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: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center – Patient Pavilion & CAC Modernization and Expansion				
Street Address: 836 W Wellington Avenue				
City and Zip Code: Chicago, IL 60657-5147				
County:	Cook	Health Service Area:	6	Health Planning Area: A-01

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

Exact Legal Name: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Street Address: 836 W. Wellington Ave
City and Zip Code: Chicago, IL 60657-5147
Name of Registered Agent: Michael Kerns
Registered Agent Street Address: 3075 Highland Parkway, Suite 600
Registered Agent City and Zip Code: Downers Grove, IL 60515
Name of President: William P. Santulli
President Street Address: 3075 Highland Parkway, Suite 600
President City and Zip Code: Downers Grove, IL 60515
President Telephone Number: (630) 573-9393

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Susan Nordstrom Lopez
Title: President, Advocate Illinois Masonic Medical Center
Company Name: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Address: 836 W. Wellington Ave, Chicago, IL 60657-5147
Telephone Number: (773) 296-7081
E-mail Address: susannordstrom.lopez@aah.org
Fax Number: (773) 296-5251

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

Name: Myndee Balkan
Title: Health Facility Planning, Director
Company Name: Advocate Aurora Health, Inc
Address:
Telephone Number: (847) 721-0376
E-mail Address: myndee.balkan@aah.org

Name: Roberto Orozco
Title: Director, Planning, Design, & Construction
Company Name: Advocate Aurora Health, Inc
Address: 1775 Dempster Street, Park Ridge, IL 60068
Telephone Number: (773) 308-4474
E-mail Address: roberto.orozco@aah.org
Fax Number: N/A

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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City and Zip Code: Chicago, IL 60657-5147				
County:	Cook	Health Service Area:	6	Health Planning Area: A-01

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

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

Type of Ownership of Applicants

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
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Street Address: 836 W Wellington Avenue
City and Zip Code: Chicago, IL 60657-5147
County: Cook Health Service Area: 6 Health Planning Area: A-01

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

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

Type of Ownership of Applicants

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
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Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Susan Nordstrom Lopez
Title: President, Advocate Illinois Masonic Medical Center
Company Name: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
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Telephone Number: (847) 721-0376
E-mail Address: myndee.balkan@aah.org

Name: Roberto Orozco
Title: Director, Planning, Design, & Construction
Company Name: Advocate Aurora Health, Inc
Address: 1775 Dempster Street, Park Ridge, IL 60068
Telephone Number: (773) 308-4474
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City and Zip Code: Chicago, IL 60657-5147				
County:	Cook	Health Service Area:	6	Health Planning Area: A-01

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

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

Type of Ownership of Applicants

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

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Name: Susan Nordstrom Lopez
Title: President, Advocate Illinois Masonic Medical Center
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Title: Health Facility Planning, Director
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Fax Number:

Name: Roberto Orozco
Title: Director, Planning, Design, & Construction
Company Name: Advocate Aurora Health, Inc
Address: 1775 Dempster Street, Park Ridge, IL 60068
Telephone Number: (773) 308-4474
E-mail Address: roberto.orozco@aah.org
Fax Number: N/A

Post Permit Contact

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

Name: Scott Nelson
Title: Vice President, Planning, Design & Construction
Company Name: Advocate Aurora Health, Inc
Address: 3075 Highland Parkway, Suite 400, Downers Grove, IL 60515
Telephone Number: (630) 929-5575
E-mail Address: scott.nelson@aah.org
Fax Number: (630) 990-4798

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Address of Site Owner: 836 W. Wellington Avenue, Chicago, IL 60657-5147
Street Address or Legal Description of the Site: 836 W. Wellington Avenue, Chicago, IL 60657-5147 **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: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Address: 836 W. Wellington Avenue, Chicago, IL 60657-5147
☒ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o 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. o **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.

Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center, Advocate Health and Hospitals Corporation, Advocate Health Care Network, and Advocate Aurora Health, Inc., the applicants, propose to construct a 4-story Center for Advanced Care (CAC) building expansion attached to the Hospital's Center for Advanced Care (CAC) and a 5-story Bed Tower (including the penthouse) on top of the existing and expanded Center for Advanced Care (CAC) at Advocate Illinois Masonic Medical Center. The site is located on hospital campus at 836 Wellington Avenue, Chicago, IL.

CAC Expansion

The project will include a three-floor addition with a penthouse attached to the Center for Advanced Care (**CAC**). The expansion of the CAC will provide additional access and coordination to support the expanding growth of the outpatient services and patients utilizing Advocate Illinois Masonic Medical Center's destination programs. The project will include other non-clinical spaces including physician offices, staff and administration support areas, family support and conference space. In addition to the expansion of the Outpatient Cancer Center and Breast Imaging, this building will expand the facility to include the surgical and cardiac catherization platform to accommodate growth and replace outdated and inadequate facilities.

- The **new ground floor/lower level** is being designed to include a Breast Center with Mammography, Breast Ultrasound and DEXA services that are currently in leased medical office building space and will return to the hospital space as a result of the project.
- The **first floor** will be an expansion of the Oncology Outpatient clinic services with dedicated multidisciplinary offices and additional oncology examination and consultation rooms.
- There is no second floor as the floors must match with the existing hospital.
- The **third floor** of the CAC will include expansion of the OR platform to connect with the existing CAC and the main hospital building (Stone). This project will include relocation and modernization of the operating rooms, the cardiac catherization labs and electrophysiology rooms; providing up to date and appropriately sized rooms. In addition to the ORs and cath labs, prep and recovery rooms are included to create a comprehensive interventional floor.
- The **fourth floor** will provide the required mechanical, plumbing, and electrical equipment for the new CAC building extension.

New Bed Tower

A new bed tower will be built on top of the expanded and current CAC. This will include relocation of Inpatient Medical/Surgical and Intensive Care Beds from the Main Hospital Bed Tower (Stone building) and Postpartum and NICU beds from a 1908 building. The modernization of these Inpatient units will be designed to provide Inpatient rooms that meet current standards and provide all single occupancy private rooms.

The number of beds in each of the Clinical Services have been determined based on current and projected inpatient utilization. The Hospital currently has 397 total hospital CON authorized beds. At completion of the project, the total beds will be reduced to 326 beds.

The fifth floor of the new bed tower will include LDR, C-Section, triage, and Postpartum Rooms with the NICU beds to create an Obstetric/NICU floor.

- The number of Post-partum beds will be reduced from 44 to 24.
- The number of NICU beds will be reduced from 34 to 22.

The sixth floor of the new bed tower will include 19 Medical/Surgical and 37 Intensive Care beds.

The seventh and eight floors of the new bed tower will include Medical/Surgical beds, with 56 beds on each floor.

Two medical surgical units totaling 56 M/S beds will remain in the Classic (Stone) building and be modernized. Upon project completion:

- The total number of M/S beds will reduce from 225 to 187.
- The number of ICU beds will increase from 33 to 37.

Modernization of the Main Hospital

Modernization of the first and third floor of the Main hospital (Stone) will include renovation and expansion of the existing cardiology services and current operating rooms.

- The current first floor will include expansion of Cardiac non-invasive (diagnostic testing). This will increase the Cardiology/ Heart Institute Outpatient services to include additional infusion, exam space, and clinics such as heart failure, structural heart, valve, chest pain and other cardiovascular clinics. The design will provide appropriate space, greater staff efficiency and a cohesive patient experience to increase access for these patients.
- The project expands the surgical interventional platform and includes modernization of the ORs and the surgical areas to create a coordinated platform for all surgical services including Cardiac Cath, and EP. The third floor will connect the current CAC, the CAC expansion, and the existing Stone building to create one floor.
  There are currently 17 Class C operating rooms (including 2 eye OR rooms) and one class C cystoscopy procedure room. Upon project completion, there will be 19 Class C operating rooms. One additional OR will be used for cystoscopy procedures and will allow for the discontinuation of the Cysto procedure room.

These new operating and procedural rooms will provide up to date, appropriate room sizes to

meet current technology and procedures.

- The 2 Eye OR rooms located in the main hospital will remain in their current location and do not require modernization as part of the project.
- Four rooms for Cath/EP interventional procedures are being relocated to new space adjoining the surgery department. These rooms will be used for diagnostic cardiac catherization, interventional catherization, peripheral intervention and electrophysiology cardiology procedures.

The Project will provide a 17 bed Phase I post anesthesia care unit (PACU) and a 38 bed Phase II prep/recovery area to support the 17 ORs in the project.
Phase II pre/recovery rooms will increase from 26 to 38 surgical prep and recovery rooms in the expansion to provide the appropriate ratio required for IP and OP surgical procedures. There will additionally be 4 PACU and 12 Phase II prep/recovery for the Cath/EP rooms.
This co-location of the procedural suites on one interventional floor provides the maximum efficiency, effective clinical coverage, and a better coordinated patient experience.

Inpatient Rehabilitation will remain at 22 licensed beds and will be relocated to the sixth floor of the Stone building in areas vacated by the relocation of M/S and ICU beds. These areas will be modernized to provide updated private patient rooms.

Inpatient Acute Mental Illness beds will be relocated to the Stone building areas vacated by the relocation of M/S beds and will decrease from 39 to 34 beds. This area will also be modernized to provide updated patient rooms.

The project will also modernize and relocate multidisciplinary physician exam rooms and other non-clinical areas including the lobby, waiting, registration, administration, staff locker rooms, and support services that will be moved from buildings that will be demolished into vacated space in the hospital.

Demolition of outdated buildings 4, 5 and 6 will be included at the end of the project, as these buildings will no longer be appropriate for patient care areas and these units are relocated to the newly constructed buildings. The facility and functional assessments determined that these buildings no longer are within contemporary planning standards and are not candidates for continued facility investment.

The project is expected to cost $644,718,104 with 332,780 square feet of new construction (187,278 of clinical and 145,502 of non clinical) and 260,493 square feet of modernization (67,469 of clinical and 193,024 of non clinical space).

The project is being designed to target LEED Silver for Healthcare to improve indoor environmental quality, energy efficiency, the use of sustainable materials and keep staff and patients healthier.

The anticipated completion date is June 30, 2030.
The project is classified as a non-substantive project, as the project does not establish or discontinue a catagory of service.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			

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

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

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

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

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

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): June 30, 2030

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: Advocate Illinois Masonic Medical Center		**CITY: Chicago**			
REPORTING PERIOD DATES:		**From: Jan 1, 2020**		**to: Dec. 31, 2020**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	225	6,752	37,740	-38	187
Obstetrics	44	1,794	4,849	-20	24
Pediatrics					
Intensive Care	33	2,325	9,495	+4	37
Comprehensive Physical Rehabilitation	22	386	5,771	0	22
Acute/Chronic Mental Illness	39	1,040	7,807	-5	34
Neonatal Intensive Care	34	210	1,735	-12	22
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other – peds			10		
TOTALS:	397	12,105	67,407	-71	326

CERTIFICATION

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

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

This Application is filed on the behalf of Advocate North Side Health Network* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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
James H. Skogsbergh PRINTED NAME	William P. Santulli PRINTED NAME
Executive Vice President, Chief Operating Officer PRINTED TITLE	President PRINTED TITLE
Notarization: Subscribed and sworn to before me this 21st day of January, 2022	Notarization: Subscribed and sworn to before me this 20th day of January, 2022
Signature of Notary	Signature of Notary
Seal "OFFICIAL SEAL" MICHAEL E. KERNS Notary Public, State of Illinois My Commission Expires on May 26, 2022	Seal "OFFICIAL SEAL" MICHAEL E. KERNS Notary Public, State of Illinois My Commission Expires on May 26, 2022

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of Advocate Health and Hospitals Corporation* 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

James H. Skogsbergh
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of January

OFFICIAL SEAL
MICHAEL E. KERNS
Notary Public, State of Illinois
My Commission Expires on May 24, 2022
Signature of Notary

Seal

THIS 26TH Day of January, 2022

SIGNATURE

William P. Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of January

"OFFICIAL SEAL"
MICHAEL E. KERNS
Notary Public, State of Illinois
Signature of Notary
My Commission Expires on May 24, 2022

Seal

THIS 26TH DAY of January, 2022

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- 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 Advocate Health Care Network* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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
James H. Skogsbergh PRINTED NAME	William P. Santulli PRINTED NAME
President and CEO PRINTED TITLE	Chief Operating Officer PRINTED TITLE
Notarization: Subscribed and sworn to before me this 26th day of January 2022	Notarization: Subscribed and sworn to before me this 26th day of January 2022
Signature of Notary	Signature of Notary
Seal "OFFICIAL SEAL" MICHAEL E. KERNS Notary Public, State of Illinois My Commission Expires on May 26, 2022	Seal "OFFICIAL SEAL" MICHAEL E. KERNS Notary Public, State of Illinois My Commission Expires on May 26, 2022

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of Advocate Aurora Health, Inc * 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

James H. Skogsbergh
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26TH day of January, 2022

Signature of Notary

Seal

"OFFICIAL SEAL"
MICHAEL E. KERNS
Notary Public, State of Illinois
My Commission Expires May 26, 2022

SIGNATURE

William P. Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26TH day of January, 2022

Signature of Notary

Seal

"OFFICIAL SEAL"
MICHAEL E. KERNS
Notary Public, State of Illinois
My Commission Expires May 26, 2022

*Insert the 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.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

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

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

1. Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Medical/Surgical**		
☐ **Obstetric**		
☐ **Pediatric**		
☐ **Intensive Care**		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

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

B. Criterion 1110.205 - Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize the Comprehensive Physical Rehabilitation category of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Comprehensive Physical Rehabilitation**		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.205(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110. 205(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.205(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.205(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.205(b)(5) - Planning Area Need - Service Accessibility	X		
1110.205(c)(1) - Unnecessary Duplication of Services	X		
1110.205(c)(2) - Maldistribution	X		
1110.205(c)(3) - Impact of Project on Other Area Providers	X		
1110.205(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.205(d)(4) - Occupancy			X
1110.205(e)(1) - Staffing Availability	X	X	
1110.205(f) - Performance Requirements	X	X	X
1110.205(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.210 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize the Acute Mental Illness and Chronic Mental Illness categories of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Acute Mental Illness**		
☐ **Chronic Mental Illness**		

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

APPLICABLE REVIEW CRITERIA	**Establish**	**Expand**	**Modernize**
1110.210(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.210(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.210(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.210(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.210(b)(5) - Planning Area Need - Service Accessibility	X		
1110.210(c)(1) - Unnecessary Duplication of Services	X		
1110.210(c)(2) - Maldistribution	X		
1110.210(c)(3) - Impact of Project on Other Area Providers	X		
1110.210(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.210(d)(4) - Occupancy			X
1110.210(e)(1) - Staffing Availability	X	X	
1110.210(f) - Performance Requirements	X	X	X
1110.210(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Criterion 1110.225 - Cardiac Catheterization

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

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

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

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

1. Criterion 1110.225(a), Peer Review

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

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

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

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

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

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

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

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

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

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

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

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

5. Criterion 1110.225(e), Support Services

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

6. Criterion 1110.225(f), Laboratory Location

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

7. Criterion 1110.225(g), Staffing

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

8. Criterion 1110.225(h), Continuity of Care

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

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

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

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

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

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

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

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

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

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

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 22 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

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

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 30, 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]:**

_____	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.
	TOTAL FUNDS AVAILABLE

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 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: _____
(Name) (Address)

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

2. Project Location: _____
(Address) (City) (State)

_____
(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 ___

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

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: _____

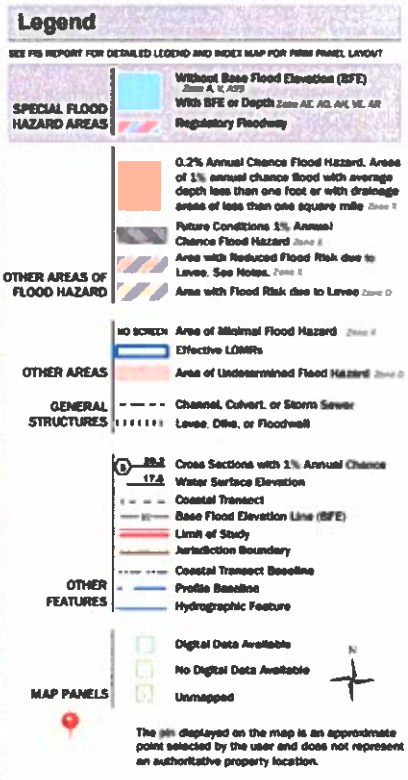
NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

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.

National Flood Hazard Layer FIRMette



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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	44 - 56
2	Site Ownership	57 - 58
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	59 - 71
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	72 - 73
5	Flood Plain Requirements	74 - 75
6	Historic Preservation Act Requirements	76
7	Project and Sources of Funds Itemization	77 - 79
8	Financial Commitment Document if required	80
9	Cost Space Requirements	81 - 82
10	Discontinuation	NA
11	Background of the Applicant	83 - 99
12	Purpose of the Project	100 -113
13	Alternatives to the Project	114 - 119
14	Size of the Project	120 -122
15	Project Service Utilization	123 - 126
16	Unfinished or Shell Space	NA (127)
17	Assurances for Unfinished/Shell Space	NA (128)
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	129 - 164
19	Comprehensive Physical Rehabilitation	165 - 168
20	Acute Mental Illness	169 - 172
21	Open Heart Surgery	NA
22	Cardiac Catheterization	173 - 181
23	In-Center Hemodialysis	NA
24	Non-Hospital Based Ambulatory Surgery	NA
25	Selected Organ Transplantation	NA
26	Kidney Transplantation	NA
27	Subacute Care Hospital Model	NA
28	Community-Based Residential Rehabilitation Center	NA
29	Long Term Acute Care Hospital	NA
30	Clinical Service Areas Other than Categories of Service	182 - 207
31	Freestanding Emergency Center Medical Services	NA
32	Birth Center	NA
	Financial and Economic Feasibility:	
33	Availability of Funds	208 - 235
34	Financial Waiver	NA (236)
35	Financial Viability	NA (236)
36	Economic Feasibility	237- 242
37	Safety Net Impact Statement	243 – 250
38	Charity Care Information	251 - 252
39	Flood Plain Information	253 - 254

Type of Ownership of Applicants

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

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

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

See Attachment #1, Exhibits 1, 2, 3, 4, 5.

File Number 5237-115-5

To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE NORTH SIDE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 2132702616 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 2132702582 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

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

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

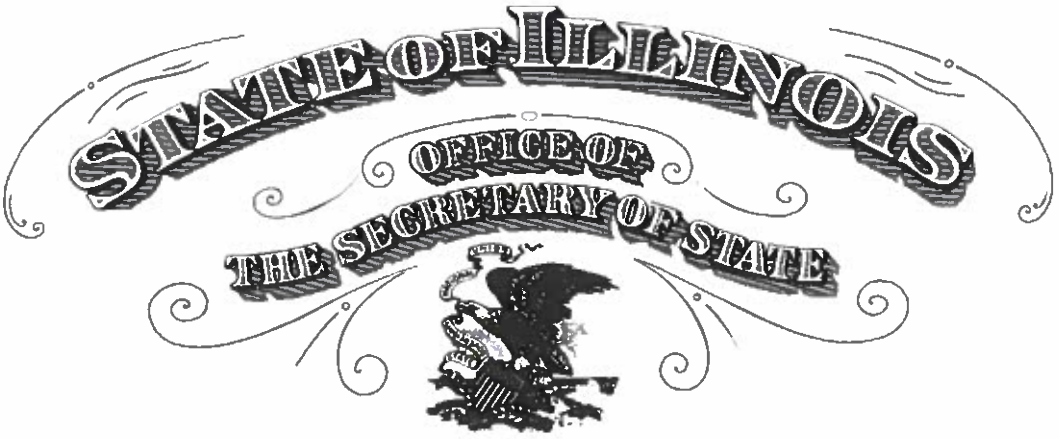
Authentication #: 2132702514 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

File Number 7155-851-7



To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE AURORA HEALTH, INC., INCORPORATED IN DELAWARE AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 03, 2018, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

Authentication #: 2132702480 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

11/23/2021 4:27:38PM

File Number: 6645600 Incorporation Date / Formation Date: 12/4/2017

Entity Name: ADVOCATE AURORA HEALTH, INC.

Entity Kind: Corporation Entity Type: Exempt

Residency: Domestic State: DELAWARE

Status: Good Standing Status Date: 3/4/2019

Registered Agent Information

Name: THE CORPORATION TRUST COMPANY

Address: CORPORATION TRUST CENTER 1209 ORANGE ST

City: WILMINGTON Country:

State: DE Postal Code: 19801

Phone: 302-658-7581

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

APRIL 3, 2018 7155-851-7

CT CORPORATION SYSTEM
118 W EDWARDS #200
SPRINGFIELD IL 62704

RE ADVOCATE AURORA HEALTH, INC.

DEAR SIR OR MADAM:

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

PAYMENT OF THE FILING FEE IS HEREBY ACKNOWLEDGED.

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

SINCERELY,

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

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

Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1594
www.cyberdriveillinois.com

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

FILED

APR 0 3 2018

JESSE WHITE
SECRETARY OF STATE

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

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

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

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

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

2. a. State or Country of Incorporation: Delaware

   b. Date of Incorporation: December 4, 2017

   c. Period of Duration: Permanent

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

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

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

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

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

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

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

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

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

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

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

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

See attached.

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

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

Dated April 1, 2018 (Month, Day) , 2018 (Year) Advocate Aurora Health, Inc. (Exact Name of Corporation)

(Authorized Officer's Signature)

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

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

7155-8517

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

Section 6: NAMES AND ADDRESSES OF DIRECTORS AND OFFICERS

Officers:

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

4835-2888-4084.2

7155 8517

Directors:

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

7155-8517

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

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

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

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

7155-8517

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: **Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center**
Address of Site Owner: **836 W. Wellington Avenue, Chicago, IL 60657-5147**
Street Address or Legal Description of the Site: 836 W. Wellington Avenue, Chicago, IL 60657-5147 **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.

See Attachment #2, Exhibit 1.

AdvocateAuroraHealth

3075 Highland Parkway
Suite 600
Downers Grove, Illinois 60515

T (630) 572-9393
advocateaurorahealth.org

January 27, 2022

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

RE: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center Patient Pavilion and CAC Modernization and Expansion Project

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center owns the site.

We trust this attestation complies with the State Agency Proof of Ownership requirements indicated in the Permit application – September 2018 edition.

Respectfully,

William Santulli
Chief Operating Officer
Advocate Aurora Health, Inc.

Notarization:

Subscribed and sworn to before me
This 27th day of January, 2022.

(Seal of Notary)

"OFFICIAL SEAL"
MICHAEL E. KERNS
Notary Public, State of Illinois
My Commission Expires on May 26, 2022

Signature of Notary

Advocate Health Care Aurora Health Care

Operating Identity/Licensee

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

Exact Legal Name: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Address: 836 W. Wellington Ave, Chicago, IL

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

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

Certificates of Good Standing for Advocate North Side Health Network, Advocate Health and Hospital Corporation, Advocate Health Care Network, and Advocate Aurora Health Inc. are appended as Attachment #03, Exhibits 1, 2, 3, 4, and 5.

File Number 5237-115-5

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

ADVOCATE NORTH SIDE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1981, 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.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

Authentication #: 2132702616 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White
SECRETARY OF STATE

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 2132702582 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 2132702514 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

File Number 7155-851-7

To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE AURORA HEALTH, INC., INCORPORATED IN DELAWARE AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 03, 2018, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

Authentication #: 2132702480 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

11/23/2021 4:27:38PM

File Number: 6645600 Incorporation Date / Formation Date: 12/4/2017

Entity Name: ADVOCATE AURORA HEALTH, INC.

Entity Kind: Corporation Entity Type: Exempt

Residency: Domestic State: DELAWARE

Status: Good Standing Status Date: 3/4/2019

Registered Agent Information

Name: THE CORPORATION TRUST COMPANY

Address: CORPORATION TRUST CENTER 1209 ORANGE ST

City: WILMINGTON Country:

State: DE Postal Code: 19801

Phone: 302-658-7581

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

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

CT CORPORATION SYSTEM
118 W EDWARDS #200
SPRINGFIELD IL 62704

RE ADVOCATE AURORA HEALTH, INC.

DEAR SIR OR MADAM:

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

PAYMENT OF THE FILING FEE IS HEREBY ACKNOWLEDGED.

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

SINCERELY,

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

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

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

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

FILED

APR 0 8 2018

JESSE WHITE
SECRETARY OF STATE

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

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

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

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

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

2. a. State or Country of Incorporation: Delaware

   b. Date of Incorporation: December 4, 2017

   c. Period of Duration: Permanent

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

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

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

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

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

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

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

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

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

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

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

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

See attached.

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

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

Dated April 1, 2018 (Month, Day) , 2018 (Year) Advocate Aurora Health, Inc. (Exact Name of Corporation)

(Authorized Officer's Signature)

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

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

7155-8517

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

Section 6: NAMES AND ADDRESSES OF DIRECTORS AND OFFICERS

Officers:

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

4835-2888-4084.2

7155 8517

Directors:

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

7155-8517

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

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

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

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

7155-8517

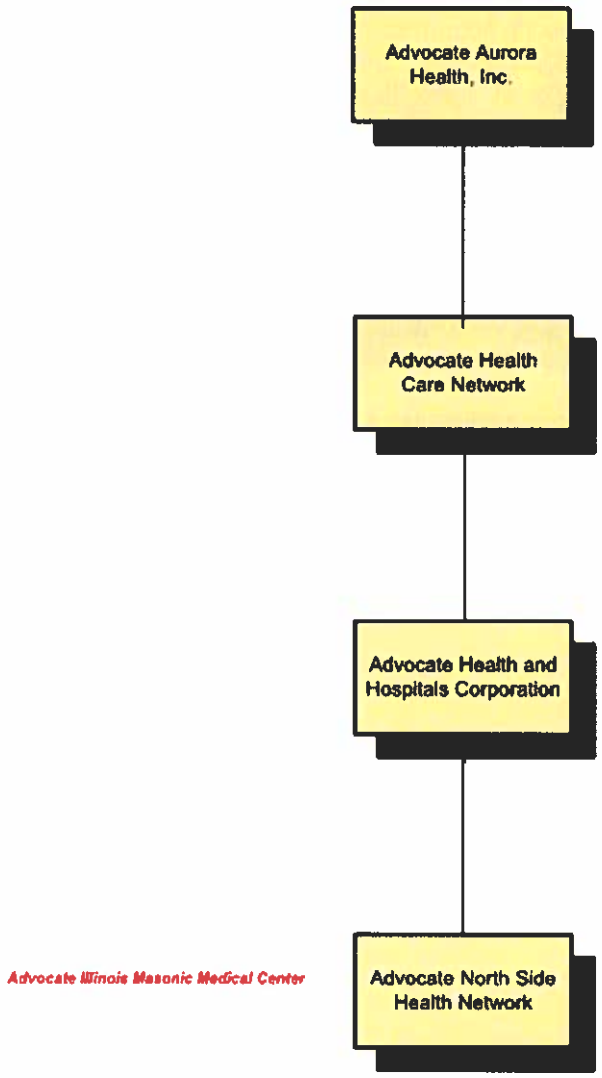
- Aurora Health Care Metro, Inc.
- Aurora Health Care Southern Lakes, Inc.
- AMG Illinois, Ltd.
- Aurora Medical Center Grafton

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.

See Attachment #4, Exhibit 1.



= Not for Profit

Red = Operating Divisions

100% Ownership

11/23/202

Flood Plain Requirements

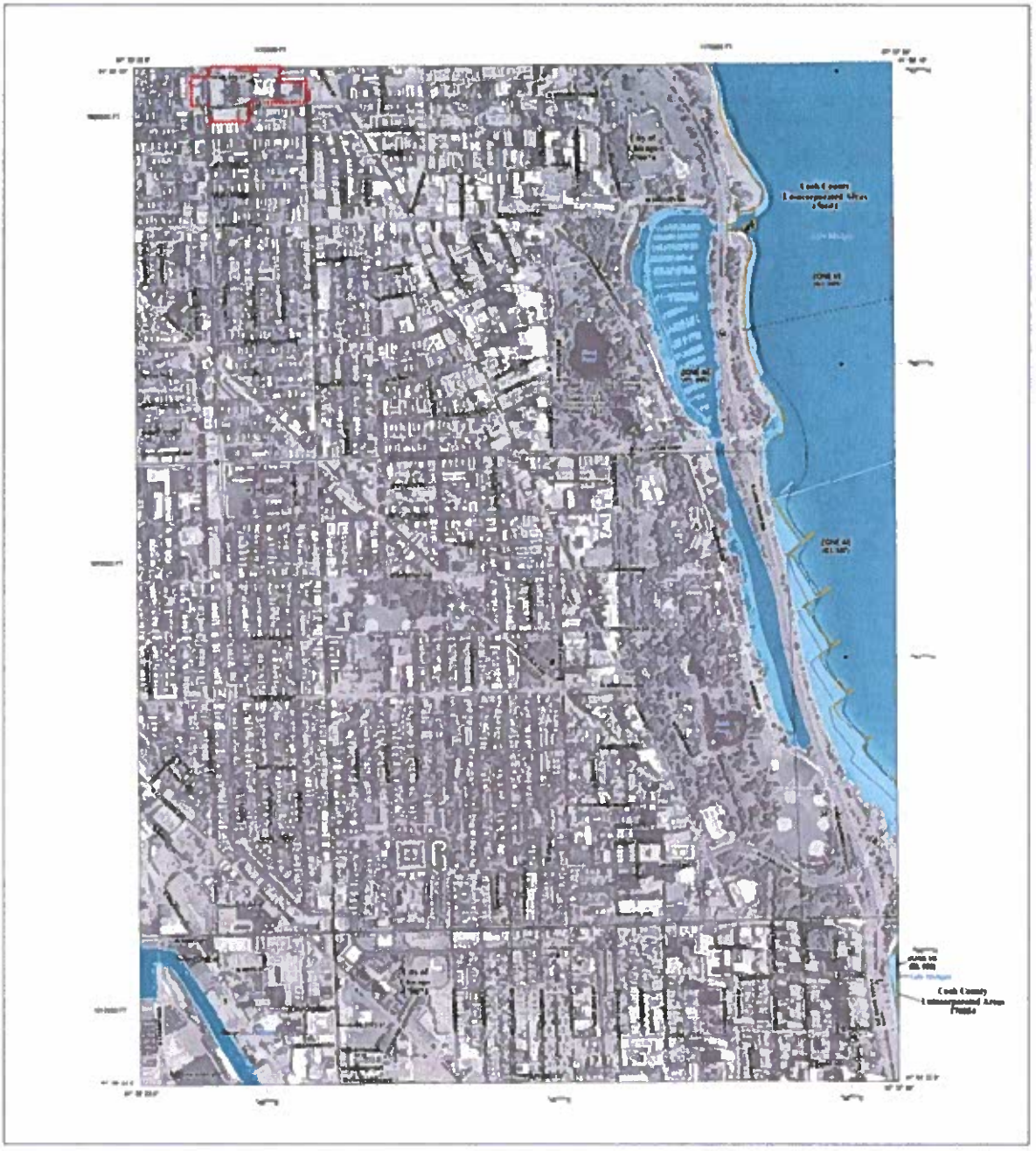
[Refer to application instructions.]

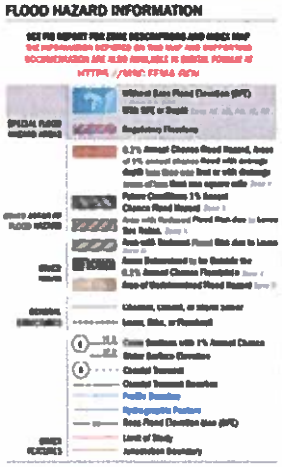
Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain 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.

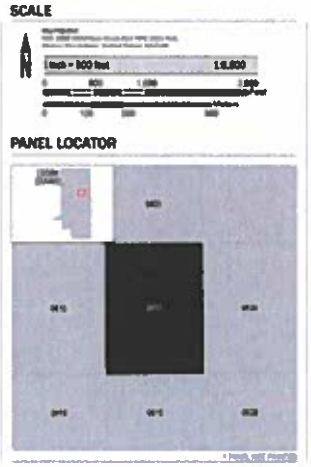
By their signatures on the certifications, the applicants certify that the site for the proposed project is not in a flood plain, as identified by the most recent FEMA Flood Insurance Rate Map for this location. Because the Project is not in a Special Flood Hazard Area, it complies with Illinois Executive Order #2006-5

See Attachment #5, Exhibit 1.




FLOOD HAZARD INFORMATION


NOTES TO USERS


SCALE
PANEL LOCATOR


FEMA
National Flood Insurance Program
NATIONAL FLOOD INSURANCE PROGRAM
COOK COUNTY, ILLINOIS

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.

A letter was sent to the Illinois Department of Natural Resources (IDNR) on February 11, 2022 requesting a determination letter for this project. The IDNR, Historic Preservation Division is in the process of replying to that request.

Project Costs and Sources of Funds

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

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	**CLINICAL**	**NON CLINICAL**	**TOTAL**
Preplanning Costs	$ 2,255,000	$ 3,965,000	$ 6,220,000
Site Survey and Soil Investigation	$ -	$ 525,000	$ 525,000
Site Preparation	$ 2,250,000	$ 12,687,303	$ 14,937,303
Off Site Work	$ -	$ 3,750,000	$ 3,750,000
New Construction Contracts	$ 119,181,114	$ 121,330,627	$ 240,511,741
Modernization Contracts	$ 32,040,400	$ 69,119,653	$ 101,160,053
Contingencies	$ 11,918,111	$ 19,590,326	$ 31,508,437
Architectural/Engineering Fees	$ 12,746,516	$ 12,251,110	$ 24,997,626
Consulting and Other Fees	$ 5,999,674	$ 4,908,824	$ 10,908,498
Movable or Other Equipment (not in construction contracts)	$ 62,568,685	$ 2,728,600	$ 65,297,285
Bond Issuance Expense (project related)	$ 2,336,691	$ 1,930,873	$ 4,267,564
Net Interest Expense During Construction (project related)	$ 63,833,724	$ 52,747,598	$ 116,581,322
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	$ 11,677,376	$ 12,375,900	$ 24,053,275
Acquisition of Building or Other Property (excluding land)		$ -	$ -
TOTAL USES OF FUNDS	$ 326,807,290	$ 317,910,814	$ 644,718,104
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	0	0	$ 303,313,017
Pledges	0	0	$ -
Gifts and Bequests	0	0	$ -
Bond Issues (project related)	0	0	$ 341,405,087
Mortgages	0	0	$ -
Leases (fair market value)	0	0	$ -
Governmental Appropriations	0	0	$ -
Grants	0	0	$ -
Other Funds and Sources	0	0	$ -
TOTAL SOURCES OF FUNDS	0	0	$ 644,718,104

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

Itemization of Costs

Items	Cost
Pre-Planning	**$6,220,000**
Site and Facility Planning	50,000
Programming thru Conceptual Planning	6,170,000
Site survey (investigation, titles, traffic)	**$525,000**
Site Preparation	**$14,937,303**
Prep Work (Demo. clearing . grading. shoring & Utility Relocation. Power Feed)	14,186,803
Earthwork. drainage. stone. foundation prep	750,500
Off-Site Work	**$3,750,000**
Grading & Concrete	1,500,000
AT&T Line Adjustments	150,000
Gas (Metering thru construction)	650,000
Upgrade Fire Pump	700,000
Misc. Street Upgrades	750,000
New Construction	**$240,511,741**
Modernization Contracts	**$101,160,053**
Contingencies	**$31,508,437**
Architect/Eng. Fees	**$24,997,626**
Consulting and Other Fees	**$10,908,498**
Const Admin & Misc. Consultants	3,975,000
Reimbursable & Other fees	1,578,498
Activation/Transition Team	500,000
Renderings / Misc. support	550,000
Zoning Consultants	355,000
MEP /Envelope. LEED Commissioning	1,800,000
Equipment planner	950,000
Graphics and Wayfinding	250,000
Sustainability	350,000
Miscellaneous	600,000
Movable / Equipment	**$65,297,285**
Patient Rooms (Med/Surg)	12,870,000
Patient Rooms (ICU)	5,292,000
C-Section	1,400,000
NICU	3,738,000
LDR Equipment	1,365,000
Mobile X-Rays	550,000

Miscellaneous Equipment/Costs	3,275,000
EP/CATH equipment	12,025,000
Surgery Equipment	11,321,545
Recovery Equipment	3,748,775
Infusion equipment	152,677
Heart Clinic Examination Equipment	154,000
Heart Center Diagnostic equipment	4,819,976
Cancer Examination Equipment	273,701
Breast Imaging equipment	4,311,611
Bond Issuance / Finance Expense	$4,267,564
Net Interest	$116,581,322
Other Costs to be Capitalized	$24,053,275
FF&E	2,307,418
Security Systems and Head End Equipment	3,270,000
Patient Entertainment System	1,750,000
Site Signage	575,000
Utilities / Taps	2,630,000
Data Infrastructure, wireless, telecom	9,900,000
Testing Soils and Materials	875,500
Miscellaneous costs including CON, City of Chicago Public Development Update	2,745,357
TOTAL	$644,718,104

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): June 30, 2030

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.

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.**

		Department Gross Square Feet		Proposed Total Department Gross Square Feet			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
Breast Imaging	$ 13,218,815	4,593	7,523	7,523	0	0	4,593
Outpatient Cancer Center	$ 8,510,172	0	6,826	6,799	27	0	0
Outpatient Heart Clinic	$ 13,444,669	2,055	8,334	0	8,334	0	2,055
Surgery	$ 46,452,301	42,216	24,886	20,696	4,190	19,742	22,474
Cath Lab	$ 12,252,151	4,641	6,879	0	6,879	0	4,641
Prep-Recovery	$ 15,191,073	1,485	13,031	0	13,031	7,710	1,485
PACU	$ 3,356,768	255	1,684	1,684	0	3,861	255
Triage	$ 3,404,828	3,012	2,013	2,013	0	0	3,012
LDR	$ 11,502,961	6,037	7,824	7,824	0	0	6,037
C-Section	$ 6,588,825	1,883	3,921	3,921	0	0	1,883
Post-Partum	$ 17,227,053	12,111	15,158	15,158	0	0	12,111
NICU	$ 19,182,310	4,971	11,060	11,060	0	0	4,971
Intensive Care Unit	$ 33,702,950	15,041	24,202	24,202	0	0	15,041
Med/Surg Unit	$ 91,177,299	37,129	86,398	86,398	0	0	37,129
Clinical Backfill Renovations	$ 2,255,334	2,500	2,500	0	2,500	0	2,500
Inpatient Rehabilitation	$ 16,133,564	7,331	16,447	0	16,447	0	7,331
Inpatient Behavioral Health	$ 14,545,713	12,069	16,061	0	16,061	0	12,069
Total Clinical	$328,146,785	157,329	254,747	187,278	67,469	31,313	137,587
NON-CLINICAL Non-Reviewable							
Administration	$ 7,937,062	3,926	7,632	6,464	1,168	0	3,926
Public Lobby, Waiting, Toilets	$ 44,642,889	2,003	27,997	20,470	7,527	0	2,003

Support, Staff Respite, Staff Lockers, Lounge, Workroom, Gowning, Equip Storage	$ 26,110,478	7,653	30,398	26,572	3,826	0	7,653
Circulation	$ 5,934,335	948	4,846	1,824	3,022	0	948
Building Systems	$ 78,442,695	157	62,113	60,872	1,241	0	157
Boiler Plant Upgrades	$ 12,515,800	0	5,000	0	5,000	0	0
Demo Buildings 4,5 & 6	$ 54,444,208	0	122,890	0	122,890	0	0
Storage, EVS	$ 5,431,464	302	4,349	3,747	602	0	302
Elevator Lobby	$ 7,612,281	245	4,842	4,842	0	0	245
Elevator Shafts, MEP Shafts	$ 11,901,163	0	11,612	9,989	1,623	0	0
Stairs	$ 13,409,919	0	11,554	10,722	832	0	0
Non-Clinical Backfill Renovations	$ 30,311,460	0	33,855	0	33,855	0	0
Nursing Administration	$ 2,985,340	0	1,500	0	1,500	0	0
OR Waiting	$ 8,131,987	0	5,850	0	5,850	0	0
Non-Clinical Renovations at Inpatient Rehabilitation	$ 3,429,198	1,266	2,186	0	2,186	0	1,266
Non-Clinical Renovations at Behavioral Health	$ 3,331,040	1,996	1,902	0	1,902	0	1,996
Total Non-Clinical	$316,571,319	18,496	338,526	145,502	193,024	0	18,496
Total	$644,718,104	175,825	593,273	332,780	260,493	31,313	156,083

The proposed use of the vacated space is outlined below.

Current Dept. / Area	Uses:	Gross Square Feet
Breast Imaging	Medical Off. Ctr. - Re-rent	4,593
Outpatient Heart Clinic	Building Demolished	2,055
Surgery	Prep & Recovery / Support	22,474
Cath Lab	Outpatient Heart Clinic	4,641
Prep-Recovery	Outpatient Heart Clinic	1,485
PACU	Outpatient Heart Clinic	255
Triage	Admin. / Support Offices	3,012
LDR	Admin. / Support Offices	6,037
C-Section	Admin. / Support Offices	1,883
Post-Partum	Building Demolished	12,111
NICU	Building Demolished	4,971
Intensive Care Unit	Cath Lab	15,041
Med/Surg Unit	Building Demolished	37,129
Non-Clinical Backfill Renovations	Building Demolished	2,500
Inpatient Rehabilitation	Building Demolished	7,331
Inpatient Behavioral Health	Building Demolished	12,069
	TOTAL	137,587

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

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

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

7. 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.

8. 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.

9. 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.**

10. 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.

See Attachment #11, Exhibits 1,2,3,4,5,6,7,8

1. **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.**

   Attachment 11, Exhibit 1, is the listing of all facilities owned by Advocate Health Care Network. Exhibit 2 is the current state hospital license for Advocate North Side Network d/b/a Advocate Illinois Masonic Medical Center. The most recent DNV accreditation certificate for Illinois Masonic Medical Center is included as Attachment 11, Exhibit 3.

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

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

3. **Authorization permitting HFSRB and DPH access to any documents necessary.**

   By the signatures on the certification pages, the applicants hereby authorize the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection

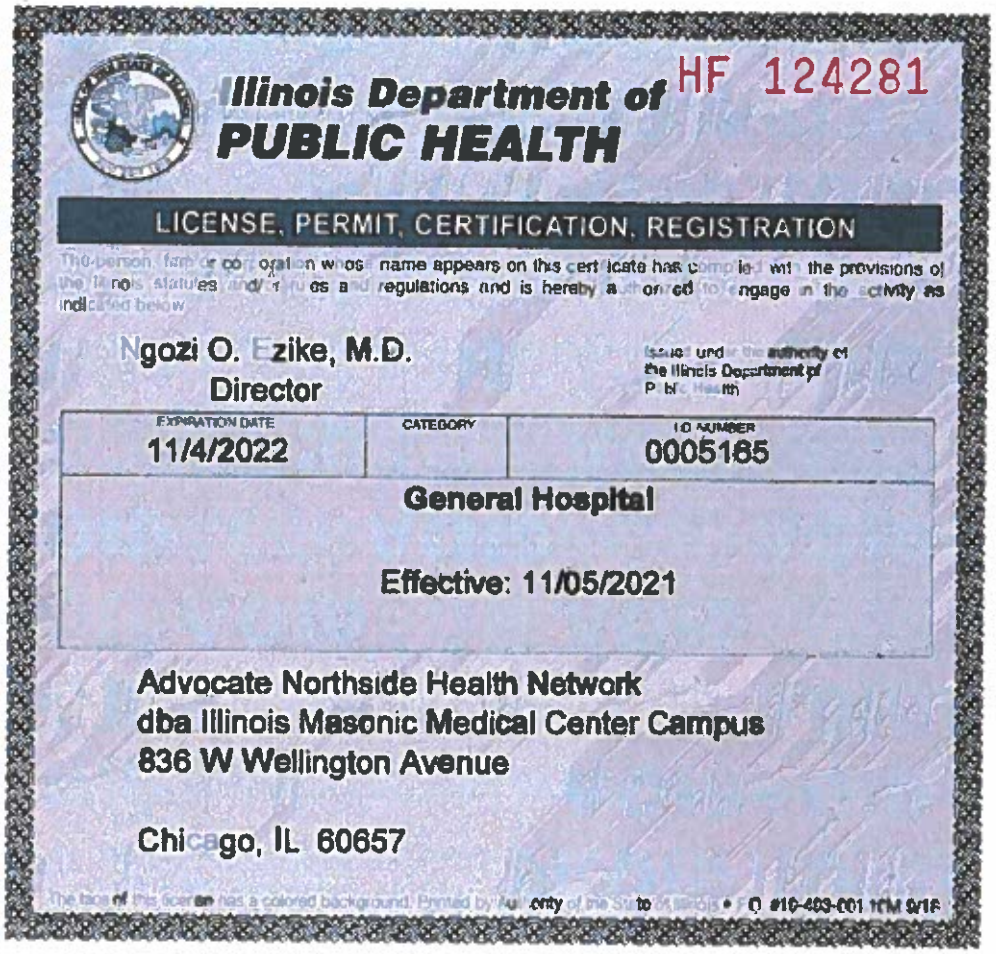
4. **If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously 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 is able to submit amendments to previously submitted information, as needed, to update and/or clarify data**

   Not applicable. This is the first Certificate of Need application filed by Advocate Illinois Masonic Medical Center in 2022.

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

Facility	Location	License No.	DNV Accreditation No.
Advocate Illinois Masonic Medical Center	836 West Wellington Ave Chicago, IL 60657	0005165	PRJC-529782-2015-AST-USA
Additional Hospitals owned and operated as part of Advocate Health Care Network			
Facility	**Location**	**License No.**	**DNV Accreditation No.**
Advocate Christ Medical Center	4440 West 95th St Oak Lawn, IL 60453	0000315	PRJC-435588-2012-MSL-USA
Advocate Good Samaritan Hospital	3815 Highland Ave Downers Grove, IL 60515	0003384	PRJC-369029-2012-MSL-USA
Advocate Good Shepherd Hospital	450 West Highway 22 Barrington, IL 60010	0003475	PRJC-369027-2012-MSL-USA
Advocate Lutheran General Hospital	1775 Dempster St Park Ridge, IL 60068	0004796	PRJC-369033-2012-MSL-USA
Advocate Condell Medical Center	801 South Milwaukee Ave Libertyville, IL 60048	0005579	PRJC-492361-2013-AST-USA
Advocate Sherman Hospital	1425 North Randall Rd Elgin, IL 60123	0005884	PRJC-496379-2013-MSL-USA
Advocate South Suburban Hospital	17800 South Kedzie Ave Hazel Crest, IL 60429	0004697	PRJC-409982-2012-MSL-USA
Advocate Trinity Hospital	2320 East 93rd Street Chicago, IL 60617	0004176	PRJC-408213-2012-MSL-USA

Additionally, AHHC has ownership interest of 50% or more in the following licensed health care facilities			
Facility	**Location**	**License No.**	**Joint Commission Accreditation No/ Accreditation Association for Ambulatory Health Care, Inc.**
Dreyer Ambulatory Surgery Center	1220 N. Highland Ave, Aurora, IL	7001779	AAAHC



Illinois Department of PUBLIC HEALTH

HF 124281

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

EXPIRATION DATE	CATEGORY	ID NUMBER
11/4/2022		0005165

General Hospital

Effective: 11/05/2021

Advocate Northside Health Network
dba Illinois Masonic Medical Center Campus
836 W Wellington Avenue

Chicago, IL 60657

The face of this license has a colored background. Printed by authority of the State of Illinois • IDPH #10-403-001 10M 9/16

DNV

HEALTHCARE CERTIFICATE

Certificate no	Initial certification date	Valid
10000442539-MSC-CMS-USA	15 December, 2015	15 December, 2021 – 15 December, 2024

This is to certify that the management system of

Advocate Illinois Masonic Medical Center
836 W. Wellington Avenue, Chicago, IL, 60657, USA

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

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

Place and date:
Milford, OH, 03 January, 2022

ACCREDITED
Hospital

CMS

For the issuing office:
DNV Healthcare USA Inc.
400 Techne Center Drive, Suite 100,
Milford, OH, 45150, USA

Patrick Horine
Management Representative

Lack of fulfilment of conditions as set out in the Certification Agreement may render this Certificate invalid.
ACCREDITED UNIT: DNV Healthcare USA Inc., 400 Techne Center Drive, Suite 100, Milford, OH, 45150, USA - TEL: +1 513-947-6043. www.dnvhealthcare.com

File Number 5237-115-5

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

ADVOCATE NORTH SIDE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1981, 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* 23RD *day of* NOVEMBER *A.D.* 2021 .

Authentication #: 2132702616 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Authentication #: 2132702582 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

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

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

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Authentication #: 2132702514 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

File Number 7155-851-7

To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE AURORA HEALTH, INC., INCORPORATED IN DELAWARE AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 03, 2018, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

Authentication #: 2132702480 verifiable until 11/23/2022
Authenticate at: http://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

11/23/2021 4:27:38PM

File Number: 6645600 Incorporation Date / Formation Date: 12/4/2017

Entity Name: ADVOCATE AURORA HEALTH, INC.

Entity Kind: Corporation Entity Type: Exempt

Residency: Domestic State: DELAWARE

Status: Good Standing Status Date: 3/4/2019

Registered Agent Information

Name: THE CORPORATION TRUST COMPANY

Address: CORPORATION TRUST CENTER 1209 ORANGE ST

City: WILMINGTON Country:

State: DE Postal Code: 19801

Phone: 302-658-7581

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

APRIL 3, 2018 7155-851-7

CT CORPORATION SYSTEM
118 W EDWARDS #200
SPRINGFIELD IL 62704

RE ADVOCATE AURORA HEALTH, INC.

DEAR SIR OR MADAM:

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

PAYMENT OF THE FILING FEE IS HEREBY ACKNOWLEDGED.

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

SINCERELY,

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

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

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

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

FILED

APR 0 3 2018

JESSE WHITE
SECRETARY OF STATE

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

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

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

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

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

2. a. State or Country of Incorporation: Delaware

   b. Date of Incorporation: December 4, 2017

   c. Period of Duration: Permanent

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

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

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

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

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

   Downers Grove 60515 DuPage County
   City ZIP Code County

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

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

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

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

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

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

See attached.

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

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

Dated April 1, 2018 (Month, Day) , 2018 (Year) Advocate Aurora Health, Inc. (Exact Name of Corporation)

(Any Corresponding Officer's Signature)

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

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

7155-8517

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

Section 6: NAMES AND ADDRESSES OF DIRECTORS AND OFFICERS

Officers:

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

7155 8517

Directors:

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

7155-8517

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

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

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

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

7155-8517

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

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

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

Advocate Illinois Masonic Medical Center is proposing a modernization project that focuses on continuing to provide complex state of the art, high quality, Inpatient, Surgical and Outpatient care to the communities in the service area. The Project proposes to construct a new bed tower located above the existing and expanded CAC to include single occupancy, private inpatient beds, modernize and consolidate the surgical/interventional suite and expanded outpatient services replacing outdated infrastructure in the main hospital building.

In 2011, Advocate Illinois Masonic Medical Center developed a strategic plan to continue to service Chicago as a vital community teaching hospital with identified regional destination services. This requires the development of a campus plan for the current and long-term future that secures health care for Chicago's North Side. To achieve the master plan imperatives and address existing deficiencies identified through the facility and operations assessment it was determined that an expansion of the hospital is required. This approach also begins the process of replacing outdated facilities and providing a more contemporary environment while leveraging the existing buildings and new buildings.
The Master Facility Plan and needs assessment prepared by Kurt Salmon Associates provided a comprehensive plan encompassing a review of all services and buildings on the campus. The plan identified significant needs and this modernization project addresses:

IP Bed Tower -M/S and ICU floors

- Replacing the current Inpatient units located in the original bed towers built 1908 to 1972. The project proposes to replace patient rooms that are outdated and undersized and no longer support the infrastructure or technology needed. The need for private rooms has become critical with the acuity and infection demands highlighted over the last two years.
  Private, renovated M/S and ICU beds will be designed with an efficient layout. The ICU unit will be designed on one ICU floor replacing two units and the M/S units will be developed on 2 ½ floors in the new building replacing many small distinct units.
  In addition, to privatizing and updating the Inpatient beds, the project realigns the inpatient bed configuration with the number of licensed beds supported by utilization trends and the calculated beds need for the current services and long-term need of the communities that IMMC serves.
  The hospital currently has 225 medical/surgical beds and 33 ICU beds. Upon project completion, the new bed tower will have 131 medical/surgical beds and 37 ICU beds. 56 beds will be modernized in the Stone building to provide a total of 187 private M/S beds and 37 ICU beds.

Inpatient Bed Tower -Postpartum and NICU floor

- Creating an Obstetric floor that co-locates the Post-partum beds, on the same floor with the LDR rooms, Triage, C-Section Rooms and NICU beds. This includes providing private, updated room sizes and configuration with the appropriate number of beds on each unit.
  The hospital currently has 44 Postpartum beds and 34 NICU beds. Upon project completion, the hospital will have 24 Postpartum beds and 22 NICU beds.

Modernization of AMI and Inpatient Rehabilitation beds

- Inpatient Rehabilitation will remain at 22 licensed beds and will be relocated to the sixth floor of the Stone building in areas vacated by relocated M/S and ICU beds. These areas will be modernized to provide updated private patient rooms.
- Inpatient AMI beds will be relocated to the Stone building areas vacated by M/S beds and will decrease from 39 to 34 beds. These areas will also be modernized to provide updated patient rooms.

Procedural floor including ORs and Cardiac Cath

- Developing a comprehensive surgical suite with right sized operating rooms using current standards and improved layout of the suites. This co-location of procedural rooms geographically on one interventional floor creates maximum efficiency, effective clinical staff coverage and a better coordinated patient experience. The enhanced surgical operating suite will be better equipped to perform current surgical procedures and the future of surgery. Upgrading antiquated, undersized surgical suites will align surgical care infrastructure with surgical case complexity.

- The proposed plan will replace the original operating room suites that are 50+ years old. Seven of the operating rooms range in size from 423 square feet to 638 square feet. The current minimum standard for an operating room is 650 sq feet. The number of operating rooms will increase from 18 Class C operating rooms and one class C cystoscopy procedure room to 19 Class C operating rooms (and no cystoscopy procedure room) based on the volume projections.
- The project will also expand the perioperative area, co-locating cardiac catherization and EP with the operating rooms to create a surgical platform on one floor. This includes relocation of the three cardiac catheterization/electrophysiology procedural rooms with the creation of one additional EP lab in the new space adjoining surgery replacing worn, outdated, inadequate spaces. The modernized CV suite design including the Cardiac Cath rooms will provide flexibility to support the growing demand for the interventional procedures.
- This project will provide 17 Phase I post anesthesia care (PACU) and a 38 bed Phase II prep/recovery area to support the 17 ORs in the project and 4 Phase I post anesthesia care (PACU) and a 12 bed Phase II prep/recovery area for the Cardiac Cath program. The prep/recovery bed capacity, configuration, and adjacency will be designed to optimize the workflow and efficiency and provide current standards of privacy and infection control.

Center for Advanced Care (CAC) expansion

- Expansion of the Outpatient Cancer services in the CAC will provide space needed as the destination programs continue to grow. Outpatient Oncology clinics and services have expanded, and clinicians need sufficient space for patient evaluations, consultations, and multidisciplinary clinics. Expansion will include additional examination and consultation rooms and additional infusion bays for cancer patients. The expanded breast center will include relocation of mammography, breast ultrasound, DEXA and procedural space with dedicated multidisciplinary space to support the patients and staff.
- Relocation of outpatient cardiology and cardiovascular services from several outdated 1930's buildings into a true Heart Institute will include expanded treatment and examination rooms. These will provide comprehensive outpatient care delivery with a multi-disciplinary model, expanded clinics, greater staff efficiency and a cohesive patient experience.

The Hospital has established a long history of providing for patients, their families, and the professionals who serve them. The comprehensive approach to this major modernization project, that includes the Inpatient Bed Tower and the westward expansion of the CAC, continues the mission to provide up to date quality facilities, improve access for the service area and to serve the health and well-being of this growing population.

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

Advocate Illinois Masonic Medical Center (AIMMC, the Medical Center) is a tertiary referral center and teaching hospital. It serves the north-east section of Chicago, in the Lakeview Area. The hospital is located in the IHFSRB Planning Area A-01 as shown in Attachment 12, Exhibit 1.

The primary market area defined by the Medical Center is very similar to IHFSRB Planning Area A-01. Advocate Illinois Masonic Medical Center's service area extends farther north along the Lake to include Avalon Park, and Rogers Park and does not include the O'Hare area or Norwood Park as part of its service area. Attachment 12, Exhibit 2 provides a map of the hospital's service area.

Population projections for the Service Area are provided in the table below. Although the total population in the service area is projected to remain stable, the 65+ population is projected to grow by 11%, expecting over 25,000 additional older residents. The Hospital is preparing for the increased demand for healthcare that accompanies that change.

Illinois Masonic PSC Demographics					
Age Group	**2021 Population**	**2026 Population**	**2021 % of Total**	**Population Change**	**Population Change**
0-19	450,525	430,788	23.3%	(19,737)	-4.4%
20-44	846,807	839,314	43.7%	(7,493)	-0.9%
45-64	408,554	412,710	21.1%	4,156	1.0%
65+	230,716	256,179	11.9%	25,463	11.0%
TOTAL	**1,936,602**	**1,938,991**	**100.0%**	**2,389**	**0.1%**

The race and ethnicity are reflective of this community and differ significantly from the National percentages. It is notable that there are increases in some of the ethnic populations. The Hospital has a strong pattern of providing care to the Hispanic population with multilingual staff in many areas. As the multicultural aspects of the community change, the Hospital is committed to meet the social and medical needs of the population.

Illinois Masonic PSC Demographics					
Ethnicity/Race	2021 Population	2026 Population	2021 % of Total	Population Change	Population Change
Asian	173,089	193,088	8.9%	19,999	11.6%
American Indian	9,483	9,500	0.5%	17	0.2%
Black	416,116	398,619	21.5%	(17,497)	-4.2%
Pacific Islander	887	863	0.0%	(24)	-2.7%
White	956,744	946,900	49.4%	(9,844)	-1.0%
Other Race	310,623	316,749	16.0%	6,126	2.0%
Multiple Races	69,661	73,273	3.6%	3,612	5.2%
TOTAL	**1,936,602**	**1,938,991**	**100.0%**	**2,389**	**0.1%**
Hispanic	**665,949**	**686,695**	**34.4%**	**20,746**	**3.1%**

Source: Esri 2021

The hospital has continued to adapt to the changing health care needs and provide the continuum of health care services to families that live in the hospital's defined service area.

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

Advocate Illinois Masonic Medical Center has a long history of caring for people in the Chicago area. Its origin dates back to 1897 with the formation of Union Hospital, which became Illinois Masonic Medical Center in 1921. In November 2000, Advocate Illinois Masonic Medical Center became a member of Advocate Health Care. Advocate merged with Aurora Health Care in Wisconsin in 2018. Advocate Illinois Masonic Medical Center is now part of Advocate Aurora Health, the 12th largest integrated not-for-profit system in the United States.

As the system continues to carry out its mission to be the best place for patients to receive care and physicians to practice, there is a continuous evaluation of the hospitals assets and the infrastructure. The project addresses the need to replace outdated facilities with inpatient rooms sized to meet industry standards to accommodate current procedures, technology, and privatization of the bed units.

The 2011 facility assessment evaluated existing hospital infrastructure to determine appropriateness for continued investment of each of the buildings on the campus.
This assessment determined that several buildings 4, 5 and 6 were at the end of their useful life and they were no longer appropriate for continued investment.
Key building deficiencies include the mechanical, heating, electric, and plumbing systems that are over 70+ years old and require complete replacement.

The functional assessment and space analysis that compared department space to industry standards for size, and the capacity analysis that evaluated utilization of key clinical rooms against industry standards highlighted the scope needed in this modernization project. The project addresses the facility and infrastructure deficiencies and creates patient care designed with contemporary standards.

Inpatient Bed Tower

The newly designed inpatient units will update and improve the design of the patient care room including modernization to address the deficiencies in the size and functionality of current units.

The main hospital structure has infrastructure issues that make it difficult to continue to modernize to develop the appropriate rooms to introduce new technology and efficiencies.

The new bed tower inpatient beds built on top of the expanded and current CAC will be designed with the layout of clinical services that allows coordination, collaboration, and continuity of care. The room designs reflect the increased acuity and higher level of specialty care required by current inpatients. Private rooms allow improved patient placement, infection control and patient satisfaction. The room design will optimize staff effectiveness to spend more time in direct patient care and at the patient beds side and sharing of resources enhancing patient care coordination.

The bed tower will include relocation of Inpatient Medical/Surgical, Intensive Care, Postpartum and NICU Beds from the outdated Main Hospital buildings.

One floor will be designed to include all ICU rooms with a M/S unit, 2 floors will be private M/S inpatients and one floor of the new bed tower will include LDR, C-Section, triage, and Postpartum Rooms with the NICU beds to create an Obstetric/NICU floor.

The new building is designed to have units appropriately sized and connected to adjacent hospital clinical areas. Needed support space will be addressed in the new bed tower to support clinical and staffing needs.

Surgery Modernization

The project addresses the modernization of the 11 OR rooms located in the Stone Pavilion located in the outdated 50-year-old surgical suite. These will replace 10 ORs and the 1 cysto procedure room. The other 6 hospital ORs located in the CAC constructed in 2012 will remain as is and not be included in the modernization work. The two ORs used exclusively for eye procedures will also not be included in the project and will remain in their current location on the fifth floor of the hospital.

The existing room sizes and configuration of the ORs located in the Stone building are limiting the through-put and access for specific procedures. The newly designed ORs will update and improve the design of the operating rooms including modernization to address the deficiencies in the size and functionality.

Surgical services will now be equipped with technical capacity to accommodate new procedures and technology. The rooms will be designed with flexibility to support procedures that are now

limited to specific rooms. As a Trauma 1 Level hospital, specific operating rooms need to be held for emergency and trauma, neurosurgery and heart cases. The expanded room size would be more flexible allowing timely case placement.
The current OR room sizes are too small to accommodate the high complexity of cases at Advocate Illinois Masonic Medical Center and inhibits the ability to schedule cases that require a larger room such as Robotic/Minimally Invasive cases, Orthopedic, Neurosurgery and Trauma cases.

The operating room has experienced, year-over-year surgical growth. This has been influenced by the hospital's recruitment of additional board certified, fellowship trained surgeons from top training programs to perform complex cases in niche areas such as:

- Cardiovascular surgery
- Vascular surgery
- HIPEC (Hyperthermic intraperitoneal chemotherapy for abdominal and gynecologic cancers)
- Surgical Oncology including melanoma, colon and rectal cancers, peritoneal malignancies, and endocrine cancers
- Colon and rectal surgery
- Robotic and minimally invasive surgery
- Complex gynecologic surgery
- Bariatric and metabolic surgery
- Complex eye surgery and state of the art cornea and retina laser treatment

The co-location with cardiac catherization, EP and the Hybrid ORs create an interventional platform that provides efficiencies and coordination of care in one location. This creates improved efficiencies for anesthesia support all located on one floor and staffing efficiencies as currently staff supports cases on two floors.

The Recovery Suite will be included on this floor and will contain the Post Anesthesia Care unit (PACU) and the Phase II Recovery stations to support the 17 Operating Rooms and the 4 Cardiac Cath/EP labs.
The co-location of these services will create the platform for coordination of care supported by the clinical teams and the ability to share common support space.

The project addresses deficiencies of the current Phase II Recovery spaces including an insufficient number of rooms to accommodate through-put needed for pre- and post- operative recovery phases. The project provides relocation of these rooms from the aging facility and is designed for contiguous anesthesia oversight of all of these operative and procedural suites by having all surgical spaces on one floor.

Outpatient Services -CAC expansion

Advocate Illinois Masonic Medical Center continues to expand its Outpatient services to reflect the changes in the site of care delivery. The expansion of the OP Oncology, Cardiology and Imaging services reflects the volume growth over the last 5 years.

OP Cancer Services

The Creticos Cancer Center offers comprehensive, multidisciplinary services to patients and their families, who have full access to clinical and support needs in one convenient location. Since the Creticos Cancer Center relocated to the Center for Advanced Care in 2015, the cancer program has experienced significant growth in medical, surgical and radiation oncology as well as support services and survivor care. Oncology clinic visits have grown by 20% and infusion treatments have grown by 57%. Sg2 also forecasts an increase in the AIMMC service area for outpatient oncology: clinic visits are projected to increase by 10% and chemotherapy visits by 11% over the next five years.

The Creticos Cancer Center provides support services such as cancer genetic counseling, financial navigation, patient navigation and psychosocial support including counseling. Additionally, the oncology team hosts multidisciplinary clinics for patients and their families to see multiple specialists in one visit and have their care coordinated from diagnosis through treatment. These offerings contribute to a holistic, patient-centered experience for patients and their families on the cancer journey.

The expanded space will provide increase patient access by adding 9 exam rooms, 2 consultation rooms, 6 additional infusion bays, offices, and additional staff space. The area will be designed to provide space for preventative care separate from those undergoing current treatment. The space will include needed space for alternative therapies and additional multidisciplinary clinics to support this patient population, their families, and the staff.
The Breast Imaging services including Mammography, Breast Ultrasound and DEXA will be relocated to the expanded CAC, on the floor directly below the newly designed OP Cancer Services. This department is currently in leased space in the Medical Office Building, and this will provide a critical component to the comprehensive preventive care services.

OP Cardiovascular Services

The Outpatient Heart Center of Advocate Illinois Masonic Medical Center provides comprehensive outpatient services for cardiovascular patients such as multispecialty clinics, infusions, and diagnostic testing. The current program is an integrative care model that include congestive heart failure and structural heart clinics in addition to infusion space for these patients. This model allows patients to have multiple appointments the same day and coordinated by a navigator to create a comprehensive care plan.
Since the program was developed in 2018, the outpatient heart clinic has grown by 65% and has expanded the number and types of clinics. Sg2 forecasts a 10% increase in OP cardiovascular volume over the next five years and 20% total over the next ten years. With

higher acuity and improved survivorship, demand for these Outpatient Cardiovascular programs is projected to continue to grow over the next five years.
The Outpatient center expansion will also allow an increased number of patients to utilize these multidisciplinary clinics and develop additional clinics to include chest pain, Afib patients and a valve clinic expansion.

The project is being designed to target LEED Silver for Healthcare to improve indoor environmental quality, energy efficiency, the use of sustainable materials and keep staff and patients healthier.

4. Cite the sources of the documentation.

Information used in this application included reports submitted to the State and various credentialing organizations, the Strategic Master Plan, analysis done by external planners, architects, and engineers. Physician experts were consulted as well as independent professionals in relevant disciplines.

Sources included:

- Clinical, administrative, and financial data from Advocate Health and Hospitals Corporation and Advocate Illinois Masonic Medical Center
- Advocate Illinois Masonic Medical Center Strategic Master Facility Plan
- Illinois Department of Public Health Hospital Licensing Code
- Illinois Health Facilities and Services Review Board (HFSRB) Administrative Rules
- IHA Compdata
- AIA/FGI Guidelines for Design and Construction of Health Care Facilities
- Advocate Illinois Masonic Medical Center Financial Data
- Esri Population 2021 and the US Census Bureau
- Sg2 Market Estimates and Projections
- Advocate Medical Group
- HFSRB Hospital Profiles
- HFSRB Inventories and Data
- HFSRB State Agency Reports
- Health care literature regarding current trends

The codes used in the design included:

- Chicago Building Code,
- Chicago Electric Code
- Life Safety Code
- IDPH Licensing Act
- 2000 NFPA 101, and, as referenced by the 2000 NFPA 101:
- 1998 NFPA 10, Standard for Portable Fire Extinguishers
- 1999 NFPA 13, Standard for the Installation of Sprinkler Systems
- 1999 NFPA 70, National Electrical Code

- 1999 NFPA 72, National Fire Alarm Code
- 1999 NFPA 80, Standard for Fire Doors and Fire Windows
- 1999 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems
- 1999 NFPA 99, Standard for Health Care Facilities
- 1999 NFPA 110, Standard for Emergency and Standby Power Systems
- 1999 NFPA 220, Standard on Types of Building Construction
- 2000 NFPA 14, Standard for the Installation of Standpipe, Private Hydrants, and Hose Systems

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

The primary purpose of the Project is to provide updated infrastructure that supports the health services to improve the healthcare and wellbeing of the population in the service area. The proposed project will provide enhanced patient, physician, and team member satisfaction. The improvements in the physical space will include private and updated inpatient rooms that are designed for coordinated services. The units will be designed with the appropriate number of beds by category of service and the space designed to reflect the changes in case mix acuity and infection control needs.
The larger, state of the art ORs will accommodate the increasing technology and equipment required to care for complex surgical procedures, while standardization of all rooms ensures continual familiarity and intuitive functions for the healthcare team. Reduction in variability in room configuration and supply placement supports optimum function and performance. The rooms will be sized and configured to meet the Advocate and current industry standards.

Growth in complex cases is projected in both inpatient surgery and outpatient surgery. Advancements in implant technology and improvements in devices in Cardiology and Orthopedics have improved outcomes. As these patients are living longer, they require higher acuity care.
For outpatient surgery, there are key areas that will need to remain in the Hospital outpatient surgical area due to complexity of these cases, patient age and co-morbidities of the patients.
Sg2's Impact of change model for the Advocate Illinois Masonic Medical Center's service area forecasts inpatient surgical growth for:

- IP Neuroscience Surgery to increase by 19% over the next five years
- IP Cardiovascular Surgery to increase by 14% over the next five years

Each room is larger to accommodate the increasing technology and equipment required to this surgical care.

Advocate Illinois Masonic Medical Center continues to expand its Outpatient services to reflect the changes in the site of care delivery. The expansion of the outpatient Oncology, Cardiology and Breast Imaging services is due to the volume growth over the last 5 years.

This project is one that supports the underlying goal of Advocate Aurora's diversity, equity, and inclusion strategy; anchored by our purpose to help people live well and fueled by a commitment to transform our workplace and our communities. This is due to the belief that a diverse workforce and strong community partnerships allow Advocate to deliver equitable care for all.
Advocate Aurora is working to close gaps, foster a thriving inclusive environment and ensure outcomes that are consistent and fair.

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

The principal goals for this project are to invest in and develop a modern and updated infrastructure, to allow Advocate Illinois Masonic to continue to provide the highest level of care to residents in the community including:

- Develop a bed tower that includes the appropriate number and sized Inpatient rooms for each of the Clinical Services.
- Create a comprehensive interventional procedural floor that provides right sized operating and cardiac catherization rooms and expands pre/post recovery to support the needed number of rooms.
- Relocate the inpatient beds categories and clinical services to modernized areas in contemporary buildings.
- Develop expanded space for key Outpatient designation programs to continue to support the patients in the service area.

Throughout this project, Advocate Illinois Masonic Medical Center is committed to spending 35% of construction cost with diversity, equity, and inclusion focused companies.
The phasing of this project was well thought out to provide the safest, high quality care and minimized disruption to patients and clinicians.

<u>Phase 1</u>

- Site Work
- CAC West Expansion
  - 6 new Operating Rooms (3rd Floor)
  - Creticos Outpatient Cancer Center Expansion (1st Floor)
  - Breast Imaging (Ground Floor)
  - New Lobby and circulation (Entry Level)
- Bed Pavilion
  - New 37 Bed ICU (6th Floor)
  - Begin 56 Bed Med/Surgical (7th and 8th Floors – 28 beds each floor)
- January 2025 MOVE-IN

Phase 2

- Continue Site Work
- Bed Pavilion
  - Complete 56 Bed Med/Surgical (7th and 8th Floors – 28 beds each floor)
  - New 19 Bed Med/Surgical (6th floor)
  - Birthing Center (5th Floor)
    - 24 Post-Partum Rooms
    - 8 LDR Rooms
    - 22 NICU positions
    - 2 C-Section Rooms
- August 2026 MOVE-IN

Phase 2A

- 3rd Floor Perioperative Suite
  - 5 new Operating Rooms
  - Prep/Recovery Bays
  - 2 Cath Labs
  - 2 EP Labs
- August 2026 MOVE-IN

Phase 2B

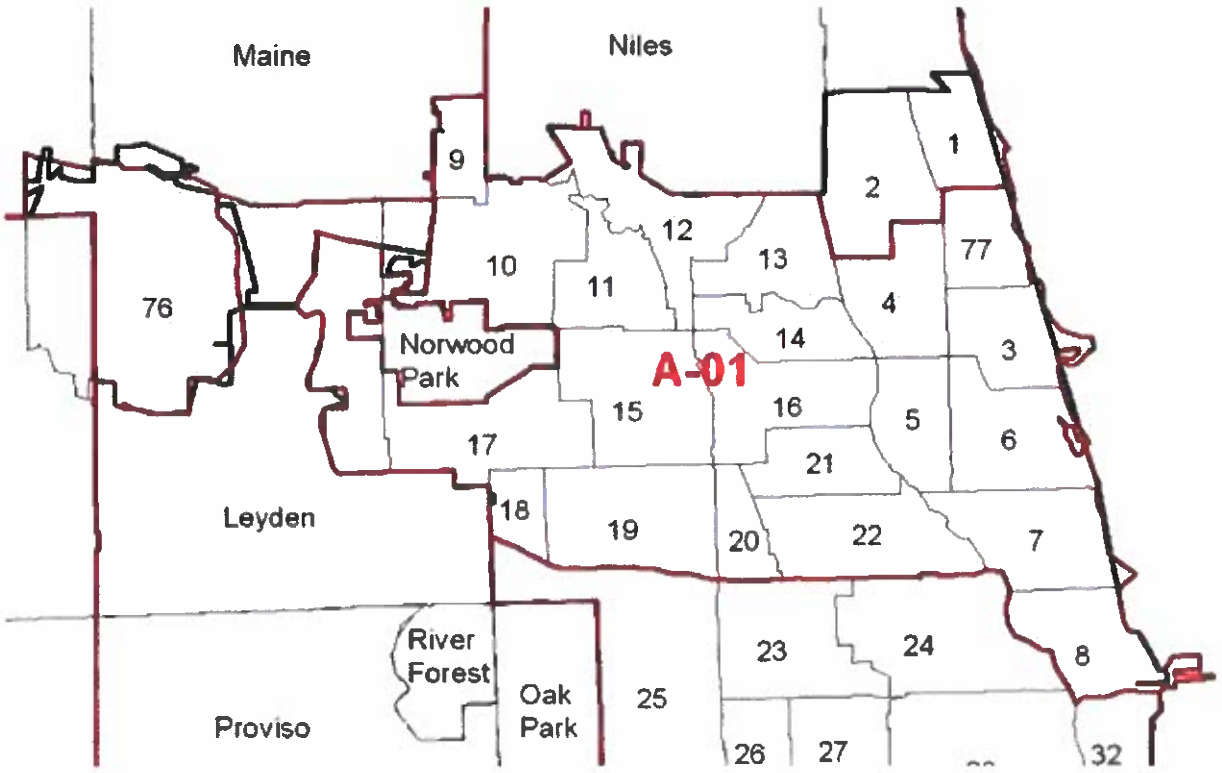
- 1st Floor Cardiology Renovations
- Building 3 and 7 renovations to support modernization of Med/Surgical floors in Stone (8th and 9th floors), Inpatient Rehab (floor 6) and Inpatient AMI (floor 7) and programs relocated from Buildings 4, 5 and 6
- December 2027 MOVE-IN

Phase 3

- Demolish Buildings 4, 5 and 6
- Re-Skin Buildings 3, 7 and 8 to accommodate the removal of demolished buildings.
- June 2030 Completion

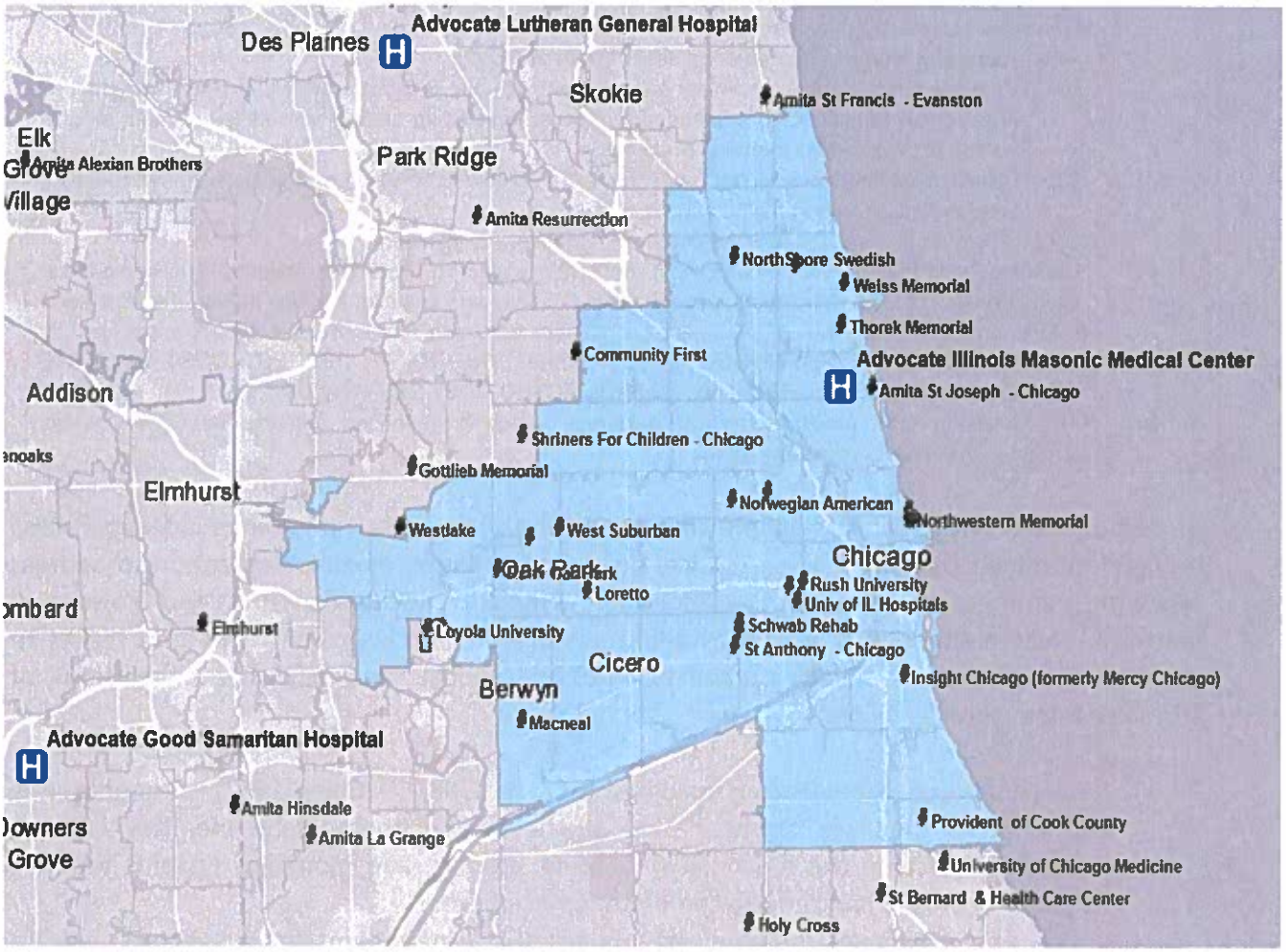
The entire project is expected to be completed and operational by June 30, 2030.

Map of Planning Area A-01



Note: Advocate Illinois Masonic Medical Center is located in Lincoln Park/Lakeview in Area 7

Advocate Illinois Medical Center
Patient Service Area



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

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.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

ALTERNATIVES

1) Identify **ALL** of 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.

As part of the overall, Advocate Illinois Masonic Medical Center Master Facility Planning process it was determined that there was a critical need for expansion and modernization to address space programming and infrastructure issues across most of the inpatient units and the surgical platform. Recommendations were provided to resolve the limitations of the current facility to enhance patient safety, health outcomes, and operational efficiency. The conclusions of administration were as follows:

- Replacement of three existing buildings, (built in 1908, 1926 and 1957) is imperative at this time as they are outdated and at the end of their useful life. Key building deficiencies include the mechanical, heating, electric, and plumbing systems that are over 70+ years old and require complete replacement.
  - The mechanical heating systems are still using steams for convectors and are operating by 70+ years steam converters and pump systems.
  - Forty percent of the building is still using induction units that do not meet air exchange requirements for patient care.
  - Existing duct work/risers are starting to deteriorate with 10% of leakage or more due to corrosion in a 75-year-old building.
  - Electric systems have obsolete switch gears and automatic transfer switches; there is an inadequate emergency power system.
  - Domestic water piping and drains are over 70+ years old and need to be completely replaced.

- Medical gas systems need to replace alarm system and zone boxes and replacement of all piping would be required to stay complaint.

It is no longer fiscally appropriate to continue to invest in and operate these buildings. The new Bed Tower replaces the outdated and extremely fragmented clinical areas. These buildings will be torn down at the completion of the project.

- Relocation of the outdated Inpatient bed units will be designed to create efficient units created providing comprehensive care by service line units in the new bed tower. These will be all private beds, replacing rooms that are antiquated, and designed to be right sized for current patient care.
  - The new Intensive Care bed unit, replacing two units, will be located in the new Bed tower, and designed on one continuous floor adjacent to a Medical Surgical floor. Two additional medical surgical floors will be created in the Bed tower creating floors designed for staffing flexibility and multispecialty collaboration.
  - All Obstetric and NICU services will provided on one floor replacing services located throughout the existing buildings. This will include the OB Inpatient Beds, LDR Rooms, Cesarean Section Rooms, Triage, NICU Beds and required support services.
  - The Inpatient Rehabilitation unit and Inpatient Acute Mental Illness unit will be relocated out of buildings that will be removed from the campus into space modernized in the Hospital's Stone Pavilion.
  - All Inpatient units were evaluated to determine the appropriate number of beds by category of service for current and future patients.

- Creation of a comprehensive procedural floor that includes modernization and replacement of the Hospital's Operating Rooms, Recovery Suites and Cardiac Cath/EP rooms.
  - The Operating procedural floor created will address the need to replace and modernize 11 of the operating rooms to meet physician and patient needs in addition to creating operational efficiencies. These will be co-located with the remaining Operating Rooms. The physical facility has an immediate need to upgrade these undersized Operating rooms and improve the functionality and update the technological capabilities.
  - These will be designed with maximum room flexibility and elimination of infection control risks. The complexity of the procedures in the Vascular, Cardiovascular and Interventional Neurosurgery cases cannot be achieved in the outdated and undersized Operating Rooms.
  - It is critical to remove and replace the outdated, dedicated cystoscopy/urology room, which in the current state restricts scheduling, room utilization and surgeon access.
  - The renovation will create a central pre- and post- operative patient care recovery area, thereby eliminating the present circumstances in which there are 4 separate areas where patient care is currently rendered. In addition to improving the room sizes, the workflow, productivity, and communication

efficiencies related to this change address concerns raised by anesthesiologists, surgeons, and the clinical team members. This will be designed with the appropriate configuration for privacy and infection control.
  - This floor includes relocation of the 3 cardiac catheterization labs and adds 1 additional cath lab/electrophysiology procedural room replacing the worn, outdated, inadequate spaces.
  - Additional prep and recovery rooms will be added for the new Operating Rooms and Cardiac Cath/EP rooms to create a comprehensive interventional floor. The co-location of procedural suites geographically unifies all procedural rooms to one floor for maximum efficiency, effective clinical staff coverage and a better coordinated patient experience.

- As the Center for Advanced Care, which opened in 2015, has exceeded the anticipated growth and achieved the quality outcomes, an expansion of the outpatient Oncology and Cardiology services is essential to continue to provide access to needed services. Relocation of the Breast Imaging services to create the multidisciplinary program will provide the collaborative services in a comprehensive model of care. This will replace services in disparate locations on the Advocate Illinois Masonic Medical Center campus in old, worn, inadequate spaces that cannot accommodate current volume nor anticipated growth.

Several alternatives as outlined below were evaluated based on the recommendations of the Consultants and the Hospital's administration.

Alternative One – Construction of a replacement hospital

The option to build a new hospital on the campus or a new location while vacating and demolishing all of the existing hospital buildings was not a reasonable option. There are limited sites within or adjacent to the campus to build and replace the size of the current hospital. The structure and cost to replace all clinical and non-clinical hospital services and capabilities would be significantly higher than this project cost. Although this could address the clinical program and space facility infrastructure issues, as good financial stewards, this would be an excessive undertaking and the plan was abandoned for a modernization project.

Cost: $ 950,000,000

Alternative Two - Propose a Project of greater scope and cost

The option to build a larger Bed tower with additional floors to accommodate all inpatient beds instead of modernizing the two remaining medical surgical units, rehabilitation bed unit and AMI unit would address the capacity and appropriate design space for these patients. It was determined however, that the floors in the hospital's Stone structure could support the modernization of these units as they are vacated, and the cost to add additional floors would be significantly higher than this project cost. Although this could address the clinical program

and space facility infrastructure issues, as good financial stewards, it was determined that modernization was appropriate.

Cost: $ 703,010,000

Alternative Three – Pursue 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; develop alternative settings to meet all or a portion of the project's intended purposes

A possible option was to build or purchase surgical clinical space in other locations in a joint venture. The surgical cases included in this project are those that need to remain in the hospital location due the type of surgical procedures, the patient's conditions, or co-morbidities.

The efficiency gains of the procedural floor in this project are based on combining the operating rooms with the cardiac catherization/EP procedure rooms and this would not be achieved in this alternative. This option would not address the immediate need to update the outdated ORs to improve functionality, flexibility and improve clinical coordination and quality. The complexity of the procedures in the Vascular, Cardiovascular and Interventional Neurosurgery cases cannot be achieved in the outdated and undersized Operating Rooms.

With the complexity of cases as a Level I Trauma Center, Open Heart surgery program and teaching hospital, the operating rooms need to be developed within the hospital's procedural floor. The modernization of the surgical platform is designed to meet the needs of the current patients and physicians.

Cost: $ 57,900,000

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

The option to refer Orthopedic, Neurosurgery, Neuroendovascular and Cardiac Surgery cases to another hospital in the service area was not feasible. As a Level I Trauma Center and a significant provider of tertiary and quaternary surgical services in this service area, other health care facilities refer to Advocate Illinois Masonic Medical Center and would not have the capabilities to provide these surgical procedures at their location. The physicians seeing these patients are principally located near and on staff at Advocate Illinois Masonic Medical Center. They are significant providers of procedural cases for people that live in this community and the patients have a long-established pattern of coming to this hospital for their comprehensive care and this would disrupt continuity of care.

Cost: No construction cost but would experience a significant loss of patients and lack of continuity of care.

Alternative Five - Propose a Project of lesser scope and cost

This option would involve modernizing and expanding only the Center for Advanced Care or the Inpatient Bed Tower and would not address the imperative needs identified to modernize both. The project would either improve the infrastructure and privatization of the inpatient units or increase capacity and access for key outpatient services. It would be a challenge to prioritize one over the other, would be significantly costlier to complete these projects separately and extend the timeframe for completion. It would be more disruptive to the patients and staff to complete these two projects at separate times.

Cost: $186,000,000 CAC only
$566,369,218 Bed Tower only

Alternative Six - Modernize and Construct a new Bed Tower to include 4 Inpatient floors and a Surgical Procedural floor; Expand the Center for Advanced Care to Outpatient Services

This option was selected as it will allow the organization to replace outdated infrastructure and create space that is developed for Inpatient, Surgical and outpatient services. The number of Inpatient beds were thoroughly evaluated to continue to provide access in each of the categories of service. Resources have been devoted to investing in the critical needs to continue to support access for Advocate Illinois Masonic Medical Center patients and the community into the future.

This space will be designed to right size the Medical Surgical, Intensive Care, Postpartum and NICU rooms, achieving contemporary standards and accommodating the needs for these inpatients. Upgrading the undersized original main surgical suite will provide the infrastructure to continue to provide access for complex surgical services for patients in the hospital's service area, providing the most comprehensive care. Creating a procedural floor to include the co-location of Operating Rooms, Cardiac Cath/EP rooms, Recovery suite and support services will right size the operating rooms to current standards and improve the layout of the suites to be designed for complex cases and future surgical design.

The expansion of the Center for Advanced Care and modernization of the Stone building will provide the needed additional space to improve access for outpatient Cancer and Cardiology services for patient living in the service area.
This project will enhance safety, quality of care and provide the necessary facility infrastructure to support the future of the hospital providing the safest, most flexible environment continuing access for patients in the Advocate Illinois Masonic Medical Center service area.

Project Cost: $644,718,104

Alternative	Description	Patient Access	Quality	Cost	Financial Benefit, Short Range	Financial Benefit, Long Range	Conclusion
1	Construction of a Replacement Hospital	This would improve patient access by creating the appropriate space and design for the inpatient Bed Units, the OR and Cath procedural floor and the expansion of the outpatient Cancer and Cardiology services.	Quality of care would be improved due to right sizing and privatizing inpatient Patient Rooms, developing the procedural floor (right sizing ORs and Cath) and the expanded outpatient Cancer and Cardiology services.	The structure and cost to replace all clinical and non-clinical hospital services and capabilities would be significantly higher. The cost would be compounded due to limited sites within or adjacent to the campus to build a replacement facility.	As good financial stewards of Advocate Aurora Health Care, the plan to build beyond the scope of this project at this time was determined to be a significant financial investment and create extensive negative impact to ongoing hospital operations.	Advocate Aurora Health Care will continue to evaluate the infrastructure of all facilities on each hospital campus and the needs of the community. The cost for total hospital replacement was not supported given that the scope of the proposed project will address the current and projected needs of patients in the service area	Rejected
2	Build a larger Bed tower with additional floors for all inpatient beds including the 2 Med/Surg units, IP Rehab unit and 4MI unit	This would improve patient access by creating the appropriate space and design for the Inpatient Bed Units, the OR and Cath procedural floor and the expansion of the outpatient Cancer and Cardiology services.	Quality of care would be improved due to right sizing and privatizing Inpatient Patient Rooms, developing the procedural floor (right sizing ORs and Cath) and the expanded outpatient Cancer and Cardiology services.	The cost will be increase exponentially with increased construction. The total project cost needs to be measured against the true needs of the organization and the patients it serves.	As good financial stewards of Advocate Aurora Health Care, the plan to build beyond the scope of this project at this time was determined to be a significant financial investment and create extensive negative impact to ongoing hospital operations.	Advocate Aurora Health Care will continue to evaluate the infrastructure of all facilities on each hospital campus and the needs of the community. The cost for total hospital replacement was not supported given that the scope of the proposed project will address the current and projected needs of patients in the service area.	Rejected
3	Pursue a joint venture/similar arrangement with other providers or entities to meet all or a portion of the project's intended purposes	This would not increase access for surgical patients, as these types of procedures are those that require the hospital location due to the type of procedure or patient condition.	The quality of care would not be improved for the inpatient and surgical patients. The hospital inpatient rooms and operating rooms continue to be undersized and not address the capacity or appropriate design for patients. This would not address the expansion of the OP Cancer and CV services.	While the project cost would be less; the project would not address the infrastructure needs of the current facility. Maintenance investment in the existing hospital buildings would continue to escalate and not provide the up to date and expanded services needed in the community. The clinical needs are projected to continue to grow and ultimately would require more financial resources in the future.	This project would have a lower cost, however, would not address the infrastructure and facility needs for these buildings on the hospital campus. This would not support the needed capacity for existing and future patients.	As the need for the investment in the campus infrastructure increases, the cost would continue to escalate while costing significant dollars to maintain outdated buildings. This would not provide the necessary expansion or coordination of clinical services needed currently and in the future.	Rejected
4	Utilize other health care resources that are available to serve all, or a portion of the population proposed to be served by the Project	This would create access issues for patients in the service area. Many of these patients present to the Emergency Room with immediate and critical surgical needs. The physicians admitting these patients are on the staff at Advocate Illinois Masonic Medical Center and this would not allow continuity of care for these patients.	The quality of care would not be improved for the inpatient and surgical patients. The hospital inpatient rooms and operating rooms continue to be undersized. This would not address the expansion of the OP Cancer and CV services.	There would be no additional facility cost however the project would not address the infrastructure needs of the current facility. This option would potentially add cost for the patient and their family to be transferred and cared for in two facilities.	This project would have a lower cost, however, would not address the infrastructure and facility needs for these buildings on the hospital campus. This would not support the needed capacity for existing and future patients.	As the need for the investment in the campus infrastructure increases, the cost would continue to escalate while costing significant dollars to maintain outdated buildings. This would not provide the necessary expansion or coordination of clinical services needed currently and in the future.	Rejected
5	Modernize and Expand only the Inpatient Bed Tower OR the Center for Advanced Care	This would improve patient access in the portion of the project modernized; leaving access issues in the other.	Quality of care would be improved in the modernized area, but not in the area outside of the project scope. The project would either improve the infrastructure and privatization of the inpatient units or increase capacity and access for key outpatient services.	While each project cost would be less; the total project cost to complete both individually would cost more. The need is projected to continue to grow and ultimately would require more financial resources to complete.	This project would have a lower short-term cost, however, it would not address the infrastructure and facility needs for these buildings on the hospital campus and it would be more costly to complete all aspects of the project. This would not support the needed capacity for existing and future patients.	Long term, this option would be more costly to complete. The two projects individually would drive higher total project costs and would not address the imperative needs identified for the inpatient bed tower and the outpatient clinical services. The need to replace the infrastructure and the additional capacity needed will continue to grow and the issues of access with continue long term.	Rejected
6	Modernize and Construct a new Bed Tower to include 4 Inpatient floors and a Surgical Procedural floor; Expand the Center for Advanced Care to Outpatient Services	This would improve patient access by creating the appropriate space and design for the Inpatient Bed Units, the OR and Cath procedural floor and the expansion of the outpatient Cancer and Cardiology services.	Quality of care would be improved due to right sizing and privatizing Inpatient Patient Rooms, developing the procedural floor (right sizing ORs and Cath) and the expanded outpatient Cancer and Cardiology services.	The cost of this project was designed to create the up-to-date facility design to provide the safest quality of care for current and future patients.	This space will be designed to right size and privatize the Inpatient patient rooms, achieving contemporary standards and accommodating the needs for these inpatients. Creating a procedural floor will right size the operating rooms to current standards and improve the layout for complex cases and future surgical design. The expansion of the CAC will provide improved access for outpatient Cancer and Cardiology services for patient living in the service area. The financial benefit will be an investment in the campus infrastructure, and no longer continuing to invest in outdated facilities that limit patient access	This space will be designed and built for immediate and long-term needs, achieving contemporary standards and accommodating the needs for inpatients and surgical patients. The expansion of the CAC will provide improved access for essential outpatient clinical services for patient living in the service area. The long term financial benefit will be an investment in this hospital campus and the community.	Accepted

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Intensive Care Service	24,202	600-685 dgsf/Bed (37 beds x 600-685 = 22,200-25,345)	1,143	Yes
Medical-Surgical Service	86,398	500-660 dgsf/Bed (131 beds x 500-660 = 65,500-86,460)	62	Yes
Mammography	3,761	900 dgsf/Unit (5 x 900 = 4,500)	739	Yes
Ultra-Sound	3,762	900 dgsf/Unit (4 x 900 = 3,600)	162	No
DEXA	210	1,300 dgsf /unit General x-ray (1 x 1300 = 1,300)	1,090	Yes
Ambulatory Care (Cancer Center) (17 Exam, Consult, Infusion)	6,826	800 dgsf (17 x 800 = 13,600)	6,774	Yes
Ambulatory Care (Heart Clinic) (20 Exam, Procedure)	8,334	800 dgsf (20 x 800 = 16,000)	7,666	Yes
Multi-Disciplinary Physician Office (4 exam rooms)	2,500	800 dgsf (4 x 800 = 3,200)	700	Yes
Surgical Operating Suite (Class C) (11 ORs)	24,886	2,750 dgsf/Operating Room (11 x 2,750 = 30,250)	5,364	Yes
Cardiac Catheterization (4 Cath Labs)	6,879	1,800 dgsf (4 x 1,800 = 7,200)	321	Yes
Post-Anesthesia Recovery Phase I (6 bays)	1,684	180 dgsf/Recovery Station (6 x 180 = 1,080)	604	No
Post-Anesthesia Recovery / Pre-Operative Care - Phase II (32 bays)	13,031	400 dgsf/Recovery Station (32 x 400 = 12,800)	231	No
Labor Delivery Recovery (8 LDR) & Birthing Triage	9,837	1,120-1,600 dgsf/Room (8 x 1,120-1,600 = 8,960-12,800)	2,963	Yes
C-Section Suite (2 C-Section)	3,921	2,075 dgsf/OR (2 x 2,075 = 4,150)	229	Yes
Post-partum (24 beds)	15,158	1,120-1,600 dgsf/Bed (24 x 1,120-1,600 = 26,800-38,400)	23,242	Yes
Neonatal Intensive Care (NICU) (22 beds)	11,060	434-568 dgsf/Bed or Bassinet (22 x 434-568 = 9,548-12,496)	1,436	Yes
Acute Mental Illness Service (Inpatient Behavioral Health) (34 beds)	16,061	440-560 dgsf/Bed (34 x 440-560 = 14,960-19,040)	2,979	Yes
Comprehensive Physical Rehabilitation Service (Inpatient Rehab) (22 beds)	16,447	525-660 dgsf/Bed (22 x 525-660 = 11,550-14,520)	1,927	No

The Intensive Care Unit was designed utilizing Advocate Aurora Health Patient Room and Support Room standards to provide private patient rooms and to improve operational efficiencies and clinical workflows. The proposed 600-685 dgsf/Bed for the unit has been met and is below the state standards, as outlined in the IL Administrative Code 1100.

The Medical-Surgical Units were designed utilizing Advocate Aurora Health Patient Room and Support Room standards to provide private patient rooms and to improve operational efficiencies and clinical

workflows. The proposed 500-660 dgsf/Bed for the unit has been met and is below the state standards, as outlined in the IL Administrative Code 1100.

The Mammography unit was designed utilizing Advocate Aurora Health standards to improve operational efficiencies and clinical workflow. The proposed 900 dgsf/Unit has been met and is below the state standards, as outlined in the IL Administrative Code 1100.

The Ultrasound unit was designed utilizing Advocate Aurora Health standards to improve operational efficiencies, clinical workflow, equipment mobility, and allow for future flexibility and adaptability of room usage. Therefore, the proposed 900 dgsf/Unit exceeds the state standards, as outlined in the IL Administrative Code 1100.

The Operating Rooms were designed utilizing Advocate Aurora Health standards to improve operational efficiencies and clinical workflow. The proposed 2,750 dgsf for each of the modernized Operating Rooms meet and is below the state standards, as outlined in the IL Administrative Code 1100.

The Cardiac Catheterization Rooms were designed utilizing Advocate Aurora Health standards to improve operational efficiencies and clinical workflow. The proposed 1,800 dgsf for each of the modernized Cath Labs meet and is below the state standards, as outlined in the IL Administrative Code 1100.

The proposed Post-Anesthesia Recovery Phase I bays for the recovery of Inpatient and Outpatient surgical patients are not within the state standards for Phase II Recovery bays of 180 dgsf/recovery station. The reason the proposed Phase I Recovery bays are not within the state standards is due to renovations of an existing space within the Center for Advanced Care and the physical constraints present. This contributes to the 426 dgsf overage in this department.

The proposed 400 dgsf for each of the Phase II Recovery bays is not within the state standards for Phase II Recovery bays for the recovery of Inpatient and Outpatient surgical patients. The reason the proposed Phase II Recovery bays are not within the state standards is due to renovations of an existing space within the Stone Pavilion and the physical constraints present.

The proposed Comprehensive Physical Rehabilitation Service (Inpatient Rehab) are not within the state standards of 525-60 dgsf/Bed. The reason the proposed Rehabilitation Service Department is not within the state standards is due to renovation of an existing space within the Stone Pavilion and the physical constraints present, including existing mechanical shafts, electrical rooms, and structure. This contributes to the 1,927 dgsf overage in this department.

Non-Clinical Department/Areas	PROPOSED DGSF (in project)
Ground Level	12,550 GSF
Level 1	16,375 GSF
Level 3	22,503 GSF
Level 4 Mechanical	26,733 GSF
Level 5	16,518 GSF
Level 6	14,336 GSF
Level 7	15,223 GSF
Level 8	15,223 GSF
Penthouse	31,642 GSF

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.

See Attachment #15, Exhibit 1.

The proposed Project includes 10 Departments/Services for which the Illinois Health Facilities and Services Review Board has established standards:

- Medical Surgical Beds
- ICU Beds
- Obstetric Beds
- NICU Beds
- Comprehensive Physical Rehabilitation (Inpatient Rehabilitation) Beds
- AMI Beds
- Surgical Operating Rooms
- Cardiac Catherization Labs
- Ultrasound Units
- Mammography Units
- DEXA Unit

The utilization of each service has been projected to 2026, when utilization is projected in the Project. Internal hospital financial sources were used for the services that are not included in the Annual Hospital Questionnaire. The narrative that supports the projected utilization are included in following attachments.

Inpatient Projected Bed Need

The projected utilization for the Medical Surgical, Intensive Care, Obstetric, and NICU Units, as outlined in Attachment 18, were developed using the formula for the Need Determination Assessment in Part 1100 Narrative and Planning Policies Section 1100.520. The projections for demand are driven by the pattern of growth of patients currently admitted to these Inpatient Units.

Patient days are projected to continue to increase and shift from the Medical Surgical service to the Intensive Care service. As a Level 1 Trauma Center, the increase in trauma patients and the increased acuity of Inpatients demonstrates the need for a greater number of Intensive care beds. The projected increased number of 65 and older population in the hospital's service area, will further increase the number of Inpatients with co-morbidities that will require Intensive Care services. The decrease in Medical Surgical beds, with the increase in Intensive Care rooms requested reflect the care shift anticipated to support the needs of patients living in service area.

The projections for OB and NICU demand were driven by the current postpartum utilization. Based on the declining birth rate in Chicagoland, the proposed project will decrease the number of OB and NICU beds at the project completion. The birth rate is projected to remain similar to current patient days and not continue to decline at this rate. Normal deliveries will continue to remain low, but high-risk pregnancies are projected to increase and therefore increase OB and NICU patient days.

The utilization projected for Inpatient Rehabilitation beds is outlined in Attachment 19. The number of beds in the modernization project will remain the same and will be all private rooms. Growth is projected based on the patient day increases over the last few years and projected due to the aging population in the service area and the acuity of patients requiring this level of inpatient care. Private rooms will increase access supported by improved bed placement.

The utilization projected for Acute Mental Illness beds is outlined in Attachment 20. The number of AMI beds in the project will decrease the total number of beds on the unit based on the number of patient days projected and increase the number of private rooms. The number was based on the patient day increases and those projected over the next five years. As the acuity of these patients continue to increase, the additional private rooms will be critical.

Procedural Projected Need

The project includes development of a procedural floor that includes 17 of the 19 operating rooms (2 eye rooms will remain in current location), the 4 Cardiac Cath rooms and the 21 PACU and 50 Phase II Recovery stations.
The current operating rooms built over 50 years ago are no longer current and are undersized for the complexity and technology required for Cardiovascular, Neurosurgery and Orthopedic surgical procedures presently and in the future.

The projections for the number of Operating Rooms and Cardiac Cath Labs needed are driven by the current number of surgical and procedural hours and the pattern of growth of cases and hours. These are included in Attachments 22 and 30. In addition to the projected procedural volume, as a Level I Trauma Center with an Open-Heart Surgery program, the need to maximize flexibility and maintain access outlined one additional operating room; replacing the cysto room upon completion of the project.

Outpatient Breast Imaging and DEXA

The Breast Imaging service will be designed for mammography to be co-located with other breast services such as breast ultrasound, the nurse navigator and other screening services such as bone density screening/scanning.

The projected utilization for these services as outlined in Attachment 30, is based on the increasing number of women seeking these diagnostic and outpatient cancer clinic services. The number of mammography and breast ultrasound units were established based on the projected number of women requiring these services and the desire to provide increased access in the service area.

UTILIZATION						
DEPT./SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.		PROJECTED UTILIZATION **based on 2019	STATE STANDARD	Number in Project	MEET STANDARD?
	2019	2020**	2026			
Med/Surg Beds	39,915 patient days	37,740 patient days	48,486 pt days	310 days/rm = 157	187 beds	No
ICU Beds	6,984 patient days	9,495 patient days	9,054 pt days	219 days/rm =42	37 beds	Yes
Obstetric Beds	5,852 patient days	4,849 patient days	5,852 pt days	284 days/rm = 21	24 beds	No
NICU Beds	5,348 patient days	4,157 patient days	5,348 pt days	273 days/rm = 20	22 beds	No
CPR/IP Rehab Beds	5,314 patient days	5,771patient days	5,986 pt days	273 days/rm = 22	22 beds	Yes
AMI Beds	7,707 patient days	7,807 patient days	8,764 pt days	310 days/rm = 29	34 beds	No
Surgical Operating Suite Class C	28,813 hours	21,929 hours	34,940 hrs	1,500 hrs/rm	20 rooms	Yes
Cardiac Catherization Labs	4,412 procedures	4,303 procedures (2021)	5,068 procedures	1,500 hrs/rm	4 rooms	Yes
Mammography	12,961 procedures	13,536 procedures (2021)	15,337 procedures	5,000/unit	4 units	Yes
Mammography (Stereotactic Biopsy)	203 procedures	325 procedures (2021)	847 procedures	5,000/unit	1 unit	Yes
Breast Ultrasound	5,869 procedures	7,323 procedures (2021)	10,545 procedures	3,100/unit	3 units	Yes
Breast Ultrasound (US Guided Breast Biopsy)	449 procedures	742 procedures (2021)	1,459 procedures	3,100/unit	1 unit	Yes
DEXA Unit	2,030 procedures	2,773 procedures (2021)	5,463 procedures	6,500/unit	1 unit	Yes

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

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

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

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

Not applicable

ASSURANCES:

Submit the following:

4. 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.

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

6. 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.

Not applicable

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

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

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

1. Applicants proposing to establish, expand and/or modernize the Medical/Surgical,

   Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Medical/Surgical**	**225**	**187**
☐ **Obstetric**	**44**	**24**
☐ **Pediatric**	**0**	**0**
☐ **Intensive Care**	**33**	**37**
☐ **NICU**	**34**	**22**

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

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

Category of Service		
Medical Surgical Beds		
Expansion of Existing Services	(b)(2)	– Planning Area Need – Service to Planning Area Residents
	(b)(4)	– Planning Area Need – Service Demand – Expansion of Existing Category of Service
	(e)	– Staffing Availability
	(f)	– Performance Requirements
	(g)	– Assurances

Modernization	(d)(1) & (2) & (3) – Deteriorated Facilities
	(d)(4) – Occupancy
	(f) – Performance Requirements

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.

The proposed project will include 187 medical surgical beds replacing the 225 medical surgical beds at Advocate Illinois Medical Center, decreasing the number of CON authorized beds by 38 medical surgical beds. The project will include 3 floors with medical surgical units in the new bed tower.

- The sixth floor will include 19 private medical surgical beds and 37 private ICU beds.
- The seventh and eighth floors will include only medical surgical beds with 56 private beds on each floor.

Medical surgical beds will also be modernized and remain on two floors in the existing Stone building. A 44-

semi-private bed unit will be located on the seventh floor and a 12-bed unit will be located on the ninth floor in this existing building.

These units will be designed with the current standard of care, supporting patient safety and quality, enhancing the patient experience, improving staff efficiency, and reducing unnecessary costs. The patient rooms will be right sized and designed in the Advocate Aurora Health (AAH) standard developed by a team of clinicians and hospital facility experts from throughout the AAH system. This will provide the updated infrastructure for more integrated and advanced technology and offer more appropriate space for patients and their families. These units will replace the current units that are undersized in functional space and not connected to each other. The small units in the current hospital building creates staffing challenges, inefficiencies and are challenging for patients and their families to navigate. These units are located in buildings that have infrastructure issues that would be costly to renovate for future patient care.

The new units will be designed to support clinicians, nurses and physicians spending more time with the patient at their bedside. The larger patient room provide improved workspace for the multidisciplinary health care team. The rooms will provide comfortable designated space for family members to stay with the patient, improved safety with newest technologic solutions for alarms, nurse call systems and computers in each room for ease of access to the electronic medical record (EMR). These medical surgical units will have large storage areas for medical supplies and patient care equipment for a variety of patients. A key principle in the design is flexibility to meet the changing needs of the patients and respond to changes in the delivery of health care. This flexibility will include the infrastructure for future implementation of Smart Room technology.

The pandemic has highlighted the need for private rooms that address improved bed placement, effective throughput, and infection control needs. The floors are designed to group patients based on plan of care and the design of these three floors will provide staffing flexibility, increased productivity, and improved care coordination.

> *B) Applicants proposing to add beds to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.*

In 2021, 88% of the Medical Surgical patients resided in the Hospital's service area and 96% within Cook County. The table below provides the Med Surg IP patient origin.

Medical Surgical IP Patient Origin 2021 (Jan-Jul)	
Service Area	
Primary – Patient Service Community	77%
Secondary – Patient Service Area	11%
Other	12%
Cook County	96%

Medical Surgical patient origin by zip code for 2021TYD is shown in Attachment 18, Exhibit 1.

C) Applicants proposing to expand an existing category of service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The Hospital expects that the additional Medical Surgical patients to have similar patient origin.

4) Service Demand – Expansion of Existing Category of Service

The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest 2 years;

Medical Surgical Care Bed Utilization 2017-2021				
Year	Beds Authorized	Patient Days	Average Daily Census	CON Occupancy
2017	225	36,557	100.2	57.2%
2018	225	37,127	101.7	58.1%
2019	225	39,915	109.4	62.5%
2020	225	37,740	103.1	45.8%

Prior to the Covid pandemic, medical surgical occupancy had grown consistently year over year.

Sg2 estimates that although inpatient discharges are projected to decline by 1% over the next 5 years, inpatient days are projected to increase by 5% over the next 5 years, 9% over the next 10 years.

Patient days reported are reflective of the census at midnight. The average mid-day daily census at 1:00pm is 8-10% higher in the medical surgical units and 5% higher in the Intensive care unit.

National trends project the acuity of inpatient admissions will continue to rise and result in an increase in average length of stay and patient days. Inpatient days are projected to continue to increase in part due to the growth of the aging population in the service area.
The population for the IMMC service area illustrated a projected 11% growth in the 65+ population; expecting an increase of over 25,000 additional older residents.
Due to the increased number of critically ill patients, Advocate Illinois Masonic Medical Center has experienced an increase in patient acuity on the Medical Surgical units. The higher census on peak flow days over the past 3-6 months has highlighted the need for 170-180 medical surgical beds in the future.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest 2 years.

Inpatient admissions would not need to be transferred out to other facilities as it is the routine practice of the hospital to admit all patients that present needing inpatient care. No referrals to other facilities have been included.

B) Projected Referrals
The applicant shall provide the following:

The applicant did not include letters of referral from physicians. The patients are already presenting to the hospital and included in the current demand. The members of the medical staff continue to send their patients to Advocate Masonic Medical Center.
Therefore, criteria i) to iv) are not included.

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;
ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;
iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and
iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth:

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

The growth in population does not meet the criteria for Rapid Growth so criteria i) to vii) are not included.

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;
ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township, or community area, by the U.S. Census Bureau or IDPH;
iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;
iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;
v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;
vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application; and
vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

The proposed modernization to create these replacement medical surgical units address many advancements in the standards of care and space for diagnostic and therapeutic purposes. The new medical surgical rooms will be constructed and sized according to industry standards. The current size of the medical surgical and ICU rooms are too small. They lack the room proportions needed for high tech bedside care.

The limitations in the medical surgical nursing units include insufficient space:

- to accommodate families, patient care, procedures and/or medical equipment at the patient bedside,
- for storage of routine pharmaceuticals, patient care supplies and medical equipment utilized routinely,
- for the multidisciplinary healthcare team to document patient care, provide team education and private communication regarding patients and families.

The new medical surgical units will accommodate key patient populations. Twelve of the medical surgical rooms will be designed to accommodate bariatric patients. The number of bariatric patients has grown year over year, increasing to over 300 this year. All medical surgical and intensive care rooms in the new bed tower will be telemetry capable as will 22 of the medical surgical rooms in the existing building. Dialysis capability will be available in 20% of the medical surgical rooms and all ICU rooms.

Each floor in the new building will include administrative support, family support, staff support, MD dictation, team-work space, and conference areas.

The new medical surgical unit will provide updated facilities and equipment. The technology demands have changed the way that nurses' access and use the patient information through systems in the room. Storage of linens, supplies and medications need to be immediately available and can be replenished without entering the room thus improving infection prevention. The new unit will offer same handed rooms and standard headwalls for consistency, direct sight line to the restrooms, electronic patient information boards, improved lighting, and in-ceiling lifts to provide a safer environment for both the patient and staff.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
B) The Joint Commission reports.) Additional space for diagnostic or therapeutic purposes.

There are no reports for the Medical Surgical patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

The projections for demand are driven by the pattern of growth of patients currently admitted to the Medical Surgical Units.

	2015	2016	2017	2018	2019	2020	% Change 2015-2020	Compound Annual Growth Rate
M/S Days	36,853	37,362	36,557	37,127	39,915	37,740	2.4%	0.5%

Medical surgical patient days had been increasing prior to the pandemic and are projected to see increased admissions and patient days over the next five years.
Clinical Programs projected to increase in inpatient admissions and patient days include Cardiology, General Surgery, Rheumatology and Neurosciences.

Cardiology admissions are projected to grow due to:

- Increase in general cardiology services
- Increase in interventional access for Ablation, TAVRs, Watchman, Mitra clip and Lead Extractions and Sleep Apnea

General Surgery admissions are projected to grow due to:

- Continue growth with Bariatric Surgery
- Growing population of older adults in the area
- New providers and clinics in expanded areas of the city

Rheumatology admissions are projected to grow due to:

- Additional providers increasing access to specialties
- Oak Street health partnerships
- Growing population of older adults in the area

Neuroscience admissions are projected to grow due to:

- Increase neurology providers
- Expanded Orthopedic and Sports Medicine programs and providers
- Additional vascular services

With the increasing patient days on these units and increasing number of days at high census, patient placement is frequently challenged to accommodate additional critically ill patients. The practice of adjusting the patient placement on high-capacity days challenges staff and increases the potential for disruptive patient care. The new units were designed to create a better solution to accommodate current and forecasted demand.

To project demand for the Medical Surgical units, the Compound Annual Growth Rate (CAGR) was applied to develop the trend line to 2027. This was based off the current inpatient days in 2020. A year that experienced a decline due to the pandemic.

Compound Annual Growth Rate	2021	2022	2023	2024	2025	2026
0.5%	37,920	38,101	38,282	38,465	38,648	38,833

Prior to the pandemic, inpatient medical surgical days had been increasing year over year. A revised projection based on 2019 inpatient days, would indicate the projected utilization in the following chart.

Compound Annual Growth Rate	2021	2022	2023	2024	2025	2026
0.5%	42,802	43,882	44,991	46,127	47,292	48,486

By the proposed project completion, the patient days are projected to increase year over year to 48,486. Based on the state target occupancy, the number of CON authorized medical surgical beds would outline a need for 161 medical surgical beds and no longer supports the need for the current 225 medical surgical beds, and it was determined to reduce the number of M/S beds in this project.

The analysis outlined the number of medical surgical beds needed, knowing that many of these patients will continue to have critical care needs and there will be increasing demand in higher acuity service lines. The medical surgical units were designed for the specific service lines and the appropriate beds in each will support the destination clinical programs, the patient days at daytime census, privacy and infection control that will be needed within the next five years.

An internal assessment of mid-day census supported the need for 187 medical surgical beds to provide for current patient days and the projected clinical service growth and acuity increases.
This number of Medical Surgical beds in the project will alleviate the pressure at Advocate Illinois Masonic Medical Center for appropriate inpatient placement to better serve the needs of the patients in the service area.

e) Staffing Availability – Review Criterion
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

Advocate Illinois Masonic Medical Center has evaluated the staffing needs and does not expect any issues meeting the licensure and accreditation staffing requirements as a result of the proposed project. The hospital's ability to attract and place nurses has historically been strong.
Staffing needs for the medical surgical units were evaluated and additional staff is not projected to be needed due to the project.

The Advocate Aurora Health system has a dedicated team of Recruiters and Sourcing Specialists. If there is a significant staff need anywhere in the system, resources are shifted quickly to address the situation. The staffing consultants at Advocate Aurora Health work in a collaborative manner.
An additional source for Advocate Illinois Masonic Medical Center's applicant pool comes from our active partnerships with local nursing programs. Advocate IMMC has continually benefited from the strong reputation of AAH as an excellent place of employment, as evidenced by consistently being named as one of the Top 100 Places to work in Illinois.

f) Performance Requirements – Bed Capacity Minimum

1) Medical-Surgical

The minimum bed capacity for a new medical-surgical category of service within a Metropolitan Statistical Area (MSA), as defined by the U.S. Census Bureau, is 100 beds.

The Hospital will have 187 Medical Surgical beds, exceeding the State minimum requirements.

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The letter is provided as Attachment 18 Exhibit 5.

Category of Service		
Intensive Care Beds		
Expansion of Existing Services	(b)(2)	– Planning Area Need – Service to Planning Area Residents
	(b)(4)	– Planning Area Need – Service Demand – Expansion of Existing Category of Service
	(e)	– Staffing Availability
	(f)	– Performance Requirements
	(g)	– Assurances

Modernization	(d)(1) & (2) & (3)	– Deteriorated Facilities
	(d)(4)	– Occupancy
	(f)	– Performance Requirements

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.
Critically ill patients are often admitted to the Intensive Care Unit (ICU) as a phase in their stay for other services such as surgery, cardiac care, cancer, or trauma. As a Level 1 Trauma Hospital, the ICU unit is often at maximum capacity. Advocate Illinois Masonic Medical Center has seen an increasing number of the most critically ill patients as the volumes in neurosurgery, cardiac and critical care services have grown. Many advanced procedures require patients to be monitored and receive care for extended periods of time. The shortage of critical care capacity will continue to be compounded with key service line expansion and the aging of the population projected in the service area.
As a Level 1 Trauma Center, ICU beds need to be available to for emergency trauma or patients who require an immediate higher level of care from a medical surgical unit or the ED.

The Hospital currently has 33 CON authorized ICU beds. With the changes in patient acuity and increase in patients needing intensive level care as part of their inpatient stay, it was determined that Illinois Masonic would decrease the number of medical surgical beds in the project, while including 4 additional ICU beds needed, increasing to 37 ICU beds at project completion.
Although, the Intensive Care Beds in Planning Area A-01 outlines an excess of ICU beds in the Illinois Health Facilities and Services Review Board "Health Facilities Inventory Data", the largest number of ICU beds in the Planning Area is at dedicated Children's Hospital.

The proposed project would fulfill the need for the clinical and acuity increases due to the aging and growth projected over the next 5 years.

B) Applicants proposing to add beds to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

In 2021, 84% of the Intensive Care patients resided in the Hospital's service area and 94% within Cook County. The table below provides the Intensive Care Unit patient origin.

Intensive Care Patient Origin 2021 (Jan-Jul)	
Service Area	
Primary – Patient Service Community	72%
Secondary – Patient Service Area	12%
Other	16%
Cook County	94%

Intensive Care patient origin by zip code for YTD 2021 is shown in Attachment 18, Exhibit 2.

C) Applicants proposing to expand an existing category of service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The Hospital expects that the additional ICU patients will have similar patient origin.

4) Service Demand – Expansion of Existing Category of Service

The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

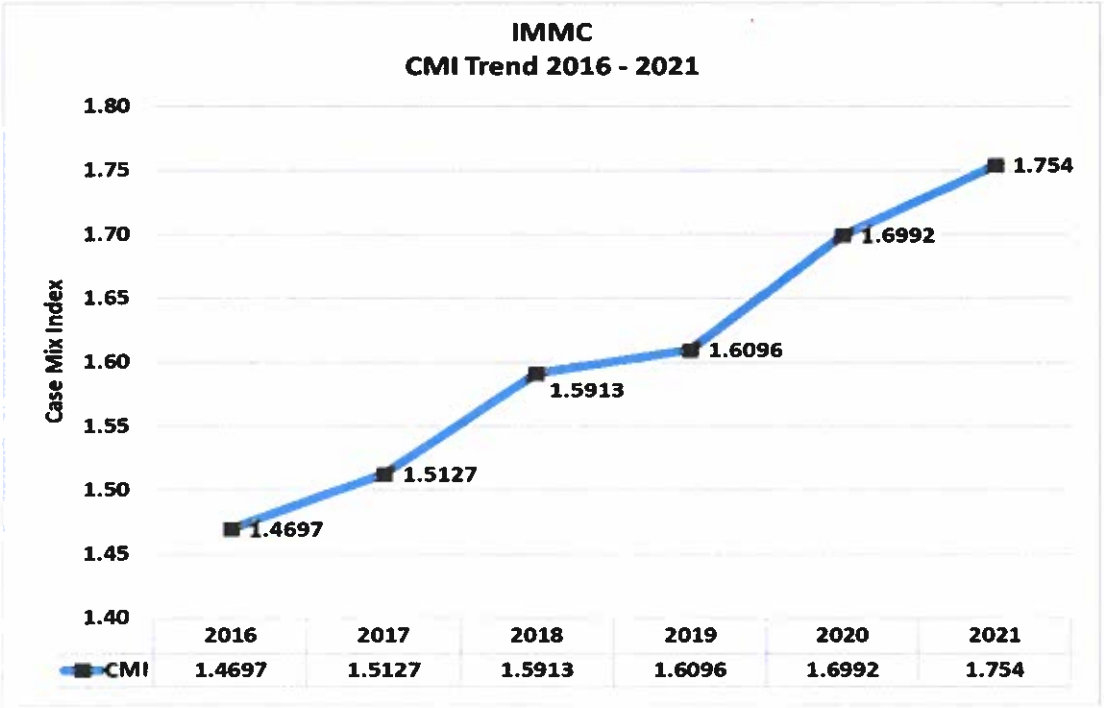
i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest 2 years;

Advocate Illinois Masonic Medical Center's ICU occupancy has increased consistently year over year and has significantly exceeded the State Standard minimum of 60% in 2020 and 2021.

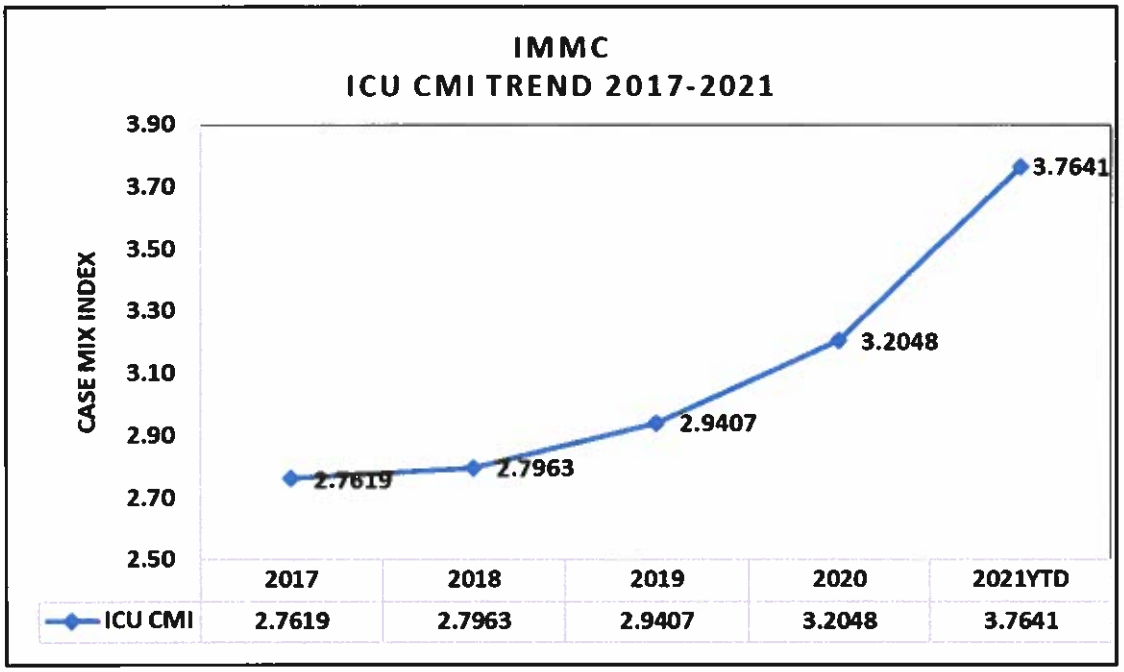
Intensive Care Bed Utilization 2017-2021				
Year	Beds Authorized	Patient Days	Average Daily Census	CON Occupancy
2017	33	6,703	18.4	55.6%
2018	33	6,402	17.5	53.2%
2019	33	6,984	19.1	57.7%
2020	33	9,495	26.0	78.6%

Source: Annual Hospital Questionnaire and Hospital Profiles

In addition to the increased number of critically ill patients, Advocate Illinois Masonic Medical Center has experienced a 19% increase in the Case Mix Index (CMI) increasing from 1.4697 in 2016 to 1.754 in 2021.



The ICU Case Mix Index mirrors this increase in acuity growing year over year from 2.7619 in 2017 to 3.7641 in 2021.



Sg2 identified national trends that project the acuity of inpatient hospital admissions will continue to rise and result in an increase in average length of stay and patient days in Intensive Care units. The utilization of the ICU at Advocate Illinois Masonic Medical Center is expected to continue to increase in part due to the growth

of the aging population in this Chicago area.
The population for the Advocate Illinois Masonic Medical Center service area illustrated a projected 11% growth in the 65+ population; expecting an increase of over 25,000 additional older residents.

The projected increase in intensive care admissions is attributed to many factors including: the aging population, increased obesity, mental health and other co-morbidities, access inequities, chronic disease, and survivorship.

According to Sg2, "At the same time, rising chronic disease and mental health rates continue to fuel inpatient demand and drive higher-acuity care demands across the System of CARE. Hospitals are left with sicker patients with longer lengths of stay. COVID-19 exacerbated this trajectory, due to long-term conditions caused by this virus, and due to delayed and deferred care. In addition, the pandemic exposed significant gaps in health care services and harsh differences in health outcomes and access related to race and socioeconomics. Health inequity is projected to continue to be a factor in rising demand for chronic disease and mental health services, particularly avoidable care utilization, offsetting some of the gains in outpatient shift and inpatient declines."

The ratio of Medical Surgical Beds to Intensive Care Beds in the State of Illinois is approximately 5.80 medical surgical beds per ICU bed.
The proposed project would bring the current ratio at Illinois Masonic to 5.05, which would be an appropriate level to meet the needs of patients progressing from intensive care. This is supported in national publications that recommend that 20-30% of all acute beds should be classified as critical care.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest 2 years.

Critically ill patients requiring ICU care would not be transferred out other facilities as it is the routine practice of the hospital to admit all patients that present needing inpatient care. The current critical care services provided are inclusive of all critical care therapies except organ transplantation and burns which is provided in regional designated centers. No referrals to other facilities have been included.

B) Projected Referrals
The applicant shall provide the following:

The applicant did not include letters of referral from physicians. The patients are already presenting to the hospital as shown by the current demand. The members of the medical staff are sending their patients to Advocate Illinois Masonic Medical Center including times of high occupancy.

Therefore, criteria i) to iv) are not included.

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;
ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;
iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and
iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth:

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

The growth in population does not meet the criteria for Rapid Growth so criteria i) to vii) are not included.

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;
ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;
iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;
iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;
v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;
vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application; and
vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

The proposed modernization in the ICU unit addresses many advancements in the standards of care and space for diagnostic and therapeutic purposes since the current ICU unit built in 1973. As Critical Care services expand, for Advocate Illinois Masonic Medical Center to provide current evidenced based practice based on the Society of Critical Care Medicine, the current ICU has limitations. There are limited headwall space for gases and electrical outlets and a lack of space to add advanced technologies such as Smart Room technology.

This proposed modernization will increase the ICU capacity from 33 to 37 beds by adding 4 ICU beds to its authorized bed count. The new ICU floor will be constructed and sized according to industry standards while right sizing the new ICU rooms including a private bathroom to provide the safest, most flexible environment. The increase in provider, patient and family space will support the intensity and technology required to care for these patients.

The new ICU unit will offer additional space to support the acuity and requirements of this patient populations including:

- Expanded storage for equipment on the unit
- Improved lighting and in-ceiling lifts to provide a safer environment for both the patient and staff.
- Increased number and size of utility rooms strategically located for improved workflow and storage of medications, supplies, and equipment.

- Improved medication safety with 2 large medication rooms with updated pharmaceutical distribution technology and space for safe medication preparation.
- 3 Consultation Rooms for private medical consultation with families.
- Four ICU rooms will be equipped for bariatric patients. These rooms will include a special patient lift system capable of 1000 lb. limit, bariatric bathroom accommodations, and bariatric critical care specialty bed and chairs. The larger room size accommodates the size of such equipment and patient as well as providing enough space for the healthcare team and to improve safety for the patient and staff during the provision of care.
- All intensive care rooms in the new bed tower will be telemetry capable
- Dialysis capability will be available in all ICU rooms.
- There will be 8 negative air flow isolation rooms in ICU rooms creating a designated pod if needed.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
B) The Joint Commission reports.) Additional space for diagnostic or therapeutic purposes.

There are no reports for the Intensive Care patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

The projections for demand are driven by the pattern of growth of patients currently admitted to the Intensive Care Unit.

	2015	2016	2017	2018	2019	2020	% Change 2015-2020	Compound Annual Growth Rate
ICU Days	6,715	6,821	6,703	6,402	6,984	9,495	41.4%	7.2%

The high occupancy of the current ICU units continues to pose challenges to provide efficient, patient focused care. When the ICU is operating at full or near full capacity, patient placement is frequently changed to accommodate additional critically ill patients. The practice of adjusting the patient placement on high-capacity

days challenges staff and increases the potential for disruptive patient care.

The floor plan in the new bed tower with Medical and Surgical Intensive Care on one floor will improve staffing, bed placement, and improve coordination of care. This will allow patients to be grouped based on specialization of the clinical team, nurses and hospitalists and support shared plans of care. The additional ICU beds and flexibility of the design of the new unit will accommodate current and forecasted demand.

Patient days reported are reflective of the census at midnight. The average 2021 mid-day daily census at 1:00pm was 20 to 26 inpatients each day.
To project demand for Intensive care, the Compound Annual Growth Rate (CAGR) was applied to develop the trend line to 2026 upon project utilization.

Compound Annual Growth Rate (based on 2020 actual)	2021	2022	2023	2024	2025	2026
7.2%	10,176	10,906	11,689	12,527	13,426	14,389

The increase in 2020 was impacted by the Covid pandemic thus a more reasonable CAGR would apply the growth to the 2019 patient days as the base year.

Compound Annual Growth Rate (based on 2019 proj)	2021	2022	2023	2024	2025	2026
7.2%	7,904	8,122	8,346	8,575	8,812	9,054

Based on this conservative estimate, by the first year after the proposed Project is completed, the patient days are projected to be 9,054.
Based on the state target of occupancy is 60%, 42 ICU beds are needed.

365 days per year x 60% =219 days per bed
9,054 patient days divided by 219 days per bed = 42 beds

It was projected that at least 37 ICU beds will be needed in the future, increasing the ICU capacity with 4 additional ICU beds.
Based on the growth in the 65 and older population and the acuity increases demonstrated, it was determined that the additional ICU beds will be needed within the next 5 years.
The design of the ICU unit adjacent to the medical surgical unit provides for flexibility to have patients appropriately stay in the ICU unit and then moved to a medical surgical step-down unit during their inpatient stay.
As outlined in the previous medical surgical section, with this increased number of ICU beds, the hospital could decrease the number of medical surgical beds to 187 and appropriately support inpatient care in the future.

e) Staffing Availability – Review Criterion
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

Advocate Illinois Masonic Medical Center has evaluated the staffing needs and does not expect any issues meeting the licensure and accreditation staffing requirements as a result of the proposed project. The hospital's ability to attract and place nurses has historically been strong.

The Advocate Aurora system has a dedicated team of Recruiters and Sourcing Specialists. If there is a significant staff need anywhere in the system, resources are shifted quickly to address the situation. The staffing consultants at AAH work in a collaborative manner.
An additional source for IMMC's applicant pool comes from our active partnerships with local nursing programs.

Advocate IMMC has continually benefited from the strong reputation of AAH as an excellent place of employment. As evidenced by consistently being named as one of the Top 100 Places to work in Illinois.

f) Performance Requirements – Bed Capacity Minimum
3) Intensive Care
The minimum unit size for an intensive care unit is 4 beds.

The proposed unit will have 37 ICU beds, exceeding the minimum requirements.

g) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The letter is provided as Attachment 18 Exhibit 5.

Category of Service		
Obstetric Beds		
Expansion of Existing Services	(b)(2)	– Planning Area Need – Service to Planning Area Residents
	(b)(4)	– Planning Area Need – Service Demand – Expansion of Existing Category of Service
	(e)	– Staffing Availability
	(f)	– Performance Requirements
	(g)	– Assurances

Modernization	(d)(1) & (2) & (3) – Deteriorated Facilities
	(d)(4) – Occupancy
	(f) – Performance Requirements

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.
As a designated Baby-Friendly hospital, Advocate Illinois Masonic Medical Center offers the highest level of prenatal and postnatal care by board-certified obstetricians, perinatologists, neonatologists and certified nurse-midwives.
IMMC's Neonatal Intensive Care Unit has a level III designation, the highest level NICU designation in IL. Comprehensive Lactation Services include all resources to help mothers successfully breastfeed and a donor milk program that provides for newborns when moms and babies are facing high-risk pregnancies or complications. Breastfeeding support includes prenatal classes, lactation counselors during the inpatient stay and an outpatient center and support at home.

Advocate Illinois Masonic Medical Center has a strong relationship with FQHCs in the area, with Midwives and physicians providing obstetric care to these patients. As part of the oldest nurse midwifery program in Chicago and one of the city's largest, our certified nurse midwives work with our obstetricians to provide complete prenatal, labor, postpartum and well-gynecological care. Advocate Illinois Masonic Medical Center continues to coordinate partnerships within the community and most recently has become the delivering facility for Howard Brown Health Clinics and accepts referrals from the Birth Center of Chicago and the Infant Welfare Society of Chicago.

IMMC supports all types of birthing experiences and have been named an LGBT Healthcare Leader by the Human Rights Campaign.

The hospital's accredited Healthy Families program provides teen mothers with education and support. The Hospital has an OB/Gyn residency program training physician residents over a 4-year program and a nursing residency program for recent graduates. Nursing clinical rotations are coordinated within affiliated nursing schools.

The Hospital has 44 CON authorized Obstetric beds. Based on the declining birth rate at IMMC, locally and nationally, the proposed project will decrease the number of OB beds by 20 beds to develop a 24-bed unit at the project completion.

B) Applicants proposing to add beds to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

In 2021, 92% of the Obstetric patients resided in the Hospital's service area and 97% within Cook County. The table below provides the Obstetric patient origin.

Obstetric Patient Origin 2021 (Jan-Jul)	
Service Area	
Primary – Patient Service Community	77%
Secondary – Patient Service Area	15%
Other	8%
Cook County	97%

Obstetric patient origin by zip code for YTD 2021 is shown in Attachment 18, Exhibit 3.

C) Applicants proposing to expand an existing category of service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The Hospital expects that the additional Obstetric patients will have similar patient origin.

4) Service Demand – Expansion of Existing Category of Service

The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

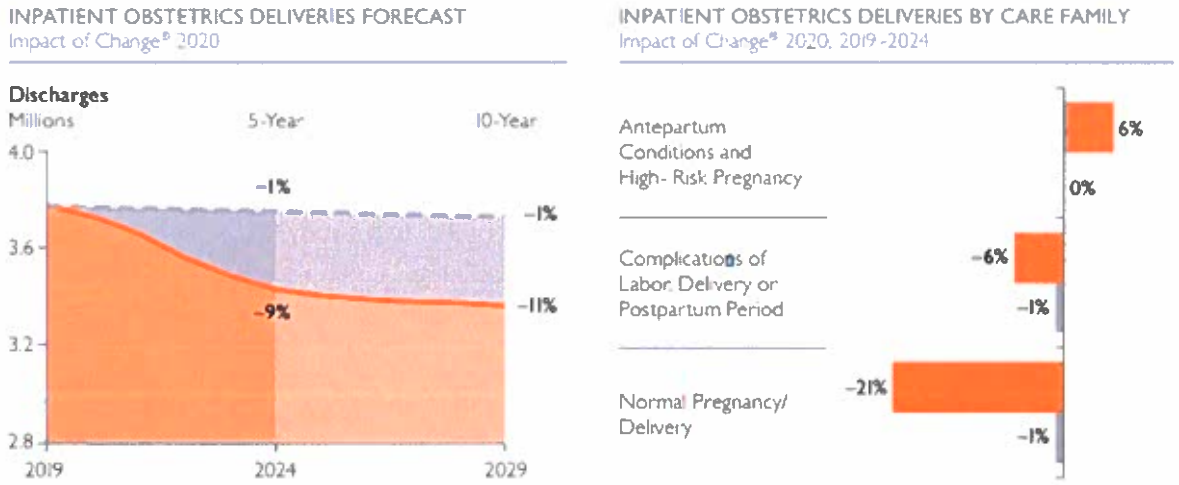
i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest 2 years;

Advocate Illinois Masonic Medical Center's Obstetric occupancy has continued to be lower than the State Standard minimum of 75%. Although peak average daily census has been between 25-30 over the last few years, based on national and local trends of declining births, it was determined that a 24-bed unit could provide the projected number of beds needed for the future.

Obstetric Bed Utilization 2017-2020				
Year	Beds Authorized	Patient Days	Average Daily Census	CON Occupancy
2017	44	6,409	17.6	43.9%
2018	44	5,933	16.3	40.6%
2019	44	5,852	16.0	40.1%
2020	44	4,849	13.2	31.5%

Source: Annual Hospital Questionnaire and Hospital Profiles

Advocate Illinois Masonic Medical Center has experienced a decrease in OB deliveries that parallel the national birth rate declines. Sg2 identified "this national trend as one that has been seen short term and continues to dampen throughout the decade due to cultural norms (e.g. childbearing, smaller family sizes) and pandemic driven economic instability. At the same time rising maternal age and co-morbidities will contribute to a growing proportion of antepartum complications and high-risk pregnancies that will increase the length of stay."



ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest 2 years.

Obstetric patients would not be referred to other facilities as it is the routine practice of the hospital to admit all patients that present needing inpatient care. No referrals to other facilities have been included.

B) Projected Referrals
The applicant shall provide the following:

The applicant did not include letters of referral from physicians. The patients are already presenting to the hospital as shown by the current demand. The members of the medical staff are sending their patients to Advocate Illinois Medical Center including times of high occupancy.

Therefore, criteria i) to iv) are not included.

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;
ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;
iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and
iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth:

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

The growth in population does not meet the criteria for Rapid Growth so criteria i) to vii) are not included.

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;
ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;
iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;
iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;
v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;
vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application; and
vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

The modernized Obstetric unit will include 8 LDR rooms, 2 C-Section rooms, 6 triage rooms and 24 Post-Partum rooms in addition to the support and staff space required for a contemporary unit on one floor of the new Bed Tower. This will replace an aging facility with room deficiencies and services that are not located for coordination.

The project design addresses many advancements in the standards of care and space for clinical flexibility and improved staffing efficiencies with all Obstetric and NICU services on one floor. Six of the postpartum rooms will be designed to be also used for antepartum patients. Currently antepartum care is provided in a separate location from Labor and Delivery. The improvement in design will allow for enhanced coordination of care.

The new unit will provide updated facilities and equipment. The technology demands have changed the way

that nurses' access and use the patient information through systems in the room, which help to promote and support patient-centered care at the bedside.

Advocate Illinois Masonic Medical Center currently has a combination of private and semi-private rooms. COVID-19 raised awareness and significant concerns about the semi-private room footprint in the facility. The new Postpartum rooms will all be Private with space designed for rooming in with the babies. The updated rooms have been improved to support the care of patients that may need to be placed in isolation and/or require care with a hoyer lift.

The current Postpartum rooms are undersized averaging 183 square feet. This is 63% smaller than the current standard Postpartum rooms of 300 net square feet. The larger room size will be right sized for equipment and patients as well as providing enough space for the healthcare team to provide care to the mother and baby

This floor is also designed to include:

- Increased storage areas strategically located for improved workflow and storage of medications, supplies, and equipment.
- Physician on call space for OB/Gyn physicians, residents, Midwives, Neonatologists.
- Staff locker room
- Teamwork space for physicians and nurses to enhanced communication and handoffs. core team stations, soiled workroom, clean supply, med prep, support, and nourishment.
- Education rooms for classes prior to and during the inpatient stay.
- Family Consultation Rooms for private medical consultation with families related to the care of the patients.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
B) The Joint Commission reports.) Additional space for diagnostic or therapeutic purposes.

There are no reports for the Obstetric patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need
The projections for demand were driven by the pattern of growth of patients currently admitted to the Obstetric Unit.

	2015	2016	2017	2018	2019	2020	% Change 2015-2020	Compound Annual Growth Rate
Postpartum Days	7,568	7,069	6,409	5,933	5,852	4,849	-22.7%	-6.2%

The number of postpartum days has declined due to the decreasing birth rate and is projected to remain at lower levels into the future.

Although the Compound Annual Growth Rate (CAGR) has been used to project the future growth or declines, the birth rate is projected to remain at these lower patient days and not continue to decline at this rate. Normal deliveries will continue to remain low, but high-risk pregnancies are projected to increase and therefore increase patient days.

By the second year after the proposed Project is completed, patient days are projected to remain around 5,000 patient days, translating to an average of 18 OB beds.

365 days per year x 78% =284 days per bed
4,849 patient days divided by 284 days per bed = 18 beds

The postpartum days provided are at midnight and the noon census is 20% higher due to the discharge time later in the day to allow the mom and baby the care, testing and education needed prior to discharge. Seasonality of the Obstetric service was also factored in to provide the necessary beds to support this critical hospital service.
Eighteen beds at the midnight census translates to 22-24 postpartum beds at midday census.

Based on the current postpartum utilization, it was determined that AIMMC's Postpartum unit would need 24 Postpartum beds in the future replacing the current 44 licensed beds due to the decline in the Chicagoland birth rate.

e) Staffing Availability – Review Criterion

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

Advocate Illinois Masonic Medical Center has evaluated the staffing needs and does not expect any issues meeting the licensure and accreditation staffing requirements as a result of the proposed project. The hospital's ability to attract and place nurses has historically been strong.

The Advocate Aurora system has a dedicated team of Recruiters and Sourcing Specialists. If there is a significant staff need anywhere in the system, resources are shifted quickly to address the situation. The staffing consultants at AAH work in a collaborative manner.
An additional source for IMMC's applicant pool comes from our active partnerships with local nursing programs and the long-standing nurse residency program.

Advocate IMMC has continually benefited from the strong reputation of AAH as an excellent place of employment. As evidenced by consistently being named as one of the Top 100 Places to work in Illinois.

f) Performance Requirements – Bed Capacity Minimum

2) Obstetrics

The minimum unit size for an obstetric care unit within an MSA is 20 beds.

The proposed unit will have 24 Obstetric beds, exceeding the minimum requirements.

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The letter is provided as Attachment 18 Exhibit 5.

Category of Service		
NICU Beds		
Expansion of Existing Services	(b)(2)	– Planning Area Need – Service to Planning Area Residents
	(b)(4)	– Planning Area Need – Service Demand – Expansion of Existing Category of Service
	(e)	– Staffing Availability
	(f)	– Performance Requirements
	(g)	– Assurances

Modernization	(d)(1) & (2) & (3)	– Deteriorated Facilities
	(d)(4)	– Occupancy
	(f)	– Performance Requirements

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.
As a designated Baby-Friendly hospital, Advocate Illinois Masonic Medical Center offers the highest level of prenatal and postnatal care by board-certified obstetricians, perinatologists, neonatologists and certified nurse-midwives.
Advocate Illinois Masonic Medical Center's Neonatal Intensive Care Unit has a level III designation, the highest level NICU designation in IL.

The Hospital has 34 CON authorized NICU beds. Based on the declining birth rate at Advocate Illinois Masonic Medical Center IMMC, locally and nationally, the proposed project will decrease the number of NICU beds by 12 to develop a 22-bed unit at the project completion.

B) Applicants proposing to add beds to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

In 2021, 89% of the NICU patients resided in the Hospital's service area and 99% within Cook County. The table below provides the NICU patient origin.

NICU Patient Origin 2021 (Jan-Jul)	
Service Area	
Primary – Patient Service Community	76%
Secondary – Patient Service Area	13%
Other	11%
Cook County	99%

NICU patient origin by zip code for YTD 2021 is shown in Attachment 18, Exhibit 4.

C) Applicants proposing to expand an existing category of service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The Hospital expects that the additional NICU patients will have similar patient origin.

4) Service Demand – Expansion of Existing Category of Service

The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest 2 years;

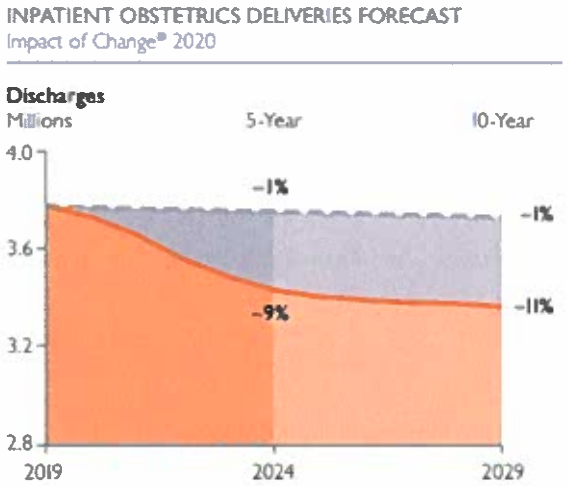
Advocate Illinois Masonic Medical Center's NICU occupancy has decreased lower than the State Standard minimum of 75% in recent years. The number of NICU and normal newborn days has declined due to the decrease in number of deliveries in the last few years. It is estimated in the future that a greater number of babies will require NICU care based on increasing maternal age and comorbidities of the mothers.

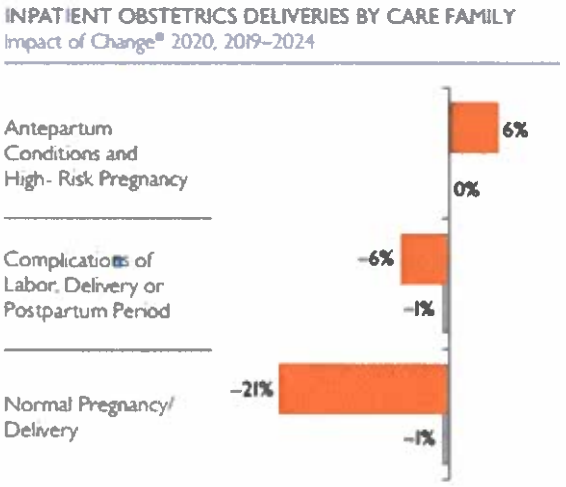
The NICU average daily census reported included only Level 4 babies that are cared for in the NICU. The Obstetric model of care at AIMMC was designed with babies remaining in the mother's room without a normal newborn nursery. All babies needing any level of nursery care will be cared with the appropriate needed level of care in these NICU beds.
Similar to Obstetric utilization, the occupancy percentages are 20-25% higher at noon compared with the midnight census reported.

NICU Bed Utilization 2017-2020				
Year	Beds Authorized	Patient Days	Average Daily Census	CON Occupancy
2017	20	7,392	20.3	101.3%
2018	20	5,587	15.9	79.3%
2019	34	5,348	14.7	43.1%
2020	34	4,157	11.4	33.5%

Source: Advocate IMMC Finance

IMMC has experienced a decrease in OB deliveries that parallel the national birth rate declines. Sg2 identified "this national trend as one that has been seen short term and continues to dampen throughout the decade due to cultural norms (e.g. childbearing, smaller family sizes) and pandemic driven economic instability. At the same time rising maternal age and co-morbidities will contribute to a growing proportion of antepartum complications and high-risk pregnancies that will increase the length of stay. "Normal deliveries are projected to decline by 1%, with high-risk pregnancies increasing by 6% over the next five years.





ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest 2 years.

NICU babies would not be referred to other facilities as it is the routine practice of the hospital to admit all patients that present needing inpatient care. No referrals to other facilities have been included. Complex cardiac cases and surgery are transferred to Advocate Children's hospitals as needed.

B) Projected Referrals
The applicant shall provide the following:

The applicant did not include letters of referral from physicians. The patients are already presenting to the hospital as shown by the current demand. The members of the medical staff are sending their patients to Advocate Illinois Medical Center including times of high occupancy.
Therefore, criteria i) to iv) are not included.

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;
ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;
iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and
iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth:

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

The growth in population does not meet the criteria for Rapid Growth so criteria i) to vii) are not included.

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;
ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;
iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;
iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;
v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;
vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application; and
vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

The new NICU rooms will all be Private rooms replacing the current ward style NICU unit. The NICU will be relocated in the new bed tower co-located on one floor with all Obstetric services. The proposed modernization will bring the NICU to the current facility codes and standards.

The newly designed NICU unit will provide updated facilities and equipment including larger room sizes to meet current NICU design and increased storage rooms strategically located for improved workflow and storage of medications, supplies, and equipment. The improved layout of these rooms minimizes the

frequency of staff needing to exit the patient room for any necessary supplies. The NICU floor will include family consultation rooms for private medical consultation with families related to the care of the patients.

This floor is designed to include physician on call space for OB/Gyn physicians, residents, Midwives, Neonatologists and physician resident work rooms, core team stations, soiled workroom, clean supply, med prep, support, and nourishment.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
B) The Joint Commission reports.) Additional space for diagnostic or therapeutic purposes.

There are no reports for the NICU patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

The projections for demand were driven by the pattern of growth of patients currently in the NICU unit.

NICU volume reported includes only Level 4 patient days. Outlined below are the total volume of NICU patient days to include Levels 1,2,3 and 4. As the unit design does not provide for a normal newborn nursery, all babies needed any level of nursery care will be in cared for in the NICU beds.

The modernized unit design was created with 18 NICU rooms with 4 rooms to be licensed for 2 beds each to accommodate multiple births. As there is no formula developed for bed need for neonatal intensive care beds, IMMC developed the following need for the number of neonatal intensive care beds needed for this service.

NICU Bed Utilization 2017-2021 – Patient Days						
	2015	2016	2017	2018	2019	2020
Level 1	4	4	8	17	21	99
Level 2	183	171	659	309	138	344
Level 3	4,080	3,931	3,107	3,330	3,075	2,050
Level 4 /NICU	4,150	4,265	3,618	2,131	2,114	1,664
TOTAL	8,417	8,371	7,392	5,787	5,348	4,157

Although the Compound Annual Growth Rate (CAGR) has been used to project the future growth or declines, the birth rate is projected to remain similar to these patient days and not continue to decline at this rate. Normal deliveries will continue to remain low, but high-risk pregnancies are projected to increase and therefore increase NICU patient days.

365 days per year x 75% =273 days per bed
4,157 patient days divided by 273 days per bed = 15 beds

The NICU days provided are at midnight and the noon census is 20-25% higher due to the discharge time later in the day to allow the mom and baby the care, testing and education needed prior to discharge. 15 beds at the midnight census translates to 18-22 NICU beds at midday census.

The analysis determined that a decrease in number of NICU beds to a 22-bed unit will provide the projected number of NICU beds needed for the future.

e) Staffing Availability – Review Criterion
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

Advocate Illinois Masonic Medical Center has evaluated the staffing needs and does not expect any issues meeting the licensure and accreditation staffing requirements as a result of the proposed project. The hospital's ability to attract and place nurses has historically been strong.
The Advocate Aurora system has a dedicated team of Recruiters and Sourcing Specialists. If there is a significant staff need anywhere in the system, resources are shifted quickly to address the situation. The staffing consultants at AAH work in a collaborative manner.
An additional source for IMMC's applicant pool comes from our active partnerships with local nursing programs and the long-standing nurse residency program.

Advocate IMMC has continually benefited from the strong reputation of AAH as an excellent place of employment. As evidenced by consistently being named as one of the Top 100 Places to work in Illinois.

f) Performance Requirements – Bed Capacity Minimum

There is no minimum unit size for a NICU unit.

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The letter is provided as Attachment 18 Exhibit 5.

Attachment 18, Exhibit 1

Medical Surgical Patient Origin 2021 (Jan-Jul)		
Patient Zip code	Service Area	Med Surg Patient Volume
60618	Primary	2,438
60614	Primary	2,154
60657	Primary	2,118
60613	Primary	1,702
60641	Primary	1,370
60647	Primary	1,355
60639	Primary	1,325
60640	Primary	1,147
60625	Primary	781
60634	Secondary	704
60660	Primary	428
60630	Secondary	420
60651	Primary	382
60610	Primary	375
60626	Primary	343
60617	Other	326
60622	Primary	323
60707	Secondary	273
60624	Primary	258
60644	Primary	246
60645	Primary	216
60653	Primary	212
60619	Other	209
60659	Primary	188
60616	Primary	186
60608	Primary	183
60623	Primary	177
60646	Secondary	164
60632	Primary	159
60636	Primary	158
Other		3,918
TOTAL		**24,238**

Attachment 18, Exhibit 2

Intensive Care Patient Origin 2021 (Jan-Jul)		
Patient Zip code	Service Area	ICU Patient Volume
60614	Primary	383
60618	Primary	365
60641	Primary	359
60657	Primary	351
60639	Primary	319
60613	Primary	282
60625	Primary	269
60647	Primary	249
60634	Secondary	235
60640	Primary	222
60630	Secondary	86
60660	Primary	84
60617	Other	80
60448	Other	61
60622	Primary	56
60610	Primary	53
60644	Primary	52
60626	Primary	51
60651	Primary	51
60652	Other	51
60659	Primary	48
60107	Other	41
60958	Other	39
60424	Other	37
60620	Other	37
60623	Primary	35
60645	Primary	33
60629	Other	32
Other		811
TOTAL		**4,772**

Attachment 18, Exhibit 3

Obstetric Patient Origin 2021 (Jan-Jul)		
Patient Zip code	Service Area	OB Patient Volume
60618	Primary	245
60647	Primary	217
60625	Primary	196
60641	Primary	188
60639	Primary	179
60640	Primary	163
60657	Primary	144
60630	Secondary	96
60613	Primary	90
60634	Secondary	88
60651	Primary	72
60622	Primary	69
60660	Primary	65
60614	Primary	64
60645	Primary	51
60626	Primary	46
60707	Secondary	44
60659	Primary	41
60804	Primary	32
60646	Secondary	27
60612	Primary	24
60608	Primary	23
60202	Secondary	22
60402	Primary	21
60644	Primary	21
60636	Other	20
60638	Other	20
60642	Primary	20
Other		509
TOTAL		**2,797**

Attachment 18, Exhibit 4

NICU Patient Origin 2021 (Jan-Jul)		
Patient Zip code	Service Area	NICU Patient Volume
60639	Primary	120
60104	Primary	65
60707	Primary	56
60625	Primary	54
60804	Primary	43
60645	Primary	40
60626	Primary	35
60636	Secondary	33
60647	Primary	28
60617	Secondary	21
60618	Primary	17
60641	Primary	15
60657	Primary	15
60630	Primary	12
60613	Primary	11
60651	Primary	9
60622	Secondary	7
60655	Primary	6
60402	Primary	5
60644	Secondary	5
60660	Primary	5
Other	Primary	40
TOTAL		**642**

Assurance of Occupancy Letter

Advocate Illinois Masonic Medical Center
836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

January 10, 2022

Ms. Debra Savage
Chairman
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Fl.
Springfield, Illinois 62761

RE: Advocate North Side Health Network
d/b/a Advocate Illinois Masonic Medical Center
Patient Pavilion and CAC Modernization and Expansion

Dear Ms. Savage:

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

Based on the information available, it is my understanding that by the second year of operation after project completion, Advocate Illinois Masonic Medical Center reasonably expects to achieve and maintain the utilization standards for the Inpatient Bed Units and Surgical/Procedural areas as specified in Administrative code 1110.

Sincerely,

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

B. Criterion 1110.205 - Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize the Comprehensive Physical Rehabilitation category of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Comprehensive Physical Rehabilitation**	**22**	**22**

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.205(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110. 205(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.205(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.205(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.205(b)(5) - Planning Area Need - Service Accessibility	X		
1110.205(c)(1) - Unnecessary Duplication of Services	X		
1110.205(c)(2) - Maldistribution	X		
1110.205(c)(3) - Impact of Project on Other Area Providers	X		
1110.205(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.205(d)(4) - Occupancy			X
1110.205(e)(1) - Staffing Availability	X	X	
1110.205(f) - Performance Requirements	X	X	X
1110.205(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Category of Service		
Comprehensive Physical Rehabilitation Beds		
Modernization		(d)(1) & (2) & (3) – Deteriorated Facilities
		(d)(4) – Occupancy
		f) – Performance Requirements

d) Comprehensive Physical Rehabilitation Modernization

1) If the project involves modernization of a CPR service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.
The proposed project will include relocation of the 22 beds in the Comprehensive Physical Rehabilitation service from the current outdated hospital building to the Stone Building (vacated by a medical surgical unit).

The new unit will be designed with all private rooms including private bathrooms and showers. This will replace a unit with semi-private rooms that share a bathroom. Many of the current rooms do not include a shower in the bathroom. The private rooms are needed for infection prevention and allow greater bed placement. The new patient rooms will be modernized to be right-sized and meet ADA specifications for clear floor space for wheelchair maneuverability including bathroom and shower wheelchair accessibility. These larger rooms are needed to accommodate lifting equipment and durable medical equipment for a population that requires equipment for mobility. These rooms would be designed in the AAH standard bringing these rooms to the current standard of care.
The number of CON authorized beds for this service will remain unchanged.

The Comprehensive Physical Rehabilitation service is important in the health care continuum for Advocate Illinois Medical Center inpatients providing the care coordination for patients requiring Inpatient Rehabilitation level of care. The staff diversity reflects that of the community with 31% white, 31% Asian, 22% Hispanic and 16% Black. The staff 2021, Advocate Illinois Masonic's Inpatient Unit was named by Newsweek as one of the top 5 Physician Rehabilitation Centers in Illinois.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and
B) The Joint Commission reports.

There are no reports for the Comprehensive Physical Rehabilitation patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

The projections for demand are driven by the pattern of growth of patients currently admitted to the Comprehensive Physical Rehabilitation service.
Statistics show that the incidence of stroke between 1990 and 2019 has increased 70%. In addition, the CDC reports that stroke continues to be a leading cause of death and a major cause of serious disability in adults. More than a third of the patients admitted for acute inpatient rehabilitation at Illinois Masonic is for stroke. The number of adults with significant disability resulting from stroke admitted to the acute inpatient rehabilitation unit at Advocate Illinois Masonic Medical Center has increased year over year and illustrates the need to maintain the 22 authorized bed number for this service.

	2017	2018	2019	2020*	% Change 2018-2020	Compound Annual Growth Rate
IP Rehab Patient Days	5,109	5,214	5,314	5,771	13.0%	0.6%

Compound Annual Growth Rate	2021	2022	2023	2024	2025	2026
0.6%	5,806	5,842	5,878	5,913	5,950	5,986

The projected patient beds at 85% occupancy show a need for 20 beds.
There are times in the year, where patient days increase due to increase Trauma or falls.
An internal assessment of mid-day census, which is higher than the reported census at midnight, supported the need for 22 Inpatient Rehabilitation beds to provide for current patient days and the clinical service growth and acuity increases projected.

Additionally, the current unit with semi-private rooms has presented challenges for bed placement due to infection control and room sharing of patients.
With the newly designed unit of all private Comprehensive Physical Rehabilitation rooms, patient days are projected to increase and will provide improved access for patients. This will support the continuity of care at Advocate Illinois Masonic for appropriate inpatient placement to better serve the needs of the patients in the

service area.

f) Performance Requirements – Bed Capacity Minimum

1) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.

2) The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.

The Hospital will continue to have a 22 CPR bed unit, exceeding the State unit size minimum requirement.

C. Criterion 1110.210 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize the Acute Mental Illness and Chronic Mental Illness categories of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Acute Mental Illness**	**39**	**34**

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.210(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.210(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.210(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.210(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.210(b)(5) - Planning Area Need - Service Accessibility	X		
1110.210(c)(1) - Unnecessary Duplication of Services	X		
1110.210(c)(2) - Maldistribution	X		
1110.210(c)(3) - Impact of Project on Other Area Providers	X		
1110.210(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.210(d)(4) - Occupancy			X
1110.210(e)(1) - Staffing Availability	X	X	
1110.210(f) - Performance Requirements	X	X	X
1110.210(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Category of Service		
Acute Mental Illness Beds		
Modernization		(d)(1) & (2) & (3) – Deteriorated Facilities
		(d)(4) – Occupancy
		f) – Performance Requirements

d) AMI and/or CMI Modernization

1) If the project involves modernization of an AMI and/or CMI service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;
B) Non-compliance with licensing or life safety codes;
C) Changes in standards of care (e.g., private versus multiple bedrooms); or
D) Additional space for diagnostic or therapeutic purposes.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.
The proposed project will include relocation of the Acute Mental Illness service from the current outdated hospital building to the Stone Building (vacated by medical surgical unit). The modernization will be including 34 private and semi-private AMI beds in 28 rooms replacing the 39 AMI beds at Advocate Illinois Medical Center, decreasing the number of CON authorized beds by 5 AMI beds.

Advocate Illinois Medical Center offers comprehensive behavioral health services that include adult inpatient treatment in addition to a wide range of outpatient services. The unit is staffed and functions as a locked inpatient unit. Staff provide inpatient psychiatric treatment to the acutely mentally ill adult who 1) is a risk to self, others or property and is serious enough to require 24-hour supervision, 2) is unable/unwilling to control own behavior and/or 3) is unable/unwilling to provide for daily needs (nutrition, sleep, hygiene).

Patients range in age from 18 years to elderly. Patients have a primary diagnosis of mental illness as identified by the DSM V. The most common diagnoses are schizophrenia and other psychotic disorders, mood disorders, and organic disorders. These primary diagnoses sometimes are accompanied by substance abuse and personality disorders. In addition, many patients have concurrent medical conditions requiring treatment. The unit-based team delivers care utilizing a multi-disciplinary collaborative team approach to patient care based upon a patient centered care model. These services are sensitive to all sexual orientations, gender identities and cultural values.

The modernization will provide an increased number of private rooms that will improve bed placement that has been impacted by infection control and increasing patient acuity.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and
B) The Joint Commission reports.

There are no reports for the AMI patient rooms.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;
B) Copies of citations for life safety code violations; and
C) Other pertinent reports and data.

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to replace and modernize outdated buildings. The new inpatient units will be designed with current industry standards for size, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

The projections for demand are driven by the pattern of growth of patients admitted to the current AMI Unit. This is similar to the growth projected by Sg2 where they outline in their Behavioral Health forecast a projected 5% growth in inpatient admissions over the next 5 years. This is complemented by an expected 23% growth in outpatient visits.

With the current inpatient volume expected to increase slightly, it was determined that the number of authorized beds can be decreased by 5 beds from 39 to 34.

	2017	2018	2019	2020*	% Change 2018-2020	Compound Annual Growth Rate
AMI Patient Days	8,046	7,454	7,707	7,807	4.7%	2.3%

Compound Annual Growth Rate	2021	2022	2023	2024	2025	2026
2.3%	7,807	7,990	8,177	8,368	8,564	8,764

The projected patient beds at 85% occupancy supports a need for 29 beds.
As mid-day census is higher, an internal assessment of patient days at mid-day supported the need for 34 AMI beds to provide for current patient days and the projected clinical service growth and acuity increases.
With more acute presentation requiring private bed placement, the modernized unit will provide for an increase number of private rooms to support the increasing patient acuity outlined in the current patient population and expected in the future.

This number of AMI beds in the project will alleviate the pressure at Advocate Illinois Masonic Medical Center for appropriate inpatient placement to better serve the needs of the patients in the service area.

f) Performance Requirements – Bed Capacity Minimum

1) Acute Mental Illness

The minimum unit size for a new AMI unit within an MSA is 20 beds.

The Hospital will have 34 AMI beds, exceeding the State minimum requirements.

E. Criterion 1110.225 - Cardiac Catheterization

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

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

Category of Service	# Existing Beds	# Proposed Beds
☐ **Cardiac Catheterization**	**3**	**4**

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

1. Criterion 1110.225(a), Peer Review

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

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

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

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

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

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

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

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

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

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

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

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

5. Criterion 1110.225(e), Support Services

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

6. **Criterion 1110.225(f), Laboratory Location**

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

7. **Criterion 1110.225(g), Staffing**

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

8. **Criterion 1110.225(h), Continuity of Care**

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

9. **Criterion 1110.225(i), Multi-institutional Variance**

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

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

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

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

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

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

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

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

   h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 22 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Advocate Illinois Masonic Medical Center is a tertiary referral center and teaching hospital located in north-east section of Chicago, in the Lakeview Area.

The proposed project will include relocation of the Cardiac Catherization and EP services to be located adjacent to the newly created Operating Rooms to create a surgical procedure floor on the third floor of the new bed tower and CAC expansion.

The project will include 4 cardiac catherization rooms located in the new building, replacing the 3 existing rooms in the main hospital. The rooms will used for cardiac cath, EP and invasive peripheral endovascular procedures.

These rooms will be designed with the current standard of care, supporting patient safety and quality, enhancing the patient experience, improving staff efficiency. The patient rooms will be right sized and designed in the Advocate Aurora (AAH) standard developed by a team of clinicians and hospital facility experts from throughout the AAH system. This will provide the updated infrastructure for more integrated and advanced technology and offer more appropriate space for patients and their families. These rooms will replace the current rooms that are undersized in functional space and not connected to each other.
The proximity to the Operating Rooms for Open Heart Surgery will improve coordination of care and anesthesia coverage.
The procedural floor was designed to add additional prep and recovery space that will be used by Cardiac Cath and surgical patients allowing for improved patient care and staff efficiency. Needed support spaces will be included to support patients and their families and allow better utilization of equipment and facilities. The design improves the coordination and flexibility of staff that will accommodate the peaks of patient volume and emergency situations.
The project design provides the flexibility to meet the changing needs of Cardiac Cath and Cardiovascular patients.

1. Criterion 1110.225(a), Peer Review

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

Cardiovascular Services Peer Review Committee is a representative physician group that meets regularly for case review as outlined by Advocate Illinois Masonic Medical Center's bylaws. Membership includes cardiologists, internists, interventional radiologists, and electrophysiologists.

Cases are referred for review based on (but not limited to) patient safety reporting, guideline non-compliance, CMS Quality Measures non-compliance (including any other department defined indicator), National Cardiovascular Data Registry (NCDR) definition, external referral (i.e. Quality Improvement Organization QIO), patient/family concerns, site leadership concerns, and/or nurse/physician referral. Case review information is electronically stored and becomes part of the hospital's focused and ongoing Physician Practice Evaluation reporting for physician privileges. This group also regularly reviews data to identify troublesome trends needing more intense evaluation.

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

This category of service offering diagnostic catherization, interventional angiography, and

electrophysiology is established and is not expanding to any new services such that the criterion does not apply.

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

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

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

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

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

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

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

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

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

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

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

This category of service is an essential patient care component to the Heart Institute at Advocate Illinois Masonic Medical Center. The 3 current rooms accommodate diagnostic and interventional procedures for Cardiac Cath, EP, and endovascular procedures. One room is dedicated to EP and one of the Cath rooms can accommodate cath, 2nd EP and endovascular procedures. The third cath room can only be used for cardiac cath procedures. Currently 2 labs are used simultaneously for EP Cases. As these high-risk procedures require anesthesia support, they are required to be scheduled early in the day and performed simultaneously verses one after another. With two rooms dedicated to EP, the remaining cath lab may need to have move cath patient mid procedure as emergent cases present. The project will allow all 4 rooms to accommodate cath and peripheral cases and 2 of the rooms will also accommodate EP procedures.

The complexity and diversity of patients has been growing and it is increasingly complicated to manage the schedules and move equipment between the current rooms. Electrophysiology procedures are a large portion of the procedures performed and are growing year over year.

Given the high complexity of these cases, EP cases take 2-8 hours verses a Cath case that takes approximately one hour. This is especially true, as Advocate Illinois Masonic is a teaching hospital with 9 cardiology fellows and 2 EP fellows in the program. Having two rooms designated for the EP procedures will allow for flexibility, and increased access for these patients.

A summary of all cardiovascular patients and procedures performed in the Cardiac Cath labs is provided in the chart below. In addition to diagnostic cardiac cath procedures, other procedures performed in the Cardiac Catherization labs include: EP, Vascular, TEE, cardioversion, and structural heart procedures.

Patients	2017	2018	2019	2020*	2021	Patient % Change 2017-2021
Cath (Heart, Structural, Peripheral)	948	917	1,043	750	1,093	15%
EP (including ablation)	571	581	687	497	610	7%
TEEs (40% of TEEs performed in cath lab)	154	167	204	124	194	26%
TOTAL Cath/EP/Peripheral	1,673	1,665	1,934	1,371	1,897	13%

Procedures	2017	2018	2019	2020*	2021	Procedure % Change 2017-2021	Compound Annual Growth Rate
Cath (Heart, Structural, Peripheral)	2,133	2,051	2,571	1,874	2,494	17%	
EP (including ablation)	1,488	1,279	1,637	1,175	1,615	9%	
TEEs (40% of TEEs performed in cath lab)	154	167	204	124	194	26%	
TOTAL Cath/EP/Peripheral	3,775	3,497	4,412	3,173	4,303	14%	3.3%

As outlined, there has been a significant growth at Advocate Illinois Masonic Medical Center (excluding 2020* pandemic year) and similar to the national growth, the projections for the Advocate Illinois Masonic service area show a 14% increase in cardiology procedures performed in the Cardiac Cath/EP labs. Additional cardiology physicians had been added to the staff between 2018-2019 to address and provide additional access for patients.

The projections below outline that volume will resume prepandemic levels and see continued growth over the next 5 years. This parallels Sg2's estimates that project growth of 24% for EP-Peripheral, 20% for intracardiac ablations and 8% for ICP/pacemaker insertions.

CAGR Projected Utilization							
Procedures	2022	2023	2024	2025	2026	Procedure % Change 2022-2026	Compound Annual Growth Rate
TOTAL Cath/EP/Peripheral	4,446	4,594	4,747	4,905	5,068	14%	3.3%
Procedures/Room	1,500	1,500	1,500	1,500	1,500		
Rooms Needed	2.96	3.06	3.16	3.27	3.38		
Rooms Needed (Rounded Up)	3	4	4	4	4		

Based on the criteria of having 1,500 procedures to support additional rooms, the projected volume with 14% projected growth in the service area, supports the need for 2 Cath rooms and 2 EP rooms in the relocated Cardiac Catherization suite in the future.
Four Cardiac Cath/EP rooms will be needed to support the current and projected growth for these Cardiovascular procedural services.

5. Criterion 1110.225(e), Support Services

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

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

A) Nuclear medicine laboratory - Open Mon-Sat 7am-5pm. On call Mon-Fri 5pm-7am. On call for weekends starting Sat from 3:30pm-7am on Mon.
B) Echocardiography Services - Open daily from 7am-5pm then covered by on call the remaining hours.
C) Echocardiography lab and services, including stress testing and continuous cardiogram monitoring. Cardiology stress testing Mon-Fri 7:30am-5pm, Sat 7am-3pm, Sun 8am-12pm. EKG testing coverage 24/7. Continuous cardiac monitoring for ICU; ER and IP telemetry beds - 24/7 with Central Telemetry Monitoring Center.
D) Pulmonary Function Unit. Mon-Fri 8am-5pm by appointment. Walk ins accepted with open appointments.
E) Blood bank - 24/7.
F) Hematology laboratory/coagulation laboratory - 24/7.
G) Microbiology laboratory - 24/7; limited to certain testing after 4pm.
H) Blood Gas laboratory - 24/7.
I) Clinical pathology laboratory 7am-4:30pm. No weekends or holidays.
J) Blood chemistry -24/7.

6. Criterion 1110.225(f), Laboratory Location

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

One of the central features of the Project is the development of an interventional platform co-locating surgery and other interventional procedures including cardiac catherization procedures. Cardiac catherization integrates diagnostic and interventional cath, endovascular and electrophysiology procedures. In addition, certain structural heart and heart failure implant cases are performed in the labs such as watchman and cardiomems. The 4 Cardiac Catherization rooms will be located in one area with 2 next to each other on each side of the hall. These rooms will be adjacent to the Operating Rooms creating a procedural third floor across the new bed tower, CAC expansion, existing CAC, and Stone building in the current hospital building. These interventional services will share Phase 1 Recovery (PACU), Phase II Prep and Recovery and support spaces on this procedural floor.

7. Criterion 1110.225(g), Staffing

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

Advocate Illinois Masonic Medical Center's Cardiac Catherization/Electrophysiology program is an established service and the following required personal are available.

1) Lab director board-certified in internal medicine, pediatrics, or radiology with subspecialty training in cardiology or cardiovascular radiology.

There is one Cath lab medical director and one EP lab medical director both board certified in Internal Medicine with a subspecialty of Cardiology and Interventional Cardiology and Electrophysiology.

The following are those in the current positions:

- Cath Lab Medical Director: Dr. Joaquin Gonzalez, MD
- EP Lab./EP fellowship Medical Director: Dr. Peter Brady, MD

A physician with training in cardiology and/or radiology present during examination with extra physician backup personnel available.

Yes

2) Nurse specially trained in critical care of cardiac patients, knowledge of cardiovascular medication, and understanding of catheterization equipment.

Yes

4) Cardiopulmonary technician for patient observation, handling blood samples and performing blood gas evaluation calculations.

The RNs and Radiologic technologist carry out this function.

5) Monitoring and recording technician for monitoring physiologic data and alerting physician to any changes.

The RNs and Radiologic technologist carry out this function.

6) Electronic radiologic repair technician to perform systematic tests and routine maintenance; must be immediately available in the event of equipment failure during a procedure.

Clinical engineering is available days and on call of hours.

7) Darkroom technician well trained in photographic processing and in the operation of automatic processors used for both sheet and cine film.

This position is no longer needed as all images are recorded electronically.

8. Criterion 1110.225(h), Continuity of Care

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

The hospital provides open heart surgery, so no transfer agreement is needed.

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

This criterion is not applicable as this is an established service.

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

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

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

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

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

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

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

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

h. The basis for the above projection.

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

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
Surgical Operating Suite, Class C	**16+ 2 eye rooms =18**	**17+2 eye rooms=19**
Surgical Operating Suite, Class B - Cysto Room	**1**	**0**
Recovery Suite (for 17 ORs in the project) *		
Phase 1 Recovery – PACU	**15**	**17**
Phase 2 Recovery - Prep & Recovery	**26**	**38**

*Recovery for 2 OR (eye rooms) will remain adjacent to these 2 ORs

Service	# Existing Key Rooms	# Proposed Key Rooms
Recovery Suite - Cardiac Cath/EP	**3 Cath/EP**	**4 Cath/EP**
Phase 1 Recovery – PACU	**3**	**4**
Phase 2 Recovery - Prep & Recovery	**7**	**12**

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

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

APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Clinical Service Area
Surgical Operating Suite, Class C

c) Service Modernization

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

1) - Deteriorated Facilities

The proposed project is designed to create a comprehensive interventional floor that address deficiencies in the current Operating Rooms in the 50-year-old surgery suite.
The co-location of procedural suites geographically unifies all procedural rooms to one floor for maximum efficiency, effective clinical staff coverage and a better coordinated patient experience.

The project will include 11 replacement ORs to be located in the new CAC modernized building and the bed tower. These will replace 10 ORs and the 1 cysto procedure room currently located in the classic Stone hospital building. The 6 ORs that were included in the CAC project, completed in 2012, will not need to be modernized in this project.
The two ORs used exclusively for eye procedures will also not be included in the project and will remain in their currently location on the fifth floor of the hospital.
Upon completion of the project, the number of ORs including the eye surgical suites, would increase from 18 to 19 ORs.
The expanded number of ORs is based on surgical volume growth and allows for added flexibility required in a hospital with Level I Trauma and CV surgery. The expansion is designed for cysto to be performed in an OR, allowing discontinuation of an outdated cysto procedure room.

The current surgical suite in the main hospital was built in 1970 and no longer meets the needs for a modern department. Larger-sized operating rooms are needed to meet current industry standards, to accommodate the number and types of equipment needed in these procedures. The size of the Operating Rooms in the Main hospital are undersized, and many complex surgical procedures cannot be performed in the operating rooms. Current operating rooms require the larger space to support the technology and increased number of staff within each operating room to manage the more complex procedures and equipment. The Advocate Aurora standard for minimum required square footage for operating rooms is 650 square feet. The majority of the existing OR Rooms do not meet the Advocate Aurora standard for square footage.

Current challenges in the undersized rooms also include lack of sufficient floor space. This is needed to adequately set up instrumentation and back tables in the optimum positions for the

surgeon and scrub teams and the current rooms create traffic flow challenges when performing complex procedures in those rooms.

The modernization of this area will right size the operating rooms to current standards and improve the layout of the suites to be designed for complex cases and the future surgical design.
The new configuration will provide the support space and storage needs for all of the surgical areas and will be designed for efficiency and upgraded clinical standards. The project addresses a critical lack of space for storage, case carts, equipment, and other specialty related carts.

The mechanical areas supporting the modernized surgical suite will be upgraded to address deficiencies in the air handling, HVAC, and electrical infrastructure. For example, the air handling unit system is over 40 years old, and the existing duct work and risers are deteriorating to the point where it is exceeding 10% of leakage due to corrosion. The air leakage leads to inconsistent air movement that is required in a modern surgical suite.
The electrical infrastructure will benefit greatly by new systems that will update new switch gears, automatic transfer switches and provide the standard emergency power.

2) - <u>Necessary Expansion</u>

The surgical services program at Advocate Illinois Masonic Medical Center has experienced programmatic growth and clinical innovation over the last five years. The operating room has experienced, year over year growth and the case mix and acuity has also increased. This project will provide an environment for high-quality surgical care for patient with some of the most complex diagnoses.

Sg2 is projecting an increase in hospital based surgical services due to the rising disease prevalence across the continuum of care in cardiovascular and other clinical areas from diagnosis to disease management. It is projected to lead to increased hospital volumes and longer inpatient lengths of stay due to the increased complexity of the patients. Sg2 is projecting a combined inpatient and outpatient intracardiac catheter ablation growth of 45% by 2029. Growth in TAVR (130%) and ablation (10%) procedures will add to the patients requiring hospital-based services.

Advocate Illinois Masonic has expanded surgical capabilities over the last 5 years and recruited board certified, fellowship trained surgeons to perform complex cases in key destination service lines, increasing access for the Lakeview and Chicagoland area residents.
Expanded programs include cardiovascular surgery, vascular surgery, surgical oncology, colon and rectal surgery, complex gynecologic surgery, gender reassignment surgery and bariatric and metabolic surgery.

Advocate IMMC's current robotic and minimally invasive surgery program currently utilizes 2 robots that support Colorectal, Gyn/Oncology, Reproductive Endocrinology, Thoracic, and Hepatobiliary. Future navigation equipment placement for Spine and Joint procedures, ENT

and other specialties is anticipated as surgical navigation technologies are advancing rapidly and offer improved patient outcomes coupled with improved operative efficiencies. These service lines require extensive equipment such as the O-arm, Microscopy, Navigation and Neuro monitoring based on current American College of Surgery recommendations.
There is a growing demand for larger sized operating rooms to support many of the surgical sub-specialties at Advocate Illinois Masonic such as Orthopedics, Neurosurgery, Colorectal, Bariatrics, and Robotic Minimally Invasive Surgery. The increase in complexity and more equipment has increased the need for larger rooms.

3)(B) - Utilization – Service or Facility
The state standard for calculation for the number of Operating Rooms is based on Surgical Hours.
The historic data in the chart below demonstrates a need for 20 Operating Rooms.
As outlined in the table below, in 2019, 28,813 hours divided by 1,500 hours per OR = 20 ORs.
**The 2020 surgical volume and hours are provided below; however surgical procedures were impacted due to the Covid pandemic.

Increasing from 18 ORs to 19 total ORs upon completion of the project will allow capacity and flexibility for the surgical growth experienced and the surgical volume projected to remain at the hospital location.
The modernization of these Operating Rooms in this project will correct the deficiencies and space issues and prepare the Hospital for the future of surgical care.

Year	TOTAL OR Rooms		Surgical Cases			Surgical Hours			State Occupancy Standard	State Occupancy Standard (rounded up)
	Combined	TOTAL OR	IP	OP	TOTAL	IP	OP	TOTAL		
2017	18	18	3,168	8,983	12,151	10,310	15,442	25,752	17.2	18
2018	18	18	3,109	9,005	12,114	9,917	16,114	26,031	17.4	18
2019	18	18	3,289	9,255	12,544	10,697	18,116	28,813	19.2	20
2020	18	18	3,036	6,857	9,893	9,682	12,247	21,929	14.6	15**

Advocate Illinois Masonic Medical Center has justified the need for the 19 Surgical Operating Rooms (Class C). The hospital meets and exceeds the utilization standards.

Clinical Service Area
Recovery Suite: PACU and Phase II Recovery

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

1) Deteriorated Facilities

Advocate Illinois Masonic's proposed surgery and cardiac catherization services will be located on one procedural floor developed across the new buildings and the existing Stone building. The Recovery Suite will be included on this floor and will contain the Post Anesthesia Care unit (PACU) and the Phase II Recovery stations to support the 17 Operating Rooms and the 4 Cardiac Cath/EP labs. The new PACU and Pre-op/Phase II Recovery Bays will provide updated monitoring technology and facilities, critical to care for post-surgical patients. These rooms will create private recovery space that affords appropriate space and privacy. The prep and recovery areas will be private rooms.

The co-location of these services will create the platform for coordination of care supported by the clinical teams and the ability to share common support space. The project will create a central pre- and post-operative patient care area, replacing the current four separate areas in the Stone pavilion and the CAC. This would enhance communication and increase coordination of care between anesthesiologists, surgeons, and clinical team members. A centralized waiting area will replace the two current family waiting areas located in separate buildings. This would eliminate confusion for surgeons and staff attempting to update and communicate with family members.

The project is proposing 17 PACU and 38 Phase II prep and recovery stations to support the 17 Surgery Operating Rooms (Class C) on this surgical floor. The 38 Phase II Recovery stations will support the Operating rooms for the outpatient surgical cases. The number of patients that recover as outpatients may increase and vary each week depending on the types of procedures and the surgeons that have block time on that day of the week. The number of Phase II Recovery rooms in the project were designed to support the flexibility for surgical specialties to have the ability to have inpatient and outpatient procedures in these operating rooms.

The pre-op/Phase II recovery supporting the 2 eye ORs rooms will not be included in this project and remain unchanged on the 5th floor of the hospital adjacent to the 2 eye OR rooms.

The project will increase the number of PACU and Phase II Recovery from 41 to 55 in this area to support the increased surgical patients in the 17 ORs.

The project is proposing 4 PACU and 12 Phase II prep and recovery stations to support the 4 Cardiac Cath/EP labs. The project will increase the number of PACU and Phase II Recovery from 10 to 16 in this area to support the current and additional Cardiac Catherization/EP procedures. The number of Phase II recovery bays were designed to provide the flexibility and additional space needed as these are often used for procedures.

The new recovery suite will provide updated monitoring technology and facilities, critical for post-surgical patients. Deficiencies of the current Phase II Recovery includes an insufficient number of rooms to accommodate through put needed for pre- and post- operative recovery phases. The project provides relocation of these rooms from the aging facility and is designed

for contiguous anesthesia oversight of all of these operative and procedural suites by having all surgical spaces on one floor.

The HVAC and electrical infrastructure will be part of the modernization. The existing supply, return, and exhaust ductwork and medical gas outlets will be modified to serve the new architectural layout and to meet current code requirements.

2) - Necessary Expansion

The Recovery Suite is designed to support the growing surgical volume with the appropriate number of rooms and sized for current standards.

The total Recovery Suite on this floor will contain the 21 Post Anesthesia Care unit (PACU) and the 50 Phase II Recovery stations to support the 17 Operating Rooms and the 4 Cardiac Cath/EP labs.

- 15 of the existing PACU are open bays with curtains and will remain as is with no change.
- 6 new PACU are added as open bays to match the Advocate Aurora Standard.
- 18 existing Phase II recovery are private rooms and will remain as is with no change.
- 32 new Phase II recovery will be added and will be private rooms.

The existing Phase II Recovery area is insufficient with cubicle curtain dividers. They do not have the standard number of medical gases and electrical outlets.
Upon project completion, this area will increase from 18 to 21 PACU and 33 to 50 Pre-op/Phase II Recovery Bays to support these ORs and cath procedures.

3)(B) No utilization standards exist– Service or Facility

IDPH Hospital Licensing Code 250, Section 250,2440, i) 4) B) defines "A minimum of one recovery room bed shall be provided for each operating room."
IDPH Hospital Licensing Code 250, Section 250,2440, i) 5) A) defines "A minimum of four recovery stations per operating room shall be provided for each operating room."

The project includes replacing the existing PACU locations to be developed on the new procedural floor. The number of stations in the PACU will increase to meet Illinois Hospital Licensing Requirements for the expanded Surgical Suite, with 21 PACU rooms supporting the 17 operating rooms on this floor and the 4 Cardiac Cath/EP rooms. This conforms with the minimum number of PACU stations as well as the contiguity of the Surgical Suite and the PACU is mandated under IDPH Licensing Code 250.

The current Phase II (Stage II) Recovery Department will also increase the number of stations to meet state licensing requirements. The number of rooms conforms with the minimum number of Pre-op/Phase II Recovery stations required for the ratio of OP surgical hours in the 17 ORs

and the 4 Cath/EP rooms. They provide the required contiguity in the Surgical Suite mandated under IDPH Licensing Code 250. These new stations will be appropriately sized and configured for surgical patients arriving the morning of the procedures and for recovery for those discharged home or admitted to the hospital. Post-procedure recovery care will also be provided in this department for Cardiac Catheterization patients. Ambulatory surgery patients require varying lengths of time for Stage II recovery before they are discharged to their homes, and the number of stations is designed to have appropriate number of patient bays for these patients to stay and recover. Pre-op/Phase II Recovery beds will be designed for outpatient surgical patients in the Hospital's Operating Rooms.

The proposed PACU and Phase II Recovery are designed to provide adequate workstations and equipment storage space, which is lacking in the current PACU areas; improving better line of sight observation and multi-disciplinary collaboration stations.

Advocate Illinois Masonic Medical Center has justified the need for 21 PACU and 50 Pre-Op/Phase II totaling 71 Recovery stations. The hospital meets the utilization standards.

	Current				Proposed Project		
	PACU	Pre-op/ Phase II	TOTAL		PACU	Pre-op/ Phase II	TOTAL
17 OR	15	26	41		17	38	55
4 Cath/EP	3	7	10		4	12	16
TOTAL	18	33	51		21	50	71

Assurance of Occupancy Letter

Advocate Illinois Masonic Medical Center
836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

January 10, 2022

Ms. Debra Savage
Chairman
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Fl.
Springfield, Illinois 62761

RE: Advocate North Side Health Network
d/b/a Advocate Illinois Masonic Medical Center
Patient Pavilion and CAC Modernization and Expansion

Dear Ms. Savage:

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

Based on the information available, it is my understanding that by the second year of operation after project completion, Advocate Illinois Masonic Medical Center reasonably expects to achieve and maintain the utilization standards for the Inpatient Bed Units and Surgical/Procedural areas as specified in Administrative code 1110.

Sincerely,

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

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

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **LDR**	**8**	**8**
☐ **C-Section Rooms**	**2**	**2**
☐ **Birthing Rooms**	**2**	**0**

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

(c)(1) Deteriorated Facilities

The modernized Obstetric unit will include 8 LDR rooms and 2 C-Section rooms in addition to the 6 triage rooms and 24 Post-Partum rooms on one floor of the new Bed Tower. Within the new structure there is one isolation room and one room that includes a hoyer lift that will be utilized to meet the changing needs of our maternal patient population. These will replace the existing 8 LDR rooms and 2 C-Section rooms that are located in various locations in the existing hospital. The current Maternal and Neonatal Services occupy separate designated physical locations within Advocate Illinois Masonic Medical Center, which add complexity to the delivery of care. The Perinatal Surveillance Beds and OB Triage Beds are located on the 4th floor of the main hospital and the LDRs, Recovery Rooms and Operating Suites in Labor and Delivery are located on the 2nd floor. The project will address modernization of the aging facility with room

deficiencies and services and create a contiguous floor for improved care coordination. The optimization of the space will help to support the ongoing participation in continuity of care for patients, families, visitors, and staff at Advocate Illinois Masonic Medical Center. The improved layout will ensure dedicated areas that support a multidisciplinary culturally competent care team approach and expand current locations to assist with providing excellent patient-centered care.

(c)(3)(B) Utilization – Service or Facility

The hospital's current C-Section suite of 2 procedure rooms will be relocated in the new Bed Tower OB floor. The existing C-Section rooms are only 315 square feet, below the contemporary standards and lack the needed support space for this type of procedural area. Within these procedural rooms, added will be a separate resuscitation room of 380 square feet, lacking in the current space. The newly designed rooms will be 480 square feet and include a work room, clean equipment, supply, and soiled areas adjacent/within the rooms. As a Level III Perinatal Center, the updated operating rooms will continue to improve the delivery of quality care.

The Obstetric unit includes 8 LDR rooms that will be relocated to the newly designed floor in the bed tower. The number of LDR rooms will remain the same and will create rooms with contemporary standards of 370 square feet, replacing the outdated rooms of 280 square feet.

Advocate Illinois Masonic Medical Center	2017	2018	2019	2020
C-Sections	658	606	584	527
Total Births	2,037	1,916	1,924	1,650

The current utilization of the C-Section rooms determined that 2 rooms would need to be relocated. Although, State Utilization guidelines of 800 procedures per C-Section room, might indicate only 1 room is needed, based on current C-Section volume, the C-Section rooms are frequently used at the same time and one room is needed to be maintained for emergency C-Sections. The c-section rooms are also utilized for the following procedures: cerclage and tubal ligation.

The State Utilization guidelines for LDR rooms of 400 Births/ LDR rooms outline a need for less than the 8 rooms replacing the current 8 rooms. Current operational analysis outlined that there are days and times of day that have a higher LDR utilization, and it was determined that 8 rooms are needed to support current and future deliveries at Advocate Illinois Masonic.

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

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **Outpatient Oncology Exam/Consult Rooms**	**14+2**	**23+4**
☐ **Outpatient Oncology Infusion**	**16**	**22**
☐ **Outpatient Breast Imaging - Mammography**	**3**	**5**
☐ **Outpatient Breast Imaging - Ultrasound**	**4**	**4**
☐ **DEXA**	**1**	**1**

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

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

APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Outpatient Breast Center Expansion – Outpatient Infusion and Clinics

c) Service Modernization

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

2) - Necessary Expansion

The Creticos Cancer Center of Advocate Illinois Masonic Medical Center, established in 1990, currently provides Outpatient Cancer services in the Center for Advanced Care (CAC) attached to the hospital. The Creticos Cancer Center provides academic level cancer care in a community hospital setting. It has achieved multiple accreditations, including Commission on Cancer, ASCO (American Society of Clinical Oncology) QOPI (Quality Oncology Practice Initiative), NAPBC (National Accreditation Program for Breast Centers) and NAPRC (National Accreditation Program for Rectal Cancer).

Due to advances in science, immunotherapy has provided many patients extended life. This translates into clinic visits with their physicians and infusion treatments for years after diagnosis. These advances have seen significant growth in clinic visits and in infusion at Advocate Illinois Masonic since the Cancer center opened in its current location in 2015. Growth in the multidisciplinary patient centered outpatient clinics see an average daily census of approximately 90-100+ outpatient each day between clinics, chemotherapy, and radiation oncology spaces.
Sg2 forecasts an increase of 10% in clinic and 11% in cancer related infusion over the next five years. With cancer cases expected to continue to rise, an expansion of the cancer center is necessary to continue to serve patients with excellent, holistic care.

The center provides wrap-around services for adult cancer patients throughout the continuum of care. The center has been responsive to the Institute of Medicine's call to action to serve cancer survivors with services such as genetic counseling and psychosocial services. Recently, the center launched its Women's Integrated Sexual Health (WISH) program to help women with pelvic and sexual side effects of cancer treatments. The center has also partnered with the Physical Medicine and Rehabilitation department to offer Lymphedema and Speech Evaluation clinics within the center so patients can receive as much of their cancer related services within the center.

There are currently 14 exam rooms and 2 consultation rooms within the clinic of the Creticos Cancer Center. On some days, there can be as many as 10 providers in clinic seeing patients. As much as providers and teams try to "run on time," patient throughput can be thwarted if patients need more time to understand information or process emotions associated with difficult updates to their prognosis. While the team strives to respect the time needed by patients to process information and feelings in the clinic exam rooms, they also want to respect the time of patients who may be waiting prolonged period of time while rooms are occupied.

The center also serves the diverse patient population of Advocate Illinois Masonic's community. Approximately 20% of the patient population identifies a non-English language as their preferred language and the team considers this and other social determinants of health in caring for their patients. This also contributes to occupancy and throughput considerations with respect to the use of patient care space. For example, a consultation visit with an English proficient patient may typically take 60 minutes. With a non-English proficient patient, this visit could double in duration, as our caregivers use medical interpreters to ensure that the team

clearly understands the patient's perspective and concerns and that the patient clearly understands the recommendations and treatment plans.

Additionally, the center offers multidisciplinary clinics (MDCs). This allows patients and their support systems an opportunity to meet with multiple specialists and support services during one visit. For example, a breast cancer patient is seen by the medical oncologist, radiation oncologist and breast surgeon during one visit. Genetic counseling, psychosocial services and other support services may also be incorporated into the visit. This type of visit can occupy exam and consult rooms for 2-3 hours. While it is a lengthy visit, it saves the patient multiple trips to the center and also provides the patient an opportunity to experience a cohesive approach to treatment planning. The patient receives a cohesive plan, which includes scheduling and coordination of all necessary diagnostic and follow up appointments. These types of visits are valuable, but they occupy clinic space for long periods of time.

Despite advances in telemedicine, most visits with cancer patients require in-person physical assessments. Physical exams allow providers to palpate lymph nodes, assess for cysts, or other physical symptoms that can help early detection of recurrence or manage side effects for patients on treatment. Therefore, the expansion of clinic space is still necessary despite the option to use virtual visits for some visits.

In addition to expansion of exam and consultation rooms, this project will provide the needed expansion of the infusion service. There are on average 40 patients each day receiving an infusion in the Cancer Center. In addition to Chemotherapy, the number of patients receiving immunotherapies as part of their ongoing treatment has growth as the number of immunotherapies has increased and expanded uses to improve quality of life.

Infusions take on average 3 ½ hours and each chair can accommodate 2-3 patients per day. The current number of infusion bays of 16, can best accommodate 32 patients each day. Many patients receive their infusion on the same day as meeting with their physician and other cancer services. With the current number of infusion bays, to accommodate all patients, there are often patients sitting and waiting for another patient to finish treatment to use the bay and their infusion lasts late into the day. This is not an ideal situation for a patient and their family during their cancer course of treatment and will be more challenging as the patient volume continues to increase.
The additional 6 infusion bays will improve access for the current and future Cancer center patients.

The proximity of the Breast Imaging Center on the lower level will provide comprehensive services to all patients. A separate entrance will outline those services for preventative and diagnostic care with those in current treatment. This provides synergies for staff and services while maintaining acute verse non-acute care. The comprehensive design will include long term survivorship in one area providing coordination and resources with all of the screenings and consultation needed for these patients.

Due to advances in treatment like immunotherapy, patients are living longer (even if not curative) which has necessitated the need to expand clinic and infusion services. The growth of the current Outpatient Cancer Center illustrated the strength of a cancer program that is designed to be patient centered by bringing all of the services to the patient - screening, treatment, and survivorship.

3)(B) -Utilization – Service or Facility

The Outpatient Oncology clinic and Infusion volume is provided below. From 2017 to 2021, infusion visits have increased by 47% and the outpatient oncology clinic visits by 34%. Due to the pandemic, cancer screening operations were halted for 3-4 months and were therefore lower in 2020 and portions of 2021. The decreased number of cancer screenings and newly diagnosed cancers for this year contributed to the decreasing infusion services. The number of patients is projected to increase based on the 2019 volume and for the next five years.

Based on projections outlined, utilization is estimated to continue to increase at IMMC and in the service area. Additionally, Sg2 projects a continued increase over the next ten years.

Advocate Illinois Masonic Medical Center Historical Utilization						
	2017	2018	2019	2020*	2021	% Change 2017-2021
Infusion						
Infusion treatments	6,866	8,146	10,241	8,747	10,066	46.6%
Outpatient Oncology Clinic						
Medical Oncology and Gynecology clinics	9,858	10,398	11,920	10,634	13,538**	37.3%

Advocate Illinois Masonic Medical Center Projected Utilization					
	2022	2023	2024	2025	2026
Infusion					
Infusion treatments	11,078	12,188	13,411	14,757	16,239
Outpatient Oncology Clinic					
Medical Oncology and Gynecology clinics	14,655	15,865	17,174	18,592	20,126

**includes virtual visits

In order to accommodate the increasing demand for infusion services at the Cancer Center, it was determined that an additional 6 infusion stations will be needed; increasing the number to 22 total stations. This will include 7 new infusion bays, as the current space will need lose 1 station with this modernization. Although there are no state standard for infusion stations, this was based on the current number of infusion treatments and those projected over the next five years.

As outlined, the Oncology Clinics have increased year over year. Outpatient Oncology clinics also have no state standards. As the number of services and multidisciplinary clinics increase, the projected utilization outlines a need for increasing the number of examination rooms to 23 and consultation rooms to 4 to continue to support patients in the service area.

Outpatient Breast Center Imaging – Mammography

c) Service Modernization

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

2) - Necessary Expansion

Advocate Illinois Masonic Medical Center currently provides Mammography services in the Medical Office Building attached to the hospital. The new Breast Center will be located in the lower level of the Center of Advanced Care (CAC) expansion providing space for 4 mammography units and an additional unit for dedicated stereotactic breast biopsies. This will be a relocation of the 3 current mammography units and 1 stereotactic biopsy unit adding 1 additional mammography unit.

The Breast Imaging service will be designed for mammography to be co-located with other breast services such as breast ultrasound, the nurse navigator and other screening services such as bone density screening/scanning. The hospital offers 100% 3D mammography and a comprehensive screening breast ultrasound program. The new location will provide multiple preventive services in one location for easy access and an enhanced care environment.

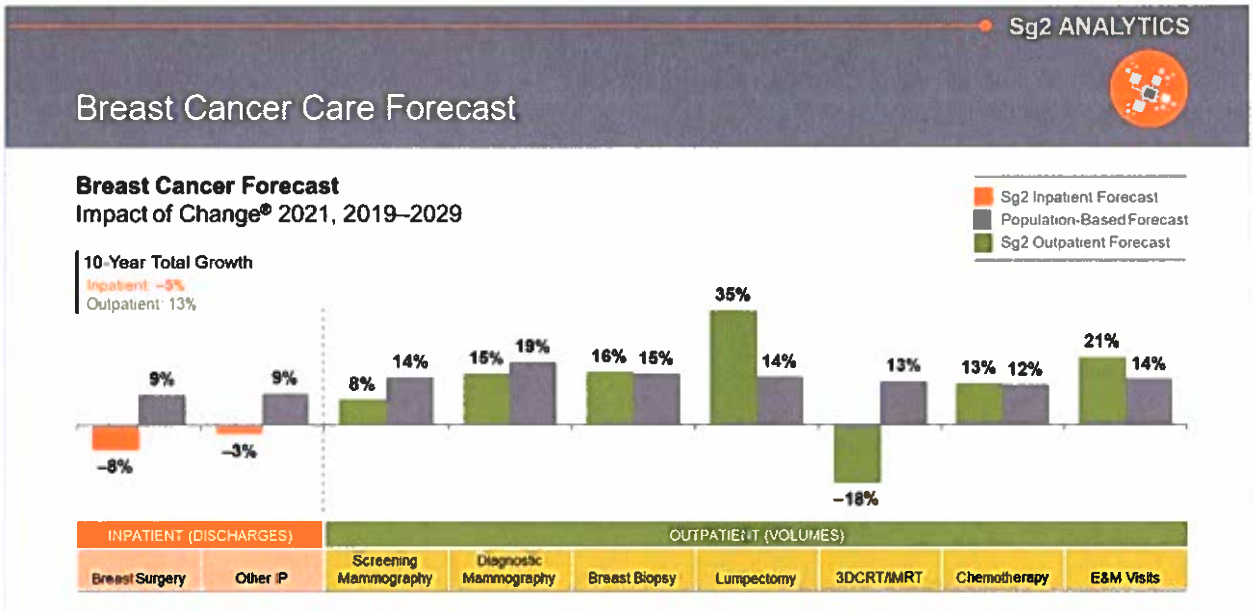
The design of the Breast Center will include the required support space and address the current deficiencies. The imaging rooms will be larger to accommodate the current equipment and staff. For the stereotactic breast biopsies larger rooms are needed to house all of the equipment including the specimen imaging unit.
Additionally, the space will be designed to relocate and include:

- Reading rooms
- Tech work rooms
- Clean and soiled utility
- Offices for the Medical Director, Navigator, Lead Tech/Mgr, PACS work office
- Staff lockers
- Storage
- Waiting, gowning

Mammography continues to be the standard for early diagnosis and recommended for all women over 35 years old. Breast cancer is the second most commonly diagnoses cancer for women. Early detection through mammography continues to be a critical service to this community.

As outlined by Sg2, mammograms are forecasted to increase over the next 10 years for both screening (8%) and diagnostic (15%). Breast biopsies are also estimated to grow by 15%. Sg2 projects a steady rise in breast cancer outpatient demand by 12%, notably for evaluation and management (E&M) visits augmented by virtual visits, imaging and OP surgical procedures required by an older, longer-surviving population. Contributing factors include patient preference, payer guidance, emerging immunotherapies, and new and developing technologies

and clinical capabilities (e.g., interventional oncology, interventional radiology) that enable advanced imaging and minimally invasive procedures.



There has been an increasing number of mammograms performed at Advocate Illinois Masonic Medical Center and the Chicago area over the past few years. Advocate Illinois Masonic has been developing partnerships with organizations in the market to increase education and access for regular cancer screenings. The pandemic also significantly impacted screening, with delayed or missed appointments now contributing to the increased likelihood of higher-acuity breast cancer cases.

The Breast Center's Medical Director and the nurse navigator have developed initiatives and expanded relationships in the Latina community to provide education and services to groups to reduce cancer disparities and access for breast cancer services.

Increasing the number of mammogram units will decrease the wait time to schedule a mammogram appointment. Currently, the number of exams scheduled is limited and there have been longer wait times to schedule an appointment due to the number of rooms. The breast imaging service has expanded evening and weekend appointments and has grown to 13,861 mammograms in 2021 and projected to increase by 11% in the next five years. Based on growth projected, the number of exams will continue to increase with expanded number of rooms.

The addition of a dedicated breast biopsy room will allow these procedures to be scheduled and not take a mammography room out of service. This will address the current delays and patient dissatisfaction.

3)(B) -Utilization – Service or Facility

Continued growth is projected for number of women utilizing breast imaging and clinic visits due to increased cancer programs and physicians at the Creticos Cancer Center. The mammography units are used for both screening and diagnostic. With additional rooms and equipment, increased access to mammography will be available to women in the service area. Mammography is a service that volume increases substantially late in the year. Almost 30% of the yearly volume is scheduled October to December.

The annual mammography volume is provided below. For Quarter 4, 2021, almost 4,000 screening and diagnostic mammograms were performed.
Based on the fourth quarter volume seasonality, using the state standard of 5,000 visits per unit/year (or 1,250 visits/quarter, the 4 rooms will be needed to support the current and future mammography services at the Cancer Center with one additional room dedicated to perform the mammography stereotactic biopsy procedures.

Advocate Illinois Masonic Medical Center Historical Utilization						
	2017	2018	2019	2020*	2021	% Change 2017-2021
Screening Mammography	8,343	8,642	8,999	7,219	9,358	12.2%
Diagnostic Mammography	3,906	3,689	3,734	3,621	4,178	7.0%
Stereotactic Biopsy Procedures	151	215	229	251	325	115.2%
TOTAL	12,400	12,546	12,962	11,091	13,861	11.8%

Advocate Illinois Masonic Medical Center Projected Utilization					
	2022	2023	2024	2025	2026
Mammography	13,878	14,229	14,589	14,958	15,337
Number of Units Needed	4	4	4	4	4
Stereotactic Biopsy Procedures	394	477	578	700	847
Number of Units Needed	1	1	1	1	1
TOTAL Units Needed	5	5	5	5	5

The volume in 2026 (at project completion) supports the need for 4 units for screening and diagnostic mammography and an additional for these biopsy procedures.

Advocate Illinois Masonic Medical Center has justified the need to continue to increase to 5 Mammography Units including one for dedicated stereotactic biopsies.

Outpatient Breast Center Imaging - Ultrasound

c) Service Modernization

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

2) - Necessary Expansion

Advocate Illinois Masonic Medical Center currently provides Breast Ultrasound services in the hospital Medical Office Building attached to the hospital. The new Breast Center located in the lower level of the Center of Advanced Care (CAC) expansion will include the relocation of the 4 existing Breast Ultrasound units to be co-located with the other Breast Center services. The new location will provide a multiple preventive service in one location for easy access and an enhanced care environment.

The Breast Center Imaging Center includes Mammography and Breast Ultrasound and will include the required support space and address the current deficiencies. The imaging rooms will be larger to accommodate the current equipment and staff.
The space for this department will be designed to relocate and include:

- Reading rooms
- Tech work rooms
- Clean and soiled utility
- Offices for the Medical Director, Navigator, Lead Tech/Mgr, PACS work office
- Staff lockers
- Storage
- Waiting, gowning

Dense breast is common, with 40-50% of women ages 40-74 have dense breasts. Screening Breast Ultrasound is offered for early diagnosis along with mammography and recommended for women with dense breast tissue. Many women include this as part of their annual screening each year as shown by the breast ultrasound service increasing by 37% from 2017-2021. Breast Ultrasound volume will increase parallel to the Mammography volume increases.

3)(B) -Utilization – Service or Facility

The annual Breast Ultrasound volume is provided below. Similar to Mammography, Breast ultrasound volume increases substantially late in the year. For Quarter 4, 2021, over 2,100 breast ultrasounds were performed. From October to December, there is often a wait to schedule appointments and even with additional staff and an expanded schedule into the evenings and weekends, it can be challenging to provide appointments.
Based on the fourth quarter volume seasonality, using the state standard of 3,100 visits per unit/year (or 775 visits/quarter, maintaining 4 rooms (3 general breast ultrasound rooms and one dedicated ultrasound guided breast biopsy room) will be needed to support the current and future Breast Ultrasound services at the Cancer Center.

Advocate Illinois Masonic Medical Center Historical Utilization						
	2017	2018	2019	2020*	2021	% Change 2017-2021
Breast Ultrasound	5,470	5,421	5,869	5,622	7,323	33.8%
Ultrasound guided Breast biopsy	432	464	449	498	742	71.8%
TOTAL Breast Ultrasound	**5,902**	**5,885**	**6,318**	**6,120**	**8,065**	**36.6%**

Advocate Illinois Masonic Medical Center Projected Utilization					
	2022	2023	2024	2025	2026
Breast Ultrasound	7,877	8,473	9,114	9,804	10,545
Number of Units Needed	3	3	3	3	3
Ultrasound biopsy	849	972	1,113	1,274	1,459
Number of Units Needed	1	1	1	1	1
Number of TOTAL Units Needed	4	4	4	4	4

Breast ultrasound volume is projected to continue to grow as this part of an annual prevention service. Ultrasound guided breast biopsies are expected to increase with these in tandem with the breast ultrasound service. The projected volume in 2026 supports the need to maintain the 4 Breast Ultrasound units including one dedicated to ultrasound biopsies.

Advocate Illinois Masonic Medical Center has justified the need to continue to operate the 4 Breast Ultrasound Units.

Outpatient Bone Density- DEXA

c) Service Modernization

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

2) - Necessary Expansion

Advocate Illinois Masonic Medical Center currently provides Bone Density procedures/services in the hospital Medical Office Building attached to the hospital. The DEXA will be relocated to the lower level of the Center of Advanced Care (CAC) expansion adjacent to the Outpatient Breast Center Imaging services.
The new location will provide a multiple preventive service in one location for easy access and an enhanced care environment.

DEXA (Dual Energy X-Ray Absorptiometry or bone densitometry) is an enhanced form of x-ray technology that is used to measure bone loss.
This test can also be used to evaluate an individual's risk for developing fractures. As the population ages, it is expected to have an increasing needed as there will be more people with fractures.
The bone density service is heavily used by post-menopausal women and will be relocated in this new area adjacent to the mammography service providing convenient access for women needing these screening services.

3)(B) -Utilization – Service or Facility

The DEXA volume is provided below. The hospital has shown year over year growth.

The DEXA service will continue to operate one DEXA machine. The current and projected volume supports maintaining one DEXA unit.

	2017	2018	2019	2020*	2021	% Change 2017-2021
DEXA procedures	1,612	1,782	2,030	1,871	2,773	72.0%

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

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **Outpatient Heart Institute Clinic/Exam Rooms**	**4**	**14**
☐ **Outpatient Cardiology Infusion**	**4**	**6**

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

OP Cardiology Program Expansion

c) Service Modernization

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

2) - Necessary Expansion

The Outpatient Heart Center of Advocate Illinois Masonic Medical Center has been providing outpatient cardiovascular services on the first floor of the hospital's Stone Pavilion building. This center includes comprehensive outpatient services for cardiovascular patients such as multispecialty clinics, infusions, and diagnostic testing.

This project will provide expanded space to allow the program to increase the number and types of clinics and improve access for patients.

The current program, which began in 2018, is an integrative care model that include heart failure and structural heart clinics and infusion space for these patients.
The Heart Failure Clinic allows heart failure patients to receive an examination and treatment in the ambulatory program offering comprehensive services with a multi-specialty team of clinicians, testing and infusions. This model eliminates the patient having to make multiple appointments for labs, echo, and other testing and allows patients to be treated that same day and referred to the clinic by their primary care physician without needing to go to the emergency room; avoiding an admission and improving quality of life for these patients.
The clinic also provides services to all patients 3-5 days post discharge. This clinic has demonstrated significant improvements and top tier results in Heart Failure readmissions, length of stay and mortality. The Clinic sees 30-40 patients each day and has seen growth double since 2018.

The Structural health programs provide a multidisciplinary team to deliver integrated care to patients. Similar to the Heart Failure clinic, all services are provided to the patient during this clinic visit in addition to meeting the surgeon, interventional cardiologist and a plan of care is developed.

The current clinics are currently at capacity and are challenged to accommodate the growing number of patients in the community. Exam space limitations required patients to be treated in overflow spaces in the hospital and additional exam rooms will provide continuity of care within the Center.

The Outpatient center expansion will also provide space to develop additional programs for chest pain and Afib patients and a valve clinic expansion. Plans are in place to develop genetic clinics to support patients and their families. These hospital-based clinics reduce the cost for patients by avoiding admissions, offer same day testing and results. They reduce patient anxiety as the patients receive services in one location and do not need to wait weeks to see a follow up physician, order additional tests, complete testing and once they receive results, meet with a physician again to plan their course of care.

According to Sg2, nearly 50% of Americans have some form of cardiovascular disease, and this population is growing in incidence, prevalence, and complexity. Increasing prevalence of chronic disease (e.g., CHF, heart valve, vascular) is driving outpatient volumes for imaging, diagnostics, and visits.
Sg2 forecasts a 10% increase in outpatient cardiovascular volume over the next five years and 20% total over the next ten years. With higher acuity and improved survivorship pushing the limits of effective outpatient care, these outpatient Cardiovascular programs provide needed care coordination.

Broadened efforts to address social determinants of health in the community will continue to fuel the volumes. Enhancing patient access and coordination of services based on diagnosis, family history and treatment type will be particularly critical.
The center also serves the diverse patient population of Advocate Illinois Masonic's community. Approximately 20% of the patient population identifies a non-English language as their preferred language and the team considers this and other social determinants of health in caring for their patients.

In complement with the Heart Failure and other Cardiology Clinics, Advocate developed a Transition Support Program that helps patients and facilities navigate the health care system, including access to care, health insurance, transportation, food insecurity and health literacy. This program has countless examples of helping patients in these outpatient heart clinics to provide the services needed, provide long term navigation, and develop a comprehensive care path to help rebuild their health and their lives.

There are currently 4 exam/consultation rooms, and 4 infusion bays within the Outpatient Cardiology Program.
The expansion will include 12 additional infusion, exam, and consultation rooms, providing appropriate space, greater staff efficiency and a cohesive patient experience. The rooms will be sized to provide space for multiple providers to meet with the patient and the family. The expanded space will allow for increased support space, equipment storage, clean and soiled utility, and offices for physicians and fellows.

3)(B) -Utilization – Service or Facility

The Outpatient cardiology clinics and Infusion volume is provided below. From 2018 to 2021, total clinic and infusion visits have more than doubled, increasing by greater that 100%.

IMMC Historical Utilization					
	2018	2019	2020*	2021	% Change 2018-2021
Outpatient Cardiology Clinics					
Heart Failure/Structural Heart Clinics	1,981	2,940	3,791	4,234	113.7%
Exam Rooms	4	4	4	4	
Infusion					
Infusion treatments	394	399	1,432	954	141.1%
# of Stations	4	4	4	4	

Based on projections outlined, utilization is estimated to continue to increase at Advocate Illinois Masonic Medical Center and in the service area. As the number of services and

multidisciplinary clinics increase, it was determined that there the number of examination rooms needed will increase from 4 to 14.
Although there are no state standards for infusion, based on the percentage of patients at the clinic that receive an infusion as part of the clinic program and the current infusion hours, an additional 2 infusion stations will be needed to meet the infusion hours and the projected occupancy over the next five years.

IMMC Projected Utilization					
	2022	2023	2024	2025	2026
Outpatient Cardiology Clinics					
Heart Failure/Structural Heart Clinics	5,454	7,025	9,049	11,657	15,015
Exam Rooms Needed	6	8	10	12	14
Infusion					
Infusion treatments	1,276	1,706	2,281	3,050	4,079
# of Stations Needed	5	5	6	6	6

There are no utilization standards for Outpatient Cardiology Clinics and Cardiovascular Infusion.

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]:**

_____	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.
	TOTAL FUNDS AVAILABLE

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

N/A, Advocate Aurora Health, Inc has a AA long-term bond rating from Fitch and Standard & Poors. Advocate Aurora Health, Inc has an Aa3 long-term bond rating from Moody's.

FitchRatings

RATING ACTION COMMENTARY

Fitch Affirms Advocate Aurora Health's (IL) IDR at 'AA'; Outlook Stable

Mon 02 Aug, 2021 - 11:49 AM ET

Fitch Ratings - Chicago - 02 Aug 2021: Fitch Ratings has affirmed Advocate Aurora Health's (AAH) Issuer Default Rating (IDR) at 'AA'. Fitch has also affirmed the outstanding revenue bonds issued by the Wisconsin Health and Educational Facilities Authority, Illinois Finance Authority, and Illinois Health Facilities Authority on behalf of AAH as well as taxable fixed-rate bonds issued directly by AAH at 'AA'. Finally, AAH's 'F1+' Short-Term Rating on variable rate debt and CP debt supported by AAH's self-liquidity has been affirmed.

The Rating Outlook is Stable.

SECURITY

Bonds are unsecured joint and several obligations of the obligated group, which consists of the vast majority of AAH hospitals, the AAH parent, and the Advocate Health Care Network and AAH physician practices.

ANALYTICAL CONCLUSION

AAH's 'AA' IDR rating is driven by the system's very strong financial profile assessment, leading market position over a broad and diversified service area covering the population centers of two states, and expectations for a return to strong operating margins over time, as Fitch believes the system's fundamental operating platform remains strong.

The 'F1+' Short-Term Rating is based on AAH maintaining a Long-Term Rating of at least 'AA-' as well as adequate internal liquidity and written procedures consistent with Fitch's criteria. AAH has "eligible" discounted cash, U.S. Treasuries, municipal bonds, and corporate bonds in excess of 125% of its maximum self-liquidity funding exposure for assignment of the 'F1+' rating.

KEY RATING DRIVERS

Revenue Defensibility: 'bbb'

Largest Health System in Two States; Competition Present in Key Markets

AAH is the largest health system in both Illinois and Wisconsin with a broad market reach operating in multiple markets across the major population centers of both states. The system benefits from a generally favorable payor mix.

Operating Risk: 'a'

Track-Record of Strong Operating Results; Margins Expected to Continue to Rebound

AAH's operating risk profile remains strong. The system has a track-record of generating an operating EBITDA margin in the 10% range. Fitch expects long-term margins should be consistent with a strong assessment, despite financial pressure presented over the last year by the coronavirus pandemic. Capital spending plans are elevated but manageable.

Financial Profile: 'aa'

Strong Capital-Related Ratios

AAH's financial profile is strong. Capital-related ratios should remain strong in Fitch's forward-looking scenario analysis, even in a stress case.

ASYMMETRIC ADDITIONAL RISK CONSIDERATIONS

There are no asymmetric risk factors identified with AAH's rating.

RATING SENSITIVITIES

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

--Sustained improvement in operating EBITDA margin consistently above 10%;

--Considerable growth in unrestricted cash levels leading to superlative cash-to-adjusted debt.

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

--Unexpectedly prolonged compression in operating margins, such that the operating EBITDA margin is expected to remain at 7% or lower for a sustained period beyond what Fitch currently expects, which would lead to an operating

risk profile more consistent with a midrange assessment;

--Weaker balance sheet metrics, leading to thinner capital-related ratios in the long term, more consistent with an 'a' assessment, particularly if compounded with an above-mentioned sustained weakening of operating EBITDA margin.

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

AAH is the result of the April 2018 merger between Advocate Health Care (IL) (Advocate) and Aurora Health Care (WI) (Aurora). The system includes 24 acute care hospitals and one behavioral health hospital (totaling more than 5,100 staffed beds), approximately 3,600 employed physicians, and operates roughly 500 outpatient locations and 100 retail clinics in contiguous markets stretching from the Chicago metro area north through Milwaukee, to Marinette, WI in the north. AAH is the largest healthcare provider in both Illinois and Wisconsin. Combined, AAH recorded more than $13 billion in operating revenue in audited fiscal 2020 (Dec. 31 year-end).

A system of AAH's size and scope of operations is constantly evaluating its portfolio of assets. Most recently, in 2020 the system sold two central Illinois hospitals (the former Advocate BroMenn Medical Center in Normal, IL and Advocate Eureka) to the Carle Foundation (AA-).

REVENUE DEFENSIBILITY

AAH's payor mix is well under the 25% threshold for a midrange assessment. Combined Medicaid and self-pay consistently account for approximately 17% of gross revenue (including 17.5% in fiscal 2020). Illinois expanded Medicaid under the Affordable Care Act (ACA), while Wisconsin did not expand Medicaid under the ACA guidelines, the state did expand eligibility in prior years.

AAH operates in multiple markets covering a contiguous service area stretching from northeastern Illinois (Chicago area) through Milwaukee to northeastern Wisconsin. AAH is the market share leader in both states. Despite the leading position, the system operates in many competitive service areas, notably Chicago (where AAH is the market leader in a crowded market) and Milwaukee, the population hubs of the combined service area. AAH's largest competitor is Ascension Health (AA+), which also operates multiple facilities in both the Milwaukee and Chicago markets. AAH also has one of the largest and most sophisticated physician integration models in the industry with broad population health management capabilities, including employing approximately 3,600 physicians, and nearly three million unique lives.

AAH operates in varying service area demographic profiles, as expected from a large and geographically diverse health system. AAH's service area characteristics are generally stable supporting a midrange assessment. Much of suburban Chicago (e.g., Lake County), suburban Milwaukee, and other markets such as Brown County, WI (Green Bay) demonstrate generally favorable characteristics such as median household income levels in-line with or better than the national average and low poverty rates. Fitch does not expect AAH's payor mix to change materially in the near term.

OPERATING RISK

AAH has a track-record of strong operating margins, with the operating EBITDA margin averaging 10.1% between fiscals 2016 and 2019. The margin compressed to 7.3% in fiscal 2020, as the system contended with the coronavirus pandemic. These results do not include nonrecurring operating expenses in recent years (e.g., early retirement incentive plans, one-time Epic EMR upgrade/installation costs, and one-time merger costs, etc.).

Management estimates that the pandemic cost AAH approximately $900 million in fiscal 2020 in terms of revenue loss and increased PPE costs, not to mention added labor costs and other disruptions. These pressures were balanced in part by the receipt of $847 million of CARES Act and related stimulus funding grants (which AAH recorded in 2020).

Despite the considerable challenges presented by the coronavirus pandemic, Fitch expects that long term the system maintains a robust operating platform and margins will return to a level consistent with a strong operating risk profile, with an operating EBITDA margin in the 9% range. Management has budgeted an operating margin of approximately 2.2% in fiscal 2021, which would translate to an operating EBITDA margin in the 7.5% range. In fiscal Q12021, AAH recorded an operating margin of 2.0% and operating EBITDA margin of 7.1% (excluding nonrecurring expenses of approximately $13 million).

Fitch expects AAH's capital spending will continue at a measured pace. The system has nearly $1.3 billion in capex budgeted for fiscal 2021, which translates to a capital spending ratio of more than 2x. Beyond that, management expects to maintain a capital spending ratio of around 1.5x. Fitch expects, however, that under a strained economic or operating environment AAH would defer or cut capex, as the system did during the early months of the pandemic and related economic recession in 2020.

Key projects are aligned with AAH's Transformation 2025 strategy, and include continued expansion of AAH's ambulatory network with a focus on consumer-driven access, as well as upgrades in certain markets. AAH has maintained a healthy pace of capex in recent years, as the capital spending ratio averaged approximately 1.3x over the last five years, and the average age of plant measured a comfortable 9.2 years at FYE 2020.

While AAH does not have formal new money debt plans in the near term, Fitch expects a system of AAH's size and scale to access the capital markets from time-to-time. Also, in September 2020 the system increased the authorization of its CP program to a maximum amount of $1 billion, although only $50 million was outstanding as of March 31, 2021.

FINANCIAL PROFILE

AAH's financial profile is strong in the context of the system's midrange revenue defensibility and strong operating risk profile assessments. Capital-related ratios should remain strong in Fitch's forward-looking analysis, even in a stress case.

AAH has nearly $3.9 billion of debt outstanding, inclusive of operating leases (which are now captured on the balance sheet). Unrestricted cash and investments measured almost $10.5 billion at FYE 2020.

AAH's debt equivalents are manageable. AAH has two frozen defined benefit (DB) pension plans. The plans combined were approximately $200 million underfunded compared to a projected benefit obligation (PBO) of roughly $2.6 billion at FYE 2020, translating to a funded ratio of 92%. Because the pension plan is more than 80% funded, Fitch does not include the underfunded status in calculating adjusted debt, and as a result AAH's adjusted debt is equal to its direct debt. AAH's net adjusted debt (adjusted debt minus unrestricted cash and investments) is favorably negative, measuring -$6.6 billion at FYE 2020. Fitch expects net adjusted debt to remain favorably negative in the coming years, even in the stress case of Fitch's scenario analysis.

Per Fitch's forward-looking scenario analysis, AAH's capital-related ratios should be consistent with the broad 'AA' category, even in a stress case. Based on fiscal 2020 results, AAH's net adjusted debt-to-adjusted EBITDA was favorably negative at better than negative 4x and cash-to-adjusted debt was about 270% at FYE 2020. Looking forward, net adjusted debt-to-adjusted EBITDA is negative in every year of the scenario analysis, including the stress case, and cash-to-adjusted debt never drops below 270% in the base case or 230% in the stress case.

The 'F1+' short-term rating is based on AAH maintaining a long-term rating of at least 'AA-'. AAH maintains sufficient discounted internal liquid resources (composed of cash, U.S. Treasuries, municipal bonds, and corporate bonds) and has implemented written procedures to fund any un-remarketed put on the $1.2 billion of theoretical maximum potential debt supported by self-liquidity. AAH's self-liquidity supported demand debt is comprised of its puttable VRDO bonds not supported by standby bond purchase agreements (SBPAs) as well as the $1 billion maximum authorized under the taxable CP program (increased from a maximum of $500 million in September 2020, although only $50 million was outstanding as of March 31, 2021). AAH had "eligible" cash, U.S. Treasuries, municipal bonds and corporate bonds in excess of the 125% threshold of its maximum self-liquidity funding exposure for assignment of the 'F1+' rating.

ASYMMETRIC ADDITIONAL RISK CONSIDERATIONS

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

The senior management team is deep and is comprised of members of both the legacy Advocate and Aurora systems. AAH added a new Chief Strategy Officer in spring 2021, and the former CSO is now the President of the system's AAH Enterprises. The system also appointed a new Chief Government Relations Officer in 2020. No significant senior management retirements are planned in the near term, although the board is engaged on succession planning.

AAH has nearly $3.9 billion of debt outstanding (including operating leases). The system has a CP program in place and other variable rate debt supported by internal liquidity. Most VRDO bonds are supported by SBPAs, which expire between January 2024 and September 2025. Maximum annual debt service (MADS) is approximately $227 million, based on smoothing debt service (actual MADS is just over $820 million, based on a bullet payment in 2050). MADS coverage based on fiscal 2020 results is strong at approximately 6x and does not pose an asymmetric risk. The MTI includes a minimum historical debt service coverage covenant of 1.10x.

AAH had just over 310 days cash on hand at FYE 2020 and just over 315 days at unaudited March 31, 2021 (excluding Medicare advance payment funds and deferred employer FICA tax), and therefore days cash does not pose an asymmetric risk.

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
Advocate Aurora Health, Inc. (WI)	LT IDR	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable
• Advocate Aurora Health, Inc. (WI) /General Revenues/1 LT	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable
• Advocate Health Care Network (IL)	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable

VIEW ADDITIONAL RATING DETAILS

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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

Advocate Health and Hospitals Corporation	EU Endorsed, UK Endorsed

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S&P Global
Ratings

RatingsDirect®

Advocate Aurora Health, Illinois; CP; System

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Table Of Contents

Advocate Aurora Health, Illinois; CP; System

Credit Profile		
Illinois Finance Authority, Illinois		
Advocate Aurora Health, Illinois		
Illinois Fin Auth (Advocate Aurora Health Credit Group) sys		
Long Term Rating	AA/Stable	Current

Rationale

S&P Global Ratings' long-term rating on Advocate Health and Hospitals Corp. (AHHC), Ill.'s various series of taxable debt and its long-term ratings on the Illinois Finance Authority's (IFA) and the Wisconsin Health and Education Facilities Authority's various series of fixed-rate, tax-exempt revenue bonds is 'AA'. S&P Global Ratings' long-term component of its dual ratings ('AA/A-1+' and 'AA/A-1'), where applicable, on the IFA's various series of variable-rate demand bonds (VRDBs) is also 'AA'. Finally, S&P Global Ratings' short-term rating on AHHC's commercial paper (CP) program (authorized to $1 billion from $500 million with $50 million outstanding) is 'A-1+'. All bonds were issued for AHHC and the related obligated group (known as Advocate Aurora Health credit group, or AAH). The outlook, where applicable, is stable. Our analysis of AAH reflects the consolidated system.

The 'A-1+' short-term component of the rating on the issuer's series 2008C-3A bonds and the 'A-1' short-term component of the rating on the series 2008C-1 and 2008C-2B bonds reflect our view of the standby bond purchase agreements (SBPAs) in effect from various financial institutions. They further reflect our view of the likelihood of payment of tenders, and our view of liquidity facilities that cover all of the bond series. The 'A-1+' short-term component of the rating on the issuer's CP and series 2011B bonds reflects our view of the credit strength inherent in the 'AA' long-term rating on AAH's debt and the sufficiency of AAH's unrestricted reserves to provide liquidity support for the bonds.

Credit overview

Specifically, the 'AA' rating reflects AAH's excellent enterprise profile and solid market position in the broad Chicagoland and eastern Wisconsin markets as well as its solid financial profile, including sound performance, healthy coverage, low debt, and favorable unrestricted reserves and operational liquidity. Increasingly, nonoperating income, primarily investment income, has helped support cash flow as operating cash flow has weakened slightly even before the pandemic. Key enterprise strengths include considerable size and scale with more than $13 billion in annual operating revenue, servicing of a large population base (albeit with some mixed economics and demographics in certain service areas, particularly Illinois), the expansive footprint of the care continuum (including inpatient and outpatient services), and physician integration models that should support value-based reimbursement as that transition continues. While operating in Illinois (compared with Wisconsin) presents some ongoing challenges given the state and payer environment, the diversity of facilities and the broad geographic region help offset some of that risk.

While operating margins are rebounding after a challenging fiscal 2020 related to COVID-19, they have lightened over

the past few years from highs in the 4% area. In the past year and a half margin declines have largely been due to COVID-19, but since the merger in 2018 AAH has absorbed operating investments for the new system and various operating pressures related to industry transitions. Management expects operating margins to be stable for the remainder of 2021 and continues to focus on identifying further areas of improvement over time , which will help support credit stability.

AAH took advantage of the Medicare Advance and Accelerated Payment program and received approximately $773 million from that program and $787 million of CARES Act funds in fiscal 2020. No additional support was received in fiscal 2021, and management has recognized all of the CARES Act funds that it received in 2020. AAH shored up additional liquidity during 2020, including establishing a $1.2 billion line (nothing outstanding at the end of 2020 or in fiscal 2021), and increased its authorized CP amount to $1 billion but with no plans to use additional CP.

AAH continues to implement its strategic plan to support financial health, growth, and delivery of quality integrated care, while positioning for the out-years with a focus on wellness and value-based payments. To that end, AAH invested in Quartz for a Medicare Advantage plan and fully acquired Senior Helpers on April 1, 2021 (a franchise-based home health entity), helping diversify revenue and positioning itself for value-based payments and patients' increasingly choosing care outside the hospital. AAH continues to have a healthy capital appetite, including both information technology and capital building projects using primarily operating cash flow and potentially some modest debt.

The 'AA' long-term rating reflects our view of AAH's:

- Broad and diverse position across two states, including the broad Chicago metro and eastern Wisconsin markets, coupled with enterprise strengths around clinical integration, employed physician models, and sound accountable care organization (ACO) and risk-based payer strategies;
- Leading and stable position in the market as a whole although AAH operates in competitive markets;
- Healthy balance sheet measures with light debt, including leverage of 20%, unrestricted reserves to long-term debt of more than 3x, and unrestricted reserves of 320 days' cash on hand; and
- Sound maximum annual debt service coverage (smoothed) returning to more than 6x in interim fiscal 2021 (after dipping in fiscal 2020) as a result of improving operating margins, very good investment returns, and a low debt burden.

Partly offsetting the above strengths, in our view, are AAH's:

- Operating margins that, while improving in 2021, are still at lower-than-historical levels;
- Strong competition in almost all of the markets in which it operates--from other systems and large academic medical centers--coupled with broader volume pressures related to both the health care industry and the economy; and
- Continued exposure to Illinois Medicaid (through legacy Advocate Health Care).

The stable outlook reflects our view of AAH's healthy business position in core markets coupled with a sound balance sheet flexibility and improving margins. The stable outlook also reflects expectations of minimal new money debt over

the next couple of years and a disciplined management team that, while generating lower-than-historical operating margins, continues to balance cash flow with execution of strategic and capital spending plans while managing expenses and looking to diversify revenue and grow.

Environmental, social, and governance factors

We view AAH's governance risks as in line with the sector and note that AAH has successfully brought two large enterprises together with minimal operating challenges; we attribute the latter to good management and governance. Additionally, the board will return to a self-perpetuating board in the next year. (Following the merger, legacy health system members populated the board evenly for four years.) We view environmental risk as line with the industry as a whole given the dispersion of facilities in a broad service area covering northern Illinois and eastern and northeastern Wisconsin with limited environmental challenges. The team is focused on reducing its environmental footprint, which we believe could benefit the organization if future regulations come into play. Social risks also remain in line with the sector, but we monitor COVID-19 and the recent variant that could cause operating pressures in case of sustained challenges in caring for these patients as a result of increased costs from supplies, labor, and or equipment or reduced revenue stemming from patients' forgoing care for safety reasons. In addition, AAH's exposure to Illinois Medicaid payer mix presents increased social risk given AAH's slightly higher Medicaid levels (relative to peers), although its diversified footprint helps offset this risk.

Stable Outlook

Downside scenario

We could revise the outlook to negative or lower the rating in case AAH records operating margins of less than 3% for a sustained period, particularly if the balance sheet weakens. Any significant issuance of debt could also result in rating pressure, as the strong balance sheet is a key credit strength.

Upside scenario

We are not likely to raise the rating over the next two years given the increased capital spending and lower-than-historical lighter margins. Over time, we could raise the rating if AAH executes on system strategies and demonstrates meaningful multiyear improvement to its financial profile with financial ratios commensurate with a higher rating.

Credit Opinion

Enterprise Profile: Very Strong

AAH maintains expanded market position with focus on changes for its future state

AAH maintains a strong presence in its various markets, but has outlined goals it believes it needs to meet over the next five years as part of its 2025 strategic plan to maintain that strength. Key supporting areas of the credit include a large revenue base supported by a broad service area across two states (with a service area population of more than 11 million) and healthy business position in its core markets. Most of its entities operate well, but Trinity remains a

challenge given a challenging payer mix. As expected, AAH divested BroMenn and Eureka hospitals in central Illinois. AAH has a full complement of inpatient and outpatient services (including tertiary and quaternary care), a wide geographic network of clinics and outpatient centers, a large employed physician and advanced practitioner base, and other post-acute-care services across the service area. AAH also has a small joint venture insurance plan in Wisconsin that is small and is in conjunction with Anthem. We also view the diversification from payers (including different Medicaid programs) and from the demographics and economies of two states (and multiple markets) as a positive for the credit, particularly given the state pressures in Illinois.

AAH's strategies over the next several years are aimed at improving its overall position in its markets by broadening its patient base through improvement of access, quality and costs of care, and the customer experience. In the markets in which it operates, AAH maintains very solid and often leading market shares, though the markets remain competitive with a host of competitors. We believe that, overall, competition in the Chicago metropolitan statistical area is increasing partly as a result of recent consolidations. While competition in the Chicagoland market is much tighter, trends are evolving in Wisconsin, as Ascension appears to be downsizing some of its facilities in the northern region.

AAH has a number of physician integration models and continues to expand those across the system and push the organization toward value-based care models. We believe that the mix of physician and payer models, including various pilot projects such as those that incorporate Medicare Advantage, allows AAH to experiment and learn what works best with which markets and populations. These strategies should help achieve the goals in AAH's 2025 strategic plan, assuming that the projects are undertaken and evaluated in a disciplined manner. More specifically, in the Illinois market AAH benefits from a clinically integrated network (Advocate Physician Partner, or APP) with both its employed (Advocate Medical Group) and independent physicians. In the Wisconsin market, AAH has a stronger physician employment model. AAH has also had success in its various Medicare ACO models, so we expect it to continue to build on that. Additionally, legacy AHCN has accepted full and partial risk (capitation) on certain commercial and Medicare advantage contracts directly and through APP. Legacy AHC has had a history of working directly with employers.

While volume recovery continues in fiscal 2021, inpatient volumes prior to the pandemic were flat to slightly down given shifts to outpatient as well as the competitive market and stable population. Outpatient volumes have historically increased with a focus on access and physician growth. AAH continues to expand its ambulatory network, but market and industry dynamics (including the impact from COVID-19) lead us to believe that growth will likely depend on AAH's ability to capture additional market share and lives under risk-based contracts, including Medicare Advantage.

While continuing to recover, AAH continues to implement initiatives for the 2025 strategic plan

We believe AAH has a very strong and capable management team with considerable bench strength throughout the organization and a history of financial discipline and strategic focus that we believe will serve the organization well as it enters a period of increased challenges both related to industry pressures as well as COVID-19 recovery. We also view favorably AAH's ability to operate from a position of strength, particularly in a challenging state and payer environment for the facilities in Illinois.

One board oversees AAH, evenly populated with legacy AHC and AHCN board members. While we view self-perpetuating boards as best practice, we also recognize that AAH will transition to a self-perpetuating board in the

next year.

Management is moving forward on its strategic plan. While core strategies focus on financial health, customer service, and safety and quality, the far years of the 2025 strategic plan begin to pivot the organization toward managing under different reimbursement models including a focus on health and wellness as demonstrated by its recent investments mentioned above. Efforts around clinical integration and decreased variability in care across the organization will continue to play a role as the organization targets its 2025 goals.

Table 1

Advocate Health Care Network and Subsidiaries Utilization

	--Three months ended March 31--	--Fiscal year ended Dec. 31--		
	2021*	2020	2019	2018
Inpatient admissions§	56,025	236,526	258,468	260,516
Equivalent inpatient admissions	155,859	630,121	707,393	551,304
Emergency visits	182,284	812,533	806,276	794,037
Inpatient surgeries	14,738	55,382	67,790	68,666
Outpatient surgeries	38,204	134,882	162,245	157,212
Medicare case mix index	N.A.	1.9617	1.8959	1.8213
FTE employees	64,000	64,000	63,000	61,000
Active physicians	9,400	9,500	9,800	8,900
Medicare (%)†	29	31	32	30
Medicaid (%)†	12	12	11	11
Commercial/Blues (%)†	57	54	54	56

*Giving recent release of second-quarter 2021 financial results, enterprise statistics reflect first-quarter 2021. §Excludes normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. †Based on net revenue. FTE--Full-time equivalent. N.A.--Not available.

Financial Profile: Very Strong

Recovery in fiscal 2021 with nonoperating revenue providing healthy support to cash flow

AAH generated steady improvement to operating margins through the first six months of fiscal 2021 following a weaker fiscal 2020. That said margins remain lighter than historical highs of around 3.5% to 4.0%. Fiscal 2020 result, while positive, were of course affected by COVID-19 and reduced volumes. In addition, AAH didn't reduce the number of full-time equivalent employees or furlough any employees to support care givers, and was further affected by higher agency costs in late 2020 and early 2021, as were many providers. Interim results through the second quarter are showing recovery and are beating budget as a result of good revenue yield, volume recovery, and ongoing expense management. While management expects no significant changes in the near term related to its payer contracts, the team is focused on trying to find solutions in value-based care in partnership with its payers over the medium term. AAH maintains some risk through capitated revenue and shared savings programs, among other modest initiatives. The team remains committed to managing expenses as well as identifying opportunities to further improve the cost structure. While all of AAH's markets are fairly competitive, we believe that Illinois is more challenging and believe that some of the growth, payer, and market trends in Wisconsin will continue to benefit AAH's operating performance. Growth and revenue diversification will remain focus, as the aforementioned acquisitions and investments indicate.

Healthy nonoperating income, particularly investment income, has helped support cash flow considerably in recent years as operating cash flow has lightened a bit. Nonoperating income, along with good cash flow, contributed to good maximum annual debt service coverage on a smoothed basis through interim 2021. The actual debt service schedule is slightly more uneven and includes a number of bullets.

The team is focused on targeting closer-to-historical operating margins over time with steady improvement over the next couple of years, but industry trends--including a muted payer environment, increased labor expense pressures, and the lingering impact of COVID-19--could challenge this.

Healthy liquidity support capital spending and strategic priorities

Unrestricted reserves have recovered since our previous review given the taxable debt issuance, healthy investment returns, and the sale of AAH's central Illinois assets in mid-2020. (AAH excludes some self-insurance reserves from its unrestricted reserve calculation, so we believe that overall cash on hand could be slightly stronger but not materially different.) Through the first half of 2021, despite good investment returns, reserve growth slowed to about 4% given ongoing capital expenditures and the acquisition of Senior Helpers.

AAH's investment allocation mix has a reduced equities exposure of only 30% but a fair amount of exposure to alternatives at about 50%, meaning that AAH has given up some liquidity with the goal of solid returns with less volatility. That said, we view overall liquidity as healthy given AAH's $781 million of cash and cash equivalents, which includes MAAP (Medicare Accelerated and Advance Payment) funds of around $700 million, a $1.2 billion syndicated line of credit, and an authorized $1.0 billion of its commercial paper program. Within its investments, AAH maintains good liquidity with about $5.3 billion (excluding MAAP funds) available in 30 days.

Capital spending was lower than expected in fiscal 2020 as projects slowed in the spring 2020 but picked up in late summer and early fall. Key projects that continued include legacy AHCN's large Epic implementation whose completion was slightly delayed but was completed in early 2021, a new enterprise resource planning system that is to be completed in fall 2022, ongoing spending at Illinois Masonic Medical Center (IMMC), a replacement facility in Sheboygan, and construction of an AAH inpatient facility and two ambulatory facilities in the Racine/Kenosha market. Management will use the 2020A proceeds to help support those projects as well as cash flow. Capital spending was around $700 million in fiscal 2020 compared with a budgeted $1 billion-plus and around $650 million in 2019. Through June 30, 2021, capital spending is slightly less than prior-year levels, excluding the acquisition of Senior Helpers and likely to be well below the $1.2 billion full year capital budget as a result of timing of projects and payments.

AAH had increased unfunded commitments on its investment portfolio of about $14 billion for its private equity and real estate partnership investments as of Dec. 31, 2020 (to be funded over the next seven years), which we view as manageable given its more than $10 billion in unrestricted reserves. Management reports that it should have no sizable calls in the next year but will monitor that.

Low debt with diversified structure supports rating but some risks in remarketing and bullets

AAH's long-term debt remains low with modest debt service relative to revenue, thus providing some ongoing flexibility. However, we note several bullets and tenders over the 34-year schedule that will have to be refinanced or paid along with some remarketing and renewal risks.

Other than the bullets and a small amount of contingent debt, we believe AAH's debt structure is reasonable, given its balance sheet profile and investment allocation. More specifically, about 80% of AAH's debt is fixed, excluding swaps, and the remainder is in some type of variable-rate mode (such as index rate bonds, floating-rate notes, VRDBs, and CP).

AAH's long-term operating lease liability is about $243 million with a commensurate operating lease right-of-use assets on June 30, 2021. We have historically incorporated lease risk into lease-adjusted debt service coverage, and we believe this continues to capture risk associated with lease exposure. Including the operating lease liability in our calculation of leverage brings debt as a percentage of capitalization to about 22%.

Based on AAH's liquidity analysis provided to our funds group, the system can amply cover its total $120 million self-liquidity-backed VRDBs and CP ($50 million outstanding).

While we don't view the bank debt as a significant risk given AAH's healthy financial profile, key rating and financial covenants related to the bank-held debt are maintenance of a credit rating of 'BBB' or higher and coverage of 1.1x or higher. Total contingent debt (as calculated by S&P Global Ratings and including other VRDBs) is about 30% of debt outstanding.

AAH maintained five floating- to fixed-rate swaps with a total notional amount of $351.6 million as of June 30, 2021 (including two that are not tied to any specific debt). Counterparties vary, and as of that date the liability on the swaps was $98.5 million with no collateral posting required in recent years.

We view AAH's defined benefit plans as being of minimal risk given the good funding and legacy AHCN's active plan's status a church plan. Legacy AHCN also has an Employee Retirement Income Security Act of 1974 plan that is frozen. Legacy AHC also maintains a defined benefit plan that is well funded (more than 90%) and frozen to new benefits and entrants (as of 2012). Together, the plans have been well funded at more than 90% for the past several years. Management is also considering investment strategies that could limit the need for future funding.

Table 2

Advocate Health Care Network and Subsidiaries Financial Summary

	--Six months ended March 31--	--Fiscal year ended Dec. 31--			'AA' rated health care system medians
	2021	2020	2019	2018*	2019
Financial performance					
Net patient revenue ($000s)	6,239,207	11,337,814	11,925,131	8,569,463	4,050,320
Total operating revenue ($000s)	6,717,433	13,068,012	12,743,703	9,186,580	4,887,899
Total operating expenses ($000s)	6,522,452	12,969,315	12,385,102	8,888,922	MNR
Operating income ($000s)	194,981	98,697	358,601	297,658	MNR
Operating margin (%)	2.90	0.76	2.81	3.24	4.40
Net nonoperating income ($000s)	158,269	(25,506)	205,956	243,543	MNR
Excess income ($000s)	353,250	73,191	564,557	541,201	MNR
Excess margin (%)	5.14	0.56	4.36	5.74	6.60
Operating EBIDA margin (%)	7.91	5.90	8.12	8.60	9.80
EBIDA margin (%)	10.03	5.72	9.58	10.96	12.70

Table 2

Advocate Health Care Network and Subsidiaries Financial Summary (cont.)

	--Six months ended March 31--	--Fiscal year ended Dec. 31--			'AA' rated health care system medians
	2021	2020	2019	2018*	2019
Net available for debt service ($000s)	689,769	745,532	1,240,827	1,033,376	603,513
MADS ($000s)	223,783	223,783	223,783	223,783	MNR
MADS coverage (x)	6.16	3.33	5.54	6.16	7.60
Operating-lease-adjusted coverage (x)	4.58	2.45	3.92	3.87	4.90
Liquidity and financial flexibility					
Unrestricted reserves ($000s)	10,946,323	10,497,642	8,812,556	7,544,843	4,057,238
Unrestricted days' cash on hand	320.1	308.8	272.2	243.6	335.5
Unrestricted reserves/total long-term debt (%)	315.6	301.7	292.9	255.0	283.1
Unrestricted reserves/contingent liabilities (%)	1,108.4	1,063.0	849.5	773.7	863.5
Average age of plant (years)	9.6	9.2	8.7	9.5	10.5
Capital expenditures/depreciation and amortization (%)	92.3	125.6	114.6	134.6	153.8
Debt and liabilities					
Total long-term debt ($000s)	3,468,185	3,480,061	3,008,901	2,958,931	MNR
Long-term debt/capitalization (%)	20.7	22.2	20.8	22.8	20.8
Contingent liabilities ($000s)	987,592	987,592	1,037,353	975,171	MNR
Contingent liabilities/total long-term debt (%)	28.5	28.4	34.5	33.0	43.2
Debt burden (%)	1.63	1.72	1.73	1.78	1.80
Defined benefit plan funded status (%)	N.A.	92.29	91.14	96.59	85.60
Miscellaneous					
Medicare accelerated and advance payments ($000s)§	703,000	773,000	N/A	N/A	MNR
Short-term borrowings ($000s)§	0	0	0	0	MNR
CARES Act ($000s)	-	786,655	N/A	N/A	MNR
Other stimulus funds	-	37,000	N/A	N/A	MNR
Total net special funding ($000s)	N.A.	232,533	199,859	156,061	MNR

*Only nine months of data. §Excluded from unrestricted reserves, long-term debt, and contingent liabilities. MADS--Maximum annual debt service. MNR--Median not reported. N/A--Not applicable. N.A.--Not available.

Credit Snapshot

- **Security:** The rated bonds are the general, unsecured joint and several obligations of the obligated group.
- **Group rating methodology status:** The rating reflects our view of AAH's group credit profile and the obligated group's core status. Accordingly, we rate the obligated group at the level of the AAH group credit profile.
- **Credit overview:** AAH operates across northern Illinois and eastern Wisconsin with more than 25 acute care hospitals, more than 3,600 employed physicians, and numerous clinics and outpatient settings. The system also includes two ACOs, Advocate Physician Partners (a clinically integrated network), and a joint venture insurance company in Wisconsin with Anthem. AAH also includes long-term teaching affiliations with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University, and Midwestern University. As part of these affiliations, AAH trains about 600 residents in 31 residency programs.
- **Self-liquidity rating:** The 'A-1+' short-term component of the rating on the $70 million series 2011B windows bonds and $50 million CP program reflects our view of the credit strength inherent in the 'AA' long-term rating on AAH's debt and the sufficiency of AAH's unrestricted reserves to provide liquidity support for the bonds. Our Fund Ratings and Evaluations Group assesses the liquidity of AAH's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. We monitor the liquidity and sufficiency of AAH's investment portfolio monthly. AAH identified approximately $800 million of discounted assets as of June 30, 2021, to provide self-liquidity. The assets are invested in highly rated money market funds, Treasuries, agencies, investment-grade debt, speculative-grade debt, and domestic equities, providing sufficient coverage in the event of a failed remarketing. Management has established clear and detailed procedures to ensure the maintenance of sufficient asset coverage and to meet liquidity demands on a timely basis. We will monitor the liquidity and sufficiency of assets pledged by AAH on a monthly basis. In addition, and as relates to the CP program, management has a restriction of only $50 million coming due within a seven-day period, but this may change depending on what management ends up using in that program.

Related Research

Through The ESG Lens 2.0: A Deeper Dive Into U.S. Public Finance Credit Factors, April 28, 2020

Ratings Detail (As Of September 1, 2021)

Advocate Aurora Health taxable bnds		
Long Term Rating	AA/Stable	Current
Advocate Aurora Health taxable comm pap nts ser 2019 dtd 02/25/2019 due 08/01/2019		
Short Term Rating	A-1+	Current
Illinois Finance Authority, Illinois		
Advocate Aurora Health, Illinois		
Illinois Finance Authority (Advocate Aurora Health) rev bnds rmktd 02/12/2020 (Advocate Hlth Care Network)		
Long Term Rating	AA/Stable	Current
Illinois Finance Authority (Advocate Aurora Health) rev bnds rmktd 1/15/2020 (Advocate Hlth Care Network) ser 2008A-1 dtd 04/23/2008 due 11/01/2030		

Ratings Detail (As Of September 1, 2021) (cont.)		
Long Term Rating	AA/Stable	Current
Illinois Fin Auth (Advocate Aurora Health Credit Group) sys		
Long Term Rating	AA/Stable	Current
Illinois Fin Auth (Advocate Aurora Health Credit Group) VRDO sys		
Long Term Rating	AA/A-1+/Stable	Current
Illinois Fin Auth (Advocate Aurora Health Credit Group) VRDO sys		
Long Term Rating	AA/A-1/Stable	Current
Illinois Fin Auth (Advocate Aurora Health Credit Group) VRDO sys		
Long Term Rating	AA/A-1+/Stable	Current
Illinois Hlth Fac Auth, Illinois		
Advocate Aurora Health, Illinois		
Illinois Hlth Fac Auth (Advocate Aurora Health Credit Group) sys		
Long Term Rating	AA/Stable	Current
Illinois Hlth Fac Auth (Advocate Aurora Health Credit Group) sys		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth, Wisconsin		
Advocate Aurora Health, Illinois		
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health Credit Group) rev bnds		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health Credit Group) rev bnds		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health Credit Group) rev bnds		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health Credit Group) (AGM)		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health Credit Group) (MBIA) (National)		
Long Term Rating	NR	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health) rev bnds rmkted 4/8/2021 (Advocate Aurora Health) ser 2018C-1 dtd 08/16/2018 due 08/15/2054		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health) rev bnds (Advocate Hlth Care) ser 2018C-2		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health) rev bnds (Advocate Hlth Care) ser 2018C-3		
Long Term Rating	AA/Stable	Current
Wisconsin Hlth & Ed Fac Auth (Advocate Aurora Health) rev bnds (Advocate Hlth Care) ser 2018C-4		
Long Term Rating	AA/Stable	Current

MOODY'S
INVESTORS SERVICE

Rating Action: Moody's affirms Advocate Aurora Health's Aa3; outlook positive

13 Aug 2021

New York, August 13, 2021 -- Moody's Investors Service has affirmed the Aa3, Aa3/VMIG 1, and Aa3/P-1 ratings assigned to Advocate Aurora Health's (AAH) outstanding debt, which includes the obligations of legacy borrower Aurora Health Care, Inc., WI. The outlook is positive. AAH has approximately $3.55 billion of debt outstanding.

RATINGS RATIONALE

Affirmation of the Aa3 reflects AAH's leading market positions across two regions, business line breadth and strong financial discipline. After achieving lower but still solid operating cash flow (OCF) margins in fiscal 2020 and YTD 2021 amid pandemic related volume disruptions, AAH will likely return to and sustain OCF margins at pre-pandemic expectations of 9% to 10%. This would be supported by ongoing recovery in volume and strategic growth but will likely take longer than anticipated when the positive outlook was first assigned due to COVID related volume disruptions and staffing challenges. Operating and balance sheet leverage will remain moderate with management expecting to maintain current levels of debt and well-funded frozen and highly hedged pension plans. A return to pre-pandemic levels of operating cash flow and ongoing improvement in cash levels, however, would help contribute to cash to total debt, total debt to cash flow and days cash metrics that would be more in line with a higher rating. In addition to intensifying wage issues, offsets include strong competition in rapidly consolidating markets and ongoing payer pressures.

The affirmation of the short-term P-1 rating is supported by Moody's market access cash flow approach to longer-term variable rate instruments and our estimation of AAH's ability to pay the purchase price of a mandatory tender when due at the end of the mandatory tender "window" as well as AAH's strong liquidity. Moody's expects that AAH will be able to access the market given its strong revenue bond rating and the system's frequency of market participation. Affirmation of the VMIG 1 reflects the presence of standby bond purchase agreements and the creditworthiness of AAH.

RATING OUTLOOK

The positive outlook reflects Moody's view that AAH will likely be able to return to and sustain OCF margins at levels expected pre-pandemic while increasing absolute cash levels (excluding Medicare Advances and FICA deferrals). This would allow AAH to achieve or exceed stronger days cash, cash to debt and debt to cash flow metrics as forecasted.

FACTORS THAT COULD LEAD TO AN UPGRADE OF THE RATINGS

- Able to recover to pre-pandemic OCF levels in the 9% to 10% range and demonstrate durability

- Evidence that operating leverage as measured by debt to cash flow will be sustained at or below 2.0 times

- Ability to show ongoing improvement in cash to debt and days cash

- Unenhanced ST rating: Not applicable

- Enhanced ST rating: Not applicable

FACTORS THAT COULD LEAD TO A DOWNGRADE OF THE RATINGS

- Sustained decline in solid operating cash flow margins

- Meaningful decline in days cash or cash to debt metrics

- Additional debt resulting in less favorable leverage metrics

- Unenhanced ST rating: downgrade by Moody's of AAH's long-term rating below A2 or material adverse changes to AAH's access to the capital markets

- Enhanced ST ratings: downgrade by Moody's of the short-term Counterparty Risk Assessment of the banks that provide the SBPAs or the long-term rating of AAH

LEGAL SECURITY

Under an Amended and Restated Master Trust Indenture, issued in 2018, security is a general, unsecured obligation of the obligated group. There are no additional indebtedness tests. The members of the obligated group under the Master Indenture are: Advocate Aurora Health, Inc., Advocate Health Care Network, Advocate Health and Hospitals Corporation, Advocate Sherman Hospital, Advocate North Side Health Network, Advocate Condell Medical Center, Aurora Health Care, Inc., Aurora Health Care Metro, Inc., Aurora Health Care Southern Lakes, Inc., Aurora Health Care Central, Inc. d/b/a Aurora Sheboygan Memorial Medical Center, Aurora Medical Center of Washington County, Inc., Aurora Health Care North, Inc. d/b/a Aurora Medical Center Manitowoc County, Aurora Medical Center of Oshkosh, Inc., Aurora Medical Group, Inc., Aurora Medical Center Grafton LLC. The Amended and Restated MTI contains a substitution of notes provision.

PROFILE

Advocate Aurora Health, Inc. (AAH; $13.1 billion revenue in FY 2020), provides a continuum of care through its 24 acute care hospitals, an integrated children's hospital and a psychiatric hospital, which in total have 6,475 licensed beds, primary and specialty physician services with approximately 3,600 employed physicians, outpatient centers, physician office buildings, pharmacies, behavioral health care, rehabilitation, home health and hospice care in northern Illinois, eastern Wisconsin and the upper peninsula of Michigan.

METHODOLOGY

The principal methodology used in the long-term ratings was Not-For-Profit Healthcare published in December 2018 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBM_1154632 . The principal methodology used in the short-term underlying rating was Short-term Debt of US States, Municipalities and Nonprofits Methodology published in July 2020 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBM_1210749 . The principal methodology used in the short-term enhanced ratings was Variable Rate Instruments Supported by Conditional Liquidity Facilities published in March 2017 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_1057134 . Alternatively, please see the Rating Methodologies page on www.moodys.com for a copy of these methodologies.

REGULATORY DISCLOSURES

For further specification of Moody's key rating assumptions and sensitivity analysis, see the sections Methodology Assumptions and Sensitivity to Assumptions in the disclosure form. Moody's Rating Symbols and Definitions can be found at: https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_79004

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The ratings have been disclosed to the rated entity or its designated agent(s) and issued with no amendment resulting from that disclosure.

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N/A, Advocate Aurora Health, Inc has a AA long-term bond rating from Fitch and Standard & Poors. Advocate Aurora Health, Inc has an Aa3 long-term bond rating from Moody's.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 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.

F. Total Effect of the Project on Capital Costs

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

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

See Attachment #36, Exhibit 1 and 2

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January 26, 2022

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

RE: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center Patient Pavilion and CAC Modernization and Expansion Project

Dear Ms. Avery:

This letter is to attest to the fact that the selected form of debt financing for the proposed Advocate Illinois Masonic Medical Center project will be at the lowest net cost available, or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term financing costs, and other factors.

Respectfully,

William Santulli
Chief Operating Officer
Advocate Aurora Health, Inc.

Notarization:

Subscribed and sworn to before me
This 26th day of January, 2022

(Seal of Notary)

"OFFICIAL SEAL"
MICHAEL E. KERNS
Notary Public, State of Illinois
My Commission Expires on May 26, 2022

Signature of Notary

Cost & Gross Square Feet by Department

	A	B	C	D	E	F	G	H	
	Cost / Sq. Ft.		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	Total Cost (G+H)
Dept. / Area	New	Mod.	New	Circ.*	Mod.	Circ.*	AxC	BxE	(G+H)
Reviewable									
Breast Imaging	$ 753	$ -	7,523	15%	0	15%	$5,664,819	$0	$5,664,819
Outpatient Cancer Center	$ 753	$ 500	6,799	15%	27	15%	$5,119,647	$13,500	$5,133,147
Outpatient Heart Clinic	$ -	$ 500	0	15%	8,334	15%	$0	$4,167,000	$4,167,000
Surgery	$ 900	$ 700	20,696	15%	4,190	15%	$18,626,400	$2,933,000	$21,559,400
Cath Lab	$ -	$ 700	0	15%	6,879	15%	$0	$4,815,300	$4,815,300
Prep-Recovery	$ -	$ 500	0	15%	13,031	15%	$0	$6,515,500	$6,515,500
PACU	$ 824	$ -	1,684	15%	0	15%	$1,387,818	$0	$1,387,818
Triage	$ 949	$ -	2,013	15%	0	15%	$1,910,418	$0	$1,910,418
LDR	$ 784	$ -	7,824	15%	0	15%	$6,131,278	$0	$6,131,278
C-Section	$ 743	$ -	3,921	15%	0	15%	$2,914,832	$0	$2,914,832
Post-Partum	$ 622	$ -	15,158	15%	0	15%	$9,435,648	$0	$9,435,648
NICU	$ 739	$ -	11,060	15%	0	15%	$8,170,464	$0	$8,170,464
Intensive Care Unit	$ 716	$ -	24,202	15%	0	15%	$17,328,390	$0	$17,328,390
Med/Surg Unit	$ 492	$ -	86,398	15%	0	15%	$42,491,400	$0	$42,491,400
Clinical Backfill Renovations	$ -	$ 367	0	15%	2,500	15%	$0	$917,980	$917,980
Inpatient Rehabilitation	$ -	$ 390	0	15%	16,447	15%	$0	$6,414,330	$6,414,330
Inpatient Behavioral Health	$ -	$ 390	0	15%	16,061	15%	$0	$6,263,790	$6,263,790
Total Clinical			187,278		67,469		$119,181,114	$32,040,400	$151,221,514
Clinical Contingency									$11,918,111
Total Clinical Reviewable + Contingency									$163,139,625
Non-Reviewable									
Administration	$ 671	$ 1,100	6,464	15%	1,168	15%	$4,339,865	$1,284,800	$5,624,665
Public Lobby, Waiting, Toilets	$ 1,307	$ 1,230	20,470	15%	7,527	15%	$26,744,575	$9,258,210	$36,002,785
Support, Staff Respite, Staff Lockers, Lounge, Workroom, Gowning, Equip Storage	$ 500	$ 500	26,572	15%	3,826	15%	$13,286,000	$1,913,000	$15,199,000
Circulation	$ 658	$ 580	1,824	15%	3,022	15%	$1,200,922	$1,752,760	$2,953,682
Building Systems	$ 917	$ 995	60,872	15%	1,241	15%	$55,823,276	$1,234,795	$57,058,071
Boiler Plant Upgrades	$ -	$ 1,860	0	15%	5,000	15%	$0	$9,300,000	$9,300,000
Demo Buildings 4,5 & 6	$ -	$ 130	0	15%	122,890	15%	$0	$15,975,700	$15,975,700
Storage, EVS	$ 571	$ 500	3,747	15%	602	15%	$2,140,511	$301,000	$2,441,511
Elevator Lobby	$ 900	$ -	4,842	15%	0	15%	$4,357,800	$0	$4,357,800
Elevator Shafts, MEP Shafts	$ 574	$ 500	9,989	15%	1,623	15%	$5,730,490	$811,500	$6,541,990

Stairs	$ 719	$ 830	10,722	15%	832	15%	$7,707,188	$690,560	$8,397,748
Non-Clinical Backfill Renovations	$ -	$ 558	0	15%	33,855	15%	$0	$18,886,528	$18,886,528
Nursing Administration	$ -	$ 648	0	15%	1,500	15%	$0	$972,000	$972,000
OR Waiting	$ -	$ 820	0	15%	5,850	15%	$0	$4,797,000	$4,797,000
Non-Clinical Renovations at Inpatient Rehabilitation	$ -	$ 475	0	15%	2,186	15%	$0	$1,038,350	$1,038,350
Non-Clinical Renovations at Behavioral Health	$ -	$ 475	0	15%	1,902	15%	$0	$903,450	$903,450
Total Non-Reviewable			145,502		193,024		$121,330,627	$69,119,653	$190,450,279
Non-Reviewable Contingency									$19,590,326
Total Non-Reviewable + Contingency									$210,040,605
Total									$341,671,794
Contingency									$31,508,437
Total + Contingency									$373,180,231

* Include the percentage (%) of space for circulation

D. Projected Operating Cost per Equivalent Pay Day in 2030

E. Impact of Project on Capital Costs in Year of Completion 2030

Projected Operating Costs			
	2030	Cost Per Equivalent Patient Day	Impact Cost per Equivalent Patient Day
Operating Costs	$ 273,339,689	$ 1,610	$ 118

Impact of Project on Capital Costs			
	2030	Cost Per Equivalent Patient Day	Impact Cost per Equivalent Patient Day
Capital Costs	$ 32,538,403	$ 192	$ 69

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, 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.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2018**	**2019**	**2020**
Inpatient	109	118	331
Outpatient	1,706	1,980	2,042
Total	**1,815**	**2,098**	**2,373**
Charity (cost in dollars)			
Inpatient	$4,578,000	$7,074,000	2,051,000
Outpatient	$4,079,000	$6,129,000	2,036,000
Total	**$8,657,000**	**$13,203,000**	**4,087,000**
MEDICAID			
Medicaid (# of patients)	**2018**	**2019**	**2020**
Inpatient	2,994	3,212	2,770
Outpatient	38,157	37,204	31,928
Total	**41,151**	**40,416**	**34,698**
Medicaid (revenue)			
Inpatient	$35,865,715	$37,581,601	$31,633,169
Outpatient	$11,737,282	$13,641,868	$14,432,761
Total	**$47,602,997**	**$51,223,469**	**$46,065,930**

Safety Net Relevant Services

Advocate Illinois Masonic Medical Center has a long history of serving the Northside of Chicago. The hospital takes great pride in the relationship it has with the neighborhood, communities, organizations, and agencies its services. The following illustrates some to the ways that the Medical Center addresses the needs of the people in their service area.

Advocate Illinois Masonic Medical Center has a strong relationship with the Hispanic community. As Chicago's Hispanic population has grown over the past decades, the Medical Center has stayed current with the community's health care needs. Advocate Illinois Masonic's Inclusion Council and Transition Support Program provide cultural competence training opportunities, program development and navigation services to limited English proficiency and Spanish speaking patients addressing non-clinical barriers to care. In addition, Advocate Illinois Masonic's *Salud Mujer Latina* outreach enhances communication and access to language and cultural concordant services, providers, and physicians.

The medical center partners with several social service agencies to support the Asian population in Chicago, specifically the Vietnamese and Chinese communities in Chinatown, Argyle and Bridgeport. In collaboration with the Inter-congregational Outreach and Parish Nurse program, services are provided including education and information for the Pilsen, Logan Square, and Avondale communities.

Advocate Illinois Masonic Medical Center offers interpretation services and translation services in almost every language through one of several methods including in person services for Spanish, Polish, Vietnamese, Cantonese, and Mandarin; translation services through registry agencies and video teleconferencing and dedicated lines.

Advocate Illinois Masonic's Inclusion Council works on addressing racism with a series of events to build allyship with Latino/Hispanic employees and other communities facing discrimination. The Inclusion Council develops a program to address racism with two other hospitals within the Advocate Aurora network surveying employees' perceptions and sentiments, engaging widely conversations on findings through open forums and define action plans based on surveys and forum.

The Medical Center is located in one of the largest LGBTQ communities in the nation. In 2020, Advocate Illinois Masonic Medical Center was named a "Leader" in LGBTQ equality based on the accreditation survey in the Human Rights Campaign Foundation's Health Care Equality Index (HEI) for the twelfth consecutive year.

Advocate Illinois Masonic Medical Center was one of only 11 facilities in Illinois to have been recognized as a Leader, demonstrating protection of LGBTQ patients and employees from discrimination through affirming their identities and serving their specific needs from infectious diseases, to gender affirming, to family obstetric and dental services.

In 2016, Illinois Masonic Medical Center created an internal LGBTQ Work Group now under the Inclusion Council to address the needs of the hospital's LGBTQ patient population and its team members. As part of the accreditation, the medical center began a process for implementing ender affirming identification and signage in its inpatient areas. Advocate Illinois Masonic led the way for all Advocate Aurora hospitals within the Advocate Aurora Health network to achieve leadership status, making Advocate Aurora Health to be the third largest system in US to achieve all sites named Leaders, generating positive change for millions of patients across Illinois and Wisconsin.

Advocate Illinois Masonic Medical Center has a referral and coordination of care agreement for HIV positive and other patients experiencing disparities, primarily Lesbian, Gay, Bisexual, Transgender and Gender Non-Conforming developing clinical and culturally competent services with Howard Brown Health, the largest LGBTQ focused Federally Qualified Health Center in the region.

Despite the circumstances and challenges that the COVID-19 pandemic brought to the entire health care system, Advocate Aurora hospitals continued their commitment to inclusive and affirming care for LGBTQ patients in 2020 with the achievement of HEI designation for all of its member hospitals. To learn more about our commitment to serving our LGBTQ community members, visit https://www.advocateaurorahealth.org/our-story/diversity-equity-inclusion/lgbtq-health/.

Advocate Aurora firmly believes that each person is shaped by their unique backgrounds, experiences, and individual identity. The system Diversity, Equity, & Inclusion (DE&I) strategy honors differences in patients, builds diverse teams, and helps communities thrive from within. Advocate Aurora advances health equity through intentional efforts in clinical operations, civil rights, business diversity, and language services. Together, these services enhance access to care, foster an inclusive workplace, and strengthen community partnerships. Examples include enhanced clinical capacity to treat and care for LGBTQ patients with HIV with new clinical screening workflows specific to referrals between primary care, infectious disease, and gastroenterology. In 2020, unconscious bias training became mandatory for all team members, and over 1,000 team members participated in REAL Talk listening sessions that offered a safe space to discuss feelings and experiences in the wake of COVID-19 and civil unrest. Within the community, 55 flu clinics were established with multiple community partners, including faith-based organizations across South and Central Chicagoland, to reach neighborhoods with the greatest gaps in immunization coverage.

You can also read more highlights about our broader Diversity, Equity & Inclusion strategies in the 2020 Diversity & Inclusion Impact Report found here.

Advocate Illinois Masonic Medical Center's Cancer Institute offers a multitude of services for patients, their families and community members:

- Partnership with ALAS-Wings, a bicultural, bilingual support community for Latin-American women and their families – offering education, support groups, yoga, and other programming free to patients - funded through philanthropy
- Free education for cancer prevention and screening
    - Partnership with Digestive Health Institute – includes distribution of free FIT tests for colon cancer screening
    - Partnership with The Silver Lining Foundation - access for free diagnostic breast imaging
    - Partnership with Amber Coalition - to provide outreach to the Polish American community
- Focused community engagement to address health access/education disparities identified by Advocate Illinois Masonic Medical Center's Health Work Groups. Salud Mujer Latina is one example, with outreach to promote mammography screening and adherence to cancer treatment based on findings of women of color disparities in advance cancer stages at time of diagnosis.
- Donor and grant funded Patient Assistance Fund. Helps patients including medication assistance, car repair, access to food (through a partnership with the Lakeview Food Pantry) and other life needs which can impact cancer care.
- Psychosocial program- Advocate Illinois Masonic Medical Center provides crisis intervention, counseling, and other support
- Free survivorship support to patients after treatment
    - Funded through philanthropy
    - Support groups, gatherings, education by providers, e.g., recent "Survivor Social" focused on educating women on sexual health needs during and after cancer treatment
- Community partnerships
    - Partnership with the Lakeview Food Pantry - offer food bags to patients who are food insecure
    - Partnership with Courage to Quit (Support Groups) to help people quit smoking
    - Alas Wings support groups for Spanish speaking cancer patients, families, and survivors

The Medical Center's Medication Assistance Program which began in 2009, helps patients unable to afford medication who often forgo treatment and their conditions worsen, resulting in higher health care costs. Advocate Illinois Masonic Medical Center's Pharmacy department envisioned this program to help patients secure prescriptions they were unable to afford. The program prevents patients from costly hospital admissions by providing medication assistance directly in the hospital's Emergency Department. The goal of the program is to match AIMMC patients who cannot afford much-needed mediations with pharmaceutical programs that provide free and discounted prescription drugs to fulfill their doctor's orders.

Advocate Illinois Masonic Medical Center is the lead hospital for the city of Chicago in the event of a disaster. It is one of only 11 hospitals to be responsible for coordinating disaster medical response upon the activation of the Emergency Medical Disaster Plan. To achieve this assignment the Medical Center is the designated resource hospital, designated Level 1 Trauma hospital that leads coordination of disaster response activities.

Advocate Illinois Masonic Medical Center has strong ties with several universities and operates a robust residency program to train physicians in various medical specialties including family medicine, internal medicine, obstetrics and gynecology, radiology, anesthesiology, surgery, dental and dental anesthesia. The medical center also offers a nurse residency program providing new nurses with the skills and confidence to have successful careers. As part of the teaching hospital, residents, medical and nursing students are exposed to the equity and inclusion structures and access to educational and research project to address the gaps in health care status in our diverse patients. An example of this is the Sexual Orientation and Gender Identity data projects to improve skills, collection and analytics of these demographic factors and document disparities and equity interventions.

Advocate Illinois Masonic's Community Health Council, a council comprised of community and internal representatives, conducts a Community Health Needs Assessment every three years to identify health needs for low income, and underserved communities and help identify programming to meet those needs with measurable impact. The 2019 CHNA Report: Illinois Masonic Medical Center identified behavioral health, healthy lifestyles, and social determinants of health as priority health needs for service development.

Other Community programs include:

- Cleveland Elementary School Obesity Program- partnership with a local school in the Avondale community to provide technical support around building and sustaining a healthy school environment for parents, teachers, and students.
- Community Pop-Up Farmers Markets- partnership with local community organizations to provide nutrition education and increase access to healthy foods through distributing produce boxes. The initiative distributed over 3,680 pounds of fresh produce to 900 individuals and families in food desert communities in 2020.
- Howard Brown partnership
- Workforce Development Program
- Advocate Workforce Initiative - Developed in 2017, provides support to our partnering job training programs and colleges:
    - Curriculum review of training and certifications -align with industry standards
    - Preferred access to internships and clinical rotations (depending on availability)
    - Job-readiness training workshops and on-campus workshops
    - Guaranteed HR interviews for participants who complete the AWI.
    - The Advocate Workforce Initiative (AWI) aims to also increase minority representation in the health care sector, enrolled 1,250 new program participants in 2020. Over 900 participants completed the program. In 2020, the

medical center's Community Heath and Advocate Workforce Development teams developed an employment and training program that provides paid externships to students completing training in entry level health care positions. The program focuses on students residing in communities with high unemployment rates and significant health disparities.

- Advocate Illinois Masonic Medical Center has a referral and coordination of care agreement with Heartland Health Centers, a FQHC offering a pediatric clinic and midwifery clinic in Uptown. A similar agreement with Infant Welfare Infant Welfare Society provides midwifery care to its patient base comprised of uninsured and Medicaid insured mostly immigrant families in Chicago.
- Senior Resource Fairs
- Food Pantry Program- I Advocate Illinois Masonic Medical Center partners with Lakeview Food Pantry to provide dry goods to food insecure patients. In addition, the medical center's food pantry, which began in 2016, distributed over 200 non-perishable food bags and 17 fresh produce boxes to 180 food insecure patients. To meet the needs of its community and patients during the COVID-19 pandemic, the medical center's food pantry expanded its services to team members and three new services lines and departments—OB/GYN, Family Medicine and the Dental Mobile Van.
- Mental Health First Aid- Community Health works with various community organizations and institutions to implement the mental health first aid training, which is a training that teaches people how to identify mental illness and what to do once they've identified this issue.
- Bridges of Hope- Community Health works with faith-based institutions in the community to provide mental health education and awareness to congregations and community members.
- Transition Support Program- This program helps increase access and transition to care through Patient Navigators, which work one-on-one with each patient to ensure access to follow-up care once discharged. Navigators also link patients to social service programs in the community to ensure patients' social barriers are being addressed. In 2020, the program served 1,245 unique patients.

Acclivus- This is a violence prevention/interruption program that works with ED patients who have been admitted due to violent trauma (e.g., gun violence, domestic violence, etc.).

- Advocate Aurora Health partnered with Acclivus in 2020 to provide violence intervention services to 117 medical center patients admitted to the ED due to domestic or community violence.

For more than 50 years, the Special Care Dentistry Program at Illinois Masonic Medical Center has provided quality and comprehensive oral health care to adults and children with developmental disabilities. There are few dentists with the skills to treat patients with these types of challenges in their offices. This program provides unique training to IMMC's

dental residents in treating this underserved population and instills in them the skills and compassion to continue such care post residency. In 2020, the Special Care Dentistry program served 1,099 unique patients and had 1,199 visits.

Since 1999, the Mobile Dentistry Program provides quality oral health care to underserved adults and children throughout Chicago, with limited access to care due to physical or financial barriers. This program focuses on senior citizens, people with disabilities and the homeless population. Partnering with 18 organizations, the custom mobile van travels to these partner sites to provide needed dental care for these populations. This program provides additional training to our dental residents in treating underserved populations. In 2020, the Mobile Dental Van served 352 unique patients and 727 visits.

The Dental Anesthesiology Residency Program provides advanced anesthesia training for licensed dentists. The goal is to improve access for pediatric and special needs patients, in need of necessary dental care, safely in the outpatient setting.

Advocate Illinois Masonic Medical Center participates in the Flexible Housing Pool; a collaborative effort in the City of Chicago to house homeless persons who have a heavy impact on emergency and hospital services. This housing first model can positively impact the health and wellbeing of these high residents. Advocate Aurora is currently a stakeholder in this 2-year project to house homeless patients that are treated at Advocate Illinois Masonic. The patients referred will be housed in scattered site permanent independent housing and will receive ongoing services from Advocate Illinois Masonic Medical Center's Medically Integrated Community Crisis Support Team.

In 2020, Advocate Illinois Masonic Medical Center placed individuals in permanent and transitional housing through its Flexible Housing Pool program. The program provides permanent housing to medical center's patients how are homeless and have high hospital readmission rates.

In addition, the medical center was involved in COVID-19 prevention and mitigation, implementing micro-mobile community COVID-19 testing, free testing, masks and mask education and materials.

In summary, the impact of the Medical Center is far reaching and is a critical organization supporting the communities of Chicago. The communities have come to rely on many of these programs outlined to meet the special needs of the population in the service area. Advocate Illinois Masonic Medical Center and team members are aware of changes in health care and in the community and have been developing new partnerships and services to support the health and wellbeing of all that they serve.

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.

See Attachment 38, Exhibit 1

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER CHARITY CARE			
	2018	2019	2020
Net Patient Revenue	$446,067,744	$464,043,788	$558,682,242
Amount of Charity Care (charges)	$37,705,943	$60,060,899	$16,519,416
Cost of Charity Care	$8,657,174	$13,202,987	$4,086,993

Source: Advocate Aurora Hospital records

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.

4. Applicant: Advocate Aurora Health Illinois Masonic Medical Center (Name) 836 West Wellington Ave (Address)

(City) Chicago (State) Illinois (ZIP Code) 60657 (Telephone Number)

5. Project Location: 900 West Nelson Street (Address) Chicago, Illinois (City) (State)

Cook (County) 40 North (Township) 29 (Section)

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

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

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

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

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

FIRM Panel Number: 17031C0417K (Panel 417 of 832) Effective Date: September 10, 2021

Name of Official: William Wood Title: Civil Engineer

Business/Agency: SmithGroup Address: 35 E. Wacker Dr., Suite 900

(City) Chicago (State) Illinois (ZIP Code) 60601 (Telephone Number) 312.641.6626

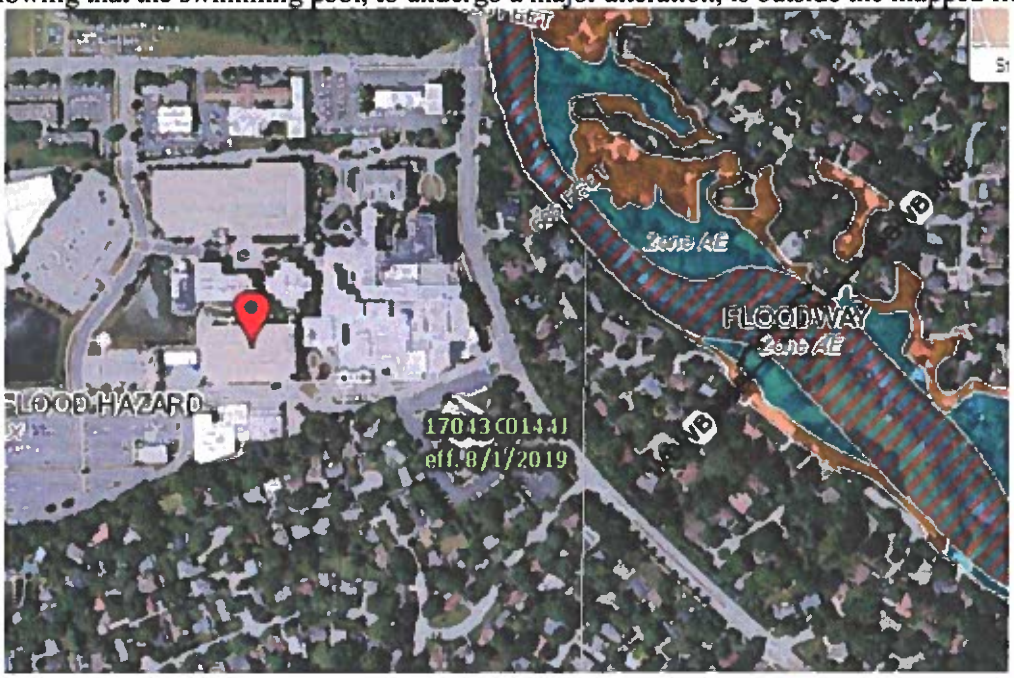
Signature: Date: February 8, 2022

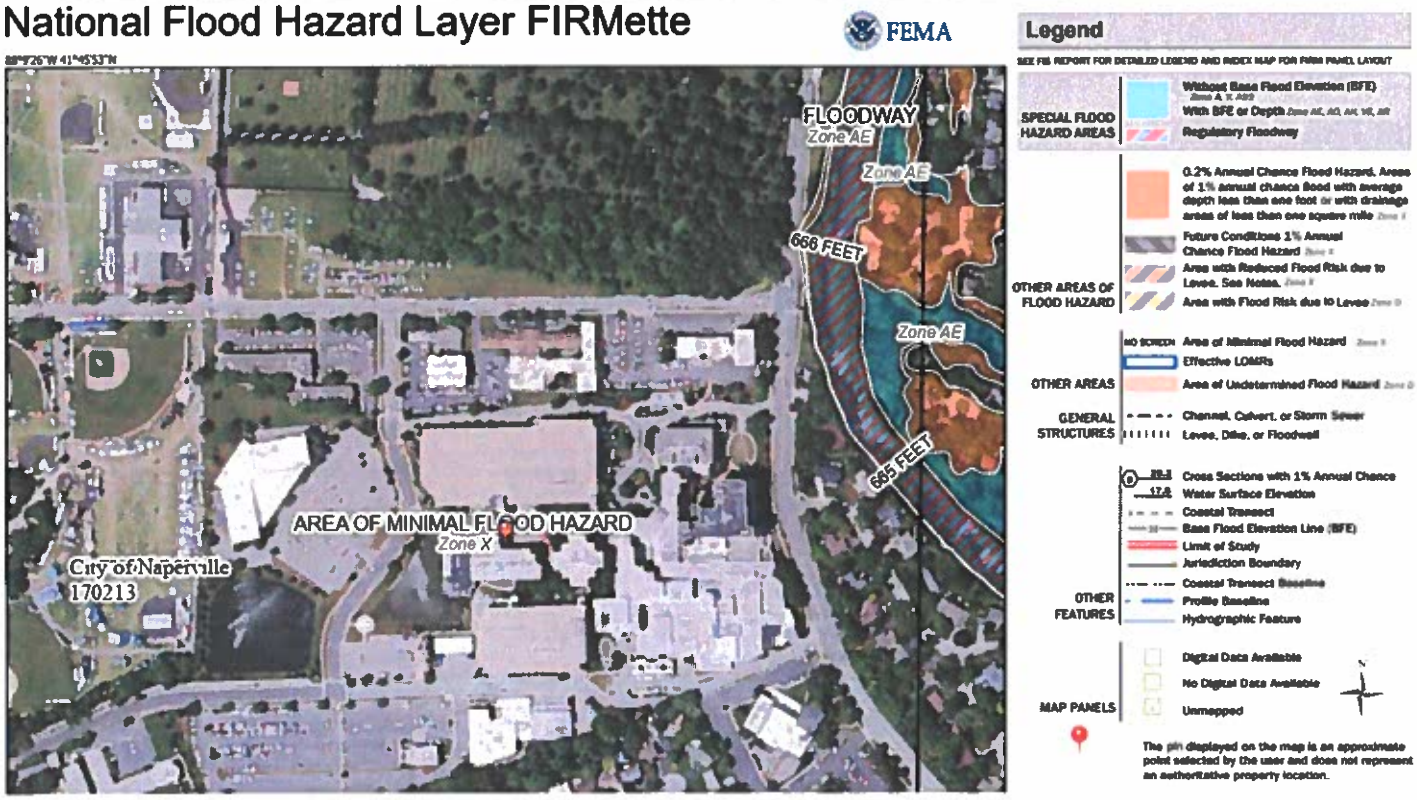
NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

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.





APPENDIX

Advocate Aurora Health, Inc.

Consolidated Financial Statements and Supplementary Information
As of and for the Years Ended December 31, 2020 and 2019

ADVOCATE AURORA HEALTH, INC.
TABLE OF CONTENTS

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Building a better working world

Ernst & Young LLP
155 North Wacker Drive
Chicago, IL 60606-1787

Tel: +1 312 879 2000
Fax: +1 312 879 4000
ey.com

Report of Independent Auditors

The Board of Directors
Advocate Aurora Health, Inc.

We have audited the accompanying consolidated financial statements of Advocate Aurora Health, Inc., which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Advocate Aurora Health, Inc. at December 31, 2020 and 2019, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

March 22, 2021

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED BALANCE SHEETS
(in thousands)

	December 31, 2020	December 31, 2019
Assets		
Current assets		
Cash and cash equivalents	$ 959,878	$ 449,712
Assets limited as to use	125,053	106,529
Patient accounts receivable	1,570,738	1,605,607
Other current assets	686,686	619,542
Third-party payors receivables	16,933	15,331
Collateral proceeds under securities lending program	19,789	18,284
Total current assets	3,379,077	2,815,005
Assets limited as to use	11,107,210	9,140,565
Property and equipment, net	5,851,977	5,901,923
Other assets		
Reinsurance receivable	50,514	52,312
Goodwill and intangible assets, net	82,752	76,830
Investments in unconsolidated entities	210,303	212,415
Operating lease right-of-use assets	309,678	352,295
Other noncurrent assets	458,132	382,024
Total other assets	1,111,379	1,075,876
Total assets	**$ 21,449,643**	**$ 18,933,369**

(Continued)

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED BALANCE SHEETS
(in thousands)

	December 31, 2020	December 31, 2019
Current liabilities		
Long-term debt and commercial paper, current portion	$ 101,996	$ 184,098
Long-term debt subject to short-term financing arrangements	119,660	147,535
Operating lease liabilities, current portion	79,934	77,957
Accrued salaries and employee benefits	1,207,672	950,391
Accounts payable and other accrued liabilities	1,341,619	912,644
Third-party payors payables	318,801	303,300
Accrued insurance and claim costs, current portion	130,391	114,741
Collateral under securities lending program	19,789	18,284
Total current liabilities	3,319,862	2,708,950
Noncurrent liabilities		
Long-term debt, less current portion	3,310,401	2,729,366
Operating lease liabilities, less current portion	268,575	314,106
Accrued insurance and claims cost, less current portion	593,739	544,839
Accrued losses subject to insurance recovery	50,514	52,312
Obligations under swap agreements	118,620	91,340
Other noncurrent liabilities	1,387,888	793,792
Total noncurrent liabilities	5,729,737	4,525,755
Total liabilities	**9,049,599**	**7,234,705**
Net assets		
Without donor restrictions		
Controlling interest	12,012,719	11,309,819
Noncontrolling interest in subsidiaries	154,645	146,740
Total net assets without donor restrictions	12,167,364	11,456,559
With donor restrictions	232,680	242,105
Total net assets	**12,400,044**	**11,698,664**
Total liabilities and net assets	**$ 21,449,643**	**$ 18,933,369**

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(in thousands)

	Year Ended December 31, 2020	Year Ended December 31, 2019
Revenue		
Patient service revenue	$ 10,216,386	$ 10,660,969
Capitation revenue	1,121,428	1,264,162
Other revenue	1,794,375	880,292
Total revenue	13,132,189	12,805,423
Expenses		
Salaries, wages and benefits	7,427,903	6,988,562
Supplies, purchased services and other	4,200,203	3,999,005
Contracted medical services	502,420	543,716
Depreciation and amortization	560,215	569,956
Interest	112,126	106,314
Total expenses	12,802,867	12,207,553
Operating income before nonrecurring expenses	**329,322**	**597,870**
Nonrecurring expenses	116,355	116,800
Operating income	**212,967**	**481,070**
Nonoperating income (loss)		
Investment income, net	593,283	1,053,898
Loss on debt refinancing	(12,244)	(21,665)
Change in fair value of interest rate swaps	(27,280)	(21,079)
Pension settlement loss	(119,658)	—
Other nonoperating (loss) income, net	(38,943)	54,473
Total nonoperating income, net	395,158	1,065,627
Revenue in excess of expenses	608,125	1,546,697
Less noncontrolling interest	(50,093)	(60,749)
Revenue in excess of expenses - attributable to controlling interest	**$ 558,032**	**$ 1,485,948**

(Continued)

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(in thousands)

	Year Ended December 31, 2020	Year Ended December 31, 2019
Net assets without donor restrictions, controlling interest		
Revenue in excess of expenses - attributable to controlling interest	$ 558,032	$ 1,485,948
Pension-related changes other than net periodic pension costs	138,208	(106,221)
Net assets released from restrictions for purchase of property and equipment	6,206	4,839
Other, net	454	1,108
Increase in net assets without donor restrictions, controlling interest	702,900	1,385,674
Net assets without donor restrictions, noncontrolling interest		
Revenues in excess of expenses	50,093	60,749
Distributions to noncontrolling interest	(41,948)	(32,488)
Other, net	(240)	11
Increase in net assets without donor restrictions, noncontrolling interest	7,905	28,272
Net assets with donor restrictions		
Contributions	22,971	27,627
Investment income, net	9,948	14,400
Net assets released from restrictions for operations	(17,074)	(18,596)
Net assets released from restrictions for purchase of property and equipment	(6,206)	(4,839)
Central IL net assets with donor restrictions sold	(18,949)	—
Other, net	(115)	(278)
(Decrease) increase in net assets with donor restrictions	(9,425)	18,314
Increase in net assets	**701,380**	**1,432,260**
Net assets at beginning of period	11,698,664	10,242,977
Adoption of ASC 2016-02 (Leases)	—	23,427
Net assets at end of period	**$ 12,400,044**	**$ 11,698,664**

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Year Ended December 31, 2020	Year Ended December 31, 2019
Cash flows from operating activities		
Increase in net assets	$ 701,380	$ 1,432,260
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation, amortization and accretion	555,515	564,270
Amortization of operating lease right-of-use assets	63,840	64,801
Loss on debt refinancing	12,244	21,665
Loss on sale of property and equipment	12,571	2,618
Change in fair value of swap agreements	27,280	21,079
Pension-related changes other than net periodic pension cost	(138,208)	106,221
Net assets released from restrictions for operations	(17,074)	(18,596)
Distribution to noncontrolling interest	50,205	29,446
Distributions from unconsolidated entities	14,951	23,707
Gain on Bay Area Medical Center acquisition	—	(81,736)
Loss on sale of Central IL disposal group	21,346	—
Central IL net assets with donor restrictions sold	18,949	—
Changes in operating assets and liabilities		
Trading securities, net	(2,025,066)	(1,433,305)
Accounts receivable, net	31,871	(103,625)
Accounts payable and accrued liabilities	1,006,265	203,877
Third-party payors receivables and payables, net	16,896	1,640
Other assets and liabilities, net	240,620	(280,549)
Net cash provided by operating activities	593,585	553,773
Cash flows from investing activities		
Capital expenditures	(703,611)	(653,207)
Proceeds from sale of property and equipment	1,998	4,102
Sales of investments designated as non-trading, net	241	69
Investments in unconsolidated entities, net	(8,016)	(31,005)
Investments acquired in Bay Area Medical Center acquisition	—	34,018
Cash received from sale of Central IL disposal group	190,000	—
Other	(15,879)	(7,534)
Net cash used in investing activities	(535,267)	(653,557)
Cash flows from financing activities		
Proceeds from issuance of debt	695,915	496,074
Repayments of long-term debt	(226,781)	(544,046)
Distribution to noncontrolling interest	(50,205)	(29,446)
Proceeds from restricted contributions and income (loss) on investments	32,919	42,027
Net cash provided by (used in) financing activities	451,848	(35,391)
Net increase (decrease) in cash and cash equivalents	**510,166**	**(135,175)**
Cash and cash equivalents at beginning of period	449,712	584,887
Cash and cash equivalents at end of period	**$ 959,878**	**$ 449,712**
Supplemental disclosures of noncash information		
Operating lease right-of-use assets in exchange for new operating lease liabilities	$ 24,272	$ 425,142

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
FOR THE YEAR ENDED DECEMBER 31, 2020
(dollars in thousands)

1. ORGANIZATION AND BASIS OF PRESENTATION

Description of Business

Advocate Aurora Health, Inc., is a Delaware nonprofit corporation (the "Parent Corporation"). The Parent Corporation is the sole corporate member of Advocate Health Care Network, an Illinois not-for-profit corporation ("Advocate") and Aurora Health Care, Inc., a Wisconsin nonstock not-for-profit corporation ("Aurora"). The Parent Corporation, Advocate, Aurora and their controlled subsidiaries are collectively referred to herein as the "System." The System was formed in furtherance of the parties' common and unifying charitable health care mission to promote and improve the quality and expand the scope and accessibility of affordable health care and health care-related services for the communities they serve.

The System is comprised of various not-for-profit and for-profit entities, the primary activities are the delivery of health care services and the provision of goods and services ancillary thereto.

The System provides a continuum of care through its 24 acute care hospitals, an integrated children's hospital and a psychiatric hospital, primary and specialty physician services, outpatient centers, physician office buildings, pharmacies, rehabilitation and home health and hospice care in northern and central Illinois and eastern Wisconsin.

On April 1, 2019, the System became the sole corporate member of Bay Area Medical Center ("BAMC") through the acquisition of the remaining 51% interest in BAMC and its results have been fully consolidated into the consolidated financial statements of the System as of this date. The acquisition will improve the availability, scope and access to health care in the communities served by BAMC.

Principles of Consolidation

Included in the System's consolidated financial statements are all of its wholly owned or controlled subsidiaries. All significant intercompany transactions have been eliminated in consolidation.

2. SIGNIFICANT EVENTS

Due to the COVID-19 pandemic, the behavior of businesses and people globally was altered in a manner that had a negative impact on global and local economies including significant investment market volatility, various temporary business closures resulting in increased unemployment and other effects which have and could continue to result in supply disruptions, lower collections on patient accounts receivable and/or decisions to defer medical treatments at the System's facilities.

At various times in 2020 and at various locations the System postponed or canceled elective procedures to comply with public health protocols. This, along with the growth in the volume of COVID-19 patients, had a negative impact on operations and revenues and has also caused the System to estimate the timing, source and rate of reimbursement for COVID-19 related patient care.

The total impact of the COVID-19 pandemic on the System is difficult to predict and could adversely impact the business, investment portfolio, financial condition or results of operations and, accordingly,

may have a material adverse impact on the financial condition of the System. The System is monitoring liquidity and cash flow and has taken, and will continue to take, steps to protect its fiscal health, including a focus on maintaining liquidity to meet its obligations. In addition, the System has applied for certain COVID-19 related resources, including supplies, financial support, payroll tax deferrals and relief and other assistance made available through local, state and federal governments.

As of December 31, 2020, the System received $786,655 in grant payments from the U.S. Department of Health and Human Services ("HHS") from the Provider Relief Fund established under the Coronavirus Aid, Relief and Economic Security Act ("CARES Act"), which has been recognized as revenue and included in other operating revenue within the consolidated statement of operations and changes in net assets. Payments from the Provider Relief Fund are intended to cover unreimbursed healthcare related expenses and lost revenue from patient care attributed to COVID-19 and are not required to be repaid provided the recipient attests to and complies with the terms and conditions of the grant funds. Management of the System believes the System is in compliance with the terms and conditions of the Provider Relief Fund distributions and will continue to monitor compliance. The CARES Act also entitled eligible employers to an employee retention tax credit designed to encourage employers to keep employees on their payroll. The refundable tax credit is limited to 50% of up to $10 in qualified wages paid to each employee by an eligible employer whose business had been financially impacted by COVID-19. As of December 31, 2020, the System recognized approximately $37,000 of revenue for the employee retention tax credit, which is included in other operating revenue within the consolidated statement of operations and changes in net assets and a corresponding receivable that is included in other current assets in the consolidated balance sheets. The recognition of the COVID-19 falls under the grant accounting guidance of accounting principles generally accepted in the United States. This guidance requires all significant terms and conditions to have been met for recognition to occur. Management of the System will continue to monitor compliance with the terms and conditions of the CARES Act grant funds and the impact of the pandemic on the System's revenues and expenses.

In addition, the System received approximately $773,000 from the Centers for Medicare and Medicaid Services ("CMS") as an advance payment for Medicare services during 2020. The funds are provided through the expansion of the Medicare Accelerated and Advance Payment Program to ensure providers and suppliers have the resources needed to combat the COVID-19 pandemic. The advances will be recouped by withholding future Medicare fee-for-service payments for claims until the full accelerated payment has been recouped, unless the System elects to repay the advances prior to full recoupment. Recoupments are scheduled to begin in April 2021. Subsequent to the twenty-nine month recoupment period any unpaid remaining balance is subject to an interest charge of 4 percent per annum. Medicare accelerated and advance payments of approximately $285,000 and $488,000 are included in accounts payable and other accrued liabilities and other noncurrent liabilities, respectively, within the consolidated balance sheets at December 31, 2020. The CARES Act also permitted employers to defer the employer portion of social security taxes through December 31, 2020. Employers are required to remit one-half of the amount deferred by December 31, 2021 and the remaining half by December 31, 2022. Through December 31, 2020, the System deferred approximately $215,000 of these taxes. At December 31, 2020, approximately $107,500 is included in accrued salaries and employee benefits and other noncurrent liabilities, respectively, within the consolidated balance sheets.

On July 1, 2020, the System sold a majority of the assets and certain liabilities (the "disposal group") related to operations of the System in Central Illinois. The disposal group had assets sold in excess of liabilities transferred of $205,273, consisting primarily of property and equipment and certain investment interests in unconsolidated entities. The purchase price for the disposal group was $190,000. The System recorded a loss, inclusive of selling costs, of $21,346 that is included in nonrecurring expenses in the consolidated statements of operations and changes in net assets.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates, assumptions and judgments that affect the reported amounts of assets, liabilities and amounts disclosed in the notes to the consolidated financial statements at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Cash Equivalents

The System considers all highly liquid investments with a maturity of three months or less when purchased, other than those included in the investment portfolio, to be cash equivalents.

Investments

The System has designated substantially all of its investments as trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices or otherwise observable inputs. Investments in private equity limited partnerships and derivative products (hedge funds) are reported at fair value using net asset value as a practical expedient. Commingled funds are carried at fair value based on other observable inputs. Investment income or loss (including realized gains and losses, interest, dividends and unrealized gains and losses) is included in the nonoperating section of the consolidated statements of operations and changes in net assets, unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue in the accompanying consolidated statements of operations and changes in net assets. Investment income that is restricted by donor or law is reported as a change in net assets with donor restrictions.

Assets Limited as to Use

Assets limited as to use consist of investments set aside by the System for future capital improvements and certain medical education and other health care programs. The System retains control of these investments and may, at its discretion, subsequently use them for other purposes. Additionally, assets limited as to use include investments held by trustees or in trust under debt agreements, self-insurance trusts, assets held in reinsurance trust accounts and donor-restricted funds.

Patient Service Revenue and Accounts Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including managed care payors and government programs and excludes revenues for services provided to patients under capitated arrangements) and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, patients and third-party payors are billed within days after the services are performed or after discharge. Revenue is recognized as performance obligations are satisfied. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and final settlements are determined.

As the System's performance obligations relate to contracts with a duration of less than one year, the System has applied the optional exemption provided in the guidance and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

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.

The System has entered into payment arrangements with patients that allow for payments over a term in excess of one year. The System has evaluated historical collections in excess of one year and current market interest rates to determine whether a significant financing component exists that would require an adjustment to the promised amount of consideration from patients and third-party payors. The System has determined that the impact of implicit financing arrangements for payment agreements in excess of one year is insignificant to the consolidated statements of operations and changes in net assets.

The System does not incur significant incremental costs in obtaining contracts with patients. Any costs incurred are expensed in the period of occurrence, as the amortization period of any asset that the System would have recognized is one year or less in duration.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is a possibility that recorded estimates will change by a material amount.

Inventories

Inventories, consisting primarily of medical supplies, pharmaceuticals and durable medical equipment, are stated at the lower of cost (first-in, first-out) or market. Retail pharmaceutical inventories are stated at replacement cost.

Reinsurance Receivables

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Goodwill and Intangible Assets, Net

Goodwill of $63,740 and $62,172 is included in goodwill and intangible assets, net in the accompanying consolidated balance sheets as of December 31, 2020 and 2019, respectively. In 2019, the System elected to amortize goodwill prospectively using the straight-line method over a 10-year period in accordance with Accounting Standards Update ("ASU") 2019-06. Goodwill amortization of $7,255 and $6,982 is included in depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets for the years ended December 31, 2020 and 2019, respectively. Intangible assets with expected useful lives are amortized over that period.

Asset Impairment

The System considers whether indicators of impairment are present and, if indicators are present, performs the necessary tests to determine if the carrying value of an asset is recoverable. Impairment write-downs are recognized in the accompanying consolidated statements of operations and changes in net assets as a component of operating expense at the time the impairment is identified. There were no material impairment charges recorded for the years ended December 31, 2020 and 2019.

Property and Equipment, Net

Property and equipment are reported at cost or, if donated, at fair value at the date of the gift. Costs of computer software developed or obtained for internal use, including external and internal direct costs of materials and labor directly associated with internal-use software development projects, are capitalized during the application development stage and included in property and equipment. Internal labor and interest expense incurred during the period of construction of significant capital projects are capitalized as a component of the costs of the asset.

Property and equipment capitalized under direct financing leases are recorded at the present value of future lease payments, adding initial direct costs and prepaid lease payments, reduced by any lease incentives. Property and equipment capitalized under direct financing leases are amortized using the straight-line method over the related lease term. Amortization of property and equipment under financing leases is included in the accompanying consolidated statements of operations and changes in net assets in depreciation and amortization expense.

Property and equipment assets are depreciated on the straight-line method over a period ranging from 3 years to 80 years.

Operating Lease Right-of-use Assets

The System records an operating lease right-of-use asset (an asset that represents the System's right to use the leased asset for the lease term) for leases that do not meet the criteria as a sales-type lease or a direct financing lease.

The System records operating lease right-of-use assets at the present value of future lease payments, adding initial direct costs and prepaid lease payments, reduced by any lease incentives. Operating lease right-of-use assets are amortized using the straight-line method over the related lease term. Amortization of operating lease right-of-use assets is included in the accompanying consolidated statements of operations and changes in net assets in supplies, purchased services and other expense.

Included within operating lease right-of-use assets are assets that the System previously sold and then leased back. Those sale/leaseback transactions, which related to various administrative and medical support buildings, did not meet the accounting criteria as a sales-type lease or a direct financing lease. The buyer-lessors for such transactions are generally unrelated special-purpose entities.

Investments in Unconsolidated Entities

Investments in unconsolidated entities are accounted for using the cost or equity method. The System applies the equity method of accounting for investments in unconsolidated entities when its ownership or membership interest is 50% or less and the System has the ability to exercise significant influence over the operating and financial policies of the investee. All other unconsolidated entities are accounted for using the cost method. The income (loss) on health-related unconsolidated entities is included in other revenue in the accompanying consolidated statements of operations and changes in

net assets. The income or loss on non-health-related unconsolidated entities is included within other nonoperating (loss) income, net.

Derivative Financial Instruments

The System has entered into transactions to manage its interest rate, credit and market risks. Derivative instruments, including exchange-traded and over-the-counter derivative contracts and interest rate swaps, are recorded as either assets or liabilities at fair value. Subsequent changes in a derivative's fair value are recognized in nonoperating (loss) income, net.

Bond Issuance Costs, Discounts and Premiums

Bond issuance costs, discounts and premiums are amortized over the term of the bonds using the effective interest method and are included in long-term debt, less current portion in the accompanying consolidated balance sheets.

General and Professional Liability Risks

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The System measures the cost of its unfunded obligations under such programs based upon actuarial calculations and records a liability on a discounted basis.

Net Assets With Donor Restrictions

Net assets with donor restrictions are those assets whose use by the System has been limited by donors to a specific time period or purpose or consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity. Net assets with donor restrictions are used in accordance with the donor's wishes primarily to purchase property and equipment, to fund medical education or to fund health programs.

Assets released from restrictions to fund purchases of property and equipment are reported in the accompanying consolidated statements of operations and changes in net assets as increases to net assets without donor restrictions. Those assets released from restriction for operating purposes are reported in the accompanying consolidated statements of operations and changes in net assets as other revenue. When restricted, earnings are recorded as net assets with donor restrictions until amounts are expended in accordance with the donor's specifications.

Nonrecurring Expenses

The System has incurred salaries, purchased services and other expenses in connection with the formation of the System, the implementation of an electronic medical records and billing system, the implementation of an enterprise resource planning system and, as part of the initiative to reduce operating expenses, an early retirement incentive program and position restructuring. Also recorded in nonrecurring expenses is the loss incurred on the divestiture of Central Illinois disposal group (see Note 2. SIGNIFICANT EVENTS). Due to the nature of these expenses, the costs were recorded as nonrecurring in the accompanying consolidated statements of operations and changes in net assets.

Other Nonoperating (Loss) Income, Net

Revenues and expenses from delivering health care services and the provision of goods and services ancillary thereto are reported in operations. Income and losses that arise from transactions that are

peripheral or incidental to the System's main purpose are included in other nonoperating (loss) income, net. Other nonoperating (loss) income, net primarily consists of a gain on the acquisition of BAMC, fund-raising expenses, contributions to charitable organizations, income taxes and the net non-service components of the periodic benefit expense on the System's pension plans.

Revenue in Excess of Expenses and Changes in Net Assets

The accompanying consolidated statements of operations and changes in net assets include the revenue in excess of expenses as the performance indicator. Changes in net assets without donor restrictions, which are excluded from revenue in excess of expenses, primarily include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), pension-related changes other than net periodic pension costs and distributions to noncontrolling interests.

Accounting Pronouncements Adopted

In February 2016, the Financial Accounting Standards Board ("FASB") issued ASU 2016-02, *Leases* (Topic 842). This guidance introduced a lessee model that brings most leases on to the balance sheet. The standard also aligns certain of the underlying principles of the new lessor model with those in ASU 2014-09, the revenue recognition standard. This standard was adopted by the System effective January 1, 2019, using the modified retrospective approach. The System elected the package of practical expedients permitted under the transition guidance within the new standard, which among other things, allowed the System to carry forward the historical lease classification.

The System recorded a right-of-use asset of $388,097, which is net of tenant improvements previously recorded prior to adoption, and right-of-use liabilities of $426,794 due to the adoption of this standard on January 1, 2019. Additionally, the System recognized a cumulative-effect adjustment of $23,427 to net assets without donor restrictions on January 1, 2019, related to the deferred gains on various sale-leaseback transactions.

In August 2018, the FASB issued ASU 2018-15, *Intangibles-Goodwill and Other-Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. This guidance requires an entity in a hosting arrangement that is a service contract to follow the guidance in Subtopic 350-40 to determine which implementation costs to capitalize as an asset and which costs to expense as incurred. Also, this guidance requires the entity to expense the capitalized implementation costs of a hosting arrangement that is a service contract over the term of the hosting arrangement. Further, the guidance requires the entity to present the expense related to the capitalized implementation costs in the same line item in the consolidated statements of operations and changes in net assets as the fees associated with the hosting element (service) of the arrangement and classify payments for capitalized implementation costs in the consolidated statements of cash flows in the same manner as payments made for fees associated with the hosting element. The entity is also required to present the capitalized implementation costs in the consolidated balance sheets in the same line item that a prepayment for the fees of the associated hosting arrangement would be presented. This guidance is effective for the fiscal years beginning after December 15, 2020, and interim periods within annual periods beginning after December 15, 2021. Early adoption is permitted. The System early adopted this guidance effective January 1, 2019, on a prospective basis. This guidance did not have a material impact on the System's accompanying consolidated financial statements.

4. COMMUNITY BENEFIT

The System provides health care services without charge to patients who meet the criteria of its charity care policies. Charity care services are not reported as patient service revenue, because payment is not anticipated while the related costs to provide the health care are included in operating expenses. Charity care is provided to patients who meet the criteria established under the applicable financial assistance policy. Qualifying patients can receive up to 100% discounts from charges and extended payment plans. The System's cost of providing charity care was $106,789 and $153,307 for the years ended December 31, 2020 and 2019, respectively, as determined using total cost to charge ratios.

In addition to the provision of charity care, the System provides significant financial support to its communities to sustain and improve health care services.

These activities include:

- The unreimbursed cost of providing care to patients covered by the Medicare and Medicaid programs.
- The cost of providing services that are not self-sustaining, for which patient service revenues are less than the costs required to provide the services. Such services benefit uninsured and low-income patients, as well as the broader community, but are not expected to be financially self-supporting.
- Other community benefits include the unreimbursed costs of community benefits programs and services for the general community, not solely for those demonstrating financial need, including the unreimbursed cost of medical education, health education, immunizations for children, support groups, health screenings and fairs.

5. REVENUE AND RECEIVABLES

Patient service revenue

Patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including managed care payors and government programs and excludes revenues for services provided to patients under capitated arrangements) and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, patients and third-party payors are billed shortly after discharge. Revenue is recognized as performance obligations are satisfied.

Performance obligations are identified based on the nature of the services provided. Revenue associated with performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. Performance obligations satisfied over time relate to patients receiving inpatient acute care services. The System measures the performance obligation from admission into the hospital to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services, the performance obligation is satisfied as the patient simultaneously receives and consumes the benefits provided as the services are performed. In the case of these outpatient services, recognition of the obligation over time yields the same result as recognizing the obligation at a point in time. Management believes this method provides a faithful depiction of the transfer of services over the term of performance obligations based on the inputs needed to satisfy the obligations.

The System uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The portfolios consist of major

payor classes for inpatient revenue and major payor classes and types of services provided for outpatient revenue. Based on the historical collection trends and other analyses, the System believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

The System determines the transaction price, which involves significant estimates and judgment, based on standard charges for goods and services provided, reduced by explicit and implicit price concessions, including contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with policy and/or implicit price concessions based on the historical collection experience of patient accounts. The System determines the transaction price associated with services provided to patients who have third-party payor coverage based on reimbursement terms per contractual agreements, discount policies and historical experience. For uninsured patients who do not qualify for charity care, the System determines the transaction price associated with services based on charges reduced by implicit price concessions. Implicit price concessions included in the estimate of the transaction price are based on historical collection experience for applicable patient portfolios. Patients who meet the System's criteria for charity care are provided care without charge; such amounts are not reported as revenue. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreements 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 new information becomes available or as years are settled or are no longer subject to such audits, reviews and investigations.

For the years ended December 31, 2020 and 2019, changes in the System's estimates of implicit price concessions, discounts and contractual adjustments or other reductions to expected payments for performance obligations related to prior years were not significant.

In the normal course of business, the System does receive payments in advance for certain services provided and would consider these amounts to represent contract liabilities. The amounts received in the normal course of business at December 31, 2020 and 2019 were not material. In 2020 the CMS accelerated and advance payments received in relation to the COVID-19 pandemic for Medicare services are deemed contract liabilities at December 31, 2020. See Note 2. SIGNIFICANT EVENTS.

Currently, the State of Illinois utilizes supplemental reimbursement programs to increase reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the CMS and are funded with a combination of state and federal resources, including assessments levied on the providers. Under these supplemental programs, the System recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement and the assessment under these programs are reflected in the accompanying consolidated statements of operations and changes in net assets are as follows:

	Classification	Year Ended December 31, 2020	Year Ended December 31, 2019
Reimbursement	Patient service revenue	$ 286,105	$ 271,260
Assessment	Supplies, purchased services and other	171,312	165,222

The State of Wisconsin assesses a fee or tax on gross patient service revenue. The revenues from this assessment are used to increase payments made to hospitals for services provided to Medicaid and other medically indigent patients. The System's patient service revenue reflects this increase in payment for services to Medicaid and other medically indigent patients and hospital tax assessment expense reflects the fees assessed by the State. Reimbursement and the assessment under these programs are reflected in the accompanying consolidated statements of operations and changes in net assets are as follows:

	Classification	Year Ended December 31, 2020	Year Ended December 31, 2019
Reimbursement	Patient service revenue	$ 137,317	$ 117,150
Assessment	Supplies, purchased services and other	101,477	100,777

Management has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payor's geographical location, the line of business that renders services to patients and the timing of when revenue is recognized and billed.

The composition of patient service revenue by payor is as follows:

	Year Ended December 31, 2020		Year Ended December 31, 2019	
Managed care	$ 5,521,363	53 %	$ 5,829,566	55 %
Medicare	3,124,812	31 %	3,380,458	31 %
Medicaid - Illinois	773,851	8 %	694,406	7 %
Medicaid - Wisconsin	481,215	5 %	457,583	4 %
Self-pay and other	315,145	3 %	298,956	3 %
	$ 10,216,386	100 %	$ 10,660,969	100 %

Deductibles, copayments and coinsurance under third-party payment programs which are the patient's responsibility are included within the primary payor category in the table above.

Capitation Revenue

The System has agreements with various managed care organizations under which the System provides or arranges for medical care to members of the organizations in return for a monthly payment per member. Revenue is earned each month as a result of the System agreeing to provide or arrange for their medical care.

Other Revenue

Other revenue is recognized at an amount that reflects the consideration to which the System expects to be entitled in exchange for providing goods and services. The amounts recognized reflect consideration due from customers, third-party payors and others. Primary categories of other revenue include grant revenues from the CARES Act, income from joint ventures, retail pharmacy revenue, grant revenue, cafeteria revenue, rent revenue and other miscellaneous revenue.

Revenue disaggregation by state and business line are as follows:

	Year Ended December 31, 2020	Year Ended December 31, 2019
Illinois	$ 5,713,977	$ 6,086,737
Wisconsin	5,623,837	5,838,394
Total patient service revenue and capitation	11,337,814	11,925,131
Other revenue	1,794,375	880,292
Total revenue	$ 13,132,189	$ 12,805,423
Hospital	$ 7,611,197	$ 7,859,715
Clinic	2,231,783	2,450,681
Home Care	240,043	241,151
Other	133,363	109,422
Total patient service revenue	10,216,386	10,660,969
Capitated revenue	1,121,428	1,264,162
Other revenue	1,794,375	880,292
Total revenue	$ 13,132,189	$ 12,805,423

Patient accounts receivable

The System's patient accounts receivable is reported at the amount that reflects the consideration to which it expects to be entitled, in exchange for providing patient care. Patient accounts receivable are reported at net realizable value based on certain assumptions. For third-party payors, including Medicare, Medicaid and Managed Care, the net realizable value is based on the estimated contractual reimbursement percentage, which is based on current contract prices or historical paid claims data by payor. For self-pay, the net realizable value is determined using estimates of historical collection experience including an analysis by aging category. These estimates are adjusted for expected recoveries and any anticipated changes in trends, including significant changes in payor mix and economic conditions or trends in federal and state governmental health care coverage.

The composition of patient accounts receivable is summarized as follows:

	December 31, 2020		December 31, 2019	
Managed care	$ 681,078	43 %	$ 698,731	44 %
Medicare	350,948	22 %	327,723	20 %
Medicaid - Illinois	188,280	12 %	216,618	13 %
Medicaid - Wisconsin	41,694	3 %	44,357	3 %
Self-pay and other	308,738	20 %	318,178	20 %
	$ 1,570,738	100 %	$ 1,605,607	100 %

The self-pay patient accounts receivable above includes amounts due from patients for co-insurance, deductibles, installment payment plans and amounts due from patients without insurance.

6. INVESTMENTS

The System invests in a diversified portfolio of investments, including alternative investments, such as real asset funds, hedge funds and private equity limited partnerships, whose fair value was $4,504,346 and $4,123,306 at December 31, 2020 and 2019, respectively. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods typically ranging from 1 to 90 days. Certain of these investments have redemption restrictions that may restrict redemption for up to 11 years.

However, the potential for the System to sell its interest in these funds in a secondary market prior to the end of the fund term does exist for prices at or other than the carrying value.

At December 31, 2020, the System had additional commitments to fund alternative investments, including recallable distributions of $1,406,684 over the next seven years.

In the normal course of operations and within established investment policy guidelines, the System may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the System's strategic asset allocation. These instruments require the System to deposit cash or securities collateral with the broker or custodian. Collateral provided was $13,031 and $6,770 at December 31, 2020 and 2019, respectively. The notional value of the derivatives in long positions was $241,232 and $104,072 at December 31, 2020 and 2019, respectively. The notional value of the derivatives in a short position was $(91,862) and $(58,527) at December 31, 2020 and 2019, respectively.

By using derivative financial instruments, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty and, therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in the underlying reference security. The market risk associated with market changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Receivables and payables for investment trades not settled are presented with other current assets and accounts payable and other accrued liabilities in the accompanying consolidated balance sheets. Unsettled sales resulted in receivables due from brokers of $49,512 and $38,355 at December 31, 2020 and 2019, respectively. Unsettled purchases resulted in payables of $88,890 and $41,977 at December 31, 2020 and 2019, respectively.

Investment returns for assets limited as to use and cash and cash equivalents are composed of the following:

	Year Ended December 31, 2020	Year Ended December 31, 2019
Interest income and dividends	$ 83,232	$ 84,684
Income from alternative investments	51,675	333,212
Net realized gains	41,293	150,422
Net unrealized gains	476,794	553,287
Total	$ 652,994	$ 1,121,605

Investment returns are included in the accompanying consolidated statements of operations and changes in net assets as follows:

	Year Ended December 31, 2020	Year Ended December 31, 2019
Other revenue	$ 49,763	$ 53,307
Investment income, net	593,283	1,053,898
Net assets with donor restrictions	9,948	14,400
Total	$ 652,994	$ 1,121,605

The cash and cash equivalents and assets limited as to use presented within the accompanying consolidated balance sheets are comprised of the following:

	December 31, 2020	December 31, 2019
Internally designated for capital and other	$ 10,291,819	$ 8,345,172
Held for self-insurance	658,466	645,697
Donor restricted	137,980	132,024
Investments under securities lending program	18,945	17,672
Total noncurrent assets limited as to use	11,107,210	9,140,565
Cash and cash equivalents	959,878	449,712
Current assets limited as to use	125,053	106,529
Total cash and cash equivalents and assets limited as to use	$ 12,192,141	$ 9,696,806

As part of the management of the investment portfolio, the System has entered into an arrangement whereby securities owned by the System are loaned primarily to brokers and investment banks. The loans are arranged through a bank. Borrowers are required to post collateral for securities borrowed equal to no less than 102% of the value of the security on a daily basis, at a minimum. The bank is responsible for reviewing the creditworthiness of the borrowers. The System has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At December 31, 2020 and 2019, the System loaned $18,945 and $17,672, respectively, in securities and accepted collateral for these loans in the amount $19,789 and $18,284, respectively, which represents cash and governmental securities, and are included in current liabilities and current assets, respectively, in the accompanying consolidated balance sheets.

7. FAIR VALUE

The System accounts for certain assets and liabilities at fair value and categorizes assets and liabilities measured at fair value in the accompanying consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are 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 pricing the asset or liability, based on the best information available under the circumstances.

The fair value of all assets and liabilities recognized or disclosed at fair value are classified based on the lowest level of significant inputs. Assets and liabilities that are measured at fair value are disclosed and classified in one of the three categories. Category inputs are defined as follows:

Level 1 — Quoted prices (unadjusted) in active markets for identical assets or liabilities on the reporting date.

Level 2 — Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 — Inputs that are unobservable for the asset or liability for which there is little or no market data.

The following section describes the valuation methodologies used by the System to measure financial assets and liabilities at fair value. In general, where applicable, the System uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments, such as domestic and international equities, exchange-traded funds and agency securities.

If quoted prices in active markets for identical assets and liabilities are not available to determine the fair value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, fixed- income securities, including fixed-income government obligations, commercial paper and certain agency, United States and international equities, which are not traded on an active exchange. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry-standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include adjustments related to the System's credit risk.

Investments owned by the System are exposed to various kinds and levels of risk. Equity securities and equity funds expose the entity to market risk, performance risk and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is the risk associated with a company's operating performance. Fixed-income securities and fixed-income mutual funds expose the System to interest rate risk, credit risk and liquidity risk. As interest rates change, the value of many fixed-income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value, resulting in additional gains and losses in the near term.

The carrying values of cash and cash equivalents, accounts receivable and payable, other current assets and accrued liabilities are reasonable estimates of their fair values, due to the short-term nature of these financial instruments.

The fair values of financial assets and liabilities that are measured at fair value on a recurring basis are as follows:

	December 31, 2020	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments				
Cash and short-term investments	$ 1,861,490	$ 1,296,986	$ 564,504	$ —
Corporate bonds and other debt securities	705,552	—	705,552	—
United States government bonds	615,723	—	615,723	—
Bond and other debt security funds	1,325,705	73,668	1,252,037	—
Non-government fixed-income obligations	18,944	—	18,944	—
Equity securities	826,194	826,194	—	—
Equity funds	2,307,912	143,521	2,164,391	—
	7,661,520	$ 2,340,369	$ 5,321,151	$ —
Investments at net asset value				
Alternative investments	4,530,621			
Total investments	$ 12,192,141			
Collateral proceeds received under securities lending program	$ 19,789		$ 19,789	
Liabilities				
Obligations under swap agreements	$ (118,620)		$ (118,620)	
Obligations to return capital under securities lending program	$ (19,789)		$ (19,789)	

	December 31, 2019	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments				
Cash and short-term investments	$ 909,297	$ 872,262	$ 37,035	$ —
Corporate bonds and other debt securities	582,327	—	582,327	—
United States government bonds	583,429	—	583,429	—
Bond and other debt security funds	688,728	102,555	586,173	—
Non-government fixed-income obligations	26,176	—	26,176	—
Equity securities	782,581	782,581	—	—
Equity funds	1,976,779	134,951	1,841,828	—
	5,549,317	$ 1,892,349	$ 3,656,968	—
Investments at net asset value				
Alternative investments	4,147,489			
Total investments	$ 9,696,806			
Collateral proceeds received under securities lending program	$ 18,284		$ 18,284	
Liabilities				
Obligations under swap agreements	$ (91,340)		$ (91,340)	
Obligations to return capital under securities lending program	$ (18,284)		$ (18,284)	

8. PROPERTY AND EQUIPMENT, NET

The components of property and equipment, net are summarized as follows:

	December 31, 2020	December 31, 2019
Land and improvements	$ 461,831	$ 497,363
Buildings and fixed equipment	7,536,013	7,519,607
Movable equipment and computer software	2,520,502	2,496,988
Construction-in-progress	478,335	355,733
	10,996,681	10,869,691
Accumulated depreciation and amortization	(5,144,704)	(4,967,768)
Property and equipment, net	$ 5,851,977	$ 5,901,923

During 2020, the System wrote off fully depreciated property and equipment totaling $233,800.

Property and equipment, net include assets recorded as finance leases and under other financing arrangements. See additional disclosure in Note 9. LEASES.

Depreciation expense was $553,634 and $560,221 for the years ended December 31, 2020 and 2019, respectively.

9. LEASES

The System leases office and clinical space, land and equipment. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheets. For lease agreements entered into after the adoption of ASU 2016-02 on January 1, 2019, the System combines lease and non-lease components, except for medical equipment leases.

The depreciable lives of assets are limited by the expected lease terms. Most leases include options to renew. The majority of leases do not provide an implicit rate; therefore, the System has elected to use its incremental borrowing rate, which is the interest rate the System would borrow on a collateralized basis over a similar term, as the discount rate. The System used its incremental borrowing rate on January 1, 2019 for operating leases that commenced prior to that date.

Operating and finance leases are classified as follows within the accompanying consolidated balance sheets:

Leases	Classification	December 31, 2020	December 31, 2019
Assets			
Operating	Operating lease right-of-use assets	$ 309,678	$ 352,295
Finance	Property and equipment, net	149,961	161,970
Total lease assets		$ 459,639	$ 514,265
Liabilities			
Current			
Operating	Operating lease liabilities, current portion	$ 79,934	$ 77,957
Finance	Long-term debt and commercial paper, current portion	9,182	8,445
Noncurrent			
Operating	Operating lease liabilities, less current portion	268,575	314,106
Finance	Long-term debt, less current portion	165,507	176,811
Total lease liabilities		$ 523,198	$ 577,319

Finance lease assets are recorded net of accumulated amortization of $57,873 and $49,743 as of December 31, 2020 and 2019, respectively.

Lease costs are classified as follows within the accompanying consolidated statements of operations and changes in net assets:

Lease cost	Classification	December 31, 2020	December 31, 2019
Operating lease cost	Supplies, purchased services and other	$ 85,253	$ 85,037
Short term lease cost	Supplies, purchased services and other	13,407	10,686
Variable lease cost	Supplies, purchased services and other	36,740	29,099
Finance lease cost			
Amortization of lease assets	Depreciation and amortization	11,629	10,719
Interest on lease liabilities	Interest	12,093	10,053
Sublease income	Other revenue	(2,434)	(2,593)
Net lease cost		$ 156,688	$ 143,001

Lease terms, discount rates and other supplemental information are as follows:

	December 31, 2020	December 31, 2019
Weighted average remaining lease term (in years)		
Operating	5.5	6.0
Finance	11.6	12.9
Weighted average discount rate		
Operating	2.24 %	2.34 %
Finance	7.54 %	7.44 %
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows from operating leases	$ 88,387	$ 86,504
Operating cash flows from finance leases	11,500	10,563
Financing cash flows from finance leases	8,184	7,605

Future maturities of lease liabilities at December 31, 2020 are as follows:

	Operating Leases	Finance Leases	Total
2021	$ 86,817	$ 19,498	$ 106,315
2022	75,933	21,094	97,027
2023	65,018	21,031	86,049
2024	48,089	21,532	69,621
2025	33,948	21,025	54,973
Thereafter	61,813	169,777	231,590
Future minimum lease payments	371,618	273,957	645,575
Less remaining imputed interest	23,109	99,268	122,377
Total	$ 348,509	$ 174,689	$ 523,198

10. INVESTMENTS IN UNCONSOLIDATED ENTITIES

The System contributed $25,000 to an independent foundation in conjunction with the BAMC transaction. See the additional discussion of this transaction in Note 21. ACQUISITION OF BAY AREA MEDICAL CENTER. Under the terms of the definitive agreement between the System and BAMC, the $25,000 contribution is designated to support the operations and capital needs of BAMC and/or Aurora Bay Area Medical Group ("ABAMG"). The interest in that foundation is reflected in investments in unconsolidated entities in the accompanying consolidated balance sheets, which amounted to $18,668 and $21,186 at December 31, 2020 and 2019, respectively. Cash distributions of $2,518 and $3,814 were received by BAMC from this Foundation under terms of the definitive agreement during the years ended December 31, 2020 and 2019, respectively.

The System has an interest in the net assets of the Masonic Family Health Foundation ("MFHF"), an independent organization, under the terms of an asset purchase agreement (the "Agreement"). Substantially all of MFHF's net assets are designated to support the operations and/or capital needs of one of the System's medical facilities. Additionally, 90% of MFHF's investment yield, net of expenses, on substantially all of MFHF's investments is designated for the support of one of the System's medical facilities. MFHF must pay the System, annually, 90% of the investment yield or an agreed-upon percentage of the beginning of the year net assets.

The interest in the net assets of MFHF amounted to $109,017 and $95,307 at December 31, 2020 and 2019, respectively, and is presented within investments in unconsolidated entities in the accompanying consolidated balance sheets. The System's interest in the investment income is reflected in the

accompanying consolidated statements of operations and changes in net assets and amounted to $17,287 and $17,433 for the years ended December 31, 2020 and 2019, respectively. Cash distributions of $3,978 and $3,347 were received by the System from MFHF under terms of the Agreement during the years ended December 31, 2020 and 2019, respectively. In addition, MFHF made $537 and $333 in contributions to the System for program support during the years ended December 31, 2020 and 2019, respectively.

At December 31, 2020, the System had a 49.5% ownership interest in RML Health Providers, L.P. ("RML") that is accounted for on an equity basis. RML is an Illinois, not-for-profit limited partnership that operates a 115-bed licensed long-term acute care hospital in Hinsdale, Illinois, and an 86-bed licensed long-term acute care hospital in Chicago, Illinois. The System's investment in RML was $35,235 and $33,462 at December 31, 2020 and 2019, respectively, and is presented within investments in unconsolidated entities in the accompanying consolidated balance sheets.

RML leases the Chicago, Illinois, facility from the System. The lease has a fixed term through June 30, 2025. The System recorded rental income of $1,192 and $1,157 for the years ended December 31, 2020 and 2019, respectively.

The summarized financial position and results of operations for significant entities accounted for under the equity method as of and for the periods ended is outlined below:

	RML	MFHF
As of December 31, 2020		
Total assets	$ 131,256	$ 112,993
Total liabilities	58,482	3,661
Partners' equity/net assets	72,774	109,332
Year Ended December 31, 2020		
Total revenue	123,067	18,613
Revenue in excess of expenses	16,677	13,697
As of December 31, 2019		
Total assets	123,345	99,827
Total liabilities	55,118	4,192
Partners' equity/net assets	68,227	95,635
Year Ended December 31, 2019		
Total revenue	111,745	19,160
Revenue in excess of expenses	12,170	13,542

11. LONG-TERM DEBT

Long-term debt, net of unamortized original issue discount or premium and unamortized deferred bond issuance costs, consisted of the following:

	December 31, 2020	December 31, 2019
Revenue bonds and revenue refunding bonds		
Series 2003A (weighted average rate of 1.38% during 2020 and 2019), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	$ 5,194	$ 7,700
Series 2003C (weighted average rate of 1.60% during 2020 and 2019), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	5,200	7,708
Series 2008A (weighted average rate of 4.41% and 5.00% during 2020 and 2019, respectively), principal payable in varying annual installments through November 2030; interest based on prevailing market conditions at time of remarketing	116,719	119,569
Series 2008C (weighted average rate of 0.58% and 1.50% during 2020 and 2019, respectively), principal payable in varying annual installments through November 2038; interest based on prevailing market conditions at time of remarketing	271,640	271,608
Series 2011A, 4.00%, principal payable in annual installments through April 2022	440	652
Series 2011B (weighted average rate of 0.86% and 1.76% during 2020 and 2019, respectively), principal payable in varying annual installments through April 2051, subject to a put provision that provides for a cumulative seven-month notice and remarketing period; interest tied to a market index plus a spread	68,983	69,297
Series 2011C (weighted average rate of 1.11% and 2.52% during 2020 and 2019, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 3,2024; interest tied to a market index plus a spread	49,540	49,753
Series 2011D (weighted average rate of 1.11% and 2.52% during 2020 and 2019, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 3, 2024; interest tied to a market index plus a spread	49,540	49,753
Series 2012, 4.00%, principal payable in varying annual installments through June 2044	39,048	40,507
Series 2013A, 5.00%, principal payable in varying annual installments through June 2027	43,918	52,486
Series 2014, 4.00% to 5.00%, principal payable in varying annual installments through August 2038	149,629	160,080
Series 2015, 4.13% to 5.00%, principal payable in varying annual installments through May 2045	88,283	102,590
Series 2015B, 4.00% to 5.00%, principal payable in varying annual installments through May 2044	15,990	72,386
Series 2018A, 4.00% to 5.00%, principal payable in varying annual installments through August 2044	105,184	105,764
Series 2018B (weighted average rate of 5.00% during 2020 and 2019), principal payable in varying annual installments through August 2054; interest based on prevailing market conditions at time of remarketing	201,762	206,479
Series 2018C (weighted average rate of 1.06% and 1.96% during 2020 and 2019, respectively), principal payable in varying annual installments through August 2054, interest tied to a market index plus a spread	198,256	198,219
	1,409,326	1,514,551
Taxable bonds		
Taxable Bond Series 2018, 3.83% to 4.27%, principal payable in varying annual installments through August 2048	709,865	709,628
Taxable Bond Series 2019, 3.39%, principal payable in October 2049	354,813	354,703
Taxable Bond Series 2020A, 2.21% to 3.01%, principal payable in varying annual installments through June 2050	695,822	—
	1,760,500	1,064,331
Finance lease obligations and financing arrangements	214,360	235,249
Commercial paper, weighted average interest rate of 1.06% for the year ended December 31, 2020 and 2.15% for the period March 5, 2019 to December 31, 2019	50,000	132,000
Taxable Term Loan, (weighted average rate of 2.68% during 2020 and 2019), principal payable in varying annual installments through September 2024	97,871	114,868
	3,532,057	3,060,999

	December 31, 2020	December 31, 2019
Less amounts classified as current		
Long-term debt, current portion	(51,996)	(52,098)
Commercial paper	(50,000)	(132,000)
Long-term debt and commercial paper, current portion	(101,996)	(184,098)
Long-term debt subject to short-term financing arrangements	(119,660)	(147,535)
	(221,656)	(331,633)
	$ 3,310,401	$ 2,729,366

Maturities of long-term debt, financing leases, and sinking fund requirements, assuming remarketing of the variable rate demand revenue refunding bonds, for the five years ending December 31, 2025, are as follows: 2021 - $51,996; 2022 - $48,255; 2023 - $52,964; 2024 - $121,479; and 2025 - $45,783.

The System's outstanding bonds are secured by obligations issued under the Second Amended and Restated Master Trust Indenture dated as of August 1, 2018, as the same may be amended from time to time, between Advocate Aurora Health, Inc., the other affiliates identified therein as the Members of the Obligated Group and U.S. Bank National Association, as master trustee ("the System Master Indenture"). Under the terms of the bond indentures and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The System Master Indenture and other debt agreements, including bank agreements, also place restrictions on the System and require the System to maintain certain financial ratios.

The System's unsecured variable rate revenue bonds, Series 2011B of $69,660 and Series 2018C-1 of $50,000, while subject to a long-term amortization period, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after December 31, 2020, the principal amount of such bonds has been classified as a current obligation as long-term debt subject to short-term financing arrangements in the accompanying consolidated balance sheets. Management believes the likelihood of a material amount of bonds being put to the System is remote. However, to address this possibility, the System has taken steps to provide various sources of liquidity, including assessing alternate sources of financing, including lines of credit and/or net assets without donor restrictions as a source of self-liquidity.

The System has standby bond purchase agreements with banks to provide liquidity support for the Series 2008C Bonds. In the event of a failed remarketing of a Series 2008C Bond upon its tender by an existing holder and subject to compliance with the terms of the standby bond purchase agreement, the standby bank would provide the funds for the purchase of such tendered bonds, and the System would be obligated to repay the bank for the funds it provided for such bond purchase (if such bond is not subsequently remarketed), with the first installment of such repayment commencing on the date one year and one day after the bank purchases the bond. As of December 31, 2020, there were no bank-purchased bonds outstanding. To the extent that the standby bond purchase agreement expiration date is within 12 months after December 31, 2020, the principal amount of such bonds would be classified as a current obligation in the accompanying consolidated balance sheets. The standby bond purchase agreements expire as follows: $129,456 in January 2024, $87,694 in September 2024 and $58,225 in September 2025.

In March 2019, the System issued commercial paper in the amount of $50,000. The proceeds of the commercial paper were used to redeem the Series 2008C-2A bonds of $49,230 plus accrued interest and certain costs related to the issuance of the commercial paper. The remaining proceeds were used

for general corporate purposes. The standby bond purchase agreement related to the Series 2008C-2A bonds was canceled effective March 5, 2019.

In connection with the BAMC acquisition, the System assumed $81,465 of outstanding tax-exempt bonds originally issued for the benefit of BAMC, which were redeemed in November 2019 with a portion of the proceeds of $82,000 of the System's commercial paper. Also in connection with the BAMC acquisition, the System acquired an interest rate swap. As the debt related to the swap is no longer outstanding, it is being held as a swap portfolio. This swap is secured under the System Master Indenture.

In November 2019, the System issued its Series 2019 Taxable Bonds in the amount of $357,970. The proceeds of the Series 2019 Taxable Bonds were used to refinance all or a portion of the Series 2011A-2, Series 2012, Series 2013A and Series 2014 Bonds and to pay certain financing costs. In connection with this issuance, the System recognized a loss on refinancing in the amount of $21,103.

In May 2020, the System issued its Series 2020A Taxable Bonds in the aggregate principal amount of $700,000. The proceeds of the Series 2020A Taxable Bonds were used for general corporate purposes, to refinance a portion of the Series 2011B, Series 2011C, Series 2011D, Series 2012, Series 2013A, Series 2015 and Series 2015B Bonds, to repay $82,000 of commercial paper and to pay certain financing costs. In connection with this transaction, the System recognized a loss on refinancing in the amount of $12,231.

As of December 31, 2020, the System authorized the issuance of up to $1,000,000 in commercial paper aggregate principal outstanding. As of December 31, 2020, $50,000 of commercial paper notes were outstanding, with maturities ranging from 119 to 122 days. As of December 31, 2019, $132,000 of commercial paper was outstanding, with maturities ranging from 27 to 62 days.

At December 31, 2020, the System had lines of credit with banks aggregating to $1,425,000 in available commitments. These lines of credit provide for various interest rates and payment terms and as of December 31, 2020 expire as follows: $1,225,000 in April 2021, $100,000 in August 2021 and $100,000 in December 2022. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures for general working capital purposes or to provide for certain letters of credit. At December 31, 2020, letters of credit issued totaling $58,365 have been issued under one of these lines. At December 31, 2020, no amounts were outstanding on these lines or letters of credit.

The System maintains an interest rate swap program on certain of its variable rate debt, as described in Note 12. INTEREST RATE SWAP PROGRAM.

The System's interest paid amount includes all debt agreements including revenue bonds and revenue refunding bonds, taxable bonds, finance lease obligations, financing arrangements and interest rate swaps. The System's interest paid, net of capitalized interest, amounted to $116,953 and $119,870 for the years ended December 31, 2020 and 2019, respectively. The System capitalized interest of $8,198 and $4,087 for the years ended December 31, 2020 and 2019, respectively.

12. INTEREST RATE SWAP PROGRAM

The System has interest rate-related derivative instruments to manage the exposure of its variable rate 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. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The System also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

At December 31, 2020, the System maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose the System to variability in interest payments due to changes in interest rates. The System believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, the System entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps convert the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in the principal outstanding under various bond series. As the Series 2008C-2A bonds were redeemed on March 5, 2019, the portion of the swap related to these bonds is now held as a swap portfolio.

In connection with the BAMC acquisition, the System acquired an interest rate swap. As the debt related to the swap is no longer outstanding, it is being held as a swap portfolio.

The following is a summary of the outstanding positions under these interest rate swap agreements at December 31, 2020:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	$ 129,900	November 1, 2038	61.7% of LIBOR + 26bps	3.605 %
2008C-2B	58,425	November 1, 2038	61.7% of LIBOR + 26bps	3.605 %
2008C-3A	88,000	November 1, 2038	61.7% of LIBOR + 26bps	3.605 %
Swap portfolio	50,000	November 1, 2038	61.7% of LIBOR + 26bps	3.605 %
Swap portfolio	26,170	February 1, 2038	70.0% of LIBOR	3.314 %

The swaps are not designated as hedging instruments and, therefore, hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are classified as changes in fair value of interest rate swaps in the accompanying consolidated statements of operations and changes in net assets. The net cash settlement payments, representing the realized changes in fair value of the swaps, are included as interest expense in the accompanying consolidated statements of operations and changes in net assets.

The fair value of the interest rate swap agreements was a liability of $118,620 and $91,340 as of December 31, 2020 and 2019, respectively. No collateral was posted under these swap agreements as of December 31, 2020 and 2019.

Amounts recorded in the accompanying consolidated statements of operations and changes in net assets are as follows:

	Year Ended December 31, 2020	Year Ended December 31, 2019
Net cash payments on interest rate swap agreements (interest expense)	$ 10,241	$ 6,711
Change in fair value of interest rate swaps	$ (27,280)	$ (21,079)

The interest rate swap instruments contain provisions that require the System to maintain an investment grade credit rating on its bonds from certain major credit rating agencies. If the System's bonds were to fall below investment grade, it would be in violation of these provisions and the counterparties to the swap instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on interest rate swap instruments in net liability positions.

13. RETIREMENT PLANS

The System maintains various employee retirement benefit plans available to qualifying employees and retirees.

The Condell Health Network Retirement Plan ("Condell Plan") was frozen effective January 1, 2008 to new participants and participants ceased to accrue additional pension benefits. During the years ended December 31, 2020 and 2019, $3,000 and no contributions, respectively, were made to the Condell Plan.

The Aurora Health Care, Inc. Pension Plan ("Aurora Plan") was frozen on December 31, 2012. During the years ended December 31, 2020 and 2019, no contributions were made to the Aurora Plan.

In June 2019, the System approved a plan to freeze the Advocate defined benefit pension plan ("Advocate Plan") that covered substantially all of Advocate's employees. Effective December 31, 2019, the Advocate Plan was closed to new participants and participants ceased accruing additional pension benefits. The Advocate Plan was remeasured as of June 30, 2019 and a curtailment gain of $72 was recorded in nonoperating income (loss), net in the accompanying consolidated statements of operations and changes in net assets as of December 31, 2019. In addition, $86,396 of previously unrecognized net actuarial loss was recognized in net assets without donor restrictions as a component of pension-related changes other than net periodic pension cost at December 31, 2019. The accompanying consolidated balance sheets contain an other noncurrent liability related to the Advocate Plan totaling $134,325 and $173,939 at December 31, 2020 and 2019, respectively. During the years ended December 31, 2020 and 2019, $40,000 and $22,000, respectively, in cash contributions were made to the Advocate Plan.

In September 2020, the System transferred benefit obligations for certain participants of the Advocate Plan, Condell Plan and Aurora Plan through the purchase of annuity contracts. As a result of this transaction, all three Plans were remeasured as of September 30, 2020 and a combined settlement loss of $119,658 was recorded in the nonoperating income (loss) section in the accompanying consolidated statements of operations and changes in net assets as of December 31, 2020.

On December 31, 2020, the Condell Plan liabilities and assets were merged into the Aurora Plan. There was an other noncurrent liability related to the Aurora Plan of $66,494 and $83,321 at December 31, 2020 and 2019, respectively. There was an other noncurrent liability related to the Condell Plan of $1,824 at December 31, 2019.

A summary of changes in the plan assets, projected benefit obligation and the resulting funded status for the year ended December 31, 2020 is as follows:

	Advocate	Condell	Aurora	Total
Change in plan assets:				
Plan assets at fair value at beginning of period	$ 1,011,800	$ 64,211	$ 1,588,504	$ 2,664,515
Actual return on plan assets	28,898	10,975	212,412	252,285
Employer contributions	40,000	3,000	—	43,000
Benefits paid	(128,110)	(16,950)	(412,564)	(557,624)
Effect of Plan merger	—	(61,236)	61,236	—
Plan assets at fair value at end of period	$ 952,588	$ —	$ 1,449,588	$ 2,402,176
Change in projected benefit obligation:				
Projected benefit obligation at beginning of period	$ 1,185,739	$ 66,035	$ 1,671,825	$ 2,923,599
Interest cost	34,835	1,995	51,860	88,690
Actuarial loss	(5,551)	8,543	145,338	148,330
Benefits paid	(128,110)	(16,950)	(412,564)	(557,624)
Effect of Plan merger	—	(59,623)	59,623	—
Projected benefit obligation at end of period	$ 1,086,913	$ —	$ 1,516,082	$ 2,602,995
Plan assets less than projected benefit obligation	$ (134,325)	$ —	$ (66,494)	$ (200,819)
Accumulated benefit obligation at end of period	$ 1,086,913	$ —	$ 1,516,082	$ 2,602,995

A summary of changes in the plan assets, projected benefit obligation and the resulting funded status for the year ended December 31, 2019 is as follows:

	Advocate	Condell	Aurora	Total
Change in plan assets:				
Plan assets at fair value at beginning of period	$ 929,365	$ 58,230	$ 1,327,366	$ 2,314,961
Actual return on plan assets	117,288	10,604	308,509	436,401
Employer contributions	22,000	—	10,000	32,000
Benefits paid	(56,853)	(4,623)	(57,371)	(118,847)
Plan assets at fair value at end of period	$ 1,011,800	$ 64,211	$ 1,588,504	$ 2,664,515
Change in projected benefit obligation:				
Projected benefit obligation at beginning of period	$ 974,935	$ 56,806	$ 1,432,345	$ 2,464,086
Service cost	57,645	—	—	57,645
Interest cost	38,384	2,327	62,649	103,360
Actuarial loss	258,024	11,525	234,202	503,751
Gain due to curtailment	(86,396)	—	—	(86,396)
Benefits paid	(56,853)	(4,623)	(57,371)	(118,847)
Projected benefit obligation at end of period	$ 1,185,739	$ 66,035	$ 1,671,825	$ 2,923,599
Plan assets less than projected benefit obligation	$ (173,939)	$ (1,824)	$ (83,321)	$ (259,084)
Accumulated benefit obligation at end of period	$ 1,185,739	$ 66,035	$ 1,671,825	$ 2,923,599

The Advocate Plan paid lump sums totaling $75,349 in 2020. The amount in 2020 was greater than the sum of the Advocate Plan's service cost and interest cost, resulting in a settlement charge in the amount of $5,455. The Condell Plan paid lump sums totaling $4,235 and $2,989 in 2020 and 2019, respectively. The amount in 2020 and 2019 was greater than the sum of the Condell Plan's service cost and interest cost, resulting in a settlement charge in the amount of $104 and $642, respectively. The Aurora Plan paid lump sums totaling $5,400 in 2020. The amount in 2020 was greater than the sum of the Aurora Plan's service cost and interest cost, resulting in a settlement charge in the amount of $452.

Pension plan expense included in the accompanying consolidated statements of operations and changes in net assets is as follows for the year ended December 31, 2020:

	Advocate	Condell	Aurora	Total
Interest cost	$ 34,835	$ 1,995	$ 51,860	$ 88,690
Expected return on plan assets	(43,456)	(1,473)	(61,085)	(106,014)
Amortization of:				
Actuarial loss	4,897	323	11,475	16,695
Prior service cost	—	—	3	3
Settlement	33,561	1,932	90,175	125,668
Net pension expense	$ 29,837	$ 2,777	$ 92,428	$ 125,042

Pension plan expense (income) included in the accompanying consolidated statements of operations and changes in net assets is as follows for the year ended December 31, 2019:

	Advocate	Condell	Aurora	Total
Service cost	$ 57,645	$ —	$ —	$ 57,645
Interest cost	38,384	2,327	62,649	103,360
Expected return on plan assets	(55,543)	(2,413)	(76,183)	(134,139)
Amortization of:				
Actuarial loss	3,634	108	7,631	11,373
Prior service cost	(72)	—	3	(69)
Settlement/curtailment	(72)	642	—	570
Net pension expense (income)	$ 43,976	$ 664	$ (5,900)	$ 38,740

The components of net periodic benefit costs, other than the service cost component, are included in other nonoperating (loss) income, net in the accompanying consolidated statements of operations and changes in net assets.

The net change recognized in net assets without donor restrictions as a component of pension-related changes other than net periodic pension cost was as follows for the year ended December 31, 2020:

	Advocate	Condell	Aurora	Total
Net change recognized	$ 29,450	$ 3,214	$ 107,641	$ 140,305

The net change recognized in net assets without donor restrictions as a component of pension-related changes other than net periodic pension cost was as follows for the year ended December 31, 2019:

	Advocate	Condell	Aurora	Total
Net change recognized	$ 106,393	$ 2,584	$ (5,758)	$ 103,219

Included in net assets without donor restrictions at December 31, 2020 are the following amounts that have not yet been recognized in net pension expense:

	Advocate	Aurora	Total
Unrecognized prior credit	$ —	$ 99	$ 99
Unrecognized actuarial loss	275,718	357,902	633,620
	$ 275,718	$ 358,001	$ 633,719

The expected amortization amount to be included in the net periodic pension cost in 2021 is as follows:

	Advocate	Aurora	Total
Net actuarial loss	$ 4,593	$ 10,410	$ 15,003
Prior service (credit)/cost	—	3	3
	$ 4,593	$ 10,413	$ 15,006

Expected employee benefit payments to be paid from the pension plans are as follows:

	Advocate	Aurora	Total
2021	$ 60,586	$ 46,832	$ 107,418
2022	61,578	52,219	113,797
2023	62,241	55,154	117,395
2024	61,506	58,191	119,697
2025	61,336	61,722	123,058
2026-2030	294,108	345,472	639,580
Total	$ 601,355	$ 619,590	$ 1,220,945

Expected contributions to the pension plans are as follows:

	Advocate	Aurora	Total
2021	$ 30,000	$ —	$ 30,000

Employer contributions were paid from employer assets. No plan assets are expected to be returned to the employer. All benefits paid under the Advocate Plan, Condell Plan and Aurora Plan (collectively referred to as the "Plans") were paid from the Plans' assets.

The System's asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors and manager style to minimize the risk of loss. The System utilizes investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. The System regularly monitors manager performance and compliance with investment guidelines.

The System's target and actual pension asset allocations for the Plans are as follows:

	December 31, 2020		December 31, 2019	
Asset Category - Advocate Plan	**Target**	**Actual**	**Target**	**Actual**
De-risking portfolio	75 %	67 %	75 %	58 %
Domestic and international equity securities	21	22	21	20
Alternative investments	2	7	2	13
Cash and fixed-income securities	2	4	2	9
	100 %	100 %	100 %	100 %

	December 31, 2020		December 31, 2019	
Asset Category - Condell Plan	**Target**	**Actual**	**Target**	**Actual**
De-risking portfolio	90 %	90 %	75 %	85 %
Domestic and international equity securities	4	4	11	6
Cash and fixed-income securities	6	6	14	9
	100 %	100 %	100 %	100 %

	December 31, 2020		December 31, 2019	
Asset Category - Aurora Plan	**Target**	**Actual**	**Target**	**Actual**
De-risking portfolio	85 %	82 %	75 %	73 %
Domestic and international equity securities	12	15	21	22
Real estate	1	1	2	2
Cash and fixed-income securities	2	2	2	3
	100 %	100 %	100 %	100 %

The de-risking portfolio is comprised of cash and fixed-income instruments designed to hedge Plan liabilities.

At December 31, 2020, the Advocate Plan had commitments to fund alternative investments, including recallable distributions of $22,369 over the next five years.

In the normal course of operations and within established investment policy guidelines, the Plans may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the Plans' strategic asset allocation. These instruments require the Plans to deposit cash collateral with the broker or custodian.

Derivative contract information at December 31, 2020 are as follows:

	Advocate	Aurora	Total
Cash and security collateral provided	$ 16,922	$ 10,455	$ 27,377
Notional value - long position	$ —	$ 339,520	$ 339,520
Notional value - short position	$ (527,126)	$ (31,680)	$ (558,806)

By using derivative financial instruments, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty and, therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in the underlying reference security. The market risk associated with market changes is

managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Receivables and payables for investment trades not settled are presented within Advocate Plan assets. Unsettled sales resulted in receivables due from brokers of $3,313 and $45,871 at December 31, 2020 and 2019, respectively. Unsettled purchases resulted in payables of $10,846 and $45,351 at December 31, 2020 and 2019, respectively.

Receivables and payables for investment trades not settled are presented within Aurora Plan assets. Unsettled sales resulted in receivables due from brokers of $10,108 and $12 at December 31, 2020 and 2019, respectively. Unsettled purchases resulted in payables of $19,198 and $2,987 at December 31, 2020 and 2019, respectively.

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 7. FAIR VALUE. Real estate commingled funds for which an active market exists are included in Level 2. The System opted to use the net asset value per share, or its equivalent, as a practical expedient for the fair value of the Plans' interest in hedge funds, private equity limited partnerships and real estate commingled funds. There is inherent uncertainty in such valuations and the estimated fair values may differ from the values that would have been used had a ready market for these investments existed. Private equity limited partnerships and real estate commingled funds typically have finite lives ranging from five to ten years, at the end of which all invested capital is returned. For hedge funds, the typical lockup period is one year, after which invested capital can be redeemed on a quarterly basis with at least 30 days' but no more than 90 days' notice. The Plans' investment assets are exposed to the same kinds and levels of risk as described in Note 7. FAIR VALUE.

The following are the Plans' financial instruments at December 31, 2020, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 7. FAIR VALUE:

Description	December 31, 2020	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and short-term investments	$ 58,006	$ 32,876	$ 25,130	$ —
Corporate bonds and other debt securities	985,564	—	985,564	—
United States government obligations	646,797	—	646,797	—
Bond and other debt security funds	128,142	—	128,142	—
Equity securities	22,280	22,280	—	—
Equity funds	473,728	11,648	462,080	—
Real estate funds	17,855	—	17,855	—
	2,332,372	$ 66,804	$ 2,265,568	$ —
Investments at net asset value				
Alternative investments	69,804			
Total investments	$ 2,402,176			

The following are the Plans' financial instruments at December 31, 2019, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 7. FAIR VALUE:

Description	December 31, 2019	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and short-term investments	$ 137,453	$ 32,415	$ 105,038	$ —
Corporate bonds and other debt securities	1,045,015	—	1,045,015	—
United States government obligations	644,077	—	644,077	—
Bond and other debt security funds	126,516	—	126,516	—
Equity securities	67,724	67,724	—	—
Equity funds	482,682	11,841	470,841	—
Real estate funds	17,604	—	17,604	—
	2,521,071	$ 111,980	$ 2,409,091	$ —
Investments at net asset value				
Alternative investments	143,444			
Total	$ 2,664,515			

Assumptions used to determine benefit obligations are as follows:

	December 31, 2020	December 31, 2019
Discount rate - Advocate Plan	2.49 %	3.23 %
Discount rate - Condell Plan	— %	3.37 %
Discount rate - Aurora Plan	2.79 %	3.37 %
Assumed rate of return on assets - Advocate Plan	4.40 %	4.50 %
Assumed rate of return on assets - Condell Plan	— %	2.50 %
Assumed rate of return on assets - Aurora Plan	3.40 %	4.50 %

Assumptions used to determine net pension expense are as follows:

	December 31, 2020	December 31, 2019
Discount rate - Advocate and Condell Plans	3.23 %	4.38 %
Discount rate - Condell Plans	3.37 %	4.38 %
Discount rate - Aurora Plan	3.37 %	4.48 %
Assumed rate of return on assets - Advocate Plan	4.50 %	7.00 %
Assumed rate of return on assets - Condell Plan	2.50 %	4.25 %
Assumed rate of return on assets - Aurora Plan	4.50 %	5.50 %

The assumed rate of return on each of the Plan's assets is based on historical and projected rates of return for asset classes in which the portfolio is invested. As the Advocate Plan was frozen on December 31, 2019, the assumed rate of return and the target asset allocations were adjusted and actual allocations are being adjusted to more closely align with the new target allocations.

The 2020 mortality assumption for the Plans was the amounts-weighted aggregate rates from the Pri-2012 mortality study, with white-collar adjustments projected generationally from 2012 with Scale MP-2020. The 2019 mortality assumption for the Plans was the amounts-weighted aggregate rates from the Pri-2012 mortality study, with white-collar adjustments projected generationally from 2012 with Scale MP-2019.

In addition to these Plans, the System sponsors defined contribution plans for its employees. As of January 1, 2020, three plans merged into one existing plan, the Advocate Health Care Network 401(k) plan. At this time the Advocate Health Care Network 401(k) plan was restated and became known as the Advocate Aurora Health 401(k) plan ("AAH 401(k)"). Effective January 1, 2020, the AAH 401(k) contribution plan was enhanced to add an annual contribution component to the employer match. Expense related to these plans, which are included in salaries, wages and benefits expense in the consolidated statements of operations and changes in net assets, were $300,971 and $207,194 for the years ended December 31, 2020 and 2019, respectively.

14. NET ASSETS WITH DONOR RESTRICTIONS

Net assets with donor restrictions are available for the following purposes:

	December 31, 2020	December 31, 2019
Purchases of property and equipment	$ 17,504	$ 22,763
Medical education and other health care programs	215,176	219,342
	$ 232,680	$ 242,105

15. FUNCTIONAL OPERATING EXPENSES

Operating expenses directly attributable to a specific functional area of the System are reported as expenses of those functional areas. Expenses other than interest expense are directly allocated to functional departments at the time they are incurred. Interest expense that relates to debt financing is allocated based on the use of the related funds. General and administrative expenses primarily include legal, finance, purchasing and human resources. Health care services require the benefit of and the expense of general and administrative services; therefore, these costs are further allocated to health care services. A majority of fundraising costs are reported as other nonoperating (loss) income, net in the accompanying consolidated statements of operations and changes in net assets.

Functional operating expenses for the year ended December 31, 2020 are as follows:

	Health care services	General and administrative	Consolidated
Salaries, wages and benefits	$ 6,789,955	$ 659,016	$ 7,448,971
Supplies, purchased services and other	3,701,429	675,846	4,377,275
Contracted medical services	420,587	—	420,587
Depreciation and amortization	467,340	92,923	560,263
Interest	112,126	—	112,126
Total operating expenses	11,491,437	1,427,785	12,919,222
Allocation of general and administrative	1,427,785	(1,427,785)	—
Total operating expenses after allocation	$ 12,919,222	$ —	$ 12,919,222

Functional operating expenses for the year ended December 31, 2019 are as follows:

	Health care services	General and administrative	Consolidated
Salaries, wages and benefits	$ 6,437,864	$ 619,726	$ 7,057,590
Supplies, purchased services and other	3,526,902	519,823	4,046,725
Contracted medical services	543,716	—	543,716
Depreciation and amortization	478,765	91,243	570,008
Interest	106,314	—	106,314
Total operating expenses	11,093,561	1,230,792	12,324,353
Allocation of general and administrative	1,230,792	(1,230,792)	—
Total operating expenses after allocation	$ 12,324,353	$ —	$ 12,324,353

16. LIQUIDITY

The System's financial assets available within one year of the consolidated balance sheets date for general expenditures are as follows:

	December 31, 2020	December 31, 2019
Current assets		
Cash and cash equivalents	$ 959,878	$ 449,712
Assets limited as to use	125,053	106,529
Patient accounts receivable	1,570,738	1,605,607
Third-party payors receivables	16,933	15,331
Collateral proceeds under securities lending program	19,789	18,284
Total current assets	2,692,391	2,195,463
Assets limited as to use		
Internally designated for capital and other	10,291,819	8,345,172
Held for self-insurance	658,466	645,697
Donor restricted	137,980	132,024
Investments under securities lending program	18,945	17,672
Total assets limited as to use	11,107,210	9,140,565
Total financial assets	$ 13,799,601	$ 11,336,028
Less		
Amounts unavailable for general expenditures		
Alternative investments	(2,110,330)	(1,791,717)
Total amounts unavailable for general expenditure	(2,110,330)	(1,791,717)
Amounts unavailable to management without approval		
Held for self-insurance	(783,519)	(752,226)
Donor restricted	(137,980)	(132,024)
Investments under securities lending program	(18,945)	(17,672)
Total amounts unavailable to management without approval	(940,444)	(901,922)
Total financial assets available to management for general expenditure within one year	$ 10,748,827	$ 8,642,389

17. COMMITMENTS AND CONTINGENCIES

Aurora West Allis Medical Center has the right to operate the hospital under the terms of a lease agreement with the City of West Allis (the "City"). In accordance with the lease agreement, the City has title to all assets and any subsequent additions (with the exception of certain equipment used by Aurora for laboratory services). Aurora West Allis Medical Center has an exclusive right to the use of

the assets and the obligation to maintain and replace them. The historical cost to the System of the leased facilities is included within the System's property and equipment, net. The agreement provides for annual payments of less than $100 in lieu of annual lease payments and includes payment escalations each subsequent year. The lease expires in 2063.

The System is committed to constructing additions and renovations to its medical facilities that are expected to be completed in future years. The estimated cost of these commitments is $783,071, of which $565,517 has been incurred as of December 31, 2020.

The System entered into agreements for information technology services provided by third parties. The maximum amount of future payments that the System could be required to make under these agreements is approximately $200,000 over the next ten years and approximately $30,376 is included in accounts payable and other accrued liabilities in the accompanying consolidated balance sheets at December 31, 2020. The System has also entered into various other agreements. The future commitments under these agreements are $26,109 over the next five years.

18. GENERAL AND PROFESSIONAL LIABILITY RISKS

The System is self-insured for substantially all general and professional liability risks. The self-insurance programs combine various levels of self-insured retention with excess commercial insurance coverage. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Revocable trust funds, administered by a trustee and captive insurance companies, have been established for the self-insurance programs. Actuarial consultants have been retained to determine the estimated cost of claims, as well as to determine the amount to fund into the irrevocable trust and captive insurance companies.

The System's hospitals, clinics, surgery centers, physicians and certified registered nurse anesthetist providers that provide health care in Wisconsin are qualified health care providers that are fully covered for losses in excess of statutory limits through mandatory participation in the State of Wisconsin Injured Patients and Families Compensation Fund.

The estimated cost of claims is actuarially determined based on past experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance liabilities and contributions to the trust were determined using a discount rate of 3.00% as of December 31, 2020 and 2019. Total accrued insurance liabilities would have been $77,007 and $71,439 greater at December 31, 2020 and 2019, respectively, had these liabilities not been discounted.

The System entities are defendants in certain litigation related to professional and general liability risks, and other matters. Although the outcome of the litigations cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of the litigations will not have a material adverse effect on the System's operations or financial condition.

19. LEGAL, REGULATORY AND OTHER CONTINGENCIES

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. During the last few years, due to nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, exclusion from the Medicare and Medicaid

programs and revocation of federal or state tax-exempt status. Moreover, the System expects that the level of review and audit to which it and other health care providers are subject will increase.

Various federal and state agencies have initiated investigations, which are in various stages of discovery, relating to reimbursement, billing practices and other matters of the System. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have on the System. To foster compliance with applicable laws and regulations, the System maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

20. INCOME TAXES AND TAX STATUS

The subsidiaries of the System are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) and their related income is exempt from federal income tax. Accordingly, no income taxes are recorded for the majority of the income in the accompanying consolidated financial statements for these entities. Unrelated business income is generated by certain of these entities through the provision of services or other activities not directly related to the provision of patient care.

At December 31, 2020, the System had $87,382 of federal and $111,826 of state net operating loss carryforwards with unutilized amounts of state net operating loss carryforwards expiring between 2020 and 2037. At December 31, 2019, the System had $52,133 of federal and $74,412 of state net operating loss carryforwards, with unutilized amounts of state net operating loss carryforwards expiring between 2019 and 2037. As a result of the Tax Cuts and Jobs Act of 2017, net operating losses generated after 2017 do not expire for federal purposes. Of the $87,382 of federal net operating loss carryforwards at December 31, 2020, $76,777 was generated after 2017.

The System calculated income taxes for its taxable subsidiaries. Taxable income differs from pretax book income primarily due to certain income and deductions for tax purposes being recorded in the consolidated financial statements in different periods. Deferred income tax assets and liabilities are recorded for the tax effect of these differences using enacted tax rates for the years in which the differences are expected to reverse.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent on the generation of future taxable income during the periods in which those temporary differences become deductible.

The System had deferred tax assets of $46,711 and $31,692, including $27,161 and $16,708 related to net operating loss carryforwards, as of December 31, 2020 and 2019, respectively. These deferred tax assets were partially offset by valuation allowances of $21,620 and $16,328, respectively, which were recorded due to the uncertainty regarding the use of the deferred tax assets.

Provisions (credits) for federal, state and deferred income taxes are included in other nonoperating income, net in the consolidated statements of operations and changes in net assets as follows:

	Year Ended December 31, 2020	Year Ended December 31, 2019
Federal	$ 5,677	$ (891)
State	2,100	(328)
Deferred	(9,311)	10,273
	$ (1,534)	$ 9,054

21. ACQUISITION OF BAY AREA MEDICAL CENTER

The System had a 49% interest in BAMC that was accounted for under the equity method of accounting until the remaining equity interest was purchased on April 1, 2019. BAMC is a 99-bed general acute care hospital located in Marinette, Wisconsin.

At the time of the acquisition, BAMC and the System owned a 73% and 27% interest, respectively, in ABAMG. ABAMG provides inpatient, outpatient and other professional medical services in Marinette, Wisconsin and its surrounding communities. As part of the acquisition of BAMC, the System now owns 100% of ABAMG and its financial results are included in the consolidated financial statements of the System.

The acquisition will improve the availability, scope and access to health care in the communities served by BAMC. As of April 1, 2019, BAMC and ABAMG are fully consolidated within the accompanying consolidated financial statements of the System.

In conjunction with the BAMC transaction, the System contributed $25,000 to a newly formed independent foundation. This interest in that foundation is reflected in investments in unconsolidated entities in the accompanying consolidated balance sheets. Under the terms of the definitive agreement between the System and BAMC, the use of the $25,000 contribution is designated to support the operations and capital needs of BAMC and/or ABAMG.

As the System previously had an interest in BAMC, this transaction was accounted for as an acquisition achieved in stages. The System remeasured its previously held equity interest in BAMC to fair market value resulting in a gain of $44,000, which was recorded within nonoperating (loss) income, net in the consolidated statements of operations and changes in net assets as of December 31, 2019. The System then recorded its 100% interest in BAMC at fair market value, resulting in an inherent contribution of $37,736, which was recorded within nonoperating (loss) income, net in the consolidated statements of operations and changes in net assets as of December 31, 2019.

The fair value of assets and liabilities of BAMC acquisition at April 1, 2019 consisted of the following:

Current assets	$	37,239
Assets limited as to use		18,795
Property and equipment		157,206
Other noncurrent assets		7,879
Other intangible assets		460
Total assets	$	221,579
Current liabilities		19,812
Long-term debt, less current portion		78,959
Other noncurrent liabilities		12,080
Total liabilities		110,851
Net assets with donor restrictions		792
Net assets without donor restrictions		109,936
Total liabilities and net assets	$	221,579

Total 2019 revenue and operating loss from the date of acquisition for BAMC of $109,309 and $(9,599), respectively were included in the consolidated statements of operations and changes in net assets. The 2019 BAMC related changes in net assets without donor restrictions of $(13,074) from the date of acquisition is included in the consolidated balance sheets.

The proforma financial information presented below were prepared on a consolidated basis utilizing the accounting records of the System and BAMC as if the acquisition had occurred for the entirety of the period presented. The proforma information presented have been adjusted to eliminate activity between the System and BAMC. Management believes the assumptions underlying the proforma financial information presented, including the assumptions regarding the elimination of intercompany activity are reasonable. Nevertheless, the proforma information may not reflect the results of operations had BAMC been a combined company during the periods presented and is not intended to project the System's results of operations for any future periods.

	Year Ended December 31, 2019
Total revenue	$ 12,833,303
Operating income	480,701
Revenues in excess of expenses	1,546,032

22. SUBSEQUENT EVENTS

The System evaluated events and transactions subsequent to December 31, 2020 through March 22, 2021, the date of consolidated financial statement issuance.

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Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Advocate Aurora Health, Inc.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying details of consolidated balance sheets and details of consolidated statements of operations and changes in net assets are presented for purposes of additional analysis and are not a required part of the 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 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 financial statements or to the 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 financial statements as a whole.

Ernst + Young LLP

March 22, 2021

ADVOCATE AURORA HEALTH, INC.

CONSOLIDATING BALANCE SHEET

December 31, 2020

(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Assets				
Current assets				
Cash and cash equivalents	$ 1,376,822	$ (416,944)	$ —	$ 959,878
Assets limited as to use	114,886	10,167	—	125,053
Patient accounts receivable	1,383,745	186,993	—	1,570,738
Other current assets	606,441	116,821	(36,576)	686,686
Third-party payors receivables	15,969	964	—	16,933
Receivable from subsidiaries	296,800	358,734	(655,534)	—
Collateral proceeds under securities lending program	19,789	—	—	19,789
Total current assets	3,814,452	256,735	(692,110)	3,379,077
Assets limited as to use	11,017,677	89,533	—	11,107,210
Note receivable from subsidiaries	137,772	—	(137,772)	—
Property and equipment, net	5,410,542	453,001	(11,566)	5,851,977
Other assets				
Reinsurance receivable	50,514	—	—	50,514
Goodwill and intangible assets, net	45,833	38,072	(1,153)	82,752
Investment in subsidiaries	(87,424)	—	87,424	—
Investments in unconsolidated entities	508,864	(7,915)	(290,646)	210,303
Operating lease right-of-use assets	272,655	37,023	—	309,678
Other noncurrent assets	745,834	37,095	(324,797)	458,132
Total other assets	1,536,276	104,275	(529,172)	1,111,379
Total assets	**$ 21,916,719**	**$ 903,544**	**$ (1,370,620)**	**$ 21,449,643**

ADVOCATE AURORA HEALTH, INC.

CONSOLIDATING BALANCE SHEET

December 31, 2020

(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Current liabilities				
Long-term debt and commercial paper, current portion	$ 100,573	$ 21,640	$ (20,217)	$ 101,996
Long-term debt subject to short-term financing arrangements	119,660	—	—	119,660
Operating lease liabilities, current portion	70,720	9,214	—	79,934
Accrued salaries and employee benefits	1,101,630	106,042	—	1,207,672
Accounts payable and accrued liabilities	1,213,268	148,927	(20,576)	1,341,619
Third-party payors payables	316,220	2,581	—	318,801
Accrued insurance and claims costs, current portion	119,334	11,057	—	130,391
Accounts payable to subsidiaries	383,985	270,786	(654,771)	—
Collateral under securities lending program	19,789	—	—	19,789
Total current liabilities	3,445,179	570,247	(695,564)	3,319,862
Noncurrent liabilities				
Long-term debt, less current portion	3,305,614	86,035	(81,248)	3,310,401
Operating lease liabilities, less current portion	238,269	30,306	—	268,575
Accrued insurance and claims cost, less current portion	558,237	35,502	—	593,739
Accrued losses subject to insurance recovery	50,514	—	—	50,514
Obligations under swap agreements	118,620	—	—	118,620
Due to subsidiaries	287,566	(149,794)	(137,772)	—
Other noncurrent liabilities	1,344,466	44,373	(951)	1,387,888
Total noncurrent liabilities	5,903,286	46,422	(219,971)	5,729,737
Total liabilities	**9,348,465**	**616,669**	**(915,535)**	**9,049,599**
Net assets				
Without donor restrictions				
Controlling interest	12,031,276	276,012	(294,569)	12,012,719
Noncontrolling interest in subsidiaries	152,922	1,846	(123)	154,645
Total net assets without donor restrictions	12,184,198	277,858	(294,692)	12,167,364
With donor restrictions	384,056	96,564	(247,940)	232,680
Common stock	—	1,862	(1,862)	—
Additional paid-in capital	—	43,581	(43,581)	—
Retained (deficit) earnings/partnership losses	—	(132,990)	132,990	—
Total net assets	**12,568,254**	**286,875**	**(455,085)**	**12,400,044**
Total liabilities and net assets	**$ 21,916,719**	**$ 903,544**	**$ (1,370,620)**	**$ 21,449,643**

ADVOCATE AURORA HEALTH, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended December 31, 2020

(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Revenue				
Patient service revenue	$ 9,186,603	$ 1,343,867	$ (314,084)	$ 10,216,386
Capitation revenue	510,941	620,662	(10,175)	1,121,428
Other revenue	1,374,734	799,173	(379,532)	1,794,375
Total revenue	11,072,278	2,763,702	(703,791)	13,132,189
Expenses				
Salaries, wages and benefits	6,494,245	971,195	(37,537)	7,427,903
Supplies, purchased services and other	3,427,287	982,348	(209,432)	4,200,203
Contracted medical services	288,186	599,375	(385,141)	502,420
Depreciation and amortization	513,718	48,794	(2,297)	560,215
Interest	107,343	12,455	(7,672)	112,126
Total expenses	10,830,779	2,614,167	(642,079)	12,802,867
Operating income (loss) before nonrecurring expenses	**241,499**	**149,535**	**(61,712)**	**329,322**
Nonrecurring expenses	116,355	—	—	116,355
Operating income (loss)	**125,144**	**149,535**	**(61,712)**	**212,967**
Nonoperating income (loss)				
Investment income, net	568,663	24,620	—	593,283
Loss on debt refinancing	(12,244)	—	—	(12,244)
Change in fair value of interest rate swaps	(27,280)	—	—	(27,280)
Pension settlement loss	(119,658)	—	—	(119,658)
Other nonoperating (loss) income, net	(38,567)	2,793	(3,169)	(38,943)
Total nonoperating income (loss), net	370,914	27,413	(3,169)	395,158
Revenue in excess of (less than) expenses	496,058	176,948	(64,881)	608,125
Less noncontrolling interest	—	(607)	(49,486)	(50,093)
Revenue in excess of (less than) expenses- attributable to controlling interest	**$ 496,058**	**$ 176,341**	**$ (114,367)**	**$ 558,032**

Notes to Supplementary Information

1. Credit Group

The supplementary financial information for the Credit Group is in accordance with the Second Amended and Restated Master Trust Indenture dated as of August 1, 2018 between Advocate Aurora Health, Inc, the other affiliates identified therein as the Members of the Obligated Group, the Restricted Affiliates, and U.S. Bank National Association, as master trustee ("the System Master Indenture").

2. Credit Group Members

The Credit Group is comprised of the Obligated Group in combination with the Restricted Affiliates. The Obligated Group includes Advocate Aurora Health, Inc.; Advocate Health Care Network; Advocate Health and Hospitals Corporation; Advocate North Side Health Network; Advocate Condell Medical Center; Advocate Sherman Hospital; Aurora Health Care, Inc.; Aurora Health Care Metro, Inc.; Aurora Health Care Southern Lakes, Inc.; Aurora Health Care Central, Inc. d/b/a Aurora Sheboygan Memorial Medical Center; Aurora Medical Center of Washington County, Inc.; Aurora Health Care North, Inc. d/b/a Aurora Medical Center Manitowoc County; Aurora Medical Center of Oshkosh, Inc.; Aurora Medical Group, Inc.; Aurora Medical Center Grafton LLC; and Aurora Medical Center Bay Area, Inc. The Restricted Affiliates include Advocate Charitable Foundation; Advocate Insurance SPC; Advocate Home Care Products, Inc.; EHS Home Health Care Services, Inc.; Evangelical Services Corporation, d/b/a Advocate Network Services, Inc.; High Technology, Inc.; Meridian Hospice; and West Allis Memorial Hospital Inc. d/b/a Aurora West Allis Medical Center. The Credit Group is with U.S. Bank National Association, as master trustee ("the System Master Indenture").