A copy of UCMC's Good Standing Certificate is attached.

ATTACHMENT 1

File Number 5439-757-7

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, 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* 25TH *day of* OCTOBER *A.D.* 2021 .

Authentication #: 2128603018 verifiable until 10/25/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

39521756.6

Section I, Site Ownership

Attachment 2

Attached is a signed letter of intent for a lease in which The University of Chicago will lease the property to The University of Chicago Medical Center.

Cancer Center Lease Letter of Intent (LOI)
The University of Chicago
and
The University of Chicago Medical Center

Lessor: The University of Chicago

Lessee: The University of Chicago Medical Center

Premises: Premises shall mean the real property set forth in the legal description contained in EXHIBIT A-1 and depicted as the Leased Premises in EXHIBIT A-2. together with all buildings, appurtenances and fixtures located thereon.

Effective Date of Lease: The Lease shall commence upon mutual execution of the Lease by both parties.

Lease Term: The term of this Lease (the "Lease Term") shall commence on the Effective Date. The Lease Term shall end upon the earliest of the following events: (a) the termination of the Affiliation Agreement entered into by Lessor and Lessee as of October 1,1986, or any extensions thereof; (b) the expiration of the Affiliation Agreement as a result of an exercise of the election not to renew for additional 10 year terms; (c) termination of the Lease otherwise in accordance with its terms.

Conveyance of Premises to Tenant: On the date of payment in full of all amounts of Rent due under the Ground Lease, Landlord shall convey Premises to Tenant by special warranty deed transferring absolute title to the Tenant. Lessee agrees that it shall reimburse Lessor for Lessor's cost of acquiring the Premises.

Lease of Premises: Upon the terms and conditions hereinafter set forth and in consideration of the payment of the rent hereinafter set forth and of the performance by Lessor and Lessee of each and every one of the covenants and agreements hereinafter contained to be kept and performed by each of them, Lessor will lease, let and demise unto Lessee, and Lessee does hereby lease of and from Lessor the Premises.

Condition of Premises: Premises are demised and let in their condition as in effect at the commencement of the lease term relating thereto, "as is," and without any representation or warranty by Lessor of any kind as to any matter whatsoever express or implied (including, without limitation, the physical condition thereof).

Use of Premises: Lessee shall manage and operate the facilities on the Premises in a manner consistent with the Affiliation Agreement. The Premises, and every part thereof, shall be used and occupied only for the purposes of building and operating a not-for-profit hospital and related outpatient clinics, each of which is supportive of the Lessor's academic, educational and research mission. Lessee may operate certain facilities incidental to, or supportive of, the operation of ordinary course of Lessee's business but at no time may such incidental use materially affect Lessor or Lessee, be a nuisance, against public policy or otherwise be used for unlawful activity.

ATTACHMENT 2

Possession: At any time during the Lease Term, Lessee shall have the right (subject to the terms and conditions of the Lease) to enter upon, occupy, possess and peaceably and quietly have, hold and enjoy the Premises, provided that Lessor shall retain the right to enter upon the Premises with reasonable notice in order to make inspections or to exercise any other rights of Lessor hereunder and further provided that except in the case of emergency, any entry by Lessor shall not unreasonably interfere with Lessee's use of the Premises; and (b) Lessor shall with reasonable notice to Lessee, retain the right to enter upon and occupy certain portions of the Premises in order to install and maintain conduits for utility services (including but not limited to gas, water, sewer, electricity and telecommunications services) through and under the Premises, provided that no such access, use or occupancy shall materially interfere with or materially impair the Lessee's operation of the Premises.

Basic Rent: The lease will be Triple Net (NNN). Lessee covenants to pay Lessor basic rent that will include, but not be limited to, the amount of Ten Dollars ($10.00) for the first year, and the fixed amount of Ten Dollars ($10.00) for every year after ("Basic Rent") during the Lease Term.

Additional Rent: Lessee covenants to pay and discharge when the same shall become due or payable, as additional rent hereunder, each and every cost, tax, assessment and other expense on or with respect to the Premises or any part thereof.

Property Taxes: At Lessee's request, Lessor will apply for real estate tax exemptions for those portions of the Premises which are exempt from such taxes and will charge the expenses of obtaining the exemption to the Lessee. Lessee shall cooperate with Lessor in filing or causing to be filed any documentation required to retain the Premises' status as exempt from real estate taxes and shall pay prior to delinquency, as additional rent for the Premises, its share (based on a reasonable allocation thereof determined by Lessor and acceptable to Lessee as between the Premises and any other property on which such taxes or impositions were levied, assessed, or charged, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the square footage of the premises covered by such taxes or Impositions) of any and all taxes and assessments (general and special), and water rates and other Impositions (ordinary and extraordinary), of every kind and nature whatsoever, which are levied, assessed, charged or imposed upon or with respect to the Premises, or any part thereof, or which become payable during the Lease Term, or any ad valorem taxes assessed thereon or on or in connection with any personal property used in connection therewith which Lessor shall be required to pay, becoming due and payable during or with respect to the term of this Lease.

Maintenance of Insurance: The parties shall procure, and maintain in effect at all times, insurance policies or self-insurance covering the Premises, and the operations conducted thereon, against casualties, contingencies and risks (including but not limited to public liability and employee dishonesty) in amounts not less than customary in the case of corporations engaged in the same or similar activities and similarly situated and adequate to protect the Premises and operations.

Indemnity: Lessee will protect, indemnify and save harmless Lessor and Lessor's agents from and against all liabilities, obligations, claims, damages, penalties, causes of action, judgments, costs and expenses (including without limitation, attorneys' fees and expenses) imposed upon or incurred by or asserted against Lessor by reason of: (a) any failure on the part of the Lessee to

perform or comply with any of the terms or provisions of this Lease to be performed by Lessee; or (b) performance of any labor or services or the furnishing of any materials or other property at the request of and on behalf of Lessee or any other person (except only Lessor) in respect of the Premises or any part thereof.

Construction on Premises: Lessor and Lessee understand that Lessee shall commence and complete the construction of a mixed-use medical project for the delivery of cancer care upon the Premises that is anticipated approximately five-hundred forty-four thousand (544,000) gross square feet but not more than one million three hundred thousand (1,300,000) gross square footage and a minimum building height of eighty feet and no more than 200 feet (the **"Project"**).

feet but not more than one million three hundred thousand (1.300,000) gross square footage and a minimum building height of eighty feet and no more than 200 feet (the **"Project").**

Non-Binding: This LOI does not include material and substantive business terms that still must be negotiated between both parties and therefore is not intended to be, nor would it be considered, a binding agreement. The terms and conditions set forth herein are subject to final University of Chicago and University of Chicago Medical Center approval and further mutual negotiation and agreement and are not binding upon any part unless, and until, they are embodied in a final and legally binding mutually acceptable agreement signed by all parties. After 90 days from receipt, the LOI shall be void and of no force and effect unless extended by mutual agreement of the parties.

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Lease as of the day and year first above written, pursuant to proper authority duly granted.

THE UNIVERSITY OF CHICAGO	**THE UNIVERSITY OF CHICAGO MEDICAL CENTER**
Brett Padgett **Interim Vice President and** **Chief Financial Officer** **Associate Vice President for Finance**	**Thomas Jackiewicz** **President** **The University of Chicago Medical Center**

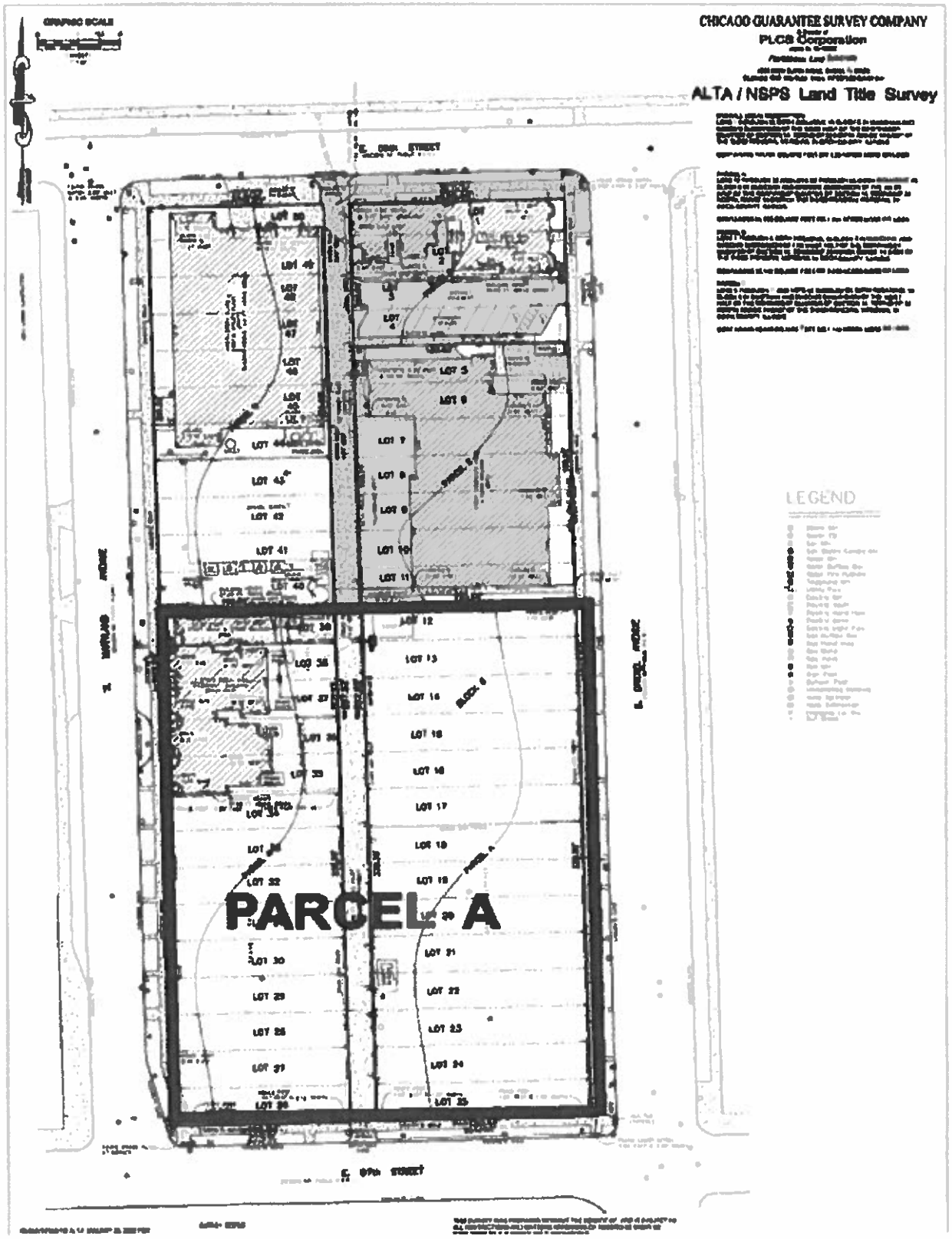
ATTACHMENT 2

CANCER CENTER LEASE LETTER OF INTENT
EXHIBIT A-1
THE PREMISES
[Legal Description]

PARCEL A
LOTS 12 THROUGH 25 AND LOTS 26 THROUGH 39, BOTH INCLUSIVE, IN BLOCK 6 IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

CONTAINING 79,795 SQUARE FEET OR 1.831 ACRES MORE OR LESS.

CANCER CENTER LEASE LETTER OF INTENT
EXHIBIT A-2
THE PREMISES
[Parcel Map]



ATTACHMENT 2

Section I, Operating Identity/Licensee

Attachment 3

The University of Chicago Medical Center is an Illinois not-for-profit corporation and will be the operating entity and licensee.

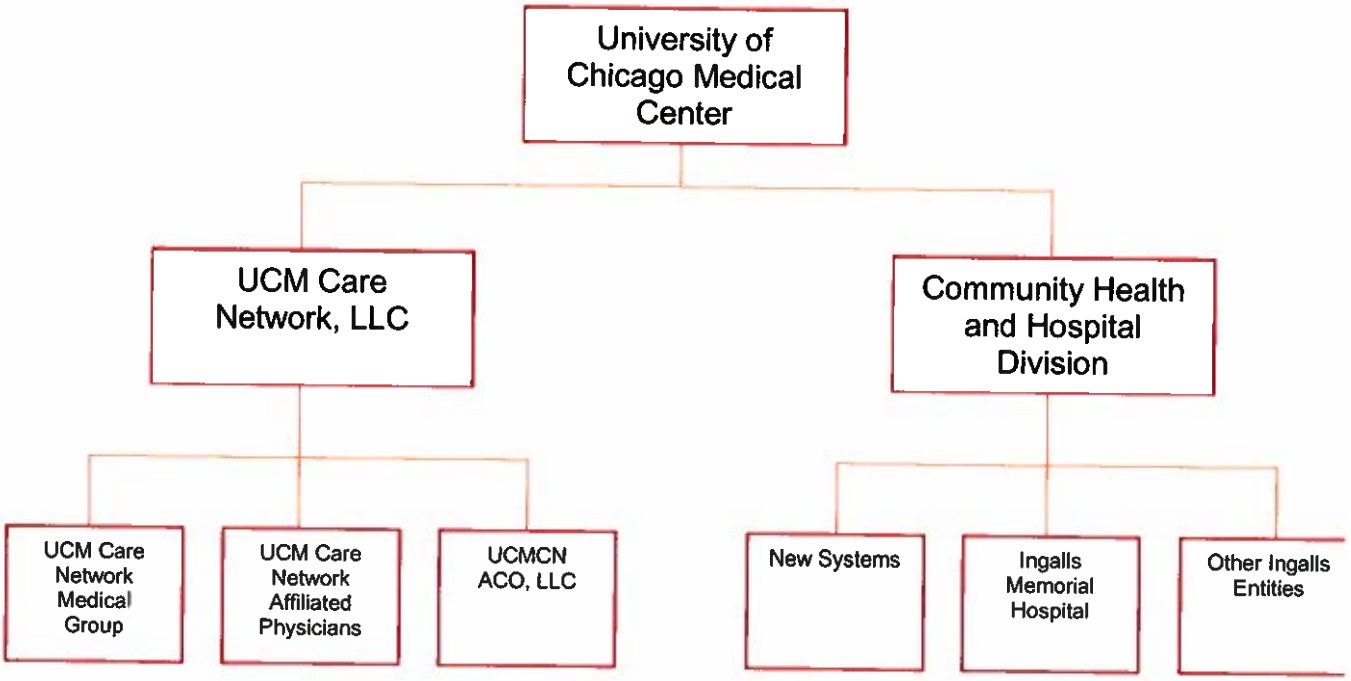
Section I, Organizational Relationships

Attachment 4

A copy of The University of Chicago Medical Center organizational chart is attached.

AT THE FOREFRONT
UChicago Medicine

System Structure



Section I, Flood Plain Requirement

Attachment 5

Evidence that the site of the Project is not located in a flood plain and that the Project complies with the Flood Plain Rules under Illinois Executive Order #2005-5 is attached.

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

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

1. Applicant: University of Chicago Medical Center, 5841 S. Maryland Avenue
(Name) (Address)
Chicago IL 60637
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 5654 South Drexel Ave Chicago, IL 60637
(Address) (City) (State)
Cook
(County) (Township) (Section)

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

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

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No X

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

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

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title:_____

Business/Agency _____ Address:_____

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

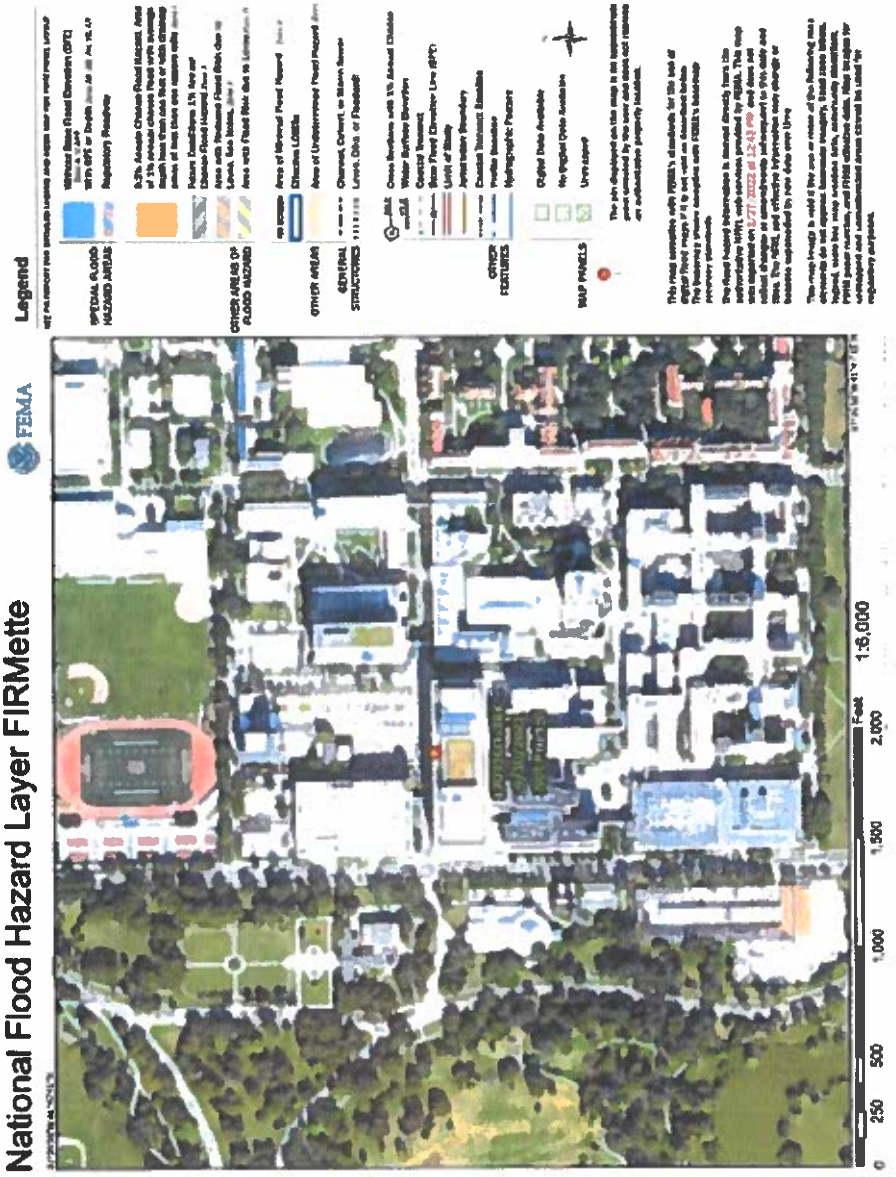
Signature:_____ Date:_____

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

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

39813609.4

ATTACHMENT 5


National Flood Hazard Layer FIRMette
FEMA
Legend
SPECIAL FLOOD HAZARD AREAS
OTHER AREAS OF FLOOD HAZARD
OTHER AREAS
GENERAL STRUCTURES
OTHER FEATURES
MAP PANELS
0
250
500
1,000
1,500
2,000
Feet
1:6,000

Section I, Historic Resources Preservation Act Requirements

Attachment 6

Attached is a letter to the Illinois Department of Natural Resources requesting confirmation that no historic, architectural or archaeological sites exists within the Project area.

SAUL EWING
ARNSTEIN
& LEHR LLP

Joe Ourth
Phone: 312.876.7815
Fax: 312.876.6215
joe.ourth@saul.com
www.saul.com

January 28, 2022

Via Overnight Mail
Robert F. Appleman
Deputy State Historic Preservation Officer
Illinois Department of Natural Resources
One National Resources Way
Springfield, Illinois 62701-1512

RE: Review to Determine Impact Upon Historic Resources
5654 South Drexel Avenue, Chicago Illinois 60637
Certificate of Need Application

Dear Mr. Appleman

This letter requests your comments as to whether a proposed project has historical, architectural or archeological impact. This request is made in connection with a Certificate of Need application to be filed in soon with the Illinois Health Facilities and Services Review Board.

The proposed project is for construction of a new dedicated Cancer Hospital on the campus of The University of Chicago Medical Center located at 5654 South Drexel Avenue, Chicago Illinois 60637. Enclosed please find a map showing the property together with a street view and satellite view. The site is currently being used for surface parking.

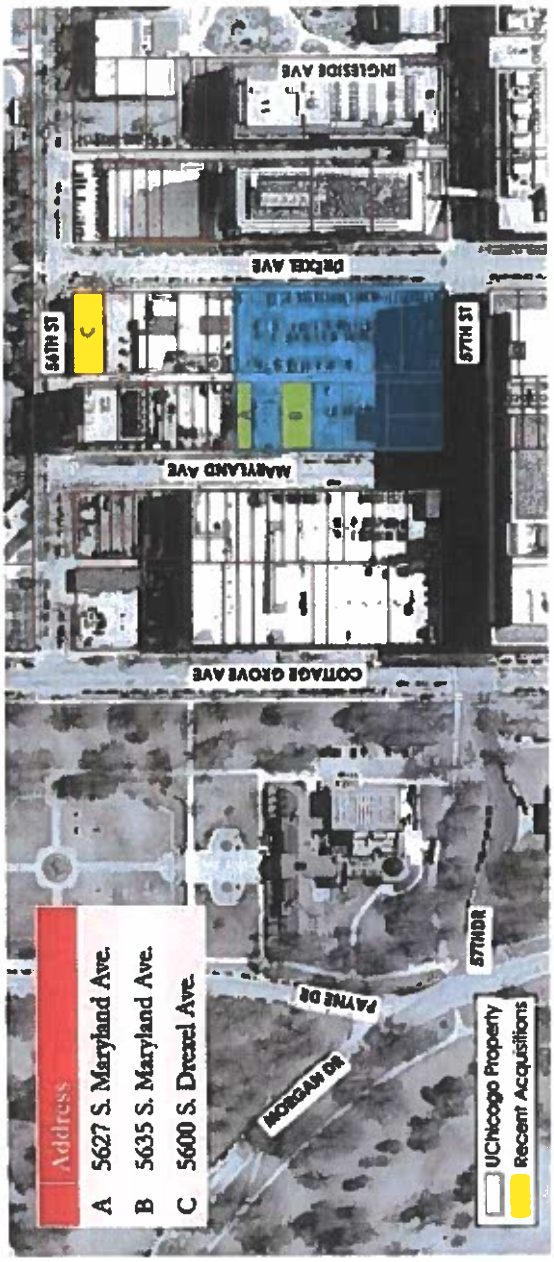
We would appreciate a letter in response that we can include as part of the CON application. If you have questions or comments, or need additional information, please contact me at (312) 876-7815. I appreciate your assistance.

Sincerely,

Joe Ourth

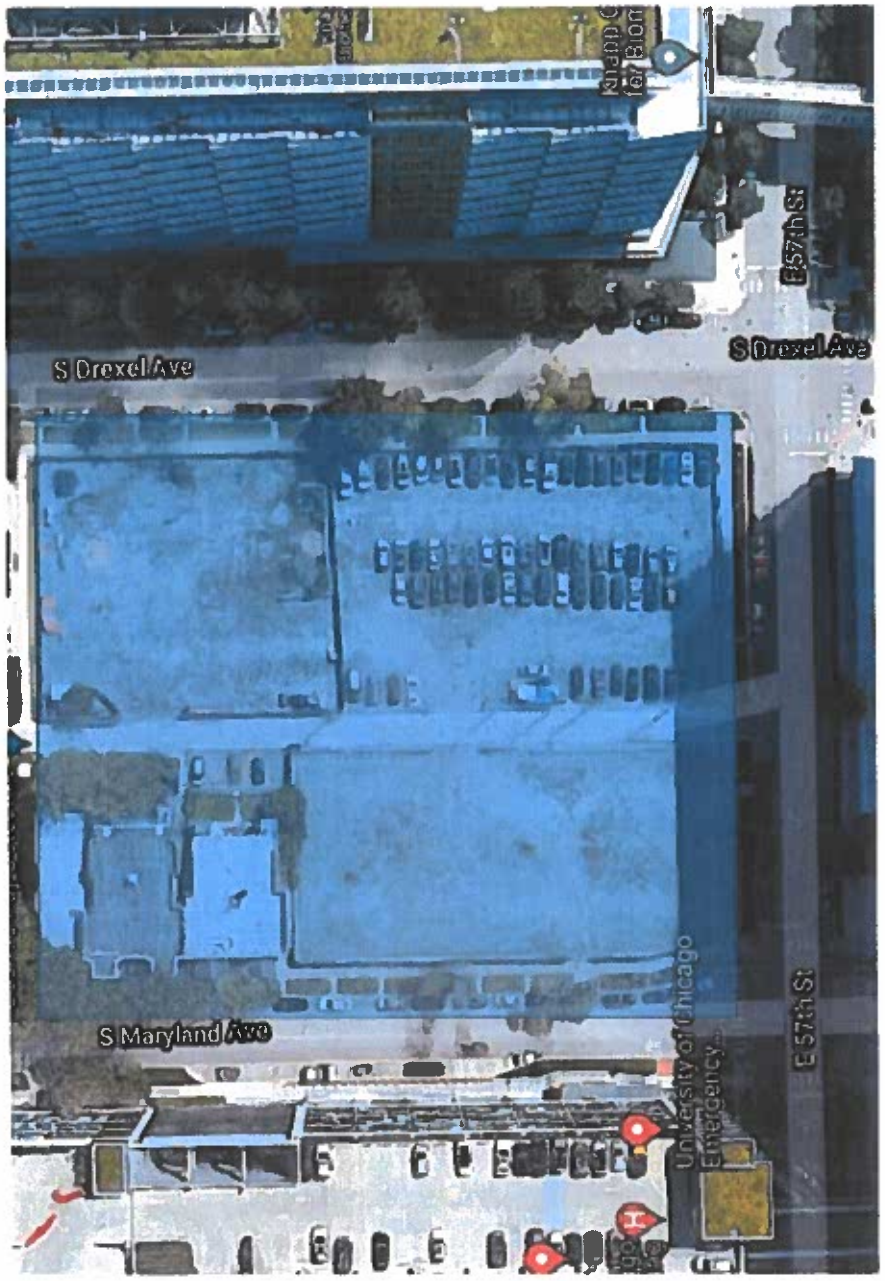
JRO/bz
Enclosures
01/28/2022

ATTACHMENT 6

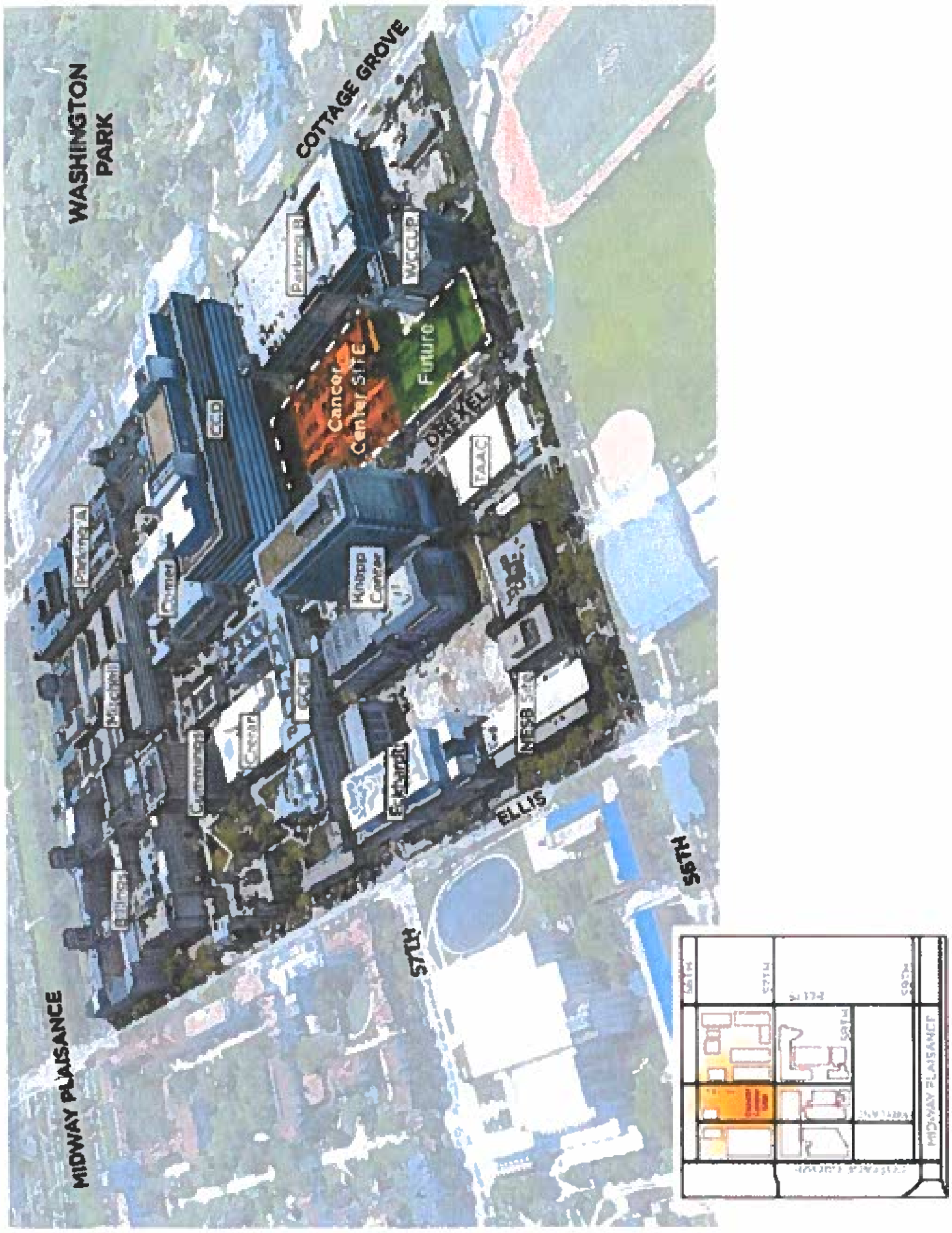


ATTACHMENT 6

ATTACHMENT 6



ATTACHMENT 6



ATTACHMENT 6

Section I, Project Costs and Source of Funds

Attachment 7

Section 1120.110, Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**REVIEWABLE**	**NONREVIEWABLE**	**TOTAL**
Preplanning Costs		$2,400,000	$2,400,000
Site Survey and Soil Investigation		$215,000	$215,000
Site Preparation		$500,000	$500,000
Off Site Work		$10,500,000	$10,500,000
New Construction Contracts			
Modernization Contracts			
Contingencies		$1,800,000	$1,800,000
Architectural/Engineering Fees	$7,300,000	$7,200,000	$14,500,000
Consulting and Other Fees	$2,800,000	$1,870,000	$4,670,000
Movable and Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)		$1,800,000	$1,800,000
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to be Capitalized	$2,450,000	$534,000	$2,984,000
Acquisition of Building or Other property (excluding land)			
TOTAL USES OF FUNDS	**$12,550,000**	**$26,819,000**	**$37,569,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$12,550,000	$26,819,000	$37,569,000
Pledges			
Gifts and Bequests			
Bond Issue (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOUCES OF FUNDS	$12,550,000	$26,819,000	$37,569,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Cost Detail

		Total	Clinical	Non-Clinical	Subtotal
Preplanning		**2,400,000**			
	Campus Master Planning Efforts		-	$1,450,000	**$1,450,000**
	Urban Design Planning		-	150,000	**150,000**
	Campus Utility Planning		-	500,000	**500,000**
	Site Evaluation		-	200,000	**200,000**
	Evaluation of Sustainability and Resiliency		-	100,000	**100,000**
Site Survey and Soil Investigation		**215,000**			
	Survey of Site		-	20,000	**20,000**
	Environmental Testing and Abatement		-	50,000	**50,000**
	Seismic Testing		-	30,000	**30,000**
	Soil Investigation		-	115,000	**115,000**
Site Preparation		**500,000**			
	Demolition of Existing Buildings		-	450,000	**450,000**
	Termination and Rerouting of Existing Utilities		-	50,000	**50,000**
Off Site Work		**10,500,000**			
	Demolition of Excavation of Existing Roadway		-	350,000	**350,000**
	Installation of Service and Utility Tunnels		-	2,700,000	**2,700,000**
	Installation of Storm Water Retention Cisterns		-	3,450,000	**3,450,000**
	Alley and Street Vacation by City of Chicago		-	500,000	**500,000**
	Electrical Service Extensions		-	2,750,000	**2,750,000**
	Increased Utility Services		-	750,000	**750,000**
New Construction		-			
			-	-	-
Modernization Contracts		-			
			-	-	-
Contingencies		**1,800,000**			
			-	1,800,000	**1,800,000**
Architecture/Engineering Fees		**14,500,000**			
			7,300,000	7,200,000	**14,500,000**
Consulting and Other Fees		**4,670,000**			
	Permits and Fees		-	350,000	**350,000**
	Investigation, Prototyping and Code Analyses		-	950,000	**950,000**
	Consulting		-	3,370,000	**3,370,000**
Movable and Other Equipment		-	-	-	-
Other Costs to be Capitalized		**2,984,000**			
	Contracted Manager and Program Directors		-	2,159,000	**2,159,000**
	Insurances		-	450,000	**450,000**
	Project Office and Software		-	375,000	**375,000**
		$37,569,000			**$37,569,000**
			$7,300,000	$30,269,000	

ATTACHMENT 7

Section I, Cost Space Requirements

Attachment 9

Cost Space Requirements

This project is for a Master Design Permit and Cost Space Information will be submitted as a part of the specific Project Application.

Section III, Background of Applicant

Attachment 11

Section 1110.230, Background, Purpose of the Project and Alternatives

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

   UCMC's full general hospital license #0003897, effective July 1, 2021, issued by the Illinois Department of Public Health ("IDPH"), is attached. UCMC's most recent accreditation letter from the Joint Commission, dated May 12, 2016, is attached.

   UCMC also owns Ingalls Memorial Hospital ("Ingalls Hospital") and Ingalls Same Day Surgery Center, an ambulatory surgery treatment center ("Ingalls ASTC").

   Ingalls Hospital's full general hospital license is #0001099, effective January 1, 2022.

   Ingalls ASTC's ambulatory surgery treatment center license #7001043, effective June 18, 2021.

2. **A certified listing of any adverse action taken against any facility owned and/or operated by applicant during the three years prior to the filing of the application.**

   By signature of this application, UCMC certifies that there has been no adverse actions taken against UCMC within the prior three years.

3. **Authorization permitting HFSRB and DPH access to documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other States; when applicable; and the records of nationally recognized accreditation organizations.**

   By its signature to this application, UCMC grants the Review Board and the IDPH access to information to verify information in the application.

Illinois Department of PUBLIC HEALTH

HF 122928

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

Ngozi O. Ezike, M.D.
Director

06/30/2022

0003697

General Hospital

Effective: 07/01/2021

The University of Chicago Medical Center
5841 S Maryland Ave MC 1000
Chicago, IL 60637

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 06/30/2022

Lic Number 0003697

Date Printed 05/14/2021

The University of Chicago Medical Cen
5841 S Maryland Ave MC 1000
Chicago, IL 60637

FEE RECEIPT NO

ATTACHMENT 11

University of Chicago Medical Center

Chicago, IL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

March 12, 2016

Accreditation is customarily valid for up to 36 months.

The Joint Commission is an independent, not-for-profit national body that evaluates the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Illinois Department of PUBLIC HEALTH HF 123993

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.

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

[illegible]	[illegible]	[illegible]
12/31/2022		0001099

General Hospital

Effective: 01/01/2022

Ingalls Memorial Hospital
1 Ingalls Drive
Harvey, IL 60426

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. [illegible]

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2022
Lic Number 0001099

Date Printed 10/12/2021

Ingalls Memorial Hospital

1 Ingalls Drive
Harvey, IL 60426

FEE RECEIPT NO.

ATTACHMENT 11

Section III, Purpose of Project

Attachment 12

Executive Summary

- **A dedicated cancer hospital will enhance access to the full continuum of cancer care on the South Side of Chicago where the incidence and mortality from cancer is disproportionately high and the available resources are disproportionately low.**

A half-century ago, a cancer diagnosis still seemed unbeatable. Despite remarkable advances in detection and treatment during this time, the benefits have not been distributed equally, and the prognosis for many cancers, and many populations with cancer, remains poor, with residents on the South Side some of the farthest behind. People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America.

Cancer is the second leading cause of death on the South Side. The problem is expected to grow worse in the years ahead, with the incidence of cancer projected to grow 19% in the next five years on the South Side compared to only 9.1% in the five collar counties surrounding the City. Currently, 67% of South Side residents leave their communities to get cancer care. Compared to North Side residents, South Siders in some neighborhoods have a 30-year lower life expectancy.

- **UCMC knows that the war on cancer is a team effort. Robust community and patient engagement will be at the core of the design process.**

With a Master Design Permit, UCMC can engage effectively with not just architects and consultants, but also current and former patients, community hospitals and health centers, as well as scientists and direct health care providers, as UCMC seeks to enhance not just cancer care but the entire level of care on the South Side.

UCMC has fostered strong relationships with civic leaders, community organizations, health care providers and residents to improve health and access to quality care on the South Side of Chicago, culminating in its work to bring Adult Level I Trauma to the South Side four years ago. UCMC has already actively reached out to all of the community hospitals in its Planning Area A-03 and is pleased that this application includes several of their letters of support.

- **Cancer is not a single disease, but a collection of hundreds of diseases, and no two patients' cancers are the same.**

Traditional therapies for cancer, or "one size fits all" approach, such as surgery, chemotherapy and radiation, underestimate the aggressiveness and heterogeneity of cancer. Precision and personalized medicine ("PPM") is the future of cancer therapy, which means the development of specialized treatments for each type of cancer that can be tailored to specific tissues based on an understanding of a patient's genetic data. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as

harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

- **UCMC seeks to build a cancer hospital that has not been built before with a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient, whether in the clinic or at bedside.**

One of the major challenges to harnessing the power of PPM is the interpretation of enormous amounts of data, for which special technology, a robust computing infrastructure and data processing algorithms play a major role. The design planning for the new cancer hospital will contemplate an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach, to improve outcomes for patients and, ultimately, to save lives.

Section III, Purpose of Project

Attachment 12

Overview

Purpose of Master Design Project. The purpose of the Master Design Project is to plan for the design and development of a dedicated cancer hospital on the University of Chicago Medical Center's ("UCMC") Hyde Park campus on the South Side of Chicago in a strategic and inclusive manner. As a National Cancer Institute ("NCI") designated Comprehensive Cancer Center, UCMC knows that the war on cancer is a team effort. Cancer is not a single disease, but a collection of hundreds of diseases, and there is no single solution to get over the finish line.

As a critical first step, UCMC now seeks approval for a Master Design Permit to expend funds in excess of the capital threshold for activities such as architectural services and site preparation. The primary costs are for determining and developing the vision and design of a dedicated cancer hospital that will optimize care for the future. With a Master Design Permit, UCMC can engage effectively with the representation of the entire team, not just architects and consultants, but also current and former patients, community hospitals and health centers, as well as scientists and direct health care providers, as UCMC seeks to enhance not just cancer care but the entire level of care on the South Side necessary to keep patients healthy and to save lives.

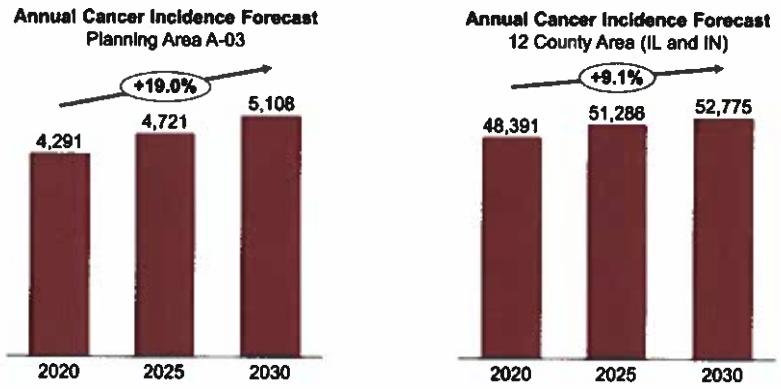
Purpose of Dedicated Cancer Hospital. The purpose of a dedicated cancer hospital is to enhance access to the full continuum of cancer care to the South Side of Chicago in communities where the incidence and mortality from cancer is disproportionately high and the available resources are disproportionately law. With almost 50 years as an NCI-designated cancer center, UCMC seeks to further its mission by building a world-class cancer hospital to continue to address the disparate distribution of high-quality health care resources in the communities that UCMC serves.

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy. These health disparities reflect a history of racial inequities and underinvestment – both of which have contributed to a fragmented healthcare delivery landscape with limited resources. Today, over 50% of all adult South Side residents leave the South Side to receive their care and almost two-thirds of all adult South Side residents specifically leave for cancer care.

These trends have been both caused and been compounded by insufficient, inadequate and declining medical services in both primary and specialty care: there is a stark shortage of primary care and OB providers; the CMS star rating for most hospitals on the South Side falls below the national average; and there has been over a dozen inpatient service or hospital closures in the past ten years – all contributing to the large number of South Side residents leaving their

community for care. Paradoxically, this dearth of care has partly contributed to overutilization as high as 60% in expensive emergency and inpatient settings, including at UCMC, even as local hospitals continue to see occupancy of less than 60% due to outmigration. The end result of these care delivery challenges is a staggering disparity in health outcomes: compared to North Side residents, South Siders in some neighborhoods have a 30 year lower life expectancy, the problem is expected to grow worse in the years ahead, with the incidence of cancer projected to grow 19% in Planning Area A-03 in the next ten years compared to 9.1% in the 12 county metropolitan area over the same time frame. These tolls have been further exacerbated by the COVID-19 pandemic, as evidenced in the highly disparate unemployment and death rates relative to white residents and North Side neighborhoods.

Cancer Incidence Forecast



Incidence of cancer is expected to grow 9.1% in the 12 County Metro Area, and 19.0% in the A-03 Planning Area over 10 years

AT THE FOREFRONT UChicagoMedicine

Source: Advisory Board Cancer Incidence Estimator; based on incidence rates from NCI SEER Program

The Federal Government declared a war on cancer 50 years ago with the passage of the National Cancer Act (the "Act") and created the National Cancer Institute to promote and to coordinate the significant nexus of cancer research, treatment and community engagement. The NCI was charged with establishing cancer centers throughout the United States and to bringing treatment closer to a patient's home. This milestone recognizes years of growth in cancer prevention, diagnostics and treatment and reinvigorates the need for specialized cancer centers to coordinate the full spectrum of cancer research, from the most basic to the most applied, to improve the implementation of therapies, and to help patients live longer and healthier lives.

Although the 50th Anniversary of the Act recognizes the progress that has been made during this time, there is a long way to go to reduce the burden of cancer for everyone. The understanding of cancer is dramatically different than it was a few decades ago. At a fundamental level, it starts with the understanding of genes; some of this information has been translated into improving lives, and the outcome is far better than before. It is clear that no two patients' cancers are the same, and the standard of care therapies, or "one size fits all" approach, such as surgery,

chemotherapy and radiation underestimate the aggressiveness and heterogeneity of cancer.[1] Precision and personalized medicine ("PPM") is the future of cancer care, which means the development of specialized treatments for each type of cancer that can be tailored to specific tissues based on an understanding of a patient's genetic data.

One of the major challenges to harnessing the power of PPM is in the interpretation of these enormous data sets, for which special technology, a robust computing infrastructure and data processing algorithms play a major role. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

UCMC believes it is the responsibility of an NCI-designated comprehensive cancer center to continue to push the envelope in the delivery of cancer care, a move taken by many of UCMC's peer institutions in the U.S. that built cancer centers within the past ten years. But UCMC is not seeking to build a facility comparable to its peers, it seeks to build a facility that has not been built before – one that recognizes the revolution underway in cancer therapies because of the understanding of cancer at the molecular level, that is ready to grow with the future of cancer research, and that can optimize the delivery of cutting-edge treatment.

A cancer diagnosis is complicated, and patients are understandably anxious and looking for solutions. The science behind cancer is also complicated, and a lot more is learned about cancer each year. While many facets of a cancer diagnosis are complex, UCMC wants to design a facility that makes navigating the continuum of cancer care cancer as simple, welcoming and efficient as possible. The proposed cancer hospital would put patients and their families first and strive to provide a full-service, personalized experience – from the environment of care to the cancer therapy itself.

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

UCMC has been serving the City of Chicago since 1927 and is one of the nation's leading academic medical institutions. Its mission is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish this mission, UCMC relies upon the skills and expertise of all who work together to advance medical innovation, serve the health needs of the community and further the knowledge of those dedicated to caring for patients.

UCMC is a nationally recognized leader in patient care, research and medical education and is the primary teaching hospital for the University of Chicago, Pritzker School of Medicine. UCMC

[1] **The growing role of precision and personalized medicine for cancer treatment** Paulina Krzyszczyk, Alison Acevedo, Erika J. Davidoff, Lauren M. Timmins, Ileana Marrero-Berrios, Misaal Patel, Corina White, Christopher Lowe, Joseph J. Sherba, Clara Hartmanshen, Kate M. O'Neill, Max L. Balter, Zachary R. Fritz, Ioannis P. Androulakis, Rene S. Schloss & Martin L. Yarmush; Technology 2018:06:79-100.

is the sole academic medical center on the South Side of Chicago. It is the closes support for the surrounding community hospitals, offering a full array of tertiary and quaternary patient services otherwise not available in the planning area. Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago and continues to invest in the capital resources necessary to maintain this effort. Moreover, UCMC routinely ranks among the top providers of Medicaid services in Illinois. Through the Project, UCMC seeks to facilitate access to integrated, interdisciplinary ambulatory and inpatient care, to reduce wait times to treatment initiation and for ongoing appointments, and to minimize travel distances for existing patients who currently leave the planning area for care.

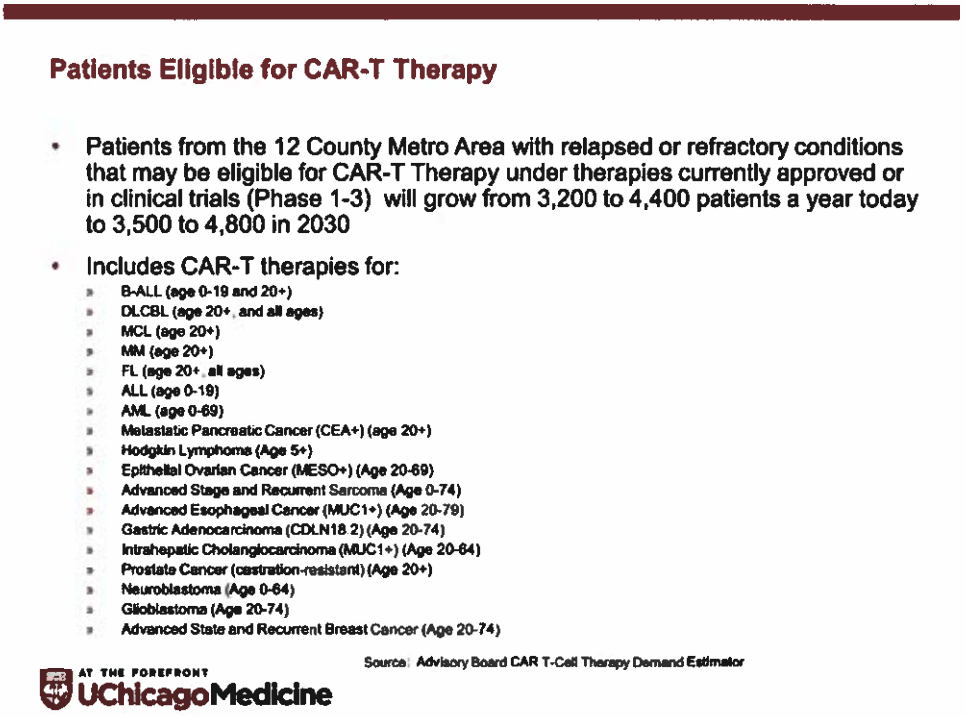
The mission of the Comprehensive Cancer Center is three-fold: to discover what leads to cancer, train the next generation of cancer researchers and bring advances in cancer to the surrounding community. The Medical Center and its more than 200 cancer researchers and physicians are committed to developing innovative ways to prevent and reduce cancer's devastating effects. Over the past three years, UCMC participated in 321 clinical trials for cancer treatment and accrued over 4,000 patients to those trials, including 1,341 minority patients. Additionally, during this same time period, UCMC faculty published more than 1300 peer-reviewed, journal articles with their research findings. In 2021, even in midst of the public health emergency, faculty published 441 scholarly articles, and a representative list of these publications has been included at the end of this section.

Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago and continues to invest in the capital resources necessary to maintain this effort. Chimeric antigen receptor T-cell therapy (CAR-T Therapy) is one prime example of UCMC's pioneering efforts and is one of the biggest advances in cancer treatment in recent years. It is an approach to cellular therapy where cells are collected from a patient, modified in a lab so that they can find and destroy cancer cells, and returned to the patient's body to do this important work.

UCMC was the first hospital in Illinois and one of the first few in the country to offer CAR-T Therapy. UCMC started to offer CAR-T in 2016 in clinical trials. Since then, UCMC has done over 250 adult cell therapy infusions of commercial products and clinical trials. UCMC was the first center in the country to offer Novartis's Kymriah® for all three of its indications and the second center to offer Kite's Yescarta®. UCMC also has one of the largest cell therapy clinical trial portfolios in the US with trials in leukemia, lymphoma, multiple myeloma, and several solid tumors (breast, cervical, melanoma, NSCLC, GI malignancies, and H&N cancers).

UCMC has also built a state- of-the-art cell therapy lab to be able to offer CAR-T and other cellular therapies. UCMC has demonstrated both the ability to take care of cancer patients and the ability to work with pharmaceutical partners with product development as part of the clinical trial process for CAR-T therapy – highlighting its basic and translational research. UCMC continues to offer twice as many clinical trials for CAR-T therapies than any other hospital in Illinois, and has the most doctors recognized for their research in cellular therapy. UCMC is currently offering therapies not available elsewhere in Illinois, and that are only available at five (5) to six (6) medical centers across the US.

CAR-T therapy is used for patients with relapsed and refractory cancers, where conventional cancer treatments have not been effective. Multiple Myelomas are one of the focus areas for CAR-T therapy, which is a disease that disproportionately affects African American populations. CAR-T therapies are currently being developed for other tumor areas, particularly for solid organ tumors, and will require utilization of inpatient beds for treatment, which the new cancer hospital would offer. In addition to inpatient care, cellular therapies will also be partially offered using "day hospital" ambulatory care, which will also be included in the new cancer hospital. New therapies will require inpatient beds, cellular therapy lab space, day hospital treatment space, and resources to be able to perform cellular manipulation in the clinical care areas. UCMC anticipates significant growth in the number of people with relapsed or refractory conditions that will be eligible for CAR-T therapy through 2030.



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

As a major national academic medical center, UCMC essentially has two market areas. First, it serves much of the South Side of the City of Chicago, as well as South Suburbs. UCMC is targeting a service area spanning 15 zip codes and approximately 900,000 residents on Chicago's South Side, The A-03 planning area was approximated using the 15 zip codes.

60605
60615
60616
60653
60609

= 60632
60638
60629
60636
60621
60637
60649
60619
60617
60628

In addition, for its highly specialized tertiary and quaternary services, and other services necessary for the coordinated delivery of specialty medicine, UCMC serves much of the Chicago metropolitan area, the state and the Midwest, and even includes international patients. UCMC seeks to provide greater access and an enhanced patient experience on UCMC's main campus in Hyde Park by bringing these services closer to the patient.

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

A. People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. In fact, cancer is the second leading cause of death on the South Side.

- Inequities in the burden of cancer are largely driven by the social determinants of health, including access to cancer prevention, screening and care.
- The problem is expected to grow worse in the years ahead, with the incidence of cancer projected to grow 19% in Planning Area A-03 in the next ten years compared to 9.1% in the 12 county metropolitan area over the same time frame.
- The Centers for Disease Control and Prevention ("CDC") predicts overall cancer rates will increase by 49% from 2015 to 2050

B. Over Half of Adult South Side Patients Today Leave the Area for Care They Need.

- The South Side of Chicago has insufficient, inadequate and declining medical resources. There has been over a dozen inpatient service or hospital closures in the past ten years on the South Side residents.
- Over Two-Thirds (67%) of Adult South Side cancer inpatients were treated outside of A-03 in 2020, up from 62% in 2019 (pre-Covid), with a significant amount of medical care provided to residents of the South Side of Chicago delivered in other regions of the city and in the suburbs.

- Five (5) hospitals treated 50% of the outflowing adult cancer patients from the A-03 planning area in 2019 and 2020 (Advocate Christ, Northwestern, Rush, UIC and Stroger).

C. UCMC is almost always full and operates at capacity 90% of the time

- Too frequently, UCMC operates under "surge" conditions because of a full hospital coupled with backup of critically ill patients waiting for admission in its emergency departments. In fact, UCMC called "surge" more than 50% of the time over the past few months.
- UCMC's patients are 45% sicker than patients that occupy the same beds in other hospitals in the planning area. When UCMC is operating at capacity, it limits the ability for safety net hospitals to transfer patients who need UCMC's specialized services and a higher level of care.

D. Community hospitals lack the investments and resources they need to meet the needs of local patients.

- Residents on the South Side are a medically-underserved population with a limited medical infrastructure. As a result, patients elect to go elsewhere.
- Over the past 25 years, Planning Area A-03 has seen seven of 16 hospitals close and inpatient capacity decrease by more than 54%.
- Of the remaining safety net hospitals, the average daily census in Planning Area A-03 decreased from 2015-2019 by 7% to as much as 48% except for UCMC and Provident (which was closed for a period of time).

E. Cancer Care is dispersed throughout several buildings on UCMC's Campus

- Inpatient oncology patients are currently admitted to the Bernard Mitchell Hospital (BMH) located at 5815 South Maryland Avenue and the Center for Care and Discovery (CCD) building located at 5700 South Maryland Ave in Chicago.
- Most if not all outpatient clinical and diagnostic services, such as imaging, lab, rehabilitative therapy services, and interventional radiology are in the DCAM located at 5758 South Maryland or the BMH.
- Clinical trials research and care administration at 860 East 59TH Street in Chicago.

F. Rapid advances in cancer care have far outpaced the facilities available to deliver them to patients.

Huge amounts of data are consistently being generated in health care and existing medical buildings may not have been constructed to process the data effectively. It is tedious and cost-prohibitive to retrofit existing buildings with an adequate technology infrastructure.

4. Cite the sources of the information provided as documentation

UCMC undertakes ongoing internal utilization studies and the source of this information includes those reports and other information reported to EMS, IDFPR and IDPH. UCMC also relied upon data its own records, UCMC 2016 and 2019 CHNA, 2020 Annual Report of its NCI-CCC, PubMed Open Source publications.

5. Detail how the project will address or improve the previously referenced issues or problems.

A. A dedicated cancer hospital will increase access and help to address healthcare disparities

- With 67% of South Side residents leaving their communities to get cancer care, adding a comprehensive cancer center on the South Side will dramatically increase access and reduce time traveled. Research has established that patients living farther from healthcare facilities have worse health outcomes, longer lengths of hospital stay, non-attendance at follow-up visits, higher rates of chronic disease-related deaths, lower five-year cancer survival rates, and increased overall disease burden.
    - A dedicated cancer hospital will allow UCMC to effectively and efficiently provide increased access to world-class cancer care. As a Comprehensive Cancer Center, UCMC see a higher volume of patients with rare cancer diagnoses. For example, UCMC's Radiation Oncology program conducted a study evaluating the outcomes of patients diagnosed with a rare brain cancer – glioblastoma and found that patients who received care at high volume Cancer Center – such as UCMC – were found to have more favorable outcomes than a patient who went to a low volume institution.[2]
    - A dedicated cancer center is critical to rectifying the demand in screening and treatment that has gone unmet as a result of the COVID-19 pandemic, with the most dramatic reduction in screening occurring in medically underserved communities. This has led to decreases in diagnosis and treatment and is expected to result in thousands of preventable deaths. According to the CDC, the screening rates for breast and cervical cancers fell by more than 80%, with the most severe declines occurring in populations of low-income women of color.
    - The threat of worsening cancer outcomes has been recognized by the international cancer research community as a leading priority. Early projections showed that if these trends continue, mortality for these cancer types is expected to increase by nearly 10,000 in the next 10 years in the U.S. alone as a result of missed cancer screenings and treatment.

B. Enhanced Access to High Quality Cancer Care on the South Side will provide greater choice to patients and the option to receive care closer to home .

2 Association between hospital volume and receipt of treatment and survival in patients with glioblastoma Matthew Koshy[1,2], David J Sher[3], Michael Spiotto[4,5], Zain Husain[6], Herb Engelhard[7], Konstantin Slavin[7], Martin K Nicholas[8], Ralph R Weichselbaum[4,5], Chad Rusthoven[2] J Neurooncology 2017 Dec;135(3):529-534. DOI: 10.1007/s11060-017-2598-2

- Adding a dedicated cancer hospital to UCMC's Hyde Park campus will further strengthen UCMC's work in improving these disparities for the Southside communities. UCMC's cancer faculty have conducted research on the impact of healthcare disparities and access to quality cancer care and have found that if a patient has to travel a long distance for cancer care – it will often lead to poor outcomes for that patient. UCMC's commitment to investing in the Southside of Chicago will help reduce travel time for the communities it serves and increase access to world class cancer care.[3]

C. A dedicated cancer hospital will increase capacity for the entire spectrum of cancer services

- The cancer hospital will provide 10% more capacity for inpatient operations and 40% more capacity for ambulatory operations at UCMC. This increased access will allow UCMC's complex patient population to begin their personalized treatment plans faster.
- With the additional bed capacity, the proposed cancer hospital has the potential to reduce disparities in access to essential medical services and to transform the way life-saving medical care is providing in the community
- The new cancer hospital will enhance access to care for the South Side's most vulnerable residents and help to break down barriers including transportation and supply gaps.

D. The commitment to building a cancer center is an investment in the resources of the entire healthcare community of the South Side of Chicago.

- In an unprecedented initiative, UCMC has joined 12 other South Side providers to develop a South Side Healthy Community model to serve over 900,000 residents with better, more seamless and more accessible care. This collaborative will be better able to serve the community with additional primary care and OB providers and dedicated access to nearly 50 priority specialists, 250 community healthcare workers and coordinators, and a connected and integrated care technology platform.
- The scope and scale of the SSHCO is both comprehensive and transformative, and the effort in parallel with a dedicated cancer hospital will constitute a major step in reversing the longstanding health and economic disparities of Chicago's South Side.
- The availability of care is generally enhanced when different elements of the healthcare delivery system work together. Patients deserve access to both community hospitals and complex care Community hospitals play a critical role in providing convenient and affordable access to care to vulnerable and low-income populations for primary and secondary care. UCMC also plays a critical role in caring for the sickest and most complex patients. The healthcare missions of UCMC and

[3] https://pubmed.ncbi.nlm.nih.gov/29932220/ Racial and Ethnic Disparities in Travel for Head and Neck Cancer Treatment and the Impact of Travel Distance on Survival Evan M Graboyes 1 2, Mark A Ellis 1, Hong Li John M Kaczmar 4, Anand K Sharma 5, Eric J Lentsch 1, Terry A Day 1, Chanita Hughes Halbert

community hospitals are aligned: Provide patients access to the care they need when and where they need it.

E. The new facility will put the entire care continuum under one roof

- A key objective of a dedicated cancer hospital is to reduce fragmentation and improve coordination of care and services. ot only is this a dissatisfier for patients, it leads to a disjointed delivery of care. This fragmentation today drives high wait times, results in avoidable utilization of higher-acuity settings, and contributes to the outmigration for care. The new facility will put the entire care continuum under one roof, unlike any other center in Illinois, creating synergies that will improve patient's outcomes and experience.
- The proposed new cancer hospital will allow all providers to work under "one roof" and provide patients with a single destination to receive care from multiple disciplines. UCMC's Cellular Therapy provide a multi-disciplinary clinic ("MDC") care model for their geriatric Stem Cell Transplant population, which has led to improved outcomes. Expanding this MDC care model beyond the geriatric patient population is a priority, and a proposed new cancer center will allow for all cancer disease groups to maximize the effectiveness of an MDC care model. [4]
- Another example of the success of MDC is a collaboration between UCMC's Medical Oncologists and Radiation Oncologists to determine whether patients with Head/Neck cancer that stem from HPV are better served by congruent radiation and chemo therapy regimen. As a result of the collaboration, they have been able to reduce the amount of radiation the patient is exposed to, reduce the chemo toxicities that often have a significant impact on the quality of life for patients, and to provide the best patient outcomes in the nation for this specific type of head/neck cancer.[5]

F. UCMC will bring a coordinated, state-of-the-art, technologically advanced building for the future of cancer services for patients and their families to the South Side of Chicago.

- UCMC seeks to build a cancer hospital that has not been built before with a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient, whether in the clinic or at bedside. The design planning for the new cancer hospital will contemplate an environment wired to consume and analyze rich

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[4] Benjamin A. Derman, Keriann Kordas, Emily Molloy, Selina Chow, William Dale, Andrzej J. Jakubowiak, Jagoda Jasielec, Justin P. Kline, Satyajit Kosuri, Sang Mee Lee, Hongtao Liu, Peter A. Riedell, Sonali M. Smith, Michael R. Bishop, Andrew S. Artz,
Recommendations and outcomes from a geriatric assessment guided multidisciplinary clinic prior to autologous stem cell transplant in older patients, Journal of Geriatric Oncology,Volume 12, Issue 4, 2021,Pages 585-591
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5 Oral Oncol. 2021 Nov;122:105566.
doi: 10.1016/j.oraloncology.2021.105566. Epub 2021 Oct 18.Risk and response adapted de-intensified treatment for HPV-associated oropharyngeal cancer: Optima paradigm expanded experience
Ari J Rosenberg[1], Nishant Agrawal[2], Alexander Pearson[3], Zhen Gooi[2], Elizabeth Blair[2], John Cursio[4], Aditya Juloori[3], Daniel Ginat[6], Adam Howard[2], Jeffrey Chin[3], Sara Kochanny[3], Corey Foster[7], Nicole Cipriani[8], Mark Lingen[8], Evgeny Izumchenko[3], Tanguy Y Seiwert[9], Daniel Haraf[5], Everett E Vokes[3]
https://pubmed.ncbi.nlm.nih.gov/34662771/

stores of patient data to better flex a "molecule to medicine" approach and to improve outcomes for patients.

- UCMC anticipates a profound shift in its health care delivery model that is more data-centric than function-centric and that fuses the most advanced technology, medical research, and clinical care through real-time collaboration for the benefit of all cancer patients. The new cancer center will be built around a "smart" core allowing researchers and clinicians to leverage big data, powerful computing and artificial intelligence ("AI"). UCMC cares for some of the most complex and rare cancer diagnosis and having a facility that leverages big data/AI will allow for more precise and personalized treatment plans.
- The new cancer center will include a Translational Research Laboratory (TRL) will provide real-time analysis of detailed molecular/immunological/metabolic attributes of a patient's tumor.

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

UCMC's prevailing objective is to increase access to comprehensive cancer care, throughout the life cycle of cancer. By building a dedicated cancer hospital on its Hyde Park Campus, UCMC seeks to increasing the availability of the full range of cancer from screening through remission in closer proximity to current and future patients and to help to mitigate persistent health care disparities.

- Stimulate and support collaborative, interdisciplinary basic and clinical cancer research, and bring the benefits of our breakthroughs to patients to provide them with superior, state-of-the-art care

- Pioneer preventative strategies based on cutting-edge research
Develop and provide imaging techniques and technologies to enhance diagnostics, detect malignancies early in their development, and improve the accuracy of radiographs

- Improve quality of life for patients and provide convenient access to useful resources to support their physical, social and emotional needs

- Use clinical trials to test investigational drugs and identify effective new cancer therapies

- Apply the latest advances in imaging, molecular biology, information technology, genetics, genomics, systems biology and other disciplines to the study of human cancer

- Provide education, training and career development for students, basic scientists, translational/clinical investigators, and healthcare professionals at all levels (from high school students to senior faculty)

- Ensure clinical trial access to community oncologists and minority populations directly and through enhanced relationships with a network of affiliated hospitals and health centers and bring science and research into FQHCs and community hospital

- Develop and implement outreach programs that educate local health professionals about current approaches and new advances in cancer prevention, early detection, and treatment

These goals are ongoing and material progress can be achieved within the timeframe for Project completion.

2021 University of Chicago Comprehensive Cancer Center Faculty Publications

Total = 463

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Section III, Alternatives
Attachment 13

Alternatives

Through many years of planning, UCMC rigorously evaluated several alternatives to expand capacity and to provide reliable access to high-quality cancer care for its underserved patient population. The various alternatives that have been considered are listed below:

1. Doing Nothing.

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy. These health disparities reflect a history of racial inequities and underinvestment – both of which have contributed to a fragmented healthcare delivery landscape with limited resources. Today, over 50% of all adult South Side residents leave the South Side to receive their care and almost two-thirds of all adult South Side residents specifically leave for cancer care. People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. In fact, cancer is the second leading cause of death on the South Side.

From 2014-2018, the residents on the South Side of Chicago were 28.6% more likely to receive a cancer diagnosis than residents in other parts of the City and 25.2% more likely than others in the state. Similarly, for similar periods of time, 14.9 deaths per 100,000 residents from breast cancer (2013-2017) compared to 12 in Illinois and 19.9 colorectal cancer deaths compared to 13 for Illinois.

UCM has been unable to consistently meet community demand because of capacity challenges on an inpatient and outpatient level. This shortfall is visible in ongoing denials for inpatient transfers due to a lack of available inpatient beds and long waiting times for outpatient clinics. Currently, the delivery of cancer care on UCMC's campus is fragmented, with key portions of routine cancer care spread among several buildings on campus and multiple points of entry.

Maintaining the status quo would not require a capital expenditure, but it would not address the significant and ongoing access and service limitations confronted by the South Side of Chicago. It also would not alleviate the extremely high rate of outmigration experienced in the planning area or the travel burden imposed upon cancer patients and their families, both of which have the potential to delay care and to diminish quality of life.

As an academic medical center, and designated NCI comprehensive cancer center, doing nothing is not a viable choice. UCMC views a dedicated facility for the delivery of advanced cancer care as an imperative and understands its obligation to act to improve inequalities that have persisted in its service area.

2. Project of Greater Scope and Cost

A. Construction of a dedicated cancer hospital remote from UCMC and its Hyde Park medical campus

As part of UCMC's systematic review of its options to expand access to high-quality cancer care, UCMC considered the construction of a free-standing cancer hospital built off of UCMC's campus on a suburban, Chicagoland location. From a cost perspective, suburban construction may be less expensive, but the construction on a remote site would require UCMC to duplicate all ancillary services needed to run a hospital. Specifically, the new facility would have to be separately licensed as a hospital and meet all of the requirements under the Illinois Hospital Licensing Act, including having its own CLIA-certified clinical laboratory and an emergency department.

This option also would require the purchase of land (approximately 75 acres) and the construction of a 1,000 car parking deck. The list of central services that would need to be built include the following:

- Kitchen Services
- Central Sterile processing
- Full Pharmacy Services
- Full Imaging Services
- Surgical Services
- Administrative and Faculty services
- Roadway improvements
- Heating Plant
- Parking lots and parking decks.
- Faculty offices
- Research Facilities

In addition to clinical services, the hospital would need an administrative infrastructure, including a governing body and executives needed to manage the medical staff, medical record, and nursing services. A new hospital would also need to independently enroll as a Medicare and Medicaid provider and to obtain a CIN.

UCMC estimates that this would require an additional 300,000 sq. ft. of physical space to replicate the centralized services already available on its Hyde Park campus. This would require additional, initial capital outlays and as well as material ongoing operational costs.

A new hospital in a suburban, Chicagoland location would allow for the construction of modern facilities to meet patient and provider needs and to deliver technologically advanced medical care. However, the site would not be in the heart of the South Side of Chicago where patients in the Hyde Park area are struggling with some of the highest rates of cancer. The site would also not be able to advantage of the rich academic environment of the University of Chicago Hyde Park campus.

Given that the intent and scope of the project is to increase access to cancer services in the community, UCMC rejected this option outright. Most importantly, it would not alleviate the maldistribution of resources within the City of Chicago and the healthcare disparities on the South Side. Additionally, it would require the duplication of services available on UCMC's Hyde Park campus for which there is not an independent or unmet need resulting in unnecessary expenses.

The total cost estimate for the 844,000 sq.ft. hospital, land and parking structure is $1.080 billion.

B. Comprehensive Renovation Mitchell Hospital with an addition

UCMC also considered a more comprehensive renovation of Mitchell Hospital than previously proposed previously along with the construction of an annex building.[6] The current renovation of Mitchell Hospital involves 113,452 sf of the building's total 450,000 sf. The potential use of the Mitchell Hospital would require renovation of the remaining 336,548 sf, additional upgrades to the 113,452 sf, the demolition of an adjacent building and the construction of 188,000 sf of adjacent pace to support modern clinical needs and to replace the faculty office and research space lost to the demolition.

This approach would allow the proposed cancer hospital to continue to benefit from the available central support and ancillary services on UCMC's Hyde Park campus. It would also be available to serve the residents on the Southside of Chicago and to benefit from collaboration available on the University of Chicago academic campus. However, the disadvantages of utilizing the dated, double-loaded corridor inpatient areas would not allow UCMC to provide a modern efficient experience for UCMC patients and staff. This would provide a suboptimal experience for UCMC patients and require excessive operating costs to properly staff the patient care units. The construction would also entail about 10 years to complete due to the amount of phasing required to work on an occupied inpatient facility and would be more expensive than the alternative chosen.

The total involved space for this project would be 638,000 sf and cost about $840.8 M.

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[6] UCMC already considered a project of lesser scope in Mitchell in 2016 when it originally proposed a comprehensive renovation of Mitchell to repurpose it as a hospital primarily dedicated to a broad spectrum of clinical cancer care. During the public health emergency, UCMC learned that optimizing care for its immunocompromised cancer population couldn't be accomplished in Mitchell. One notable area highlighted by COVID-19 is air handling systems and UCMC's ability to make substantial infrastructure changes to an existing building in a cost-effective manner.

Among the other problems encountered were: insufficient space to efficiently design ICU rooms and meet infection control requirements, 12 foot floor-to-floor heights prevented rerouting of HVAC ductwork needed to change layout on the current nursing units, negative impact on clinical labs and radiology due to need for new elevators, necessary replacement of the entire Mitchell Exterior Curtain Wall that could not be selectively modified; the need to modify IT infrastructure in Mitchell to accommodate a proliferation of IT systems could only be achieved at an extraordinary cost.

C. Joint Venture with Other Providers

UCMC already has entered into joint ventures with other providers in cancer care to bring advanced and investigational therapies to the community-hospital setting. The University of Chicago Cancer Center at Silver Cross Hospital opened in 2012 to operate an outpatient cancer treatment center in New Lenox, IL with two main services lines: An infusion/chemotherapy and oncology clinic and a radiation oncology clinic. It gives access to a leading academic medical center and research hospital for cancer treatment resulting in premier, community-based resource for cancer treatments, research and education and to bring world-class treatment to the suburban health care market and to treat patients closer to home.

More recently, AMITA Health and UCMC joined forces to jointly bring the South Side academic health system's specialized cancer expertise, access to advanced therapies and innovative clinical trials, and greater cancer care options to a smaller, community hospital on Chicago's North Side. The new partnership is based at AMITA Health Saint Joseph Hospital Chicago, and includes radiation and medical oncology, as well as surgical oncology and research services. Patients can now be seen by UCMC oncology physicians at the AMITA Saint Joseph Chicago campus.

A joint venture often is the only mechanism to bring comprehensive cancer care to a community that lacks ready access to academic medical centers and research institutions. Because cancer patients frequently require prolonged treatment over a number of weeks, having state-of-the-art treatment facilities closer to the patients' homes and patients' family members is optimal. Joint ventures may also provide a meaningful opportunity for a community to receive "cutting edge" care based on a relationship with academic medical centers or cancer centers and the latest research,

However, in this case, UCMC is, itself, a world-renowned academic medical center with a premier cancer program and seeks to improve the delivery of cancer care within the communities it already serves. UCMC rejected this option because a joint venture on UCMC's Hyde Park Campus is not necessary to achieve its goals.

D. Utilize Other Available Health Resources

UCMC considered whether it would be possible to simultaneously make improvements to its existing facilities to meet the demand for increased services in combination with a reliance on the resources and affiliations with neighboring hospitals. This option was rejected for several reasons. In particular, UCCM is the only academic medical center on the South Side of Chicago, where demand for cancer care is increasing and its population remains underserved. While the tertiary quaternary care provided by UCMC and the primary and secondary care provided by community hospitals in the region are complementary, UCMC has no peer hospitals in the area. Instead, UCMC receives frequent requests for transfers from most of the other hospitals in its service areas.

Similarly, UCMC rejected an affiliation with a hospital outside of the service area because it would not address the current unmet demand in Planning Area A-03.

E. Proposed Alternative

The purpose of a dedicated cancer hospital is to enhance access to the full continuum of cancer care to the South Side of Chicago in communities where the incidence and mortality from cancer is disproportionally high and the available resources are disproportionately law.

With this alternative, UCMC will bring a coordinated, state-of-the-art, technologically advanced building for the future of cancer services for patients and their families to the South Side of Chicago. UCMC already has a team of exceptionally trained specialists whose practices are grounded in the latest research with one goal in mind – to help UCMC's patients achieve the best possible outcomes – and to augment the community's access to the finest cancer care by enhancing local capabilities.

UCMC further seeks to build a cancer hospital that has not been built before with an innovative layout and a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient, whether in the clinic or at bedside.

Huge amounts of data are consistently being generated in health care and existing medical buildings may not be have been constructed to process the data effectively. It is tedious and cost-prohibitive to retrofit existing buildings with an adequate technology infrastructure, so the space planning for the proposed cancer hospital will account for this need up front. The design planning for the new cancer hospital will contemplate an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach and to improve outcomes for patients.

UCMC anticipates a profound new health care delivery model that is more data-centric rather than function-centric and that fuses the most advanced technology, medical research, and clinical care through real-time collaboration for the benefit of all cancer patients.

With UCMC's ongoing commitment to bring an even greater benefit to the communities it serves, including underserved and vulnerable populations, the alternative chose is the only option.

Alternative	Cost	Pros	Cons
Project of Greater Scope: New Hospital Apart from UCMC's main campus	$1.08 B	• Would provide modern facilities and an environment for technologically advanced care	• More expensive than alternative selected • Would duplicate services for which there is no demand • Would not address primary reason for project – to infuse underserved and at-risk population with high quality health care resources
Project of Greater Scope: Renovation of	$840.8 M	• Location on main medical campus would bring additional resources to the	• More expensive than alternative selected • Constrained by dated

ATTACHMENT 13

Mitchell/Construction of Annex		South Side of Chicago • No need to duplicate ancillary services	hospital floorplan and layout of nursing units • Construction would take up to 10 years because of phasing required to work on occupied patient units
Joint Venture	N/A	• No material advantages	• Would unnecessarily complicate the delivery of health care in one of UCMC's premier service lines in its own community
Utilize Existing Facilities	N/A	• Potentially lower cost	• UCMC fills a unique role in its planning area and there is no reliable acute care capacity for specialized cancer care that can be filled by existing hospitals.
Proposed Project	$633 M	• Enhanced access to full continuum of cancer care for medically underserved and at-risk population and improved outcomes at each stage of illness • Creation of technologically advanced and data-centric delivery model to facilitate multi-disciplinary collaboration of care providers	• More expensive than doing nothing • Material expenditure for technologically advanced infrastructure • Requires significant site preparation and underground utility work

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Attachment 14

Project Scope, Utilization and Unfinished/Shell Space

The total GSF of the proposed inpatient and outpatient building will be approximately 544,000 GSF and the cost will be approximately $633,300,000. It is estimated the building will be (six) 6 floors in height with one lower level floor. Planning and design efforts will review various options for connections between the new building and the CCD inpatient hospital building and Parking Deck B. The design cost (A&E and related expenses), prototype development along with site preparation and off-site utility work is estimated to be $62,484,000 which exceeds the current capital expenditure threshold.

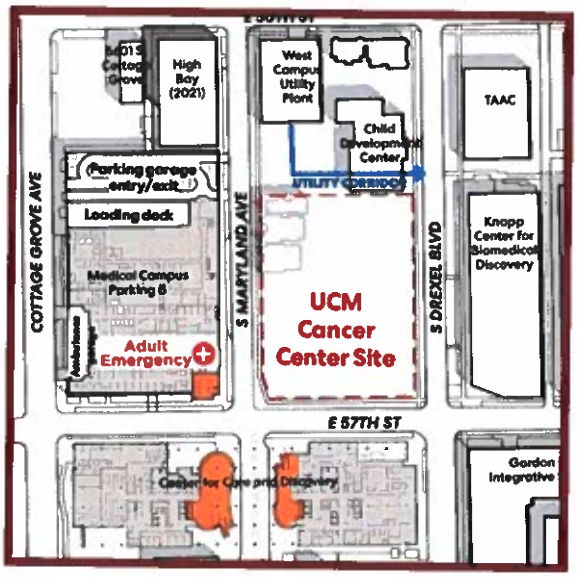

FIGURE 1: Site Plan

In addition to architectural fees, this application is requesting permission to complete demolition of existing structures and underground utility system improvements needed to ensure that the UCM Adult Level 1 trauma and Emergency Department can operate without interruption. A separate permit application for approval of the project construction and any other related work will be filed subsequent to the approval of the Master Design permit application.

There is extensive underground utility work that is required to be installed under South Maryland Ave between East 56th and East 57th streets before any work for the Cancer Center can begin. This section of S. Maryland Ave. is the primary walk-in (Ambulatory) entrance to the UChicago Adult Emergency Department Level 1 Trauma Center. The new site will be needed to allow access to the ED while the underground utility work is completed. It would not be possible to keep the ED entrance open once the planned new facility work begins and complete the underground utility work. The underground work includes the rerouting of major city water, electrical, data, sanitary and storm sewer piping systems. Additionally, a tunnel and two storm water retention cisterns will need to be installed under S. Maryland Ave. The tunnel, which will be located directly under the ambulatory entrance to the ED, will connect the new facility

directly to Parking Deck B building loading dock. The storm water retention system consists of two underground cisterns designed to meet the 100-year storm requirements with a total storage capacity of over 470,000 gallons. Accommodations for Adult ED traffic during underground work

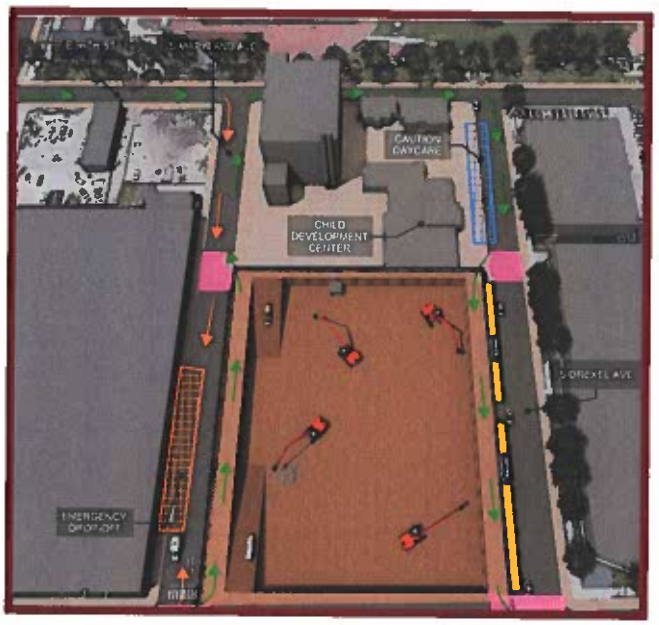

FIGURE 2: Excavation Site

We are also planning to develop large scale prototypes of the designs for the project. Our goal here is to test new technologies and how the design of the building will need to incorporate them. Likewise, we will want to incorporate the latest learnings from our experience with COVID in order to ensure that we can safety take care of patients through any similar events. We will be using a large offsite warehouse facility to construct the mockups to complete the design investigations. This includes designing state of the art inpatient, exam, consultation, telemedicine and other support care spaces for the patient and staff. These facilities are also part of our lean operations design process to ensure that the facility will be as safe and efficient as possible.

FIGURE 3: Underground Utility Work

Section IV, Project Services Utilization

Attachment 15

Appendix B, Project Services Utilization

1110.120 c) Project Size Utilization – For areas for which there are utilization standards as shown in Appendix B

Utilization discussion is addressed in Attachment 18 (Master Design Permit). Specific detailed utilization will be addressed in the Construction CON application.

Section IV, ADDITIONAL GENERAL REVIEW CRITERIA FOR MASTER DESIGN AND RELATED PROJECTS ONLY

Criterion 111.130 – Additional General Review Criteria for Master Design and Related Projects only

Criterion 1110.130 (a) SYSTEM IMPACT OF MASTER PLAN

This is a Master Design Project for design services related to building a dedicated cancer hospital on the Hyde Park campus of the University of Chicago Medical Center ("UCMC") and consolidating most, if not all, of the delivery of inpatient and outpatient cancer services in one location. The project will help UCMC meet current demand for cancer care in both the inpatient and ambulatory care arenas as described more fully in the following sections.

Only a few decades ago, prognosis after a cancer diagnosis was bleak, and survival rates were low. But cancer care is transforming thanks to rapid advances in cellular biology, cancer diagnostics, precision medicine, immunotherapy and the discovery of new drugs. The proposed construction of a dedicated cancer hospital on UCMC's main campus will strengthen the delivery of transformational cancer care by improving access to critical clinical services, participation in research, and supportive services for the whole patient. It proposes to be the first freestanding, full-service cancer hospital in the City of Chicago. With a singular focus on cancer, UCMC knows that dedicated cancer centers, with their state- of-the-art therapies and research activities, often offer the greatest possibility of successful cancer treatment. Like these institutions, UCMC already provides multi-disciplinary cancer care, including diagnostic, surgical, medical, chemotherapy and radiation treatment, but it seeks to do so within a dedicated facility to further improve both outcomes and patient experience.

Availability of alternative health care facilities with the planning area and the impact of the applicant's proposed future projects will have on the utilization of those facilities.

The proposed Master Design project seeks approval to spend funds to plan for the construction of a new cancer hospital on the UCMC's main campus. As an enhancement of UCMC's existing facilities and mission to treat tertiary and quaternary care patients, the proposed project should not have an adverse impact on the provision of care within UCMC's planning area. In fact, UCMC expects it to augment and complement the entire ecosystem of care on the South Side, which is home to numerous community hospitals and FQHCs providing primary and secondary care of its residents.

Since the founding of the Medical Center, history has been there made time and time again. Cancer research has also grown for immeasurably inside UCMC's walls; hormone treatments, chemotherapy, genetic links to cancers, the foundation of modern cancer immunotherapies and benefits of targeted therapy have all been discovered or advanced by groundbreaking research there.

Founded in 1973, the University of Chicago Medicine Comprehensive Cancer Center ("UCCCC") received its designation as an NCI-Designated Cancer Center that same year and was designated as an NCI comprehensive cancer center in 2008.

The UCCCC's mission is to better understand cancer's causes, to develop treatments for cancer, and to prevent cancer through research, clinical care, education, and community engagement. This is accomplished through innovative clinical and research programs that emphasize collaboration among a diverse and dedicated team of outstanding basic, translational, clinical, and population researchers and trainees.

The center serves more than 8.5 million residents in a diverse five-county area in northeast Illinois and northwest Indiana. More than 7,500 patients a year are diagnosed with or treated for cancer at the South Side Chicago-based academic health system.

The UCCCC has long been recognized for its strength in basic and clinical research, particularly its major contributions to drug development and early-phase clinical trials. Other areas of expertise include the genetic classification of hematological malignancies and pioneering of risk-adapted therapies, the development of new treatment paradigms in head and neck cancer, the advancement of cancer immunology, pharmacogenomics, cancer genetics, molecular epidemiology, and population-based cohort studies. The UCCCC also actively develops and supports the training and career development of the next generation of cancer researchers, especially those from underrepresented populations.

The UCCCC's interdisciplinary research programs include Molecular Mechanisms of Cancer, Immunology and Cancer, Clinical and Experimental Therapeutics, and Cancer Prevention and Control.

In addition, several large research initiatives focus on:

- developing technologies and chemistry methods to detect different epigenetic markers to understand how they affect gene and cellular function
- pioneering new imaging techniques that are helping specialists diagnose cancer earlier
- maximizing the impact of immunotherapy by identifying the determinants of antitumor immunity, host factors that contribute to response, and potent combination therapies to improve efficacy and durability of treatment
- leading national efforts in cancer bioinformatics and cloud computing to get an in-depth view of cancer genomics, and gene expression
- unraveling the molecular and genetic basis of cancer metastasis in order to develop successful treatments that will prevent cancer from spreading
- understanding the underlying causes of cancer health disparities and designing interventions to promote cancer health equity

A central tenet of UCCCC's mission is to promote cancer health equity among all populations and communities, especially among groups where there are known cancer disparities based on

race, ethnicity, language and geographic location. The team of experts specializes in cancer control, prevention and population research while implementing new approaches to screening and prevention. But because of COVID-19, now more than ever, it is critical to encourage local residents to adopt a healthy lifestyle that includes cancer screenings.

Through the Office of Community Engagement and Cancer Health Equity (OCECHE), the UCCCC has ramped up its activities that inform and empower community members to take charge of evidence-based cancer prevention strategies. The group meets monthly with its Community Advisory Board (CAB) to address concerns and actively partner on issues of importance to the community.

UCMC is proud to be in the top half of the 50 best cancer hospitals recognized by the U.S. News & World Report, one of two National Cancer Institute ("NCI") designated cancer centers in Illinois, and have the most Top Doctors in Illinois noted by Chicago Magazine for cancer. UCMC is one of 30 U.S. institutions selected as Lead Academic Participation Sites for the NCI's National Clinical Trials Network, with more than 300 open therapeutic trials and more than 1,000 patients enrolled per year. The Medical Center is also the first site in the USA to be certified to administer FDA– approved Car-T cell therapies for specific blood cancers in both adult and pediatric patients. UCMC's clinical teams are recognized leaders in delivering complex cancer care; a market leader in clinical trials and delivery of novel therapies; and a proven destination for cancer patients. The development of a new cancer hospital will have a very strong focus, both in design and processes, on the patient and family experience, and will aim to improve health equity in frontline care and the future of healthcare research. The clinical approach will be multi-disciplinary and technologically advanced, with access to the newest therapies and treatment innovations which seamlessly integrates clinical research.

With respect to alternatives, there is no other institution with equivalent breadth and depth of expertise in the area or with comparable commitments to cancer research, emerging treatments, community service and training the next generation of providers. Currently, UCMC is pioneering treatment for colorectal, ovarian, stomach and neuroendocrine cancers, offering state-of-the art therapies that include:

- **HIPEC Therapy**. Hyperthermic Intraperitoneal Chemotherapy ("HIPEC") is a targeted therapy that treats cancers existing in the abdominal cavity (*e.g.* colorectal, ovarian, stomach). HIPEC is done when a patient is in surgery and after the cancer has been removed; chemotherapy is then heated to 108 degrees and infused into the abdominal cavity to provide targeted and concentrated treatment. This therapy provides a one-two punch by having the tumor/cancer removed and immediately having the chemotherapy infused. It also minimizes the side effects of chemotherapy by allowing a patient to return to their normal lives faster. ***UCMC is one of three centers in the U.S. that offers this innovative therapy.*** Every patient who undergoes HIPEC is assigned to a multi-disciplinary team to ensure all his or her needs are met.

- **Neuroendocrine tumor (NETS) program**. UCMC has the only program in the market leader for NE tumors in the Midwest. UCMC treats neuroendocrine tumors of the GI tract, pancreas, lung and thymus and medullary thyroid cancer with a fully dedicated team consisting of Surgery, Oncology, Nuclear Medicine, Nursing, Pathology, Radiology and IR. Additionally, ***UCMC is the only center in the Midwest to use 3D-guided microwave ablation*** and the only center to that hosts a patient conference for those living and surviving with NE cancers.

How the services proposed in the applicant's future projects will improve access to area residents

As an NCI-designated Comprehensive Cancer Center, UCMC recognizes its ongoing responsibility to strive to overcome the existing barriers to high quality care and push the boundaries of what is possible for its community. Patients who are treated at comprehensive cancer centers experience superior survival rates compared to patients treated at facilities that have not received this designation.[1] While outcomes at NCI cancer centers are already strong, the rates of "textbook outcome" are even higher at dedicated cancer hospitals. The likelihood of a patient surviving their cancer after 5 years at a dedicated cancer center is 17 percent higher than at other hospitals. That is true across many types of cancer, including the most common – breast, colorectal, lung and prostate.[2]

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[1] *See also Impact of care at comprehensive cancer centers on outcome: Results from a population-based study* Julie A. Wolfson MD, MSHS, Can-Lan Sun PhD, Laura P. Wyatt BA, Arti Hurria MD; 28 July 2015; **https://doi.org/10.1002/cncr.29576**; Among individuals aged 22 to 65 years residing in Los Angeles County with newly diagnosed adult-onset cancer, those who were treated at NCICCCs experienced superior survival compared with those treated at non-NCICCC facilities. Barriers to care at NCICCCs included race/ethnicity, insurance, socioeconomic status, and distance to an NCICCC) ***Cancer* 2015;121:3885–3893.** © *2015 American Cancer Society.* https://acsjournals.onlinelibrary.wiley.com/doi/10.1002/cncr.29576

See also Second Opinions from Comprehensive Cancer Centers Changed Treatment Plans for African American Patients, American Association for Cancer Research, https://www.aacr.org/about-the-aacr/newsroom/news-releases/second-opinions-from-comprehensive-cancer-centers-changed-treatment-plans-for-african-american-patients/, African American breast cancer patients who received second opinions from an NCI-designated Comprehensive Cancer Center (CCC) experienced changes to their treatment plans, according to results of a developmental study presented at the 12th AACR Conference on The Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved, held here Sept. 20-23.

[2] Source: Medicare Data 2006-2011, CRG adjusted, Refined Provider Algorithm; available at http://www.adcc.org/sites/default/files/ADCC_Facts_On_Dedicated_Cancer_Centers.pdf;

See also Dedicated Cancer Centers are More Likely to Achieve a Textbook Outcome Following Hepatopancreatic Surgery.; Mehta R, Tsilimigras DI, Paredes AZ, Sahara K, Dillhoff M, Cloyd JM, Ejaz A, White S, Pawlik TM. Ann Surg Oncol. 2020 Jun;27(6):1889-1897. doi: 10.1245/s10434-020-08279-y

See also "What Is the Value of Undergoing Surgery for Spinal Metastases at Dedicated Cancer Centers? Azeem Tariq Malik, Safdar N Khan, Ryan T Voskuil, John H Alexander, Joseph P Drain, Thomas J Scharschmidt. Clin Orthop Relat Res. 2021 Jun 1;479(6):1311-1319. DOI: 10.1097/CORR.0000000000001640;

The proposed dedicated cancer hospital will strengthen the delivery of high-quality cancer care by improving access to critical services for its at-risk and vulnerable populations. It will bring the cancer care home to residents on the South Side, it will increase volume of available cancer care and clinical studies, and it will facilitate the interdisciplinary collaboration and care delivery necessary for targeted and precision therapies.

The proposed Project will improve access to the services in the following ways:

- The proposed cancer hospital will reduce the travel burden of South Side residents

Currently 67% of residents on the South Side leave Planning Area A-03 for cancer treatment, which means significant travel times for medical care. The burden of travel from a patient's residence to health care providers is an important issue that can affect the diagnosis and treatment of cancer. Although several studies have highlighted that the travel burden can result in delays in diagnosis and treatment of many common cancers, its role still appears to be underestimated in the treatment of patients in clinical practice. In addition, the burden of travel from a patient's residence to his or her health care provider can be an important issue that can delay and influence access to diagnosis and treatment services for cancer needs. The necessity for repeated visits for cancer diagnosis and treatment on an outpatient or an inpatient basis makes distance an important issue for the cancer patient to consider during the course of the disease. One recent review suggests that the travel burden is an important factor affecting access to appropriate and current cancer diagnosis and treatment and that it can worsen the achievement of universal high-quality care for cancer patients.[3] It suggests that even a small increase in distance can result in a substantial barrier for this subset of the population.

Specifically, it was noted that distance from the hospital had a negative impact on patients affected by cancer in four primary ways: the stage at diagnosis, treatment received, prognosis, and quality of life. In almost all the studies analyzed, patients who lived far from hospitals and had to travel more than 50 miles had a more advanced stage at diagnosis, lower adherence to recommended treatments, a worse prognosis, and a diminished quality of life. These four aspects are all very important for patients and for health care policies and costs.

The National Institutes of Health also recently released a comprehensive study of the patient economic burdens of cancer, which analyzed both patient out-of-pocket costs and time costs associated with cancer treatment as part of its annual report to the nation on the status of cancer. It found that, nationally, time costs represent approximately 23% ($4.9 billion/$21.1 billion) of a patient's economic burden.

For all cancers combined, patient out-of-pocket costs were estimated to be $16.22 billion, with the highest costs for breast ($3.14 billion), prostate ($2.26 billion), colorectal ($1.46 billion), and lung ($1.35 billion) cancers, consistent with the higher incidence of these cancers. Annual time costs in 2019 were estimated to be $4.87 billion for all cancers combined, with breast ($1.11

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1. [3] Distance as a Barrier to Cancer Diagnosis and Treatment: Review of the Literature Massimo Ambroggi,[a] Claudia Biasini,[a] Cinzia Del Giovane,[c] Fabio Fornari,[b] and Luigi Cavanna [a]; Published online 2015 Oct 28. doi: 10.1634/theoncologist.2015-0110

billion) and prostate ($1.04 billion) cancers accounting for almost one-half of time costs.[4] The estimates of patient time were associated with round-trip travel to care, waiting for care, and receiving care and were calculated separately for each service category using national data sources from previously published studies and separately for metropolitan and nonmetropolitan statistical areas.

A key aim of any cancer treatment is quality of life for cancer patients and to give patients and their families the possibility to live their lives to the greatest extent possible. In this context, UCMC must account for the travel burden of cancer patients, especially when so many patients are already leaving the area, and seeks to bring more accessible cancer care to its community.

- The proposed cancer hospital will consolidate UCMC's delivery of cancer care in one dedicated building with expanded inpatient and ambulatory capacity

UCM has been unable to consistently meet community demand because of capacity challenges on an inpatient and outpatient level. This shortfall is visible in ongoing denials for inpatient transfers due to a lack of available inpatient beds and long waiting times for outpatient clinics. Within the last five years, UCMC has expanded both its medical-surgical and ICU beds and continues to run the beds over a 90% capacity. UCMC operates at "surge" status more than 50% of the time, meaning that it has more than 20 patients in the emergency department waiting for beds in an already full hospital. The proposed cancer hospital will expand existing ambulatory capacity by 40% and inpatient capacity by 10% on the day it opens. The addition of 128 inpatient beds, both medical-surgical and ICU, would significantly improve access and would enable UCMC's complex patient population to begin their personalized treatment plan faster.

Hospitals have shown to be able to increase their efficiency through enhanced communication, improved coordination, and leveraging technology, all of which will become easier in a dedicated facility. Propelled by a patient-centric philosophy, clinicians at Cleveland Clinic Cancer Center launched a multidisciplinary effort in 2014 to reduce the amount of time it takes for a patient with cancer to receive their first cancer therapy after being diagnosed, commonly referred to as time-to-treatment initiation ("TTI"). TTI had been trending upwards to six weeks at some academic medical centers, with such delays leading to heightened anxiety and worry in cancer patients waiting for treatment. Cleveland Clinic was able to drive its TTI down 33% to 25 days from diagnosis for existing patients through more purposeful collaboration and by implementing a team approach structured around disease groups beginning in 2014[5].

The proposed dedicated cancer building will consolidate the continuum of cancer care in one facility, fostering communicating, collaboration and strategic deployment of technology.

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[4] Annual Report to the Nation on the Status of Cancer, Part 2: Patient Economic Burden Associated with Cancer Care K Robin Yabroff, PhD, Angela Mariotto, PhD, Florence Tangka, PhD, Jingxuan Zhao, MPH, Farhad Islami, MD, PhD, Hyuna Sung, PhD, Recinda L Sherman, PhD, S Jane Henley, MSPH, Ahmedin Jemal, DVM, PhD, Elizabeth M Ward, Phonics: *Journal of the National Cancer Institute*, Volume 113, Issue 12, December 2021, Pages 1670-1682, https://doi.org/10.1093/jnci/djab192; https://seer.cancer.gov/report_to_nation/?cid=pr_cgov_en_sharedlink_arn_lp

2. **5 Reducing Time-to-Treatment for Newly Diagnosed Cancer Patients**

How Cleveland Clinic initiated a multidisciplinary program to reduce time-to-treatment and accomplish a 33% reduction.
Alok A. Khorana, MD and Brian J. Bolwell, MD; February 14, 2019; NEJM Catalyst

Currently, a cancer patient has multiple points of entry to UCMC system with diffuse physical locations. The new building will be patient-centered to allow patients to have all appointments in one area and to improve multidisciplinary collaboration and cooperation, to timely address each patient's administrative and clinical needs.

This ongoing improvement of care, shaped by the fusion of clinical research and clinical practice, is at the core of UCMC's founding mission and for its future role and contribution to the health care system. At the center of cancer care is the patient, and the proposed master design project will allow UCMC to continue its tradition in transformational medicine.

- The consolidation of the entire spectrum of cancer care in the proposed cancer hospital will facilitate the interdisciplinary collaboration and care delivery necessary for targeted and precision therapies that place the patient at the center of treatment

Fifty years ago, President Nixon signed The National Cancer Act of 1971, which established the National Cancer Institute and signified what he first described as the nation's "war on cancer." After five decades of progress, cancer researchers are at an inflection point about how they think about cancer. They now know that cancer is not monolithic. Previously, when women were diagnosed with ovarian cancer, everybody got the same treatment, with the treatment working better for some than others. Then researchers began finding genetic differences in people and their cancers. These differences explained a great deal about why cancers responded differently to the same treatment. Cancer researchers have been able to see that, at a molecular level, tumors are different in different tissues even in the same body, that even cancers from the same original site, like breast cancer, can be radically different because of their molecular profiles, and that the tumors change over time. Cancer researchers also know that cancer evolves and reoccurs, so a patient's treatment over time will likely change as his or her response to the treatment changes.

Despite recent advances in the treatment of cancer, the disease remains a leading cause of death by disease worldwide and even more so in UCMC's own backyard. The CDC anticipates that one in two people will be diagnosed with cancer in their lifetime, which means there is a pressing need to ease the burden of disease, especially on those hit hardest.

Traditional therapies for cancer, or "one size fits all" approach, such as surgery, chemotherapy and radiation, underestimate the aggressiveness and heterogeneity of cancer. Precision and personalized medicine ("PPM") is the future of cancer therapy, which means the development of specialized treatments for each type of cancer that can be tailored to specific tissues based on an understanding of a patient's genetic data. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

This ability to understand the genetic makeup of tumors can make a dramatic difference in cancer care and can maximize the benefit of treatment based upon a person's genes. In a retrospective medical record review of non-small cell lung cancer patients treated at community

hospitals patients for patients who did not undergo molecular testing and did not receive a targeted cancer therapy and instead received chemotherapy, of the 482 patients who received chemotherapy, the median overall survival was 12.7 months and for the 131 patients who received a targeted therapy at some time during their treatment, the median overall survival was 31.8 months.[6]

Precancer care can now also mean mitigating genetic risk factors and reducing the chances of developing an actual cancer. This can be especially important with women found to have the BRCA1 and BRCA2 genes making them more susceptible to ovarian and breast cancers. It also means more aggressive cancer screening. Evidence is growing that wellness and lifestyle changes, including changes in exercise, nutrition, and overall well-being, and other key social determinants of health, support survival and recovery, and also reduce recurrences.

To this end, UCMC is a participant in the Chicago Multiethnic Prevention And Surveillance Study (COMPASS), which is a long-term research program that looks at the impact of factors such as lifestyle, healthcare access, the environment, and genetics on the health of Chicagoans. This longitudinal cohort study currently has over 8,000 participants throughout the city, with a long-term goal of 100,000 participants.

In particular, it is known that certain racial or population sub-groups have higher rates of occurrence or severity of cancer and chronic diseases, such as diabetes, cardiovascular, and respiratory illnesses. In Chicago, this disparity is often worse than in other parts of the United States. COMPASS seeks to understand why this is the case, and how the health of Chicagoans is shaped by where they live. With respect to cancer, Compass has already begun to focus on the genetics and environment on PSA and the barriers and facilitators to further community participation in research.

UCMC is also home to The Institute for Population and Precision Health, which was founded in response to the US Precision Medicine Initiative in 2015 and brings together researchers from multiple academic units across the University, and provides them with population-based resources to tackle the most challenging problems in preventive and population medicine. One of its most significant initiatives is participation in the NIH Connect for Cancer Prevention Study to investigate the etiology of cancer and outcomes to inform prevention and detection. UCMC can further flex its excellence in population health across disciplines in a dedicated cancer hospital that will showcase its application and impact at the individual level.

UCMC believes it is imperative to try to reduce the cancer burden for all people, reduce disparities in access to care and in clinical trials, and close the gap between researchers and community. As a result, UCMC seeks to build a cancer hospital that has not been built before with a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient. One of the major challenges to harnessing the power of PPM is the interpretation of enormous amounts of data, for which special technology, a robust computing infrastructure and data processing algorithms play a major role. The design planning for the new cancer hospital

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[6] Genomic Profiling of Advanced Non-Small Cell Lung Cancer in Community Settings: Gaps and Opportunities, Journal of Clinical Lung Cancer,Vol. 18, Issue 6 (Nov. 1, 2017), Gutierrez, Choi, Lanman, Pecora, Schultz, Goldberg.https://doi.org/10.1016/j.cllc.2017.04.004

will contemplate an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach, to improve outcomes for patients and, ultimately, to save lives.

What the potential impact on area residents would be if the proposed services were not to be replaced or developed;

UCMC is a tertiary and quaternary care center that closely collaborates with community hospitals and other providers in its planning area, including local providers of primary and secondary medical services.

From 2014-2018, the residents on the South Side of Chicago were 28.6% more likely to receive a cancer diagnosis than residents in other parts of the City and 25.2% more likely than others in the state. Similarly, for similar periods of time, 14.9 deaths per 100,000 residents from breast cancer (2013-2017) compared to 12 in Illinois and 19.9 colorectal cancer deaths compared to 13 for Illinois.

	Cancer Diagnoses (2014-2018) per 100,000 Residents				
	South Side	Chicago	Illinois	South Side vs. Chicago	South Side vs Illinois
All Cancer	665.09	517.11	531.12	28.6%	25.2%
Prostate Cancer	196.74	174.97	174.03	12.4%	13.0%
Cervical Cancer	15.52	15.01	10.45	3.4%	48.5%
Distant/Systemic Cancer	184.55	136.94	132.1	34.8%	39.7%
Other Cancers	196.44	140.85	163.9	39.5%	19.9%
Colorectal Cancer	69.09	66.64	63.03	3.7%	9.6%

While UCMC has made significant strides in the use of screening, the average stage of cancer at diagnosis remains higher on the South Side compared to the rest of Cook County and Illinois. Without a significant financial investment in the medical infrastructure of the South Side, cancer's devastating effects will continue to be distributed unequally with South Side's most vulnerable residents.

The anticipated role of the facility in the delivery system, including anticipated patterns of

	Cancer Screening Rates - % of Population			
	South Side	Chicago	Cook County	Illinois
Colorectal Screening, 2018	57.12	60.1	61.9	63.23
Pap smear use, 2018	80.76	81.7	82.7	83.55
Mammography Use, 2018	80.44	75.9	75.7	73.23

patient referral and any contractual or referral agreement between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

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UCMC seeks to enhance and optimize access to world-class cancer care and clinical research which will be achieved by building a dedicated cancer hospital.

The proposed Master Design project will enhance access to cancer care, will provide major improvements in the environment for patients who receive services there, and will facilitate UCMC's three-part mission in clinical care, teaching and research, which benefit the entire ecosystem of care on the South Side. The project does not seek to change the role of UCMC and its cancer capabilities from what it is today, it just seeks to make sure that the UCMC is more widely available to those who critically need its services.

This project, along with UCMC's work with 12 other hospitals and community health centers in the South Side Healthy Community Organization ("SSHCO"), seeks to solidify UCMC's role as a tertiary and quaternary health care provider in the delivery system on the South Side of Chicago, optimizing access to advanced cancer care, and continuing to link patients with primary care. The SSHCO will also dedicate access specifically to FQHC referrals in order to meet the needs of the most vulnerable patients and to enhance completion rates of referrals to specialty care.

The new facility would continue to be located in Planning Area A-03.

Criterion 1110.130 (b) MASTER PLAN OR RELTED FUTURE PROJECTS

The anticipated completion date(s) for the future construction or modernization projects;

The master design project should be completed by December 31st, 2023. At this time, it is anticipated that construction of the cancer hospital would be December 31st, 2026. All necessary regulatory approvals, including CON permit, will be obtained.

Evidence that the proposed number of beds and services to be developed pursuant to the master design project must be consistent with the bed or service need determination of 77 Ill. Adm. Code. 1100; or if bed or service need determinations do not support the proposed number of beds and services, there are existing factors that support the need for that development at the time of project completion.

Although programming for the cancer center will be subject to change while the design phase is in progress, the following services are the current estimates of what the net impact on services with specific review criteria will be when the new cancer center building is complete:

- 112 additional Medical-Surgical Beds
- 16 additional ICU Beds
- 3 Linear Accelerators and 2 CT Simulators for Radiation Therapy – a reduction from the current 4 Linear Accelerators and 3 CT Simulators
    - A combination of relocating current equipment and purchasing new equipment to replace current equipment is yet to be determined
- Shell space suitable for either an additional Linear Accelerator or equipment for a new technology related to Radiation Therapy in the future

- Relocation of Mammography and Breast Ultrasound equipment from the current location in UCMC's ambulatory center
- Relocation of PET equipment from the current location in UCMC's ambulatory center
- One additional MRI unit
- One additional CT Scan unit

Evidence will be summarized below for the services above that are a net increase: Medical-Surgical Beds, ICU Beds, MRI, and CT Scan. The other services noted above will be relocated from current locations on campus, either moving current equipment, or retiring current equipment and replacing with new equipment. When there will be no net increase in the number of machines, evidence for an increase in utilization will not be addressed in this application.

According to the Inventory of Health Care Facilities and Services and Need Determination released in October 2021, Planning Area A-03 has a combined excess of 518 medical surgical and pediatric beds. However, the medical-surgical beds across the planning area are not interchangeable, and the raw bed numbers provide an incomplete picture of the need for inpatient capacity in Planning Area A-03. The acuity mix of UCMC is more than 45% higher than that of any other hospital in the Planning Area, meaning that UCMC's medical surgical and ICU beds are used for more acutely ill patients – see table below. UCMC also sees a higher volume of patients. In 2019, UCMC had close to 24,000 admissions with the next highest hospital in its planning area – Mercy – had only a fourth as many admissions. In 2021, UCMC had more than 25,000 admissions even when excluding pediatric and obstetric patients – see table below. And these admissions do not account for the hundreds of transfer requests from nearby safety net hospitals that UCMC must turn down because of its shortage of available beds.

Hospital	Discharges of Patients Age 18 and Over, Excluding Obstetrics (7/1/20 to 6/30/21)	Case Mix Index
University of Chicago Medical Center	25,446	2.444
Advocate Trinity	5,975	1.671
Insight Hospital and Medical Center	2,339	1.530
Holy Cross Hospital	3,969	1.461
South Shore Hospital	744	1.433
St. Bernard Hospital	3,793	1.313
Roseland Community Hospital	2,466	1.304
Jackson Park Hospital	2,187	1.237
Provident Hospital	366	1.196

Source: IHA COMPData

As part of the ongoing renovation of Mitchell Hospital as part of CON Project 16-008, UCMC has not staffed the full complement of licensed Medical-Surgical beds as units are opened and closed for renovation work. The number of staffed beds has gone up in stages, starting in May 2018 through December 2021. During this bed expansion over time, with the exception of the first three months at the beginning of the COVID-19 pandemic in spring 2020, the staffed Medical-Surgical beds ran above 90% utilization each month. Similarly, the full complement of ICU beds has not yet been opened during renovation, yet ICU beds ran at greater than 60% utilization of the licensed number of beds from 2017 to present, even during 2020 when the onset of COVID-19 caused the cancellation of elective procedures and inpatient stays. In the summer

and fall of 2021, ICU occupancy often exceeded 90% utilization. Bed utilization data is presented in detail in the next section of this application. Planning Area A-03 is still an underserved area, especially when compared to the outmigration in its area.

The rate of cancer is increasing overall, with the incidence higher in the South Side communities than elsewhere in the city and state, but the demand for cancer treatment is not felt equally among providers. The increased demand for cancer care may soon outpace capacity of hospitals and inhibit their ability to provide timely treatment. Both the high acuity that UCMC treats and the incidence of cancer on the South Side, contribute to the pressing need for additional beds. A recently retrospective, hospital-level study using data from the National Cancer Database from January 1, 2007, to December 31, 2016, found that patient volume increased more rapidly at NCI-designated and academic centers than at community hospitals, with particularly high growth at referral centers at NCI-designated facilities. Specifically, in this study sample that included more than four million patients treated at 1351 hospitals, patient volume increased 40% at NCI centers, 25% at academic centers, and 8% at community hospitals. The mean annual patient volume growth rate was 45.2 patients at NCI hospitals and 13.9 patients at academic hospitals compared with 2.0 patients at community hospitals [7]

The study also found that, for most of the cancers studied, TTI increased regardless of hospital type. This trend may partially reflect the increasing complexity of treatment decisions and a desire to consider the results of molecular testing when making frontline treatment decisions. Because of the potential association of such delays with emotional distress and survival, continued efforts to ensure timely cancer treatment are warranted.

The health care needs of the population in Planning Area A-03 are also unique, with some of the highest rates of disease and mortality, which has only been compounded by the COVID-19 public health emergency. This incidence of disease isn't accounted for the bed utilization predicted for the future and only amplifies the critical need for additional resources.

It has been over a year since the COVID-19 pandemic created an unprecedented public health crisis throughout the world. Although the threat of COVID-19 has decreased due to vaccination efforts, its devastating effects will be felt for years to come. Especially concerning is the drop in cancer screening rates, with the most dramatic reduction in screening occurring in medically underserved communities. This has led to decreases in diagnosis and treatment and is expected to result in thousands of preventable deaths.

According to the Centers for Disease Control and Prevention, the screening rates for breast and cervical cancers fell by more than 80%, with the most severe declines occurring in populations of low-income women of color.

The threat of worsening cancer outcomes has been recognized by the international cancer research community as a leading priority. In a June 2020 editorial, the director of the National Cancer Institute, expressed concerns about the mortality related to breast and colorectal cancer in

[7] Frosch ZAK, Illenberger N, Mitra N, et al. Trends in Patient Volume by Hospital Type and the Association of These Trends With Time to Cancer Treatment Initiation. *JAMA Netw Open.* 2021;4(7):e2115675. doi:10.1001/jamanetworkopen.2021.15675

particular. Early projections showed that if these trends continue, mortality for these cancer types is expected to increase by nearly 10,000 in the next 10 years in the U.S. alone as a result of missed cancer screenings and treatment, assuming a disruption of 6 months. However, the pandemic has lasted far longer than anyone anticipated, so the effects could be greater. It is not surprising that the underserved communities comprising Black and Hispanic people are disproportionately affected.

Both due to the high acuity that UCMC treats and the incidence of disease, including cancer on the South Side, contribute to the pressing need for additional beds to ensure timely access to care.
The addition of beds will not cause any duplication of services because of the different roles served by UCMC as an academic medical center providing tertiary and quaternary care and the community hospitals with a primary and secondary care focus.

Evidence that the utilization of the proposed beds and services will meet or exceed the utilization targets established in 77 Ill. Adm Code 1100 within 2 years after completion of the future construction or modification projects. Documentation shall include:

a. Historical service/bed utilization levels;
b. Projected trends in utilization, including the rationale and projection assumptions used in those projections;
c. Anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
d. Anticipated changes in the delivery of the service due to changes in technology, are delivery techniques or physician availability that would support the projected utilization levels.

Medical-Surgical Beds

UCMC is currently renovating beds in Mitchell Hospital as part of CON Project 16-008, which was altered in September 2021, and is now licensed for 481 Medical-Surgical beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 300 Medical-Surgical beds at that time. Thirty-eight (38) additional Medical-Surgical bed licenses were then added as part of CON Project 13-025 in October 2013, which reactivated beds in Mitchell Hospital. CON Project 16-008 was then approved in May 2016, and an alteration was approved in September 2021.

UCMC anticipates that 116 additional Medical-Surgical bed licenses will be requested in the CON application subsequent to this Master Design Project, which would bring the total Medical-Surgical beds licenses up to 597.

The Medical-Surgical bed units are being renovated in stages, and UCMC has not yet opened its full complement of 481 licensed Medical-Surgical beds, which prevents it from demonstrating that it exceeds 90% utilization for two consecutive years. However, with the exception of the initial COVID-19 surge in spring of 2020 when elective patient activity was significantly

downscaled, UCMC has consistently run the Medical-Surgical beds that were available for staffing at the time at greater than 90% utilization.

The growth in utilization from 2013 to 2021, projected forward to 2029, which will be the 2nd year of operation of the new beds, justifies up to 718 Medical-Surgical beds at 90% utilization, as shown in the tables below. This exceeds the 597 Medical-Surgical beds anticipated. Note that the years shown below are based on UCMC fiscal years ending June 30th of each year.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
	Med/Surg Beds			90% Utilization	
2013	300	90,841		83%	NO
2014	338	104,256		85%	NO
2015	338	115,122		93%	YES
2016	506	118,273		64%	NO
2017	506	122,036		66%	NO
2018	506	133,479		72%	NO
2019	506	141,480		77%	NO
2020	506	130,579		71%	NO
2021	506	146,401		79%	NO
2022	481*		157,594	90%	
2023	597		168,786	77%	
2024	597		179,979	83%	
2025	597		191,172	88%	
2026	597		202,364	93%	
2027	597		213,557	98%	
2028	597		224,750	>100%	
2029	597		235,943	>100%	YES

* Licensed Medical-Surgical beds changed in September 2021 as part of alteration of CON Project 16-008

Justification for added beds:

Calculation of Beds Justified Two Years After Project Completion		
Year	Med/Surg Days	Comments
Historical, year ending 6/30:		
2013	90,841	
2014	104,256	
2015	115,122	
2016	118,273	
2017	122,036	
2018	133,479	
2019	141,480	
2020	130,579	
2021	146,401	
Average annual growth rate = 7.65% (61.16% total growth from 2013 to 2021)		
Projected:		At 7.65% per year
2022	157,594	
2023	168,786	

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2024	179,979	
2025	191,172	
2026	202,364	
2027	213,557	Occupy new beds
2028	224,750	
2029	235,943	2 years after operations begin

- Beds justified at 90% occupancy = 235,943/365/0.90 = 718
- Beds requested = 597 Medical-Surgical beds (481 current Medical-Surgical beds + 116 new Medical-Surgical beds)

Notes: This table includes observation patients treated in licensed Medical-Surgical beds; UCMC has operated dedicated observation beds starting in FY14 and continuing to present; at present UCMC has 30 dedicated observation beds set up and staffed; days in dedicated observation beds are not included

Data Source: EPIC ADT System – Midnight Census

ICU Beds

UCMC is currently renovating beds in Mitchell Hospital as part of CON Project 16-008, which was altered in September 2021, and is now licensed for 142 ICU beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 114 ICU beds at that time. Twelve ("12") additional ICU bed licenses were then added as part of CON Project 14-013 in August 2014, which was a project to build out the shelled space on the 3rd and 4th floors of the Center for Care and Discovery, relocate beds to those floors, and add ICU beds. CON Project 16-008 was then approved in May 2016, and an alteration was approved in September 2021.

UCMC has exceeded 60% utilization for ICU beds each year since 2017, based on a license for 146 ICU beds, which has since been reduced to 142. The 37,663 patient days seen in FY21would justify 172 ICU beds at 60% utilization.

UCMC anticipates that 12 additional ICU bed licenses will be requested in the CON application subsequent to this Master Design Project, which would bring the total ICU bed licenses up to 154. The requested number is lower than the 172 justified above.

In addition, if the same method of growth used previously to evaluate need for Medical-Surgical beds is applied to ICU beds, volumes justify up to 244 ICU beds at 60% utilization in 2029, which would be the 2nd year of operation of the new building, as shown in the tables below. Note that the years shown below are based on UCMC fiscal years ending June 30th of each year.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
	ICU Beds			**60% Utilization**	

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2013	114	26,544		64%	YES
2014	114	28,898		69%	YES
2015	126	31,290		68%	YES
2016	146	31,114		58%	NO
2017	146	32,629		61%	YES
2018	146	35,254		66%	YES
2019	146	36,348		68%	YES
2020	146	35,000		65%	YES
2021	146	37,663		71%	YES
2022	142*		39,635	76%	
2023	158		41,607	72%	
2024	158		43,579	76%	
2025	158		45,551	79%	
2026	158		47,523	82%	
2027	158		49,495	86%	
2028	158		51,468	89%	
2029	158		53,440	93%	**YES**

Justification for added beds:

Calculation of Beds Justified Two Years After Project Completion		
Year	**ICU Days**	**Comments**
Historical, year ending 6/30:		
2013	26,544	
2014	28,898	
2015	31,290	
2016	31,114	
2017	32,629	
2018	35,254	
2019	36,348	
2020	35,000	
2021	37,663	
Average annual growth rate = 5.24% (41.89% total growth from 2013 to 2021)		
Projected:		At 5.24% per year
2022	39,635	
2023	41,607	
2024	43,579	
2025	45,551	
2026	47,523	
2027	49,495	Occupy new beds
2028	51,468	
2029	53,440	2 years after operations begin

Beds justified at 60% occupancy = 53,440/365/0.60 = 244
Beds requested = 154 ICU beds (142 current ICU beds + 12 new ICU beds)

Source: EPIC ADT System – Midnight Census

CT Scan

In CY20, UCMC's CT Scan utilization justified 11 units, and in CY21 justified 13 units, based on the state standard, and the rounding up methodology. UCMC anticipates requesting one additional CT Scan unit as part of the cancer center project, bringing the total from 8 units to 9

units, which is still below the number justified by the state standard. In addition, an increase of utilization proportional to the increase in staffed beds expected by CY29 (20%) would justify 15 CT Scan units, which is also more than the 9 units expected at that time.

Note that the years shown below are based on Calendar Years ending December 31st of each year, consistent with the IDPH Annual Questionnaire.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
	CT Scan			**7,000 Visits Per Machine Per Year**	
2016	7 Units	44,764		49,000	YES
2017	8 Units	50,567		56,000	YES
2018	8 Units	64,393		56,000	YES
2019	8 Units	70,063		56,000	YES
2020	8 Units	71,548		56,000	YES
2021	8 Units	84,053		56,000	YES
2022	8 Units		85,734	56,000	
2023	8 Units		85,734	56,000	
2024	8 Units		85,734	56,000	
2025	8 Units		85,734	56,000	
2026	8 Units		85,734	56,000	
2027	9 Units		100,864	63,000	
2028	9 Units		100,864	63,000	**YES**

Justification for added CT Scan:

Calculation of Beds Justified Two Years After Project Completion		
Year	**CT Scan Visits**	**Comments**
Historical, year ending 12/31:		
2016	44,764	
2017	50,567	
2018	64,393	
2019	70,063	
2020	71,548	
2021	84,053	
Projected:		
2022	85,734	2% Growth in Staffed Beds
2023	85,734	
2024	85,734	
2025	85,734	
2026	85,734	
2027	100,864	18% Growth in Staffed Beds
2028	100,864	

CT Scan justified at 7,000 visits per machine = 15 (100,864 visits / 7,000 visits per machine – rounded up)

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MRI

In CY20, UCMC's MRI utilization justified 9 units, and in CY21 justified 11 units, based on the state standard, and the rounding up methodology. UCMC anticipates requesting one additional MRI unit as part of the cancer center project, bringing the total from 9 units to 10 units, which is still below the number justified by the state standard. In addition, an increase of utilization proportional to the increase in staffed beds expected by CY29 (20%) would justify 13 MRI units, which is also more than the 10 units expected at that time.

Note that the years shown below are based on Calendar Years ending December 31st of each year, consistent with the IDPH Annual Questionnaire.

	UTILIZATION				
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
	MRI			**2,500 Procedures Per Machine Per Year**	
2016	9 Units	20,640		22,500	YES
2017	9 Units	22,549		22,500	YES
2018	9 Units	22,659		22,500	YES
2019	9 Units	24,259		22,500	YES
2020	9 Units	21,723		22,500	YES
2021	9 Units	26,557		22,500	YES
2022	9 Units		27,088	22,500	
2023	9 Units		27,088	22,500	
2024	9 Units		27,088	22,500	
2025	9 Units		27,088	22,500	
2026	9 Units		27,088	22,500	
2027	10 Units		31,868	25,000	
2028	10 Units		31,868	25,000	**YES**

Justification for added MRI:

Calculation of Beds Justified Two Years After Project Completion		
Year	**MRI Procedures**	**Comments**
Historical, year ending 12/31:		
2016	20,640	
2017	22,549	
2018	22,659	
2019	24,259	
2020	21,723	
2021	26,557	
Projected:		
2022	27,088	2% Growth in Staffed Beds
2023	27,088	
2024	27,088	

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2025	27,088	
2026	27,088	
2027	31,868	18% Growth in Staffed Beds
2028	31,868	

MRI justified at 2,500 visits per machine = 13 (31,868 visits / 2,500 visits per machine – rounded up)

Criterion 1110.130 (c) RELATIONSHIP TO PREVIOUSLY APPROVED MASTER DESIGN PROJECTS

1. Schematic architectural plans for all construction or modification approved in the master design permit;

2. The estimated project cost for the proposed project and also for the total construction/modification project approved in the master design permit;

3. An item by item comparison of the construction elements (i.e., site, number of buildings, number of floors, etc.) in the proposed project to the approved master design permit; and

4. A comparison of proposed beds and services to those approved under the master design permit.

This section will be addressed in the subsequent construction CON application.

Section V, Clinical Service Areas Other Than Categories of Service

Attachment 30

Clinical Services Other Than Categories of Service

Discussion of these services is included in Attachment 18. Those services will be more directly addressed in the Construction CON Application.

Section VI, Availability of Funds

Attachment 33

Because UCMC 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, this Section is not applicable. A copy of UCMC's bond ratings letters are included in Attachment 34.

Attachment 34

Financial Viability Waiver

UCMC's most recent bond ratings from Fitch Ratings (AA-), Standard & Poor's (AA-) and Moody's (A1) are attached.

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The University of Chicago Medical Center
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527

Dear Ms. McColgan:

We wish to inform you that on December 3, 2019, Moody's Investors Service downgraded UCMC's long term rating to **A1** from **Aa3**. At the same time, Moody's upgraded Ingalls Health System's (IL) rating to **A1** from **Baa2**. The outlook for both UCMC and Ingalls Health System has been revised to **stable** from **negative**.

Credit ratings issued by Moody's Investors Service, Inc. and its affiliates ("Moody's") are Moody's current opinions of the relative future credit risk of entities, credit commitments, or debt or debt-like securities and are not statements of current or historical fact. Moody's credit ratings address credit risk only and do not address any other risk, including but not limited to: liquidity risk, market value risk, or price volatility.

This letter uses capitalized terms and rating symbols that are defined or referenced either in *Moody's Definitions and Symbols Guide* or *MIS Code of Professional Conduct* as of the date of this letter, both published on www.moodys.com. The Credit Ratings will be publicly disseminated by Moody's through normal print and electronic media as well as in response to verbal requests to Moody's Rating Desk. Moody's related research and analyses will also be published on www.moodys.com and may be further distributed as otherwise agreed in writing with us.

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March 31, 2020

Ms. Ann McColgan
Vice President, Chief Treasury Officer
The University of Chicago Medical Center
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527

and required consents to disclose the information to Moody's, and that such information is not subject to any restrictions that would prevent use by Moody's for its ratings process. In assigning the Credit Ratings, Moody's has relied upon the truth, accuracy, and completeness of the information supplied by you or on your behalf to Moody's. Moody's expects that you will, and is relying upon you to, on an ongoing basis, promptly provide Moody's with all information necessary in order for Moody's to accurately and timely monitor the Credit Ratings, including current financial and statistical information.

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If there is a conflict between the terms of this rating letter and any related Moody's rating application, the terms of the executed rating application will govern and supercede this rating letter.

Should you have any questions regarding the above, please do not hesitate to contact the analyst assigned to this transaction, Diana Lee at 212-553-4747.

Sincerely,

Moody's Investors Service Inc.

Moody's Investors Service Inc.

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FitchRatings

RATING ACTION COMMENTARY

Fitch Affirms University of Chicago Medical Center's (IL) IDR at 'AA-'; Outlook Stable

Thu 18 Mar, 2021 - 2:00 PM ET

Fitch Ratings - Chicago - 18 Mar 2021: Fitch Ratings has affirmed University of Chicago Medical Center's (UCMC) 'AA-' Issuer Default Rating (IDR) and the 'AA-' rating on approximately $584 million of revenue bonds issued by the Illinois Finance Authority on behalf of the UCMC obligated group.

The Rating Outlook remains Stable.

SECURITY

Debt payments are secured by a pledge of unrestricted receivables of the UCMC obligated group. The obligated group includes the majority of UCMC activities. The obligated group was amended in June 2019 to include the majority of Ingalls Health System operations (including Ingalls Memorial Hospital). Ingalls is now the core of UCMC's Community Health and Hospital Division (CHHD). The University of Chicago (UChicago, IDR: AA+) is not obligated on UCMC bonds.

(Unless otherwise noted, "UCMC" refers collectively to the flagship academic medical center (AMC) medical center campus located on the UChicago campus and CHHD.)

ANALYTICAL CONCLUSION

The 'AA-' rating is driven by UCMC's strong financial profile assessment in the context of the system's midrange revenue defensibility and strong operating risk profile assessments. UCMC's operating margins continue to be affected by the coronavirus pandemic. Fitch believes that the system's operating platform remains fundamentally strong, in part because of the very tight alignment with UChicago and UCMC's broad reach of high-acuity services. Fitch expects UCMC's capital-related ratios to remain strong in its forward-looking scenario analysis. These characteristics are balanced by a high degree of competition in the Chicago area and continued challenges at CHHD.

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The outbreak of coronavirus created an uncertain and generally challenging environment for the entire healthcare industry. While Fitch expects the not-for-profit healthcare sector to continue to face uncertainty and considerable pressure in the coming months, with the rollout of coronavirus vaccines, the long-term outlook for the sector should stabilize.

UCMC's Outlook remains Stable, although capital-related ratios are on the lower end of the 'AA' financial profile when subjected to a stress event in its forward-looking scenario analysis. If the coronavirus or any other operating disruption affects UCMC disproportionally a downgrade could be warranted over the longer term.

KEY RATING DRIVERS

Revenue Defensibility: 'bbb'

Broad Reach for High-Acuity Services in a Competitive Market

UCMC faces significant competition in the Chicago area, including from other prominent AMCs. The system has considerable reach for high-acuity academic services. Moreover, UCMC is a component unit of the UChicago. The service area quality of the broad Chicago area is generally stable, despite the ongoing pressures from the coronavirus and related economic challenges.

Operating Risk: 'a'

Operating Margins Pressured by Coronavirus, Long-Term Rebound Expected

UCMC's operating risk profile is considered reasonably strong, despite the pressures from the coronavirus pandemic. Over the longer term, Fitch expects the system's operating EBITDA margin to remain broadly consistent with a strong profile. Capital spending plans are manageable and remain flexible.

Financial Profile: 'aa'

Strong Capital-Related Ratios in the Forward Look Despite the Pandemic

UCMC's financial profile remains strong, despite pressures from the coronavirus pandemic.

ASYMMETRIC ADDITIONAL RISK CONSIDERATIONS

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There are no asymmetric risk factors associated with UCMC's rating.

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RATING SENSITIVITIES

Factors that could, individually or collectively, lead to positive rating action/upgrade:

--Maintenance of adjusted operating EBITDA margin consistently above 9%;

--Considerable rebound in unrestricted liquidity levels leading to much stronger capital-related ratios, such as a cash-to-adjusted debt ratio in excess of 200%.

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

--Greater and longer than expected compression in operating margins beyond what Fitch currently expects, particularly if the operating EBITDA margin is expected to remain notably below 7% for an extended period, which would lead to an operating risk profile more consistent with a midrange assessment;

--Weaker balance sheet metrics -- either increased liabilities (e.g., defined benefit pension obligations) or lower unrestricted liquidity -- leading to thinner capital-related ratios in the long term more consistent with an 'a' assessment.

BEST/WORST CASE RATING SCENARIO

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

CREDIT PROFILE

UCMC is a major AMC system, whose flagship location is on the campus of UChicago. In 2016, Ingalls joined UCMC, and now constitutes the majority of UCMC's CHHD. While UChicago is not obligated on UCMC's bonds, UCMC is a component unit of the university and there is very tight alignment between the two organizations (UChicago would be required to assume UCMC's debt only if the university terminated its affiliation agreement or lease with the medical center). UCMC's total operating revenue measured more than $2.5 billion in audited fiscal 2020 (June 30 year-end), which includes CHHD.

Feedback

REVENUE DEFENSIBILITY

UCMC's payor mix is modest. Combined Medicaid and self-pay accounted for roughly 28% of gross revenue in fiscal 2020. As an AMC with trauma services and a sizeable children's hospital (Comer Children's Hospital), high exposure to Medicaid is expected and is not reflective of the overall financial health of UCM. Both Illinois and Indiana expanded Medicaid under the Affordable Care Act (ACA).

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Despite facing considerable competition in the service area, Fitch considers UCMC's market position to be consistent with a midrange assessment. The primary service area (PSA) includes the south Chicago metro area and extends well into Northwest Indiana. The total service area (TSA) extends throughout the entirety of the Chicago metro area.

The TSA is very competitive, with no individual hospital capturing more than 4.8% market share (Northwestern Memorial Hospital, flagship of AA+ rated Northwestern Memorial HealthCare). UCMC is the third largest hospital in the TSA by market share, capturing 3.4% TSA share in fiscal 2020 (up steadily from 2.1% in calendar 2012, due to growth strategies in recent years).

UCMC achieves the midrange market position due to the system's considerable reach for very high-acuity services aided by the very tight relationship with UChicago. UCMC is among the industry national leaders for research-oriented academic clinical services, including oncology. The university is the sole corporate member of UCMC and appoints the entirety of the board. To illustrate the level of integration, the UChicago's Biological Sciences Division (BSD), of which UCMC is a fundamental part, comprises roughly half of the university's budget. In addition to governance overlap, there is considerable management integration between UCMC and the university; for example, Dr. Kenneth Polonsky, the Executive Vice President of the BSD is also the President of the UChicago Medicine Health System (of which UCMC is the majority component).

The service area economy is broadly stable, although like the metro region continues to be affected by the current economic environment. Nevertheless, as a major metro area, Chicago benefits from a diversified economy. Population trends in Cook County are stagnant to declining. Will County, immediately south of Cook, has experienced modest population growth. The median household income level in Cook County is just above the national average, and well above average in Will County. The unemployment rate in the Chicago-Naperville-Elgin MSA as of the December 2020 preliminary data was the national average (per the U.S. Bureau of Labor Statistics).

OPERATING RISK

Fitch expects UCMC's operating EBITDA margin in the long-term to remain consistent with a moderately strong profile assessment, although recognizes that the coronavirus pandemic and related economic pressures will continue to present headwinds to operating results. Prior to the outbreak, management was already engaged in a material expense savings initiative and Fitch believes that UCMC's operating platform is fundamentally sound, and long-term the adjusted operating EBITDA margin should remain in the 8% range.

Prior to the coronavirus, UCMC's adjusted operating EBITDA margin averaged nearly 8% between fiscal 2015 and fiscal 2019 (Fitch treats equity transfers to the university as an operating expense; while Fitch considers the roughly $72 million transfer as an operating expense, this expense represents investments in UCMC's operating platform supporting areas such as clinical research and physician integration.) UCMC's operating EBITDA margin compressed to 5.9% in fiscal 2018, due in part to continued integration of the CHHD into the system. The margin rebounded to adjusted 7.4% in fiscal 2019.

In fiscal 2020, UCMC's adjusted operating margin measured -0.8% and operating EBITDA margin 6.0%. Like virtually all health systems in the U.S., UCMC faced considerable operating pressure from the coronavirus. Expenses increased above budget as the system secured PPE, ventilators, and other needed equipment as well as incurring labor premium

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in response to the pandemic. Top-line revenue was affected considerably by the restrictions on elective procedures that were put in place in late March and not lifted until early May.

Operating results in fiscal 2020 were balanced in part by the Coronavirus Aid, Relief and Economic Security (CARES) Act and related stimulus funds. UCMC recognized $149 million in fiscal 2020. While the stimulus funds bolstered margins considerably, they did not balance completely UCMC's revenue loss or added expenses.

The operating results in fiscal 2020 are notable given that prior to the pandemic UCMC faced a nurse labor stoppage in September 2019 and the threat of a second stoppage in November, the combination of which cost the system approximately $25 million.

Management implemented a number of actions in response to the coronavirus, including acquiring PPE (at a premium), developing in-house testing, cutting capital spending, and securing a $100 million line of credit as additional liquidity support. Also, management has a $360 million improvement plan (expense savings and revenue enhancements) much of which was launched prior to the pandemic. The improvement plan includes one-time temporary expense cuts related to the coronavirus (such as senior management wage freezes and suspension of defined contribution pension matches), as well as more fundamental long-term improvements such as continued growth in cancer services, reduced lease expenses as more employees move to a work-from-home environment and a variety of targets at CHHD (e.g., revenue cycle, improved labor productivity, and furlough of non-clinical staff). Also, as part of UCMC's pandemic action plan, management notes that essentially all UCMC employees have been vaccinated.

Moving forward, over the long term, Fitch expects UCMC to generate an adjusted operating EBITDA margin in the 8% range. Because of the receipt of CARES Act and related stimulus funds as well as management's ongoing expense savings plans (which were initiated prior to the pandemic), UCMC's operating margins should be strong in fiscal 2021. Through the first six-months of fiscal 2021, UCMC recorded an operating margin and operating EBITDA margin of 3.4% and 9.7%, respectively (treating the transfers to UChicago as an operating expense). The interim results include approximately $27 million of CARES Act funds, roughly $18 million of which was used to fund employee compensation to recognize the challenging work environment during the pandemic.

Most key volumes have rebounded to levels roughly 95% of trend prior to the pandemic, and management notes that cancer and heart/vascular transplant volumes are ahead of pace. Like most health systems, ED volumes continue to lag. Results in fiscal 2022 should temper as the top-line revenue boost from the stimulus funds fade, but Fitch expects UCMC's operating EBITDA margin to be in the 8% range in the long term.

UCMC's capital expenditure requirements are manageable. The system has invested in property and plant in recent years, as the capital spending ratio averaged approximately 1.3x over the last five years through fiscal 2020. This has translated to a favorably low average age of plant of 9.0 years at FYE 2020 (AA median is 10.5 years). The legacy UCMC deployed the Epic electronic medical record (EMR) system in 2016; Ingalls Hospital currently is on the Cerner EMR, but management is converting the CHHD to Epic. Moving forward, management expects to invest in capital at a pace consistent with cash flow generation.

UCMC does not have new money debt plans in the near term. It is Fitch's opinion that the Chicago market is on a path to further consolidation, even with the coronavirus pandemic. This may present UCMC with strategic decisions to make in the future.

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FINANCIAL PROFILE

UCMC's financial profile remains strong, despite pressures from the coronavirus pandemic. Forward-looking capital-related ratios are consistent with a 'aa' financial profile even in a stress scenario, given UCMC's midrange revenue defensibility and strong operating risk assessments.

At FYE 2020 (June 30 year-end), UCMC had just over $1 billion of total direct debt outstanding (inclusive of operating leases, which are now captured on the balance sheet) and unrestricted cash and investments measured better than $1.5 billion (excluding Medicare advance payment funds).

UCMC's debt equivalents are manageable. The system participates in UChicago's defined benefit (DB) pension plan. The UChicago DB pension sits on the university's audit and ultimately is the responsibility of UChicago; per UChicago and UCMC management, UCMC accounts for approximately 40% of the DB plan's contributions and expenses, and therefore Fitch includes 40% of the plans projected benefit obligation (PBO) and 40% of the fair value of plan assets when calculating UCMC's DB pension debt equivalent. Along with a small plan held directly by UCMC, the combined DB pension plans were 76% funded at FYE 2020 compared to a PBO of just under $480 million.

Fitch only includes the portion of DB pensions funded below 80% in the calculation of adjusted debt; consequently, the debt equivalent of UCMC's DB pensions was less than $20 million at FYE 2020. As a result, UCMC's adjusted debt (direct debt plus underfunded DB pension plan below 80% funded) is only marginally more than direct debt. Net adjusted debt (adjusted debt minus unrestricted cash and investments) was favorably negative at FYE 2020, totally approximately -$470 million.

UCMC's capital-related ratios should remain consistent with the lower-end of the 'AA' rating category in Fitch's forward-looking scenario analysis, including in a stress case. Based on fiscal 2020 results, net adjusted debt-to-adjusted EBITDA was favorably negative, measuring -2.3x while cash-to-adjusted debt totaled approximately 145%. In the scenario analysis, net adjusted debt-to-adjusted EBITDA remains favorably negative in each year of the forward-look, including in the stress case. Cash-to-adjusted debt exceeds 120% in every year of the base case (and approaches 160% by year five), and it exceeds 120% by year three of the stress case.

ASYMMETRIC ADDITIONAL RISK CONSIDERATIONS

There are no asymmetric risk factors associated with UCMC's rating.

UCMC's former President, Sharon O'Keefe, retired in 2020. Thomas Jackiewicz was appointed President of UCMC and COO of the UChicago Medicine Health System in May 2020. Mr. Jackiewicz previously served as the CEO of Keck Medicine at the University of Southern California.

With more than $1.5 billion in unrestricted cash and investments at FYE 2020, UCMC's cash on hand measured nearly 230 days (excluding Medicare advances). Liquidity does not pose an asymmetric risk.

Debt Structure

UCMC's maximum annual debt service (MADS) is $59 million, inclusive of Ingalls debt. MADS coverage was 3.4x based on fiscal 2020 results and does not pose an asymmetric risk. Just over 50% of debt is variable rate, a portion of which is demand debt in the form of CP and variable rate demand bonds (VRDB). The VRDBs are supported by LOCs with five banks: JPMorgan Chase, PNC, Wells Fargo, Bank of America, and Sumitomo Bank. The LOCs have staggered termination dates, ranging between May 2021 and June 2022. UCMC has three fixed payor interest rate swaps, with a

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total notional amount outstanding of approximately $363 million at FYE 2020. The combined net termination value of the swaps was a liability to UCMC of nearly $194 million at FYE 2020.

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

REFERENCES FOR SUBSTANTIALLY MATERIAL SOURCE CITED AS KEY DRIVER OF RATING

The principal sources of information used in the analysis are described in the Applicable Criteria.

ESG CONSIDERATIONS

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

RATING ACTIONS

ENTITY/DEBT	RATING			PRIOR
University of Chicago Medical Center (IL)	LT IDR	AA- Rating Outlook Stable	Affirmed	AA- Rating Outlook Stable
• University of Chicago Medical Center (IL) /General Revenues/1 LT	LT	AA- Rating Outlook Stable	Affirmed	AA- Rating Outlook Stable

VIEW ADDITIONAL RATING DETAILS

Feedback

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Additional information is available on www.fitchratings.com

APPLICABLE CRITERIA

U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria (pub. 18 Nov 2020) (including rating assumption sensitivity)

Public Sector, Revenue-Supported Entities Rating Criteria (pub. 23 Feb 2021) (including rating assumption sensitivity)

APPLICABLE MODELS

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

Portfolio Analysis Model (PAM), v1.3.2 (1)

ADDITIONAL DISCLOSURES

Dodd-Frank Rating Information Disclosure Form

Solicitation Status

Endorsement Policy

ENDORSEMENT STATUS

Illinois Finance Authority (IL)	EU Endorsed, UK Endorsed

Feedback

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The ratings above were solicited and assigned or maintained at the request of the rated entity/issuer or a related third party. Any exceptions follow below.

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US Public Finance Healthcare and Pharma North America United States

Feedback

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S&P Global
Ratings

130 East Randolph Street
Suite 2500
Chicago, IL 60601
tel 312-233-7000

October 21, 2021

The University of Chicago Medical Center
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527
Attention: Ms. Ann M. McColgan, Treasurer

Re: ***Illinois Finance Authority, (University of Chicago Medical Center), Illinois***

Dear Ms. McColgan:
S&P Global Ratings hereby affirms its rating of "AA-" for the underlying rating (SPUR) on the above-listed obligations and changed the outlook to stable from negative. A copy of the rationale supporting the rating and outlook is enclosed.
This letter constitutes S&P Global Ratings' permission for you to disseminate the above-assigned ratings to interested parties in accordance with applicable laws and regulations. However, permission for such dissemination (other than to professional advisors bound by appropriate confidentiality arrangements or to allow the Issuer to comply with its regulatory obligations) will become effective only after we have released the ratings on standardandpoors.com. Any dissemination on any Website by you or your agents shall include the full analysis for the rating, including any updates, where applicable. Any such dissemination shall not be done in a manner that would serve as a substitute for any products and services containing S&P Global Ratings' intellectual property for which a fee is charged.

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Please send hard copies to:
S&P Global Ratings
Public Finance Department
55 Water Street
New York, NY 10041-0003

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Sincerely yours,

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Audited Financial Statements

UCMC's financial statements for the years June 30, 2018, 2019 and 2020 were included in the application for permit for Project No. 21-033. That application was filed November 2, 2021 and approved December 14, 2021. Those financial statements are incorporated by reference. Financial Statements for fiscal year 2021 are attached.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Financial Statements

June 30, 2021 and 2020

(With Independent Auditors' Report Thereon)

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Independent Auditors' Report

The Board of Trustees
The University of Chicago Medical Center:

Opinion

We have audited the accompanying consolidated financial statements of The University of Chicago Medical Center, which comprise the consolidated balance sheets as of June 30, 2021 and 2020, and the related consolidated statements of operations and changes in net assets without donor restrictions, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of The University of Chicago Medical Center as of June 30, 2021 and 2020, and the results of its consolidated and changes in net assets without donor restrictions, changes in net assets, and cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

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

Responsibilities of Management for the Consolidated Financial Statements

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

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

Auditors' Responsibilities for the Audits of the Consolidated Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2021 supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is 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 audits 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 of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Chicago, Illinois
October 29, 2021

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Balance Sheets

June 30, 2021 and 2020

(In thousands)

Assets		2021	2020
Current assets:			
Cash and cash equivalents	$	184,639	538,725
Patient accounts receivable		437,141	333,676
Current portion of investments limited to use		247,395	58,500
Current portion of malpractice self-insurance receivable		16,809	14,508
Current portion of pledges receivable		2,289	1,177
Prepaids, inventory, and other current assets		195,394	176,998
Total current assets		1,083,667	1,123,584
Investments limited to use, less current portion		1,722,327	1,227,624
Property, plant, and equipment, net		1,509,150	1,558,348
Pledges receivable, less current portion		5,708	1,521
Malpractice self-insurance receivable, less current portion		90,598	81,091
Other assets, net		122,867	108,664
Total assets	$	4,534,317	4,100,832
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	282,219	256,369
Current portion of long-term debt		22,875	20,430
Current portion of other long-term liabilities		4,775	11,766
Estimated third-party payor settlements and Medicare Advance		454,530	536,847
Current portion of malpractice self-insurance liability		16,809	24,441
Due to University of Chicago		29,809	37,649
Total current liabilities		811,017	887,502
Other liabilities:			
Workers' compensation self-insurance liabilities, less current portion		8,604	9,441
Malpractice self-insurance liability, less current portion		168,640	135,029
Long-term debt, less current portion		937,757	966,406
Interest rate swap liability		147,362	193,907
Other long-term liabilities, less current portion		145,633	112,769
Total liabilities		2,219,013	2,305,054
Net assets:			
Without donor restrictions		2,169,780	1,684,093
With donor restrictions		145,524	111,685
Total net assets		2,315,304	1,795,778
Total liabilities and net assets	$	4,534,317	4,100,832

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Operations and Changes in Net Assets Without Donor Restrictions

Years ended June 30, 2021 and 2020

(In thousands)

	2021	2020
Operating revenues:		
Patient service revenue	$ 2,331,509	2,049,957
Other operating revenues and net assets released from restrictions used for operating purposes	457,645	497,747
Total operating revenues	2,789,154	2,547,704
Operating expenses:		
Salaries, wages, and benefits	1,134,205	1,064,665
Supplies and other	944,587	860,110
Physician services	303,435	301,453
Insurance	39,603	30,055
Interest	39,743	42,257
Medicaid provider tax	75,683	66,640
Depreciation and amortization	132,707	131,609
Total operating expenses	2,669,963	2,496,789
Operating revenue in excess of expenses	119,191	50,915
Nonoperating gains and losses:		
Investment return, net	387,316	31,033
Change in fair value of nonhedged derivative instruments	2,637	(2,318)
Derivative ineffectiveness on hedged derivative instruments	695	(395)
Other, net	(251)	(3,677)
Revenue and gains in excess of expenses and losses	509,588	75,558
Other changes in net assets without donor restrictions:		
Net asset transfers to University of Chicago	(71,750)	(71,750)
Change in accrued pension benefits other than net periodic benefit costs	2,781	(2,823)
Effective portion of change in valuation of derivatives	44,967	(53,268)
Net assets released from restriction for capital purposes	125	5
Distributions and other, net	(24)	(11)
Increase (decrease) in net assets without donor restrictions	$ 485,687	(52,289)

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2021 and 2020

(In thousands)

	2021	2020
Net assets without donor restrictions:		
Revenue and gains in excess of expenses and losses	$ 509,588	75,558
Net asset transfers to University of Chicago, net	(71,750)	(71,750)
Change in accrued pension benefits other than net periodic benefit cost	2,781	(2,823)
Effective portion of change in valuation of derivatives	44,967	(53,268)
Net assets released from restrictions for capital purposes	125	5
Distributions and other, net	(24)	(11)
Increase (decrease) in net assets without donor restrictions	485,687	(52,289)
Net assets with donor restrictions:		
Contributions	12,513	5,671
Net assets released from restrictions used for operating purposes	(8,358)	(8,549)
Investment return, net	29,809	1,477
Net assets released from restrictions for capital purposes	(125)	(5)
Increase (decrease) in temporarily restricted net assets	33,839	(1,406)
Change in net assets	519,526	(53,695)
Net assets at beginning of year	1,795,778	1,849,473
Net assets at end of year	$ 2,315,304	1,795,778

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended June 30, 2021 and 2020

(In thousands)

		2021	2020
Cash flows from operating activities:			
Change in net assets	$	519,526	(53,695)
Adjustments to reconcile change in net assets to net cash provided by operating activities:			
Net change in unrealized gains and losses on investments		(312,323)	19,902
Net asset transfers to University of Chicago		71,750	71,750
Restricted contributions and investment return		(42,322)	(7,148)
Realized gains on investments		(63,880)	(38,505)
Net change in valuation of derivatives		(46,545)	57,721
Change in accrued pension benefits other than net period benefit cost and other		(2,781)	2,823
Loss on refinancing of long-term debt		(832)	2,347
Loss on disposal of assets		235	4,135
Net assets released from restrictions for operations		8,358	8,549
Payment of lease obligations		(10,814)	(8,383)
Depreciation and amortization		132,707	131,609
Changes in assets and liabilities:			
Patient accounts receivable		(103,465)	65,454
Other assets, net		(38,892)	(8,719)
Accounts payable and accrued expenses		21,828	12,013
Due to University of Chicago		(7,840)	6,880
Estimated settlements with third-party payors and Medicare Advance		(82,317)	273,588
Self-insurance liabilities		25,142	18,787
Other liabilities		36,767	27,642
Net cash provided by operating activities		104,293	586,750
Cash flows from investing activities:			
Purchases of property, plant, and equipment		(83,744)	(117,654)
Change in construction payables		4,022	(3,108)
Purchases of investments		(944,485)	(614,131)
Sales of investments		637,099	609,830
Net cash used in investing activities		(387,108)	(125,063)
Cash flows from financing activities:			
Proceeds from issuance of long-term debt, including bond premium		47,270	128,360
Additional repayment of long-term debt		(72,642)	(120,640)
Payments of finance/long-term lease obligation		(8,113)	(31,653)
Net asset transfers to University of Chicago, net		(71,750)	(71,750)
Net assets released from restriction for operations		(8,358)	(8,549)
Restricted contributions and investment return		42,322	7,148
Net cash used in financing activities		(71,271)	(97,084)
Net (decrease) increase in cash and cash equivalents		(354,086)	364,603
Cash and cash equivalents:			
Beginning of year		538,725	174,122
End of year	$	184,639	538,725
Noncash transactions:			
Other assets included for right-of-use assets – operating leases as a result of adopting ASU No. 842, *Leases*	$	60,148	53,042

See accompanying notes to consolidated financial statements.

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(1) Organization and Basis of Presentation

The accompanying consolidated financial statements represent the accounts of The University of Chicago Medical Center and its affiliates (the System). The University of Chicago Medical Center (UCMC) is the parent of an integrated nonprofit healthcare organization, partnering with the University of Chicago Biological Sciences Division, the University of Chicago Pritzker School of Medicine, and the University of Chicago Physicians Group to provide world-class medical care in an academic setting. UCMC operates the Center for Care and Discovery, the Bernard Mitchell Hospital, the Chicago Lying-In Hospital, the University of Chicago Comer Children's Hospital, the Duchossois Center for Advanced Medicine, the University of Chicago Medicine Care Network, the UCM Community Health and Hospital Division, Inc. (CHHD), and various other outpatient clinics and treatment areas.

UCMC's Obligated Group includes the following entities: UCMC (excluding the University of Chicago Medicine Care Network, UCMC Title Holding Corporation, and UCMC Title Holding Corporation II NFP), Ingalls Health System, Ingalls Memorial Hospital, Ingalls Development Foundation, and Ingalls Home Care as presented in the supplemental consolidating schedules. Entities of UCMC that are included in the Non-Obligated Group are the University of Chicago Medicine Care Network, University of Chicago Medicine Medical Group, UCMC Title Holding Corporation, and UCMC Title Holding Corporation II NFP. Entities of CHHD that are included in the Non-Obligated Group are Ingalls Provider Group, Ingalls Care Network, Medcentrix, Ingalls Health Ventures, Ingalls Casualty Insurance, Trulen Insurance SPC Limited, and Ingalls Same Day Surgery. These are presented in the supplemental schedules as "Other Non-Obligated Group Entities" for purposes of consolidation.

The University of Chicago (the University), as the sole corporate member of UCMC, elects UCMC's Board of Trustees (the Board) and approves its bylaws. The UCMC president reports to the University's executive vice president for Medical Affairs. The relationship between UCMC and the University is defined in the Medical Center bylaws, an affiliation agreement, an operating agreement, and several leases. See note 4 for agreements and transactions with the University.

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The consolidated financial statements of the System have been prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles. All significant intercompany accounts and transactions have been eliminated in consolidation.

(b) COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted in the last two weeks of the third quarter of fiscal year 2020 and continued to be impacted in the fourth quarter of 2020. Various policies were implemented by federal, state, and local governments in response to the COVID-19 pandemic that have caused many people to remain at home and forced the closure of or limitations on certain businesses, as well as suspended elective surgical procedures by healthcare facilities. While some of these restrictions have been eased across the U.S. and most states have lifted moratoriums on nonemergent procedures, some restrictions remain in place, and some state and local governments are reimposing certain restrictions due to increasing rates of COVID-19 cases.

During fiscal year 2021 and 2020, the System received approximately $11,136 and $200,643, respectively, in general and targeted Provider Relief Fund distributions, as provided for under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Generally, these distributions from the Provider Relief Fund are not subject to repayment, provided the recipient is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the Provider Relief Fund and the impact of the pandemic on operating results through June 30, 2021, the System recognized through June 30, 2021 and 2020, $61,802 and $149,028, respectively, related to these general distribution funds as part of 'other operating revenue' in the consolidated statements of operations and changes in net assets without donor restrictions. The unrecognized amount of general distributions and targeted distributions are recorded as estimated third-party payor settlements and Medicare Advance in the consolidated balance sheets as of June 30, 2021 and 2020 of $949 and $51,615, respectively. The System will continue to monitor compliance with the terms and conditions of the Provider Relief Fund and the impact of the pandemic on our revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, the ability to retain some or all of the distributions received may be impacted.

On June 11, 2021, the Department of Health and Human Services provided Post-Payment Notice of Reporting Requirements for providers that received funding under the CARES Act. The provisions within this notice provide new guidance on the reporting portal and requirements around healthcare related expenses attributable to COVID-19 and "lost revenue." The guidance provides for various reporting deadlines beginning September 30, 2021 for Period 1 with a 60-day grace period for compliance. The System anticipates meeting the requirements for reporting under the timelines provisioned.

In addition, during the fourth quarter of fiscal year 2020, the System received $214,500 of accelerated Medicare payments under the Medicare Advanced Payment Program (APP). After 120 days of receipt, claims for services provided to Medicare beneficiaries will be applied against the advance payment balance. Any unapplied advance payment amounts must be paid in full within one year from receipt of the advance payments for acute care hospitals. As of June 30, 2021 and 2020, the System has recorded the APP payments as estimated third-party payor settlements and Medicare advance on the consolidated balance sheets of $183,259 and $214,500. On September 30, 2020, federal legislation extended the terms of APP payments such that any claims for services provided to Medicare beneficiaries will be applied against the advance payment balance beginning 365 days after receipt.

The CARES Act also provides for a deferral of payments of the employer portion of social security payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021 and the remaining half until December 2022. The System has deferred payroll taxes and recorded the deferral under the caption of accrued expenses on the consolidated balance sheets at June 30, 2021 for $36,800. Additionally, the CARES Act provides for a payroll tax credit designed to encourage retention of employees during the pandemic. The System is evaluating its eligibility and related data for consideration of the employee retention credit.

(c) *Adoption of New Accounting Standards*

In March 2020, the Financial Accounting Standards Board issued Accounting Standards Update (ASU) 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*. The amendments provide optional guidance for a limited time to ease the potential burden in accounting for reference rate reform. The new guidance provides optional expedients and exceptions for applying U.S. GAAP to contracts, hedging relationships and other transactions affected by reference rate reform if certain criteria are met. The amendments apply only to contracts and hedging relationships that reference London Interbank Rate (LIBOR) or another reference rate expected to be discontinued due to reference rate reform. These amendments are effective immediately and may be applied prospectively to contract modifications made and hedging relationships entered into or evaluated on or before December 31, 2022. The Organization adopted this ASU in March 2020 and the adoption did not have a significant impact on the Organization's consolidated financial statements.

(d) *Use of Estimates*

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

(e) *Community Benefits*

The System's policy is to treat patients in immediate need of medical services without regard to their ability to pay for such services, including patients transferred from other hospitals under the provisions of the Emergency Medical Treatment and Active Labor Act. UCMC also accepts patients through the Perinatal and Pediatric Trauma Networks without regard to their ability to pay for services.

The System developed a Financial Assistance Policy (the Policy) under which patients are offered discounts of up to 100% of charges on a sliding scale. The Policy is based both on income as a percentage of the Federal Poverty Level guidelines and the charges for services rendered. The Policy also contains provisions that are responsive to those patients subject to catastrophic healthcare expenses. Since the System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing care under this Policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2021 and 2020, are reported in note 6.

(f) *Fair Value of Financial Instruments*

Fair value is defined as the price that the System would receive upon selling an asset or pay to settle a liability in an orderly transaction among market participants.

The System uses a framework for measuring fair value that includes a hierarchy that categorizes and prioritizes the sources used to measure and disclose fair value. This hierarchy is broken down into three levels based on inputs that market participants would use in valuing the financial instruments based on market data obtained from sources independent of the System. Inputs refer broadly to the assumptions that market participants would use in pricing the asset, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset developed based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available. The three-tier hierarchy of inputs is summarized in the three broad levels as follows:

Level 1 – Quoted market prices in active markets for identical investments

Level 2 – Inputs other than quoted prices for similar investments in active markets, quoted prices for identical or similar investments in markets that are not active, or inputs other than quoted prices that are observable, including model-based valuation techniques

Level 3 – Valuation techniques that use significant inputs that are unobservable because they trade infrequently or not at all.

(g) Cash and Cash Equivalents

Cash equivalents include U.S. Treasury notes, commercial paper, and corporate notes with original maturities of three months or less, excluding investments whose use is limited. Cash equivalents held by investment managers are treated as investing activity in the consolidated statements of cash flows.

(h) Inventory

The System values inventories at the lower of cost or market using the first-in, first-out method.

(i) Investments

Investments are classified as trading securities. As such, investment return (including realized or changes in unrealized gains and losses on investments, interest, and dividends) is included in excess of revenue and gains over expenses and losses unless the income is restricted by donor or law.

Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by an entity and an active market with quoted prices exists, the market price of an identical security is used as reported fair value. Reported fair values for shares in mutual funds are based on share prices reported by the funds as of the last business day of the fiscal year. The System's interests in alternative investment funds, such as private debt, private equity, real estate, natural resources, and absolute return, are generally reported at the net asset value (NAV) reported by the fund managers, which is used as a practical expedient to estimate the fair value, unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2021 and 2020, the System had no plans to sell investments at amounts different from NAV.

A significant portion of the System's investments are part of the University's Total Return Investment Pool (TRIP). The System accounts for its investments in TRIP on the fair value method based on its share of the underlying securities and, accordingly, records the investment activity as if the System owned the investments directly using the fair value option election. The University does not engage directly in unhedged speculative investments; however, the Board of the University has authorized the use of derivative investments to adjust market exposure within asset class ranges.

A summary of the inputs used in valuing the System's investments as of June 30, 2021 and 2020 is included in note 7.

(j) Investments Limited as to Use

Investments limited as to use primarily include assets held by trustees under debt and other agreements and designated assets set aside by the Board for future capital improvements and other specific purposes, over which the Board retains control and may at its discretion subsequently use for other purposes. Investments limited as to use also include investments held under swap collateral posting requirements, investments under the workers' compensation self-insurance trust funds, and investments whose use is restricted by donors. Investments limited as to use are reported as net assets without donor restrictions. Investments whose use is restricted by donors are reported as net assets with donor restrictions.

(k) Derivative Instruments

The System accounts for derivatives and hedging activities in accordance with Accounting Standards Codification (ASC) Topic 815, *Derivatives and Hedging*, which requires that all derivative instruments be recorded as either assets or liabilities in the consolidated balance sheets at their respective fair values.

For hedging relationships, the System formally documents the hedging relationship and its risk management objective and strategy for understanding the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging investment's effectiveness in offsetting the hedged risk will be assessed, and a description of the method for measuring ineffectiveness. This process includes linking all derivatives that are presented as cash flow hedges to specific assets and liabilities in the consolidated balance sheets.

(l) Property, Plant and Equipment

Property, plant, and equipment are reported on the basis of cost, less accumulated depreciation and amortization. Depreciation is calculated using the straight-line method over their estimated useful lives, which generally range from three to eighty years. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets with explicit restrictions by donors that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System periodically assesses the recoverability of long-lived assets (including property, plant, and equipment) when indications of potential impairment based on estimated, undiscounted future cash flows exist. Management considers factors, such as current results, trends, and future prospects, in addition to other economic factors, in determining whether there is an impairment of the asset. There were no impairments of long-lived assets during 2021 or 2020.

(m) Leases

ROU assets for operating leases are recorded in other assets, net and the corresponding liability is recorded between current portion of other long-term liabilities and other long-term liabilities, less current portion. ROU assets for financing leases are presented as property, plant, and equipment (net) on the consolidated balance sheets and the corresponding liability is presented between current portion of other long-term liabilities and other long-term liabilities, net of current portion.

The System determines if an arrangement is or contains a lease at contract inception.

For operating leases, the lease liability is initially measured at the present value of the unpaid lease payments at the lease commencement date; it is subsequently measured at the present value of the unpaid lease payments. For finance leases, the lease liability is initially measured in the same manner and date as for operating leases and is subsequently measured at amortized cost using the effective-interest method.

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

ASC Topic 842 requires a lessee to discount its unpaid lease payments using the interest rate implicit in the lease or, if that rate cannot be readily determined, its incremental borrowing rate. The System has elected to use the risk-free rate, which is the rate of a U.S. Treasury security for a period comparable to the lease term.

The ROU asset is initially measured at cost, which primarily comprises the initial amount of the lease liability. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

For finance leases, the ROU asset is amortized using the straight-line method from the lease commencement date to the earlier of the end of its useful life or the end of the lease term unless the lease transfers ownership of the underlying asset to the System or the System is reasonably certain to exercise an option to purchase the underlying asset. In those cases, the ROU asset is amortized over the useful life of the underlying asset. Amortization of the ROU asset is recognized and presented separately from interest expense on the lease liability.

The System monitors for events or changes in circumstances that require a reassessment of one of its leases.

(n) Net Assets

Net assets are classified into two classes of net assets: without donor restrictions and with donor restrictions. Descriptions of the two net asset categories and the types of transactions affecting each category follows:

Without Donor Restrictions – Net assets that are not subject to donor-imposed restrictions. Items that affect this net asset category principally consist of fees for service and related expenses associated with the core activities of the System: patient care and provision of healthcare services. In addition to these exchange transactions, changes in this category of net assets include investment returns on "funds functioning as endowment" funds, actuarial adjustments to self-insurance liabilities, changes in postretirement benefit obligations, and other types of philanthropic support. The philanthropic support includes gifts without restriction, board-designated funds functioning as endowment, and restricted gifts whose donor-imposed restrictions were met during the fiscal year, as well as previously restricted gifts and grants for buildings and equipment that have been placed in service.

With Donor Restrictions – Net assets subject to donor-imposed restrictions that will be met either by actions of the System or the passage of time. Items that affect this net asset category are gifts for which donor-imposed restrictions have not been met in the year of receipt, including gifts and grants for buildings and equipment not yet placed in service; endowment, annuity, and life income gifts; pledges and investment returns on "true" endowment funds, and endowments where the principal may be expended upon the passage of a stated period of time (term endowments). Expirations of restrictions on net assets with donor restrictions, including reclassification of restricted gifts and grants for buildings and equipment when the associated long-lived asset is placed in service, are reported as net assets released from restrictions.

Also included in net assets with donor restrictions are net assets subject to donor-imposed restrictions to be maintained permanently by the System, including gifts and pledges wherein donors stipulate that the principal/corpus of the gift be held in perpetuity and that only the income be made available for program operations. Other permanently restricted items in this net asset category include annuity and life income gifts for which the ultimate purpose of the proceeds is permanently restricted.

The description of amounts classified as donor restricted net assets (endowments only) as of June 30, 2021 and 2020 is as follows:

	Perpetual	Time restricted by law	2021 Total
Restricted for pediatric healthcare	$ 4,440	21,770	26,210
Restricted for adult healthcare	4,438	69,466	73,904
Restricted for educational and scientific programs	10,052	4,524	14,576
	$ 18,930	95,760	114,690

		Perpetual	Time restricted by law	2020 Total
Restricted for pediatric healthcare	$	4,023	17,093	21,116
Restricted for adult healthcare		4,061	56,337	60,398
Restricted for educational and scientific programs		9,196	2,589	11,785
	$	17,280	76,019	93,299

The endowment component of net assets without donor restrictions comprises of amounts designated by the Board to function as endowment, which amounted to $1,339,160 and $911,642 included within investments limited to use as of June 30, 2021 and 2020, respectively.

In addition to endowments, the System has $30,834 and $18,386, respectively, of other restricted net assets at June 30, 2021 and 2020.

(o) Consolidated Statements of Operations and Changes in Net Assets Without Donor Restrictions

All activities of the System deemed by management to be ongoing, major, and central to the provision of healthcare services are reported as operating revenue and expenses.

The consolidated statements of operations and changes in net assets without donor restrictions includes revenue and gains in excess of expenses and losses. Changes in net assets without donor restrictions that are excluded from revenue and gains in excess of expenses and losses include net asset transfers to the University, contributions of long-lived assets released from restrictions (including assets acquired using contributions, which by donor restriction were to be used for acquisition of System assets), net assets released from restriction for capital purchases, the effective portion of changes in the valuation of derivatives, change in accrued pension benefits other than net periodic benefit costs, and other, net.

(p) Patient Service Revenue, Accounts Receivable, Charity Care, and Third-Party Settlements

(i) Patient Service Revenues

Gross charges are retail charges and generally do not reflect what the System is ultimately paid and, therefore, are not displayed in the consolidated statements of operations and changes in net assets without donor restrictions. The System is typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that gross charges be the same for all patients (regardless of payor category), gross charges are what is charged to all patients prior to the application of discounts and allowances.

The System recognizes revenue in the period in which it satisfies the performance obligations under contracts by transferring the services to its customers. The performance obligations for patient contracts are generally completed when the patients are discharged, which generally

occurs within days or weeks of the end of the reporting period. In accordance with ASC Topic 606, *Revenue from Contracts with Customers*, the System does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. Revenues are recognized in the amounts to which it expects to be entitled, which are the transaction prices allocated to the distinct services.

The System has agreements with governmental and other third-party payors that provide for payments to the System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods. The transaction price is determined based on gross charges for services provided, reduced by explicit price concessions provided to third-party payors, discounts provided to uninsured patients in accordance with the Financial Assistance Program, and implicit price concessions provided primarily to uninsured patients. The estimates of explicit price concessions and discounts are based on contractual agreements, discount policies, and historical experience. The estimates of implicit price concessions are based on historical collection experience with these classes of patients using the portfolio approach.

(ii) Charity Care

The System provides charity care to patients who meet the criteria for charity care as published in their Financial Assistance Policy. Patients who qualify are provided care without charge or at amounts less than established rates. System policy is not to pursue collection of amounts determined to qualify as charity care; therefore, they do not report these amounts in patient service revenues. Patient advocates from the System screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for government programs.

(iii) Third-Party Settlements

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical Education, disproportionate share hospital, and bad debt expense reimbursement, which are based on the hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions, and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change by material amounts.

The System has an estimation process for recording Medicare patient service revenue and estimated cost report settlements. As a result, the System records accruals to reflect the expected final settlements on our cost reports. For filed cost reports, the System records the accrual based on those cost reports and subsequent activity and records a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet

to be filed is recorded based on estimates of what are expected to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments from the finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in patient service revenues of $4,035 and $9,152, for the years ended June 30, 2021 and 2020, respectively.

(q) Hospital Assessment Program/Medicaid Provider Tax

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital (collectively referred to herein as HAP) have been approved by CMS through December 31, 2022. Under HAP, the state receives additional federal Medicaid funds for the state's healthcare system administered by the Illinois Department of Healthcare and Family Services. In 2021, reimbursement under the HAP resulted in a net increase of $83,757 in operating income, which includes $159,439 in Medicaid payments included in patient service revenue offset by $75,682 in Medicaid provider tax expense. In 2020, reimbursement under HAP resulted in a net increase of $72,489 in operating income, which includes $139,129 in Medicaid payments included in patient service revenue offset by $66,640 in Medicaid provider tax expense.

(r) Other Revenue

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

Premium and capitation revenues are received and recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The System has no material contract assets or liabilities at June 30, 2021 relating to premium and capitation revenue.

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

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

(s) *Income Taxes*

The System applies ASC Topic 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in a company's financial statements. ASC Topic 740 prescribes a more likely than not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under ASC Topic 740, tax positions are evaluated for recognition, derecognition, and measurement using consistent criteria and provide more information about the uncertainty in income tax assets and liabilities. As of June 30, 2021 and 2020, the System does not have an asset or liability recorded for unrecognized tax positions.

UCMC and CHHD Obligated Groups comprise subsidiaries that are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and therefore exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. UCMC and CHHD Non-Obligated Groups consist of several not-for-profit and taxable entities, including University of Chicago Medicine Care Network, LLC; Ingalls Captive Insurance, Ltd; Trulen Insurance SPC Limited; Medcentrix, Inc.; Ingalls Same Day Surgery; and Ingalls Provider Group (IPG), which are taxable entities under applicable sections of the Code.

Deferred income taxes on the taxable entities of the Non-Obligated Groups are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the consolidated financial statement carrying amounts and the tax bases of existing assets and liabilities. As of June 30, 2021 and 2020, the UCMC and CHHD Non-Obligated groups have deferred tax assets primarily relating to net operating losses (NOL) of $17,763 and $16,431, respectively; however, it has a full valuation allowance as management believes that it was not more likely than not that the results of future operations would generate sufficient taxable income to realize the NOL.

(t) *Subsequent Events*

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, the System evaluated events and transactions through October 29, 2021, the date the consolidated financial statements were issued, noting no subsequent events requiring recording or disclosure in the consolidated financial statements or related notes to the consolidated financial statements other than the items noted within the notes to the consolidated financial statements.

(3) Financial Assets and Liquidity Resources

As of June 30, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, were as follows:

	2021	2020
Financial assets:		
Cash and cash equivalents	$ 425,799	538,725
Patient accounts receivable	437,141	333,676
Total financial assets available within one year	862,940	872,401
Liquidity resources:		
Bank lines of credit	100,000	200,000
Total financial assets and liquidity resources available within one year	$ 962,940	1,072,401

The System's cash flows have seasonal variations during the year attributable to patient service reimbursement from the State of Illinois, payments from patients and insurance. As discussed in note 10(d), to manage liquidity, the System maintains lines of credit with financial institutions to potentially draw funds as needed during the year to manage cash flows. As of June 30, 2021, amounts outstanding under lines of credit amounted to $0. Included in cash and cash equivalents as presented above, as of June 30, 2021, the System has $241,160 of cash held in current portion of investment, limited to use, $1,339,160 in funds functioning as endowment and $248,687 of CHHD investments, all available for general expenditure upon Board approval, of which $880,953 is liquid within 12 months. As of June 30, 2020, the System has $911,642 in funds functioning as endowment and $209,450 of CHHD investments, all available for general expenditure upon Board approval, of which $682,595 is liquid within 12 months.

(4) Agreements and Transactions with the University

The affiliation agreement with the University provides, among other things, that all members of the medical staff will have academic appointments in the University. The affiliation agreement has an initial term of 40 years ending October 1, 2026 unless sooner terminated by mutual consent or as a result of a continuing breach of a material obligation therein or in the operating agreement. The affiliation agreement automatically renews for additional successive 10-year terms following expiration of the initial term, unless either party provides the other with at least two years' prior written notice of its election not to renew.

The operating agreement, as amended, provides, among other things, that the University provides UCMC the right to use and operate certain facilities. The operating agreement is coterminous with the affiliation agreement.

The lease agreements provide, among other things, that UCMC will lease from the University certain of the healthcare facilities and land that UCMC operates and occupies. The lease agreements are coterminous with the affiliation agreement.

UCMC purchases various services from the University, including certain employee benefits, utilities, security, telecommunications, and insurance. In addition, certain UCMC accounting records are maintained by the University. During the years ended June 30, 2021 and 2020, the University charged UCMC $34,857 and $32,392, respectively, for utilities, security, telecommunications, insurance, and overhead.

The University's Division of Biological Sciences provides physician services to UCMC. In 2021 and 2020, UCMC recorded $271,561 and $271,868, respectively, in expense related to these services.

UCMC's Board adopted a plan of support under which it would provide annual net asset transfers to the University for support of academic programs in biology and medicine. All commitments under this plan are subject to the approval of UCMC's Board and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board are reflected as current liabilities. UCMC recorded net asset transfers of $71,750 in both 2021 and 2020 for this support.

(5) Patient Service Revenue and Patient Receivables

The System has agreements with third-party payors that provide for reimbursement at amounts different from their established rates. A summary of the reimbursement methodologies with major third-party payors is as follows:

(a) Medicare

The System is paid for various services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The System's classification of patients under the prospective payment systems and the appropriateness of the patients' admissions are subject to validation reviews.

Other services rendered to Medicare beneficiaries are reimbursed based on a combination of prospectively determined rates and cost reimbursement methodologies. For the cost reimbursement, the System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits by the Medicare fiscal intermediary. UCMC's Medicare reimbursement reports through June 30, 2014 have been audited by the Medicare fiscal intermediary. CHHD's Medicare reimbursement reports through September 30, 2014 have been audited by the Medicare fiscal intermediary.

(b) Medicaid

The System is paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rates per discharge. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicaid outpatient services are reimbursed based on fee schedules. Medicaid reimbursement methodologies may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the State of Illinois Medicaid program and any such changes could have a significant effect on the System's revenue.

(c) Blue Cross

The System also participates as a provider of healthcare services under reimbursement agreements with Blue Cross under its indemnity program. The provisions of the agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the System and a review by Blue Cross. UCMC's and CHHD's Blue Cross reimbursement reports for 2019 and prior years have been reviewed by Blue Cross.

(d) Other

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

Patient service revenue recognized in the period from these major payor sources are as follows:

		2021	2020
Medicare	$	675,959	610,312
Medicaid		580,336	467,352
Managed care		1,066,617	962,261
Patients and other		8,597	10,032
Patient service revenue	$	2,331,509	2,049,957

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

		2021	2020
Inpatient	$	1,248,492	1,117,235
Outpatient/Ambulatory care		984,841	912,195
Physician services		98,176	20,527
	$	2,331,509	2,049,957

The mix of receivables from patients and third-party payors as of June 30, 2021 and 2020 is as follows:

	2021	2020
Medicare	22.5 %	23.5 %
Medicaid	31.7	31.8
Managed care	44.4	42.0
Patients and other	1.4	2.7
	100.0 %	100.0 %

(6) Community Benefits

The following is a summary of the System's unreimbursed cost of providing care, as defined under its Financial Assistance Policy, along with the unreimbursed cost of government-sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2021 and 2020:

	2021	2020
Uncompensated care:		
Medicaid sponsored indigent healthcare	$ 110,336	140,705
Medicare sponsored indigent healthcare – cost report	142,125	163,249
Medicare sponsored indigent healthcare – physician services	87,584	43,786
Medicare prior year adjustment	(2,465)	—
Total uncompensated care	337,580	347,740
Charity care	31,282	47,033
	368,862	394,773
Unreimbursed education and research:		
Education (unaudited)	66,774	62,066
Research (unaudited)	48,000	48,000
Total unreimbursed education and research	114,774	110,066
Total community benefits	$ 483,636	504,839

The System determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries, wages and benefits, supplies, and other operating expenses, to determine a cost-to-charge ratio. The cost to charge ratio is applied to the charity care gross charges to calculate the charity care amount reported above. The System has not amended its financial assistance policies in 2021.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Notes to Consolidated Financial Statements

June 30, 2021 and 2020

(7) Investments Limited as to Use

The composition of investments limited as to use is as follows at June 30, 2021 and 2020:

	2021				
	Separately invested	TRIP	Other	Total	2020
Investments carried at fair value:					
Cash equivalents	$ 284	26,347	242,296	268,927	197,179
Global public equities	46,316	491,928	—	538,244	366,091
Private debt	—	61,525	—	61,525	50,082
Private equity:					
U.S. venture capital	161	151,524	—	151,685	73,706
U.S. corporate finance	—	70,791	—	70,791	40,391
International	—	168,427	—	168,427	87,384
Real assets:					
Real estate	—	72,146	—	72,146	56,175
Natural resources	—	70,406	—	70,406	51,808
Absolute return:					
Equity oriented	—	155,678	—	155,678	71,163
Global macro/relative value	—	—	—	—	31,161
Multistrategy	—	86,199	—	86,199	60,177
Credit oriented	—	71,734	—	71,734	39,622
Protection oriented	—	36,193	—	36,193	19,072
Fixed income:					
U.S. Treasuries, including TIPS	—	76,315	—	76,315	57,011
Other fixed income	105,846	—	—	105,846	4
Other:					
Beneficial interests in trust	—	—	10,715	10,715	9,085
Funds in trust	—	—	24,891	24,891	76,013
Total investments	$ 152,607	1,539,213	277,902	1,969,722	1,286,124

Investments classified as other consist of construction and debt proceeds to pay interest, donor restricted investments in beneficial interests in trusts, workers' compensation, self-insurance, and trustee-held funds. Investments limited as to use are classified as current assets to the extent that they are available to meet current liabilities. Investments are presented in the consolidated financial statements as follows:

	2021	2020
Current portion of investments limited to use	$ 247,395	58,500
Investments limited to use, less current portion	1,722,327	1,227,624
Total investments limited to use	$ 1,969,722	1,286,124

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Notes to Consolidated Financial Statements

June 30, 2021 and 2020

A summary of investments limited as to use for the years ended June 30 is as follows:

	2021			
	UCMC	CHHD	Total	2020
Investments limited as to use:				
By the Board for capital improvements/restrictions by donors	$ 135,558	28,900	164,458	195,163
Funds held by custodian/trustee under indenture agreements	115	—	115	145
Funds held by trustee for self-insurance	5,985	12,671	18,656	20,769
Collateral for interest rate swap	6,120	—	6,120	55,100
Working capital account – not limited as to use	241,160	—	241,160	—
TRIP investments	1,308,711	230,502	1,539,213	1,014,947
Total investments limited to use	$ 1,697,649	272,073	1,969,722	1,286,124

The composition of unrestricted investment return, net is as follows for the years ended June 30:

	2021			
	UCMC	CHHD	Total	2020
Interest and dividend income, net	$ 9,246	1,858	11,104	12,430
Realized gains on sales of securities, net	53,425	10,464	63,889	38,505
Change in unrealized gains and losses on securities, net	255,768	56,555	312,323	(19,902)
	$ 318,439	68,877	387,316	31,033

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2021, UCMC has commitments of $1,681 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

The overall investment objective of the System is to invest its assets in a prudent manner that will achieve a long-term rate of return sufficient to fund a portion of its annual operating activities and increase investment value after inflation. The System diversifies its investments among various asset classes incorporating multiple strategies and external investment managers, including the University Investment Office. Major investment decisions for investments held in TRIP and managed by the University are authorized by the University Board of Trustee's Investment Committee, which oversees the University's investment program in accordance with established guidelines.

The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, patient accounts receivable, accounts payable and accrued expenses, and estimated payables under third-party reimbursement programs. Cash equivalent investments include cash equivalents and fixed-income investments, with original maturities of three months or less, which are valued based on quoted market prices in active markets. The majority of these investments are held in U.S. money market accounts. Global public equity investments consist of separate accounts, commingled funds, and limited partnerships. Securities held in separate accounts and daily traded commingled funds are generally valued based on quoted market prices in active markets. Commingled funds with monthly liquidity are valued based on independently determined NAV. Limited partnership interests in equity-oriented funds are valued based upon NAV provided by external fund managers.

Investments in private debt, private equity, real estate, and natural resources are in the form of limited partnership interests, which typically invest in private securities for which there is no readily determinable market value. In these cases, market value is determined by external managers based on a combination of discounted cash flow analysis, industry comparables, and outside appraisals. Where private equity, real estate, and natural resources managers hold publicly traded securities, these securities are generally valued based on market prices. The value of the limited partnership interests is held at the manager's reported NAV, unless information becomes available indicating the reported NAV may require adjustment. The methods used by managers to assess the NAV of these external investments vary by asset class. The University's Investment Office monitors the valuation methodologies and practices of managers on behalf of the System.

The absolute return portfolio comprises investments of limited partnership interests in hedge funds and drawdown private equity style partnerships whose managers have the authority to invest in various asset classes at their discretion, including the ability to invest long and short. The majority of the underlying holdings are marketable securities. The remainder of the underlying holdings is held in marketable securities that trade infrequently or in private investments, which are valued by the manager on the basis of an appraised value, discounted cash flow, industry comparables, or some other method. Most hedge funds that hold illiquid investments designate them in special side pockets, which are subject to special restrictions on redemption.

Fixed-income investments consist of directly held actively traded treasuries, separately managed accounts, commingled funds, and bond mutual funds that hold securities, the majority of which have maturities greater than one year. These are valued based on quoted market prices in active markets.

Beneficial interests in trusts represent restricted investments that are assets held by third-party trustees for beneficial interests in perpetual trusts, comprising equities, fixed-income securities, and money market funds.

Funds in trust investments consist primarily of project construction funds and workers' compensation trust funds. Funds in trust comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2021 and comprise 1% cash and cash equivalents, 95% fixed income investments, and 4% equity investments at June 30, 2020.

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Notes to Consolidated Financial Statements

June 30, 2021 and 2020

The System believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2021 and 2020. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed. Assets and liabilities recorded at fair value as of June 30, 2021 and 2020 were as follows:

Assets	Quoted prices in active markets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	2021 Total fair value
Cash and cash equivalents	$ 184,639	—	—	184,639
Investments:				
Cash equivalents	268,927	—	—	268,927
Global public equities	138,138	—	—	138,138
Real assets:				
Real estate	14,440	—	—	14,440
Fixed income:				
U.S. Treasuries, including TIPS	76,315	—	—	76,315
Other fixed income	105,846	—	—	105,846
Restricted investments	—	—	10,715	10,715
Funds in trust	12,219	12,671	—	24,890
Investments measured at net asset value[1]	—	—	—	1,330,451
Total investments at fair value	800,524	12,671	10,715	2,154,361
Other assets	10,177	—	—	10,177
Total assets at fair value	$ 810,701	12,671	10,715	2,164,538
Liabilities				
Interest rate swap payable	$ —	147,362	—	147,362
Total liabilities at fair value	$ —	147,362	—	147,362

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June 30, 2021 and 2020

Assets		Quoted prices in active markets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	2020 Total
Cash and cash equivalents	$	538,725	—	—	538,725
Investments:					
Cash equivalents		197,179	—	—	197,179
Global public equities		97,864	—	—	97,864
Real assets:					
Real estate		10,270	—	—	10,270
Fixed income:					
U.S. Treasuries, including TIPS		57,011	—	—	57,011
Other fixed income		4	—	—	4
Restricted investments		—	—	9,085	9,085
Funds in trust		61,411	14,603	—	76,014
Investments measured at NAV		—	—	—	838,697
Total investments at fair value		962,464	14,603	9,085	1,824,849
Other assets		8,343	—	—	8,343
Total assets at fair value	$	970,807	14,603	9,085	1,833,192
Liabilities					
Interest rate swap payable	$	—	193,907	—	193,907
Total liabilities at fair value	$	—	193,907	—	193,907

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

During 2021, there were no transfers between investment between Levels 2 and 3. The interest rate swap arrangement has inputs, which can generally be corroborated by market data and is, therefore classified within Level 2.

The following table presents activity for the year ended June 30, 2021 for assets measured at fair value using unobservable inputs classified in Level 3:

	Level 3 rollforward
Beginning fair value	$ 9,085
Change in unrealized gains and losses, net	1,630
Ending fair value	$ 10,715

In addition, investment securities are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of the System's investments could occur in the next term and that such changes could materially affect the amounts reported in the consolidated financial statements. The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The significant unobservable inputs used in the fair value measurement of the System's long-lived partnership investments include a combination of cost, discounted cash flow analysis, industry comparables, and outside appraisals. Significant changes in any inputs used by investment managers in determining NAVs in isolation would result in a significant change in fair value measurement.

The System has made investments in various long-lived partnerships and, in other cases, has entered into contractual agreements that may limit its ability to initiate redemptions due to notice periods, lockups, and gates. Details on typical redemption terms by asset class and type of investment are provided below:

	Remaining life	Redemption terms	Redemption restrictions and terms
Cash	N/A	Daily	None
Global public equities:			
Commingled funds	N/A	Daily to triennial with notice periods of 2 to 180 days	Lock up provisions for up to 2 years; some investments have a portion of capital held in side pockets with no redemptions permitted
Partnerships	N/A	Monthly to triennial with notice periods of 7 to 90 days	Lock up provisions for up to 3 years; some investments have a portion of capital held in side pockets with no redemptions permitted
Separate accounts	N/A	Daily with notice periods of 1 to 90 days	None

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	Remaining life	Redemption terms	Redemption restrictions and terms
Private debt:			
Drawdown partnerships	1 to 11 years	Redemptions not permitted	N/A
Partnerships	N/A	Redemptions not permitted	Capital held in side pockets with no redemptions permitted
Mutual bond and equity funds	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Real estate funds	N/A	Quarterly with notice periods of 45 to 90 days	None
Funds of funds	N/A	Monthly to quarterly with notice periods of 15 to 185 days	None
Private equity:			
Drawdown partnerships	1 to 21 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 1 day	None
Partnerships	N/A	Semiannual with notice period of 90 days	A portion of capital is held in side pockets with no redemptions permitted
Real estate:			
Drawdown partnerships	1 to 16 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 5 days	None
Natural resources:			
Drawdown partnerships	1 to 17 years	Redemptions not permitted	N/A
Commingled funds	N/A	Daily with notice period of 1 day	None
Absolute return:			
Commingled funds	N/A	Daily to triennial with notice periods of 1 to 122 days	Lock p provisions for up to three years some investments have a portion of capital held in side pockets with no redemptions permitted
Drawdown partnerships	1 to 4 years	Redemptions not permitted	N/A
Partnerships	N/A	Quarterly to triennial with notice periods of 45 to 180 days	Lock up provisions for up to five years some investments have a portion of capital held in side pockets with no redemptions permitted
Fixed income:			
Commingled funds	N/A	Weekly to monthly with notice periods of 5 to 10 days	None
Separate accounts	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Funds in trust	N/A	Daily	None

(8) Endowments

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

Illinois is governed by the Uniform Prudent Management of Institutional Funds Act (UPMIFA). The Board of UCMC has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the System classifies as net assets with donor restrictions (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The System has beneficial interests in trusts. The System has recorded its share of the principal of the trusts as net assets with donor restrictions. Distributions from the trusts are recorded within net assets without restrictions if unrestricted; otherwise, they are classified as net assets with donor restrictions until appropriated for expenditure. In some instances, the historical costs basis of the funds is not available as the System received the shares in 1929. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies at June 30, 2021 and 2020, respectively.

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The System has the following donor-restricted endowment activities during the years ended June 30, 2021 and 2020 delineated by net asset class:

	2021		
	Without Donor Restrictions	With Donor Restrictions	Total
Changes in the fair value of endowment investments:			
Investment return:			
Endowment yield (interest and dividends)	$ 9,246	679	9,925
Net appreciation (realized and unrealized) on investments	309,193	29,110	338,303
Investment return, net of payout	318,439	29,789	348,228
Endowment payout	(53,673)	(8,416)	(62,089)
Net investment return	264,766	21,373	286,139
Other changes in endowment investments:			
Gifts and pledge payments received in cash	157,589	18	157,607
Other changes	5,163	—	5,163
Total other changes in endowment investments	162,752	18	162,770
Net change in endowment investments	427,518	21,391	448,909
Endowment investments at:			
Beginning of year	911,642	93,299	1,004,941
End of year	$ 1,339,160	114,690	1,453,850
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	18,930	18,930
Appreciation	- -	95,760	95,760
Board-designated "funds functioning as endowment"	1,339,160	—	1,339,160
Total – as above	$ 1,339,160	114,690	1,453,850

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	2020		
	Without Donor Restrictions	With Donor Restrictions	Total
Changes in the fair value of endowment investments:			
Investment return:			
Endowment yield (interest and dividends)	$ 10,250	676	10,926
Net appreciation (realized and unrealized) on investments	13,533	802	14,335
Investment return, net of payout	23,783	1,478	25,261
Endowment payout	(48,014)	(3,883)	(51,897)
Net investment return	(24,231)	(2,405)	(26,636)
Other changes in endowment investments:			
Gifts and pledge payments received in cash	8,302	10	8,312
Other changes	4,000	—	4,000
Total other changes in endowment investments	12,302	10	12,312
Net change in endowment investments	(11,929)	(2,395)	(14,324)
Endowment investments at:			
Beginning of year	923,571	95,694	1,019,265
End of year	$ 911,642	93,299	1,004,941
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	17,280	17,280
Appreciation	—	76,019	76,019
Board-designated "funds functioning as endowment"	911,642	—	911,642
Total – as above	$ 911,642	93,299	1,004,941

Investment and Spending Policies

The System has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. The System expects its endowment funds to provide an average rate of return of approximately 7-8% annually. To achieve its long-term rate of return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). Actual returns in any given year may vary from this amount.

For endowments invested in TRIP, the Board of the System has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula. The University utilizes the total return concept in allocating endowment income. In accordance with the

University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board with the objective of a 5% average payout over time, was 5.5% for the fiscal years ended June 30, 2021 and 2020. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

For endowments invested apart from TRIP, the System calculates a payout of 4% annually on a rolling 24-month average market value. In establishing this policy, the Board considered the expected long-term rate of return on its endowment.

(9) Property, Plant, and Equipment

The components of property, plant, and equipment as of June 30 are as follows:

	2021	2020
Land and land rights	$ 55,610	55,610
Buildings and improvements	1,941,958	1,914,984
Equipment	779,917	753,017
Construction in progress	35,712	21,759
	2,813,197	2,745,370
Less accumulated depreciation	(1,304,047)	(1,187,022)
Total property, plant, and equipment, net	$ 1,509,150	1,558,348

The cost of buildings that are jointly used by the University and the System is allocated based on the lease provisions. In addition, land and land rights include $15,400 and $17,200 for 2021 and 2020, respectively, which represents the unamortized portion of initial lease payments made to the University.

Capitalized interest costs in 2021 and 2020 were approximately $751 and $500, respectively. Construction in progress consists of various routine capital improvements and renovation projects. As of June 30, 2021, the System had total contractual commitments associated with ongoing capital projects of approximately $5,300.

(10) Long-Term Debt

The long-term debt of both UCMC and CHHD is issued pursuant to the second Amended and Restated Master Trust Indenture (MTI) dated as of June 1, 2019, as subsequently amended and supplemented. The Obligated Group Members are UCMC, CHHD, Ingalls Memorial Hospital, Ingalls Home Care, and Ingalls Development Foundation. Each series of bonds is collateralized by the unrestricted receivables of the obligated Group Members and subject to certain restrictions under the MTI.

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Long-term debt at June 30, 2021 and 2020 consists of the following:

	Fiscal year maturity	Interest rate	2021	2020
University of Chicago Medical Center:				
Fixed rate:				
Illinois Finance Authority:				
Series 2009A (2009B bonds paid off 08-15-20)	2022	5.0 %	$ 12,795	71,970
Series 2009D1 and 2009D2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E1 and 2009E2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010A and 2010B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011A and 2011B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2015A	2028	5.0	21,895	21,895
Series 2016A	2027	5.0	22,830	22,830
Series 2016B	2042	5.0	164,490	164,490
Series 2020A	2026	2.5	47,270	
Teachers Insurance and Annuity Association of America (TIAA):				
Series 2017A	2047	4.4	30,000	30,000
New York Life:				
Series 2019E fixed rate taxable	2042	2.7	60,645	63,645
Unamortized premium			15,276	18,073
Total fixed rate			700,201	717,903
Variable rate:				
Series 2013A	2050	2.5	66,963	68,403
Illinois Educational Facilities Authority (IEFA)	2038	1.1	59,028	62,590
Total variable rate			125,991	130,993
Unamortized debt issuance costs			(4,607)	(4,891)
Less current portion of long-term debt			(17,358)	(16,625)
Total UCMC long-term portion of debt, less current portion			804,227	827,380
UCMC Title Holding Corporation:				
Fixed rate:				
Brownfield Revitalization 40 - Promissory note A	2024	1.5 %	4,850	4,850
Urban Development Fund XLVI – Promissory note A	2024	1.5	4,576	4,850
Urban Development Fund LI – Promissory note A	2024	1.8	6,500	6,500
Citi NMTC – QLICI	2032	1.2	3,476	3,476
Citi NMTC – QLICI	2032	1.2	1,620	1,620

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	Fiscal year maturity	Interest rate	2021	2020
URP QLICI – Loan A	2047	1.0 %	$ 7,334	7,334
URP QLICI – Loan B	2047	1.0	2,666	2,666
SCORE QLICI – Loan A	2047	1.0	4,176	4,176
SCORE QLICI – Loan B	2047	1.0	1,704	1,704
CNI QLICI – Loan A	2047	1.0	3,455	3,455
CNI QLICI – Loan B	2047	1.0	1,545	1,545
Total UCMC Title Holding Corporation debt			41,902	42,176
Less current portion			(1,862)	(275)
Title holding company LT portion			40,040	41,901
Total UCMC debt, excluding current portion			$ 844,267	869,281
Community Health and Hospital Division:				
Fixed Rate: Series 2017	2034	4.6	$ 34,325	36,305
Fixed rate: Series 2019	2042	2.7	63,165	64,715
Unamortized debt issuance costs			(345)	(365)
Total debt and unamortized premiums (discount)			97,145	100,655
Less current portion of long-term debt			(3,655)	(3,530)
Total CHHD debt, excluding current portion			$ 93,490	97,125
Total notes and bonds payable			$ 960,632	986,836
Less current portion			(22,875)	(20,430)
Long-term debt, excluding current portion			$ 937,757	966,406

Scheduled annual repayments, excluding costs, premiums, or discounts, for the next five years and thereafter are as follows at June 30:

Year ending June 30:	
2022	$ 22,875
2023	23,598
2024	23,303
2025	25,579
2026	26,490
Thereafter	828,462
	$ 950,307

ATTACHMENT 35

(a) Letters of Credit

Under its various credit agreements, UCMC is subject to certain financial covenants, including maintaining a minimum debt service coverage ratio; maintaining minimum levels of days' cash on hand; maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise, disposing of UCMC property; and certain other nonfinancial covenants.

Payment on each of the variable rate demand revenue bonds is also collateralized by a letter of credit. The letters of credit that support the Series 2009D and 2009E bonds expire in June 2022 and June 2026, respectively. The letters of credit that support the Series 2010A and 2010B bonds expire in May 2025 and July 2024, respectively. The letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2025 and May of 2026, respectively. Payment of each of the IEFA bonds is collateralized by a letter of credit maturing May 2022. The letters of credit are subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1:35:1.

Included in UCMC's debt is $59,028 of commercial paper revenue notes and $325,000 of variable rate demand bonds. In the event that UCMC's remarketing agents are unable to remarket the bonds, the trustee of the bonds will tender them under the letters of credit. Scheduled repayments under the letters of credit are between one and three years, beginning after a grace period of at least one year from the event, and bear interest rates different from those associated with the original bond issue. Any bonds tendered are still eligible to be remarketed. Bonds subsequently remarketed would be subject to the original bond repayment schedules.

Scheduled principal repayments on long-term debt based on the variable rate demand debt being put back to the System and a corresponding draw being made on the underlying credit facility, if available, excluding costs, premiums, or discounts, are as follows:

Year ending June 30:	
2022	$ 81,703
2023	153,584
2024	107,039
2025	136,856
2026	26,490
Thereafter	444,635
	$ 950,307

(b) Recent Financing Activity

In August 2020, UCMC issued fixed rate bonds in the amount of $47,270. The Series 2020A bonds were sold to JPMorgan Chase Bank. The purpose of the Series 2020A bonds was to provide for the redemption of UCMC's Series 2009B bonds in full on August 15, 2020.

(c) Lines of Credit

At June 30, 2020, UCMC had two lines of credit totaling $200,000 from commercial banks. UCMC allowed one of the $100,000 lines to expire per its terms on April 28, 2021. As of June 30, 2021, UCMC has a $100,000 line of credit from a commercial bank. The line of credit expires March 2, 2022.

As of June 30, 2021 and 2020, no amount was outstanding under the lines.

(d) Interest Payments

The System paid interest, net of capitalized interest, of approximately $31,300 and $32,800 in 2021 and 2020, respectively.

(e) UCMC Title Holding Corporation

During fiscal years 2017 and 2018, UCMC entered into New Market Tax Credit (NMTC) financing agreements with various entities for the purposes of financing various projects at UCMC that would benefit the surrounding community. The NMTC program was established in 2000 by the United States Congress and is administered by the Department of Treasury to encourage private investment in qualifying low-income communities. Pursuant to Section 45(D) of the Internal Revenue Code, UCMC's NMTC structure consists of an NMTC investor (Investor) who provided qualified equity investments to a community development entity (CDE) who in turn provided debt financing to a separate not for profit tax exempt entity, which is a qualified active low income community business (QALICB).

In August 2017, UCMC was a lender in the NMTC structure for the construction of a new emergency department and adult trauma center. Because UCMC has the power to appoint all board members of UCMC Title Holding Corporation II NFP, the QALICB has been consolidated in the financial statements. The Investor made qualifying equity investments into various CDE funds, including UCMC Trauma Center NMTC Investment Fund, LLC (the CDE Funds), which in turn provided debt financing of $20,880 to UCMC Title Holding Corporation to fund qualified construction costs and equipment, as required under the terms of the agreement. Management anticipates that the NMTC structure will stay in effect through July 2025 when the NMTC tax compliance period expires. At that time, management believes the Investor will exercise its Put Option in the Put and Call Agreement, allowing UCMC to acquire a 100% equity interest in the investment fund. If the Put Option is not exercised, UCMC has the right to call for the purchase of a 100% equity interest in the investment fund at a fair market value. In either case, once the option is exercised, UCMC's loan to the investment fund would be extinguished, the investment fund and the CDE Funds would be dissolved, and the loans from the CDE Funds to UCMC Title Holding Corporation II NFP would be extinguished.

(11) Derivative Instruments

The System has interest rate related derivative instruments to manage its exposure on debt instruments. 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; however, the System is required to post collateral to the counterparty when certain thresholds as defined in the derivative agreements are met. 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. System management also mitigates risk through periodic reviews of their derivative positions in the context of their total blended cost of capital.

The System is required to post collateral under the specific terms and conditions for the various interest rate swap agreements as described below. At June 30, 2021 and 2020, $6,120 and $55,100 was held as collateral, respectively, and was recorded in current portion of investments limited to use and included in Note 7 as funds in trust for disclosure. Collateral postings are primarily driven by the value of the swap as measured at the reset date. Collateral requirements increase if credit ratings were to be downgraded.

The fair value of each swap is the estimated amount UCMC would receive or pay to terminate the swap agreement at the reporting date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value is included in interest rate swap liability on the consolidated balance sheets, while the change in fair value is recorded in other changes in net assets without donor restrictions for the effective portion of the change and in nonoperating gains and losses for the ineffective portion of the change.

UCMC Interest Rate Swap Agreement

In August 2006, UCMC entered into a forward starting swap transaction against contemplated variable rate borrowing for the Center for Care and Discovery. This is a cash flow hedge against interest on the variable rate debt. The fair value of these swap agreements is the estimated amount that UCMC would have to pay or receive to terminate the agreements as of the consolidated balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparty. The swap values are based on the LIBOR. The inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Management has determined that the interest rate swaps are effective and have qualified for hedge accounting. The fair value of the UCMC swap agreement liabilities was $138,563 and $182,470 at June 30, 2021 and 2020, respectively, and has been included in other long-term liabilities in the accompanying consolidated balance sheets. The net effective portion of the change in fair value on the UCMC swap agreements of $44,967 and $(53,268) in 2021 and 2020, respectively, has been included in the change in net assets without donor restrictions in the accompanying 2021 and 2020 consolidated statements of operations and changes in net assets without donor restriction. Management has recognized ineffectiveness of approximately $695 in 2021 and an ineffectiveness of $(395) in 2020 in nonoperating gains and losses. This movement reflects the spread between tax-exempt interest rates and LIBOR during the period. The effective portion of these swaps is included in other changes in net assets without donor restrictions. The interest rate swaps terminate on February 1, 2044. Cash settlement payments related to the swaps are recorded in interest expense.

On July 1, 2020 UCMC entered into a novation of the interest rate swap agreements for a five-year term. The novation to the new parties is under like-kind terms and arrangements that do not require dedesignation of the heading relationship and related accounting.

The following summarizes the general terms of each of UCMC's swap agreements:

Effective date	Associated debt series	Original term	Current notional amount	UCMC pays	UCMC receives
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	$ 162,500,000	3.89%	68% of LIBOR
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	162,500,000	3.97%	68% of LIBOR

CHHD Swap Agreement

CHHD entered into an interest rate swap agreement on June 28, 2004 to lock in long-term fixed rates on the Series 2004 variable-rate debt issuance, with a notional amount of $36,325 and a maturity date of May 15, 2034. This agreement was amended on March 1, 2013. Under the amended agreement, the notional amount and maturity did not change, and CHHD receives, on a monthly basis, 67% of one-month LIBOR plus 47.5 basis points and makes payments on a monthly basis, an annualized fixed rate of 4.61%. The swap is not designated as a hedging instrument, and therefore, the change in fair value of the 2004 interest rate swap agreement of $2,637 and $(2,318) in 2021 and 2020, respectively, was recognized as a component of nonoperating gains in the accompanying consolidated statements of operations and changes in net assets without donor restriction. The fair value of the Series 2004 interest rate swap agreement liability of $8,799 and $11,436 at June 30, 2021 and 2020, respectively, is included as a component of other long-term liabilities in the accompanying consolidated balance sheets. The differential to be paid or received under the Series 2004 interest rate swap agreement is recognized monthly and has been included as a component of interest expense in the accompanying consolidated statements of operations and changes in net assets without donor restriction.

A summary of outstanding positions under the interest rate swap agreements for CHHD at June 30, 2021 is as follows:

Series	Notional amount	Maturity date	Rate received	Rate paid
2004 Interest rate swap Agreement:	$ 40,125	May 15, 2034	% of LIBOR	Fixed 4.61%

(12) Leases

The components of lease cost for the years ended June 30, 2021 and 2020 reported as part of other expenses in the consolidated statements of operations and changes in net assets without donor restrictions, were as follows:

		2021	2020
Operating lease expense	$	10,814	10,076
Finance lease expense:			
Amortization of right-of-use assets		5,802	4,970
Interest on lease liabilities		1,146	1,191
Total finance lease expense		6,948	6,161
Total lease expense	$	17,762	16,237

Amounts reported in the consolidated balance sheets as of June 30, 2021 and 2020 were as follows:

		2021	2020
Operating Leases:			
Right-of-use assets – operating leases	$	64,323	53,043
Accumulated amortization		4,175	3,038
Other assets, net	$	60,148	50,005
Current portion of other long-term liabilities	$	4,626	4,596
Other long-term liabilities, less current portion		55,522	45,409
Total operating lease liabilities	$	60,148	50,005
Finance Leases:			
Right-of-use assets – finance leases	$	37,818	38,347
Accumulated amortization		7,643	4,970
Other assets, net	$	30,175	33,377
Current portion of other long-term liabilities	$	3,329	7,521
Other long-term liabilities, less current portion		28,055	29,466
Total operating lease liabilities	$	31,384	36,987

Other information related to leases as of June 30, 2021 and 2020 was as follows:

Supplemental cash flow information:

	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flow from operating leases	$ 10,814	8,383
Financing cash flow from finance leases	8,113	2,466
ROU assets obtained in exchange for lease obligations:		
Operating leases	14,318	53,043
Finance leases	2,202	27,681
Reductions to ROU assets resulting from reductions to lease obligations:		
Operating leases	4,175	3,038
Finance leases	8,058	4,970
Weighted average remaining lease term:		
Operating leases	12.7 years	9.1 years
Finance leases	13.4 years	11.2 years
Weighted-average discount rate:		
Operating leases	2.2 %	2.1 %
Finance leases	3.5	3.3

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

Maturities of lease liabilities under noncancelable leases as of June 30, 2021 are as follows:

	Operating	Finance
2022	$ 6,316	4,340
2023	6,233	4,061
2024	5,290	3,426
2025	3,614	2,895
2026 and thereafter	49,136	26,441
	70,589	41,163
Less amount representing interest	9,683	9,779
Present value of net minimum lease payments	$ 60,906	31,384

(13) Insurance

Professional and General Liability

The System maintains separate self-insurance programs for UCMC and CHHD. UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with

commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2021 and 2020 was $5,000 per claim and unlimited in the aggregate. Claims in excess of $5,000 are subject to an additional self-insurance retention limited to $12,500 per claim and $22,500 in aggregate. There are no assurances that the University will be able to renew existing policies or procure coverage on similar terms in the future.

CHHD maintains a self-insurance program for professional and general liability. Coverage from commercial insurance carriers is maintained for claims in excess of self-insured retentions at various levels by policy year. CHHD established a trust fund with an independent trustee for the administration of assets funded under the malpractice and general liability self-insurance program.

The System has engaged professional consultants for calculating an estimated liability for medical malpractice self-insurance and is actuarially determined based upon estimated claim reserves and various assumptions, and represents the estimated present value of self-insurance claims that will be settled in the future. It considers anticipated payout patterns, as well as interest to be earned on available assets prior to payment. The discount rate used to value the self-insurance liability is a rate commensurate with the duration of anticipated payments.

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and assets available for claims for the combined University and UCMC self-insurance program as of June 30, 2021 and 2020 is presented below:

	2021	2020
Actuarial present value of self-insurance liability for medical malpractice	$ 202,419	185,822
Total assets available for claims	344,879	259,113

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately $24,038 higher at June 30, 2021. The interest rate assumed in determining the present value was 2.75% and 2.50% for 2021 and 2020, respectively. UCMC has recorded its pro rata share of the malpractice self-insurance liability in the amount of $96,204 and $83,620 at June 30, 2021 and 2020, respectively, with an offsetting receivable from the malpractice trust to cover any related claims. The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense its negotiated pro rata share of the actuarially determined normal contribution, with gains and losses amortized over five years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2021, UCMC's expense is estimated to be approximately $11,000 related to malpractice insurance.

On April 30, 2019, CHHD entered into a loss portfolio transfer for the Ingalls Memorial Hospital medical malpractice program by obtaining an occurrence-based policy for claims through June 30, 2018 through a payment of $47,311 to an unrelated insurance company. The loss portfolio transferred was structured through Ingalls Casualty Insurance (the Captive) entity for purposes of additional insurance protection and risk management. At June 30, 2021, there was no additional liability calculated by the programs actuaries that would require additional reserves by CHHD or the Captive. Accruals for CHHD professional and general liabilities are recorded on a discounted basis consistent with the University's insurance program.

(14) Pension Plans

Active Plans

A majority of UCMC's personnel participate in the University's defined-benefit and contribution pension plans, which are considered multiemployer pension plans. Under the defined-benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last ten years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding based on the guidelines set forth by the Employee Retirement Income Security Act of 1974, on an actuarially determined basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of net assets without donor restrictions. The adjustment to net assets without donor restrictions was $2,781 and $(2,823) for the years ended June 30, 2021 and 2020. UCMC expects to make contributions not to exceed $2,200 for the fiscal year ending June 30, 2021.

Effective January 1, 2017, the 401(a) defined-benefit pension plan was frozen for UCMC employees participating in the plan and was replaced with an enhanced defined-contribution plan. Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately $11,700 and $24,900 for the years ended June 30, 2021 and 2020, respectively.

UCMC's expense related the multiemployer University's defined-benefit plans included in the University's consolidated financial statements for the years ended June 30, 2021 and 2020 is as follows:

Plan name	EIN	Contribution of UCMC 2021	Contribution of UCMC 2020
University of Chicago Retirement Income Plan for Employees	36-2177139-002	$ —	—
University of Chicago Pension Plan for Staff Employees	36-2177139-003	—	—
		$ —	—

The benefit obligation, fair value of plan assets, and funded status for the University's defined-benefit plan included in the University's consolidated financial statements as of June 30 are shown below.

	2021	2020
Projected benefit obligation	$ 1,006,857	1,057,892
Fair value of plan assets	871,372	786,782
Deficit of plan assets over benefit obligation	$ (135,485)	(271,110)

The weighted average assumptions used in the accounting for the plan are shown below.

	2021	2020
Discount rate	3.2 %	2.9 %
Expected return on plan assets	6.0	6.3
Rate of compensation increase	3.5	3.5

The weighted average asset allocation for the plan is as follows:

	2021	2020
Domestic equities	26 %	26 %
International equity	21	24
Fixed income	53	50
	100 %	100 %

Domestic and international equities are presented as Level 1 investments and fixed income securities are presented as Level 2 investments within the fair value hierarchy.

The pension and other postretirement benefit obligation considers anticipated payout patterns as well as investment returns on available assets prior to payment. The discount rate used to value the pension and other postretirement benefit obligation is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Expected future benefit payments excluding plan expenses are as follows:

Fiscal year:	
2022	$ 75,338
2023	53,519
2024	53,414
2025	52,974
2026	54,581
2027-2031	280,844

UCMC and CHHD also maintain additional defined-contribution retirement plans for employees. The System's pension expense under these distinct defined-contribution retirement plans for UCMC was $700 and $8,000 for the years ended June 30, 2021 and 2020, respectively.

CHHD expense under these distinct defined-contribution retirement plans was $800 and $2,900 for the years ended June 30, 2021 and 2020, respectively.

Curtailed and Frozen Plan

In June 2002, UCMC assumed sponsorship of the Louis A. Weiss Memorial Hospital Pension Plan (Employer Identification Number 36-3488183, Plan Number 003), which covers employees of a former affiliate. Participation and benefit accruals are frozen. All benefit accruals are fully vested.

As the plan was fully terminated and annuitized in FY 2021 UCMC will not be required to make future contributions or have benefit payments.

Components of net periodic pension cost and other amounts recognized in net assets without donor restrictions include the following:

	Years ended June 30	
	2021	2020
Net periodic pension cost:		
Service cost	$ —	—
Net periodic pension cost	$ —	—
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Interest cost	$ 683	1,730
Expected return on plan assets	(1,063)	(2,598)
Amortization of unrecognized net actuarial loss	727	1,279
Total recognized in net periodic pension cost and net assets without donor restrictions	$ 347	411

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Notes to Consolidated Financial Statements

June 30, 2021 and 2020

The following table sets forth additional required pension disclosure information for this plan:

	Years ended June 30	
	2021	2020
Changes in projected benefit obligation:		
Benefit obligation at beginning of year	$ 54,411	51,246
Interest cost	683	1,730
Net actuarial loss	(2,197)	4,929
Settlements	(50,994)	—
Benefits paid	(1,903)	(3,494)
	—	54,411
Changes in plan assets:		
Fair value of plan assets at beginning of year	48,464	45,121
Actual return on plan assets	1,477	3,837
Employer contribution	2,956	3,000
Settlements	(50,994)	—
Benefits paid	(1,903)	(3,494)
	—	48,464
Funded status at end of year	$ —	(5,947)

Amounts recognized in the consolidated balance sheets are included in other noncurrent liabilities.

Accumulated plan benefits equal projected plan benefits. Assumptions used in the accounting for the net periodic pension cost were as follows:

	2021	2020
Discount rate	2.6 %	2.6 %
Expected return on plan assets	4.3	6.0
Rate of compensation increase	N/A	N/A

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Notes to Consolidated Financial Statements

June 30, 2021 and 2020

(15) Functional Expenses

Total operating expenses by function are as follows for the years ended June 30:

	2021			
	Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$ 1,017,375	115,028	1,802	1,134,205
Supplies and other	846,656	97,190	741	944,587
Physician services	297,190	6,245	—	303,435
Insurance	39,458	145	—	39,603
Interest	36,242	3,501	—	39,743
Medicaid provider tax	75,683	—	—	75,683
Depreciation and amortization	131,844	863	—	132,707
Total	$ 2,444,448	222,972	2,543	2,669,963

	2021			
	Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$ 970,553	92,033	2,079	1,064,665
Supplies and other	776,521	82,437	1,152	860,110
Physician services	290,999	10,454	—	301,453
Insurance	29,841	214	—	30,055
Interest	39,490	2,767	—	42,257
Medicaid provider tax	66,640	—	—	66,640
Depreciation and amortization	130,744	865	—	131,609
Total	$ 2,304,788	188,770	3,231	2,496,789

In accordance with ASU 2016-14, Topic 958, Not-for-profit entities are required to report expenses both by their natural classification and their functional classification. Functional classifications have been determined based on their relationship to major program services and supporting activities. For support functions directly related to major program services, an allocation has been applied based on the percentage of time and effort devoted to the program service. For overhead expenses such as utilities and interest expense, an allocation based on square footage has been applied. The costs related to support functions not directly related to program activities have been fully classified as supporting activities.

(16) Contingencies

(a) Litigation

The System is subject to various legal proceedings and claims that are incidental to its normal business activities. In the opinion of the System, the amount of ultimate liability with respect to these actions will not materially affect the consolidated operations or net assets of the System.

(b) Regulatory Investigation and Other

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The System is subject to these regulatory efforts. Additionally, the laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the System and other healthcare organizations. Recently, the federal government has increased its enforcement activity, including audits and investigations related to billing practices, clinical documentation, and related matters. The System maintains a system-wide compliance program and conducts audits and other activities to identify potential compliance issues, including overpayments by governmental payors. Compliance reviews may result in liabilities to government healthcare program, which could have an adverse impact on the System's net patient service revenue.

(c) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the governor of Illinois signed into law, Public Act 97-0688, which created new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. The System certified in 2021 and 2020 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

Schedule 1

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Balance Sheet Information

June 30, 2021

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Eliminations	Consolidated total
Assets											
Current assets:											
Cash and cash equivalents	$ 115,886	23,230	24	1,047	—	—	139,985	7,315	37,028	—	184,639
Patient accounts receivable	393,268	—	40,252	—	2,674	—	436,114	898	129	—	437,141
Current portion of investments limited to use	247,395	—	—	—	—	—	247,395	—	—	—	247,395
Current portion of malpractice self-insurance receivable	16,809	—	—	—	—	—	16,809	—	—	—	16,809
Current portion of pledges receivable	2,289	—	—	—	—	—	2,289	—	—	—	2,289
Due from affiliates	75,109	2,962	106,451	7	10,055	(51,696)	141,888	1,347	531	(144,386)	—
Prepaids, inventory, and other current assets	138,051	944	10,792	243	172	—	150,202	2,513	43,898	(1,217)	195,394
Total current assets	988,636	27,136	156,519	1,297	12,901	(51,696)	1,134,693	12,973	81,584	(145,583)	1,083,667
Investments, limited as to use, less current portion	1,450,252	9,149	151,830	81,212	21,390	(3,185)	1,710,658	—	11,669	—	1,722,327
Property, plant, and equipment, net	1,291,468	6,560	182,836	—	9	—	1,480,880	21,337	6,963	—	1,509,180
Pledges receivable, less current portion	5,708	—	—	—	—	—	5,708	—	—	—	5,708
Malpractice self-insurance receivable, less current portion	90,598	—	—	—	—	—	90,598	—	—	—	90,598
Other assets, net	419,445	(4,773)	5	—	—	(325,220)	89,460	59,950	2,105	(28,658)	122,857
Total assets	$ 4,248,098	38,072	491,189	82,509	34,200	(380,081)	4,511,987	94,270	102,301	(174,241)	4,534,317
Liabilities and Net Assets											
Current liabilities:											
Accounts payable and accrued expenses	$ 229,097	(25,206)	55,868	340	2,392	—	262,486	2,580	18,853	—	282,219
Current portion of long-term debt	17,358	—	3,655	—	—	—	21,013	1,862	—	—	22,875
Current portion of other long-term liabilities	4,442	—	—	—	—	—	4,442	1,550	—	(1,217)	4,775
Estimated third-party payor settlements and Medicare Advance	386,870	—	66,109	—	400	—	452,379	—	2,151	—	454,530
Current portion of malpractice self-insurance liability	16,809	—	—	—	—	—	16,809	—	—	—	16,809
Due to affiliates	—	57,772	8,871	235	75	(51,695)	15,258	71,278	57,830	(144,366)	—
Due to the University of Chicago	29,809	—	—	—	—	—	29,809	—	—	—	29,809
Total current liabilities	684,386	32,564	133,501	575	2,867	(51,695)	802,196	77,570	78,834	(145,583)	811,017
Workers' compensation self-insurance liability, less current portion	8,604	—	—	—	—	—	8,604	—	—	—	8,604
Malpractice self insurance liability, less current portion	90,598	—	(1)	—	—	—	90,597	—	78,043	—	168,640
Long-term debt, excluding current installments	804,227	—	93,490	—	—	—	897,717	40,040	—	—	937,757
Interest rate swap liability	138,563	—	8,799	—	—	—	147,362	—	—	—	147,362
Other long-term liabilities, less current portion	139,904	5,105	14,042	—	325	(2,358)	156,919	28,060	104	(37,470)	145,633
Total liabilities	1,868,181	37,670	249,831	575	3,192	(54,054)	2,103,395	143,690	154,981	(183,053)	2,219,013
Net assets (deficit):											
Without donor restrictions	2,236,167	402	238,199	68,060	31,003	(309,740)	2,263,090	(49,420)	(52,702)	8,812	2,169,780
With donor restrictions	144,750	—	3,160	13,874	5	(16,287)	145,502	—	22	—	145,524
Total net assets (deficit)	2,379,917	402	241,359	81,934	31,008	(326,027)	2,408,592	(49,420)	(52,680)	8,812	2,315,304
Total liabilities and net assets	$ 4,248,098	38,072	491,189	82,509	34,200	(380,081)	4,511,987	94,270	102,301	(174,241)	4,534,317

See accompanying independent auditors' report.

ATTACHMENT 35

39521756.6

Schedule 2

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Statement of Operations and Changes in Net Assets Without Donor Restrictions Information

Year ended June 30, 2021

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CNHD Entities	Eliminations	Consolidated total
Revenue:											
Patient service revenue	$ 1,982,368	—	301,564	—	9,327	—	2,303,237	7,697	22,419	(2,044)	2,331,309
Other operating revenue and net assets released from restriction	403,516	12,583	32,180	1,797	483	(12,600)	437,959	7,716	25,814	(13,844)	457,645
Total operating revenues	2,385,884	12,583	333,744	1,797	9,810	(12,600)	2,741,196	15,413	48,233	(15,888)	2,788,954
Operating expenses:											
Salaries, wages, and benefits	836,458	2,594	144,099	241	6,012	—	1,004,372	12,466	28,803	(1,466)	1,134,205
Supplies and other	799,134	2,469	125,276	1,639	1,872	(1,553)	927,338	8,239	12,358	(3,846)	944,887
Physician services	273,105	972	23,488	24	226	(4,566)	293,269	3,382	14,422	(7,810)	303,436
Insurance	15,722	6,546	8,839	—	145	(6,481)	24,873	1,275	14,993	(1,539)	39,603
Interest	36,234	—	4,294	—	—	—	40,528	943	1	(1,729)	38,743
Medicaid provider tax	19,256	—	19,445	—	—	—	78,663	—	—	—	75,663
Depreciation and amortization	113,175	535	15,888	—	8	—	129,610	2,179	818	—	132,707
Total operating expenses	2,232,085	13,116	341,409	1,904	9,972	(12,600)	2,585,671	28,484	71,485	(15,887)	2,669,063
Operating revenue in excess (deficit) of expenses	153,794	(533)	(7,666)	(107)	(162)	—	154,525	(12,681)	(23,252)	(1)	119,191
Nonoperating gains (losses), net:											
Investment income, net	318,489	2,309	40,808	19,686	6,974	—	387,316	—	—	—	387,316
Change in fair value of nonhedged derivative instruments	—	—	2,537	—	—	—	2,537	—	—	—	2,537
Derivative ineffectiveness on hedged derivative instruments	695	—	—	—	—	—	695	—	—	—	695
Other, net	853	29	(683)	(280)	(85)	—	(186)	—	(433)	368	(251)
Net nonoperating gains (losses)	319,987	2,338	42,662	19,406	6,889	—	390,482	—	(433)	368	390,397
Revenue and gains in excess (deficient) of expenses and losses	483,781	1,805	35,197	19,299	6,727	—	545,787	(12,681)	(23,685)	367	509,588
Other changes in net assets without donor restriction:											
Net asset transfers to University of Chicago, net	(71,750)	—	—	—	—	—	(71,750)	—	—	—	(71,750)
Change in accrued pension benefits other than net periodic benefit costs	2,761	—	—	—	—	—	2,761	—	—	—	2,761
Effective portion of change in valuation of derivatives	44,997	—	—	—	—	—	44,997	—	—	—	44,997
Net assets released from restriction for capital purposes	125	—	—	—	—	—	125	—	—	—	125
Distributions and other, net	—	12,784	(31,255)	(1)	—	—	(18,472)	—	18,456	(27)	(24)
Increase (decrease) in net assets without donor restrictions	$ 459,864	14,587	3,942	19,298	6,727	—	503,418	(12,681)	(5,190)	340	485,687

See accompanying independent auditors' report.

Schedule 3

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2021

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls North Building	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CMHD Entities	Eliminations	Consolidated total
Net assets without donor restrictions:											
Revenue and gains in excess (deficit) of expenses and losses	$ 493,761	1,803	34,187	19,299	5,727	—	945,787	(12,681)	(22,665)	367	809,598
Net asset transfers to University of Chicago, net	(71,760)	—	—	—	—	—	(71,760)	—	—	—	(71,760)
Change in accrued pension benefits other than net periodic benefit cost	2,781	—	—	—	—	—	2,781	—	—	—	2,781
Effective portion of change in valuation of derivatives	44,867	—	—	—	—	—	44,867	—	—	—	44,867
Net assets released from restriction for capital purposes	125	—	—	—	—	—	125	—	—	—	125
Distributions and other, net	—	12,784	(31,220)	(1)	—	—	(18,437)	—	15,495	(27)	(25)
Increase (decrease) in net assets without donor restrictions	469,804	14,587	3,042	19,298	5,727	—	903,418	(12,681)	(7,170)	340	485,687
Net assets with donor restrictions:											
Contributions	12,118	—	—	366	—	—	12,613	—	—	—	12,613
Change in net interest in Foundation	—	—	(547)	—	—	547	—	—	—	—	—
Net assets released from restrictions used for operating purposes	(7,413)	—	—	(845)	—	1,848	(6,510)	—	—	(1,848)	(8,358)
Net assets released from restrictions used for capital purposes	(125)	—	—	—	—	—	(125)	—	—	—	(125)
Investment return, net	28,157	—	—	1,630	—	—	29,787	—	22	—	29,809
Increase (decrease) in net assets with donor restrictions	32,734	—	(547)	1,083	—	2,395	35,665	—	22	(1,848)	33,839
Change in net assets	502,618	14,587	3,395	20,381	5,727	2,395	939,083	(12,681)	(7,148)	(1,508)	519,526
Net assets (deficit) at beginning of year	1,887,299	(14,185)	237,893	61,553	25,281	(329,432)	1,869,599	(36,539)	(47,812)	10,320	1,796,770
Net assets (deficit) at end of year	$ 2,379,917	402	241,288	81,934	31,008	(326,037)	2,408,682	(49,420)	(55,660)	8,812	2,316,296

See accompanying independent auditors' report.

Economic Feasibility

Attachment 36

Economic Feasibility

F. Reasonableness of Financing Arrangements.

The Project will be financed through cash on hand and securities and a lease. Letters attesting to the reasonableness of the financing arrangements are attached.

G. Conditions of Debt Financing.

The Project is being paid for through cash and securities and therefore, these criteria do not apply.

H. Reasonableness of Project and Related Costs.

There are no state standards for Master Design Permits and those standards will be addressed in the Construction CON application.

I. Project Operating Costs

Because this project is for a Master Design Permit, there are no associated operating costs.

J. Total Effect of Project on Capital Costs

Annual Project Depreciation	$5,262,188
Equivalent Patient Days	831,367
Capital Cost per Equiv. Pat. Day	$6.33
UCMC Capital Cost FY 2021	$37,569,000

Section XI, Safety Net Impact Statement

Attachment 37

Since the proposed Project is a non-substantive project, the safety net impact statement is not applicable. Nevertheless, for informational purposes, a copy of UCMC's 2020 Community Benefit Report is included in Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**FY19**	**FY20**	**FY21**
Inpatient	695	940	340
Outpatient	10,535	21,192	14,870
Total	**11,230**	**22,132**	**15,210**
Charity (cost in dollars)			
Inpatient	$12,182,929	$17,320,551	$3,505,779
Outpatient	$11,497,252	$24,157,208	$16,982,180
Total	**$23,680,181**	**$41,477,759**	**$20,487,959**
MEDICAID			
Medicaid (# of patients)	**FY19**	**FY20**	**FY21**
Inpatient	12,278	11,635	12,335
Outpatient	152,071	147,940	138,695
Total	**164,349**	**159,576**	**151,030**
Medicaid (revenue)			
Inpatient	$346,893,000	$334,038,769	$409,276,752
Outpatient	$110,369,000	$88,188,976	$143,646,625
Total	**$457,262,000**	**$422,227,745**	**$552,923,377**

Charity Care Information

Attachment 38

Shown below is the amount of charity care provided by UCMC

CHARITY CARE			
	FY19	**FY20**	**FY21**
Net Patient Revenue	**$2,121,969,000**	**$1,746,725,000**	**$2,000,232,997**
Amount of Charity Care (charges)	$138,262,328	$181,577,629	$115,238,011
Cost of Charity Care	$23,680,181	$41,477,759	$20,487,959
Ratio of Charity Care Cost to Net Patient Rev.	1.12%	2.37%	1.02%


AT THE FOREFRONT
UChicago Medicine
AT THE FOREFRONT OF HEALTH EQUITY
2020 Community Benefit Report Highlights

To you, our community.

Through community benefit programs, partnerships and other investments, the University of Chicago Medicine, with its Urban Health Initiative and its community and healthcare partners, seek to improve health equity for residents of Chicago's South Side. We want to make sure that everyone is able to live their most healthful life.

In 2020, the COVID-19 pandemic highlighted stark health disparities. Our Black and Brown communities bore the heaviest burden of the COVID-19 pandemic, through illness, loss of life and economic hardship. These disparities demonstrate how racism is a public health crisis.

Throughout the pandemic, the University of Chicago Medicine has been focused on providing world-class care to our patients and our community and working with our Community Advisory Council and community partners to continue to advance health equity.

We invite you to learn about our community investment and how we partner with the community to respond to crisis, deal with community health priorities and work to build a healthier South Side.

Kenneth S. Polonsky, MD
Dean and Executive Vice President for Medical Affairs

Tom **Jacklewicz**
President, University of Chicago Medical Center

Branda Battle, RN, BSN, MBA
Senior Vice President for Community Health Transformation and Chief Diversity, Equity and Inclusion Officer

TO VIEW THE FULL REPORT, VISIT
Community.UChicagoMedicine.org/2020

COVER: OSCAR SANCHEZ PHOTO

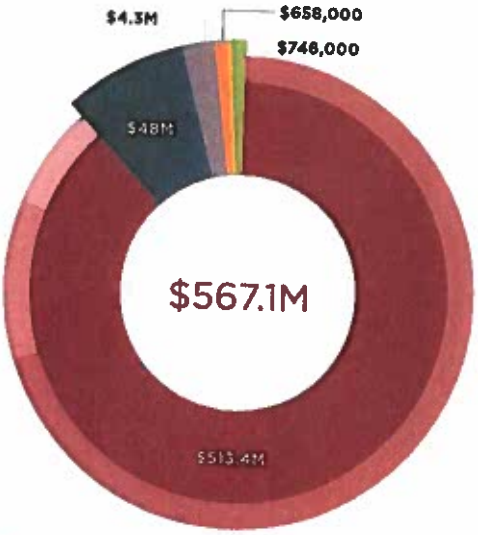
Fiscal 2020 Investment in the Community:

$567.1 Million

Increase of 9.2% over fiscal 2019

This investment included supporting patients who rely on Medicare or Medicaid or who were not able to pay for care. It also included teaching and training future healthcare professionals, funding medical research and donating to community groups for health and wellness programs.

Total Investment: Fiscal 2020



- Uncompensated care
  - $405.6M Medicaid and Medicare program losses
  - $66.3M Unrecoverable patient debt
  - $41.5M Medicaid program losses
- $48M Medical research
- $4.3M Uncategorized community benefits
- $658,000 Cash/in kind
- $746,000 Medical education

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HEALTH EQUITY

It is undeniable: Racism is a public health crisis.

UChicago Medicine is working within the medical center, in the community and across the city to end health disparities and promote health equity, including:

- In June 2020, UChicago Medicine and more than 40 healthcare organizations took a health equity pledge to overcome health disparities in minority communities. The open letter was published in the Chicago Sun-Times and Chicago Tribune.
- UChicago Medicine announced a system-wide Equity Plan to identify and address inequities in the workforce, work climate, healthcare delivery and services, and community.
- Along with St. Bernard Hospital and Advocate Trinity Hospital, UChicago Medicine launched the South Side Health Transformation Project to bring together federally qualified health centers (FQHCs), faith leaders, community organizations, elected officials and residents to secure state funding and support for a new South Side health transformation plan. Nearly 500 people have joined the effort.

Life expectancy on Chicago's South Side in Englewood is **only 60 years old.** Just 9 miles north in Streeterville, the average life expectancy is **90.**

Source
City Health Dashboard

In fiscal 2020, the Diversity, Inclusion and Equity Office provided 7,418 hours of cultural competence training to staff — an increase of 121 percent over the prior year.

HEALTH PRIORITIES

Health priorities identified in 2018-2019 Community Health Needs Assessment:

- Prevent and manage chronic diseases (asthma, diabetes)
- Build trauma resiliency (violence recovery, mental health)
- Reduce inequities caused by social determinants of health (access to care, food insecurities, employment)

In 2020, UChicago Medicine provided important programs, events* and resources to support community health priorities:

ASTHMA

- 830 in-person and virtual visits made to 279 children and families by community health workers to provide asthma education (via South Side Pediatric Asthma Center (SSPAC))
- 119 attendees for SSPAC's virtual asthma education summit

DIABETES

- 698 attendees for 215 fitness sessions for South Side Fit program
- 94 attendees for 9 workshops for Diabetes Education & Empowerment Program (DEEP™)

TRAUMA RESILIENCY

- 1,500 patients and 586 families served by the Violence Recovery Program, a part of the Block Hassenfeld Casdin (BHC) Collaborative for Family Resilience
- Violence prevention summit hosted by Southland RISE (Resilience Initiative to Strengthen and Empower), a collaboration with Advocate Health Care inspired by U.S. Senator Dick Durbin's Chicago HEAL (Hospital Engagement, Action and Leadership) program
- $100,000 awarded to 14 grassroots organizations by Southland RISE for summer violence prevention programs

*includes virtual and in-person events prior to pandemic

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COVID-19 RESPONSE

Meeting the community's needs during the pandemic

Since the pandemic started, UChicago Medicine has worked with its partners to quickly identify and respond to the community's needs, providing such resources as:

- PPE donations
- Food pantry
- COVID-19 testing
- Patient contact tracing
- Phase 3 vaccine trials
- Emergency relief funding
- Vaccine distribution and information
- COVID-19 educational resources

Community Health Workers: Healthcare ambassadors to our South Side neighborhoods
Community health workers (CHWs) play an important role in providing care and health-related education to patients, often in their homes. In addition to asthma education offered through the South Side Pediatric Asthma Center, CHWs also provided 124 families with food, transportation and supplies in response to the pandemic.

WORKFORCE AND COMMUNITY INVESTMENT

We can reduce inequities by increasing employment opportunities for our South Side residents

$22 million
funds granted for local hiring since 2019, leading to 76 local hires (minimum 3- to 5-year, living wage jobs)

85% 90-day retention rate of South Side hires

24% of total workforce live in the UChicago Medicine service area

Hiring local talent: UChicago Medicine hires local talent like Dwayne Johnson to help build its workforce and strengthen communities. A South Shore resident, Johnson is a founding team member of the Violence Recovery Program, the only hospital-based violence intervention program in Chicago serving adults and children.

We value local and diverse partnerships for purchasing and construction projects

$20.8 million
contracts awarded and paid to certified minority and women-owned firms

$4.3 million
wages to minority and female construction workers

$1.9 million
wages earned by 208 Chicago residents working on UChicago Medicine construction projects

Community benefit service area by ZIP code

60609	60628
60615	60636
60617	60637
60619	60643
60620	60649
60621	60653

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