25-015

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.

RECEIVED
MAR 31 2025
HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	UChicago Medicine AdventHealth Bolingbrook		
Street Address:	500 Remington Boulevard		
City and Zip Code:	Bolingbrook, IL 60440		
County: Will	Health Service Area: 9	Health Planning Area: IV-13	

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

Exact Legal Name:	Adventist Bolingbrook Hospital d/b/a UChicago Medicine AdventHealth Bolingbrook
Street Address:	500 Remington Boulevard
City and Zip Code:	Bolingbrook, IL 60440
Name of Registered Agent:	The Corporation Company
Registered Agent Street Address:	600 S. 2nd Street, Suite 104
Registered Agent City and Zip Code:	Springfield, IL 62704-2550
Name of Chief Executive Officer:	Kenneth Rose
CEO Street Address:	500 Remington Boulevard
CEO City and Zip Code:	Bolingbrook, IL 60440
CEO Telephone Number:	630-312-2051

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Joe Ourth
Title:	Senior Partner
Company Name:	Saul Ewing LLP
Address:	161 N. Clark Street, Suite 4200, Chicago, IL
Telephone Number:	312-876-7815
E-mail Address:	Joe.Ourth@saul.com
Fax Number:	

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

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	

E-mail Address:	
Fax Number:	

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	UChicago Medicine AdventHealth Bolingbrook		
Street Address:	500 Remington Boulevard		
City and Zip Code:	Bolingbrook, IL 60440		
County: Will	Health Service Area: 9	Health Planning Area: A-13	

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

Exact Legal Name:	Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth
Street Address:	900 Hope Way
City and Zip Code:	Altamonte Springs, FL 32714
Name of Registered Agent:	The Corporation Company
Registered Agent Street Address:	600 S. 2nd Steet, Suite 104
Registered Agent City and Zip Code:	Springfield, IL 62704-2550
Name of Chief Executive Officer:	Terry Shaw
CEO Street Address:	900 Hope Way
CEO City and Zip Code:	Altamonte Springs, FL 32714
CEO Telephone Number:	407-357-1000

Type of Ownership of Applicants

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

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Telephone Number:
E-mail Address:
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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	UChicago Medicine AdventHealth Bolingbrook		
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City and Zip Code:	Bolingbrook, IL 60440		
County: Will	Health Service Area: 9	Health Planning Area: A-13	

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

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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	UChicago Medicine AdventHealth Bolingbrook		
Street Address:	500 Remington Boulevard		
City and Zip Code:	Bolingbrook, IL 60440		
County: Will	Health Service Area: 9	Health Planning Area: A-13	

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

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

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
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- ☐ Other

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Fax Number:	

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

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

Post Permit Contact

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

Name: Kurt Martz
Title: Regional Director, Facilities Administration
Company Name: UChicago Medicine AdventHealth
Address: 500 Remington Blvd., Bolingbrook, Illinois 60440
Telephone Number: 630-856-8369
E-mail Address:Kurt.Martz@AdventHealth.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Adventist Bolingbrook Hospital
Address of Site Owner: 500 Remington Blvd., Bolingbrook, IL 60440
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name:	Adventist Bolingbrook Hospital
Address:	500 Remington Boulevard, Bolingbrook, IL 60440

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

Adventist Bolingbrook Hospital d/b/a UChicago Medicine AdventHealth Bolingbrook ("UCMAH Bolingbrook") proposes to construct a new addition to increase its cardiac catheterization capacity and for other non-clinical space. UCMAH Bolingbrook currently has one cath lab and proposes increasing to two labs to provide needed redundancy, allow for growth, and to increase Interventional Radiology services.

UCMAH Bolingbrook is a 138-bed general acute care hospital and Level II Trauma Center. It is part of the four-hospital system operated as a joint venture between The University of Chicago Medical Center ("UCMC") and Adventist Health System/Sunbelt, Inc. ("Adventist Health"). UCMC is an academic medical center in Chicago and Adventist Health is part of a faith-based not-for-profit health system – known as AdventHealth – that operates approximately 55 hospitals nationwide. Their joint venture, Adventist Midwest Health, operates three other hospitals in Illinois in addition to UCMAH Bolingbrook:

Adventist GlenOaks Hospital d/b/a UChicago Medicine AdventHealth GlenOaks
Adventist La Grange Hospital d/b/a UChicago Medicine AdventHealth La Grange
Adventist Hinsdale Hospital d/b/a UChicago Medicine AdventHealth Hinsdale

All four of these hospitals operate their cardiac catheterization program in an integrated program with coordinated protocols.

The new construction will be a 15,558 bgsf addition that will include the relocated and additional cath lab plus needed administrative, storage, circulation and other non-clinical space. Total Project Cost is $21,625,782 and project completion is projected to be May 31, 2027. This project does not establish a facility or category of service and does not add beds and is classified as "non-substantive" under the Review Board's regulations.

The same cardiology medical group that staffs UCMAH Bolingbrook also staffs Hinsdale and La Grange hospitals.

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	$ 45,900	$ 21,600	$ 67,500
Site Survey and Soil Investigation	$ 6,256	$ 2,944	$ 9,200
Site Preparation	$ 301,155	$ 141,720	$ 442,875
Off Site Work	$ -	$ -	$ -
New Construction Contracts	$ 7,530,820	$ 3,546,245	$ 11,077,065
Modernization Contracts	$ -	$ -	$ -
Contingencies	$ 1,470,553	$ 692,025	$ 2,162,578
Architectural/Engineering Fees	$ 760,689	$ 357,971	$ 1,118,660
Consulting and Other Fees	$ 1,351,526	$ 626,600	$ 1,978,126
Movable or Other Equipment (not in construction contracts)	$ 3,231,914	$ 431,814	$ 3,663,728
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	$ 752,114	$ 353,936	$ 1,106,050
Acquisition of Building or Other Property (excluding land)	$ -	$ -	$ -
TOTAL USES OF FUNDS	**$ 15,450,927**	**$ 6,174,855**	**$ 21,625,782**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 15,450,927	$ 6,174,855	$ 21,625,782
Pledges	$ -	$ -	$ -
Gifts and Bequests	$ -	$ -	$ -
Bond Issues (project related)	$ -	$ -	$ -
Mortgages	$ -	$ -	$ -
Leases (fair market value)	$ -	$ -	$ -
Governmental Appropriations	$ -	$ -	$ -
Grants	$ -	$ -	$ -
Other Funds and Sources	$ -	$ -	$ -
TOTAL SOURCES OF FUNDS	**$ 15,450,927**	**$ 6,174,855**	**$ 21,625,782**

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 $ N/A .

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): May 31, 2027

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 departments 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: Adventist Bolingbrook Hospital		**CITY: Bolingbrook**			
REPORTING PERIOD DATES:		**From: 1-1-2023**		**to: 12-31-2023**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	82	4,001	19,579	0	82
Obstetrics	20	782	2,264	0	20
Pediatrics	0	0	0	0	0
Intensive Care	12	749	2,204	0	12
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	24	599	6,660	0	24
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	138	5,131	30,707	0	138

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 Adventist Bolingbrook Hospital d/b/a AdventHealth Bolingbrook Hospital * 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

KENNETH ROSE
PRINTED NAME

PRESIDENT/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24 day of March, 2025

Signature of Notary

Seal

Official Seal
Henry Scott Hagner
Notary Public State of Illinois
My Commission Expires 10/31/2025

SIGNATURE

Tristan Shaw
PRINTED NAME

CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24 day of March, 2025

Signature of Notary

Seal

Official Seal
Henry Scott Hagner
Notary Public State of Illinois
My Commission Expires 10/31/2025

*Insert the EXACT legal name of the applicant

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This Application is filed on the behalf of Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth * 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

Lynn Addiscott

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of March 2025

Signature of Notary

Seal

ILA KNIGHT
Commission # HH 490798
Expires June 8, 2028

SIGNATURE

Michael E. Saunders

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of March 2025

Signature of Notary

Seal

ILA KNIGHT
Commission # HH 490798
Expires June 8, 2028

*Insert the EXACT legal name of the applicant

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- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Adventist Health System/Sunbelt, 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	SIGNATURE
Lyon Addiscott	Michael E. Saunders
PRINTED NAME	PRINTED NAME
Assistant Secretary	Assistant Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 26th day of March 2025	Notarization: Subscribed and sworn to before me this 26th day of March 2025
Signature of Notary	Signature of Notary
Seal: ILA KNIGHT Commission # HH 490798 Expires June 8, 2028	Seal: ILA KNIGHT Commission # HH 490798 Expires June 8, 2028

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

Thomas Stackiewicz
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of March, 2025

Signature of Notary

Seal

OFFICIAL SEAL
ANA RIOS-RICO
Notary Public - State of Illinois
Commission No. 643145
My Commission Expires November 5, 2026

SIGNATURE

B Rachel Spitz
PRINTED NAME

SVP & General Counsel
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of March, 2025

Signature of Notary

Seal

OFFICIAL SEAL
ANA RIOS-RICO
Notary Public - State of Illinois
Commission No. 643145
My Commission Expires November 5, 2026

*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.

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):

☐ **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 23 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:**

$21,625,782	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, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.

$21,625,782	**TOTAL FUNDS AVAILABLE**

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

1. "A" Bond rating or better
2. All the 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 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

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

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

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

A table in the following format must be provided as part of Attachment 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 38, 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 39, 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 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)

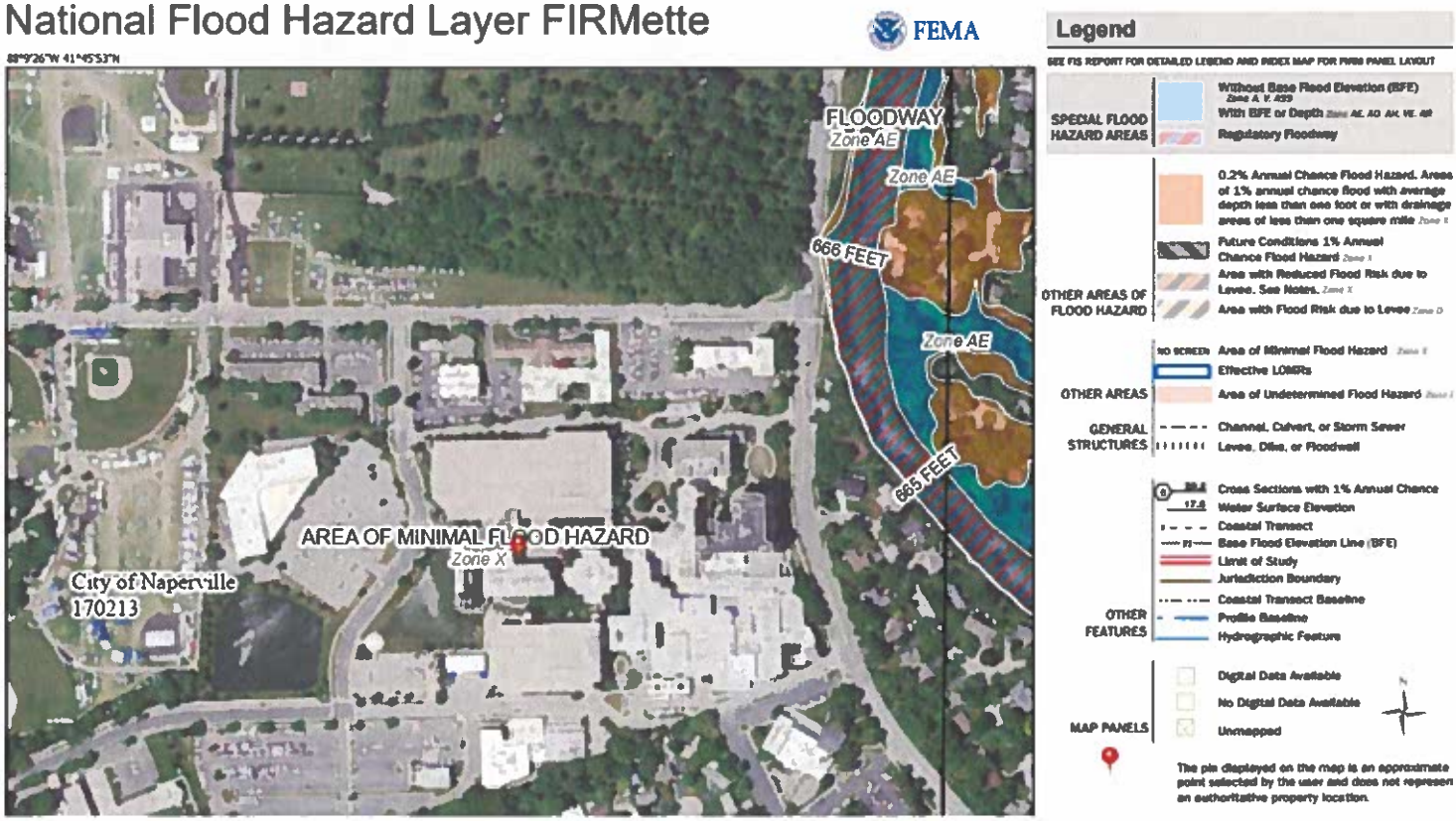
Signature:_____ Date: _____

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.



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

INDEX OF ATTACHMENTS

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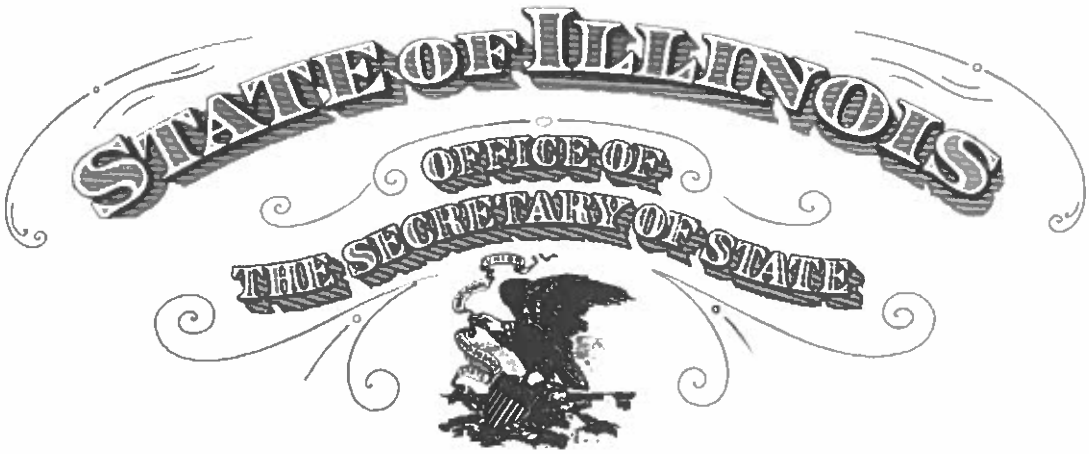
Section I. Type of Ownership of Applicant/Co-Applicant

Attachment 1

Adventist Bolingbrook Hospital d/b/a UChicago Medicine AdventHealth Bolingbrook ("UCMAH Bolingbrook") is an Illinois not-for-profit corporation. A copy of a Certificate of Good Standing is attached.

ATTACHMENT 1

File Number 6322-329-8



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

ADVENTIST BOLINGBROOK HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 25, 2003, 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* 11TH *day of* MARCH *A.D.* 2025 .

Authentication #: 2507004608 verifiable until 03/11/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1

Section I. Type of Ownership of Applicant/Co-Applicant

Attachment 1

Adventist Health System Sunbelt HealthCare Corporation d/b/a AdventHealth is a Florida not-for-profit corporation, authorized to do business in Illinois. A copy of a Certificate of Good Standing is attached.

ATTACHMENT 1

File Number 5938-890-8

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION, INCORPORATED IN FLORIDA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 28, 1997, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 11TH *day of* MARCH ***A.D.*** 2025 .

Authentication #: 2507004704 verifiable until 03/11/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1

Section I. Type of Ownership of Applicant/Co-Applicant

Attachment 1

Adventist Health System/Sunbelt, Inc. is a Florida not-for-profit corporation, authorized to do business in Illinois. A copy of Certificate of Good Standing is attached.

File Number 5938-879-7

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

ADVENTIST HEALTH SYSTEM/SUNBELT, INC., INCORPORATED IN FLORIDA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 28, 1997, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 11TH *day of* MARCH *A.D.* 2025 .

Authentication #: 2507005214 verifiable until 03/11/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1

Section I. Type of Ownership of Applicant/Co-Applicant

Attachment 1

The University of Chicago Medical Center is an Illinois not-for-profit corporation. A copy of a Certificate of Good Standing is attached.

ATTACHMENT 1

File Number 5439-757-7

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 11TH *day of* MARCH *A.D.* 2025 .

Authentication #: 2507005268 verifiable until 03/11/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1

Section I. Site Ownership

Attachment 2

Attached is information from the Will County Assessor's office evidencing that UCMAH Bolingbrook owns the real estate at the location of the project.

ATTACHMENT 2

Will County CCAO
Dale D. Butalla, CIAO-M
302 N. Chicago Street
2nd Floor
Joliet, Illinois 60432
Phone: 1-815-740-4648

PIN 12-02-22-100-012-0000

Parcel Information | << Prev Parcel | Next Parcel >>

DUPAGE TOWNSHIP

Owner Name: ADVENTIST BOLINGBROOK HOSPITAL

Street Address: View Additional Addresses
394 REMINGTON BLVD
BOLINGBROOK IL 60440

View on Bing Maps

Additional Addresses
400 S SCHMIDT RD
BOLINGBROOK IL 60440
500 REMINGTON BLVD
BOLINGBROOK IL 60440

Subdivision:

Property Class: 0090 Exempt Property

Homesite Acres:	0.00
Farm Acres:	0.00
Open Space Acres:	0.00
Non-Farm Acres:	32.35
Total Acres:	32.35

GIS Map & Address Information

Will County Treasurer's Tax Information

Assessment Information

Year	Assess Level	Land Unimproved/Farm	Land Improved	Building Other/Farm	Building	Total	Market Value	Instant Date	Instant Amount
2024	BOR	0	0	0	0	0	0		0
2024	SA/E	0	0	0	0	0	0		0
2024	TWP	0	0	0	0	0	0		0
2023	BOR	0	0	0	0	0	0		0
2022	BOR	0	0	0	0	0	0		0

Sale Information

Building Information

** Building information is submitted periodically from the DUPAGE TOWNSHIP Assessor; therefore, the building information listed may not be accurate or the most current. **

Style:		**Bathrooms:**	
Year Built:	0	**Central Air:**	
Total Sq. Ft:	0	**Fireplace:**	
Basement:		**Porch:**	
Garage:		**Attic:**	

** This property has multiple buildings on it. For more information, please contact the Township Assessor. **

** For the most comprehensive building characteristics and relevant information, please contact the DUPAGE TOWNSHIP Assessor. **

Legal Description

TRACT 1: LOTS 1 & 2 IN A.H.R. ASSESSMENT PLAT NO. 1 OF PRT OF THE W1/2 OF SEC 22, T37N-R10E, (EXCEPT THAT PRT

ATTACHMENT 2

Section I. Operating Identity/Licensee

Attachment 3

UCMAH Bolingbrook is an Illinois not-for-profit corporation and the licensed operator of the facility.

Section I. Organizational Relationships

Attachment 4

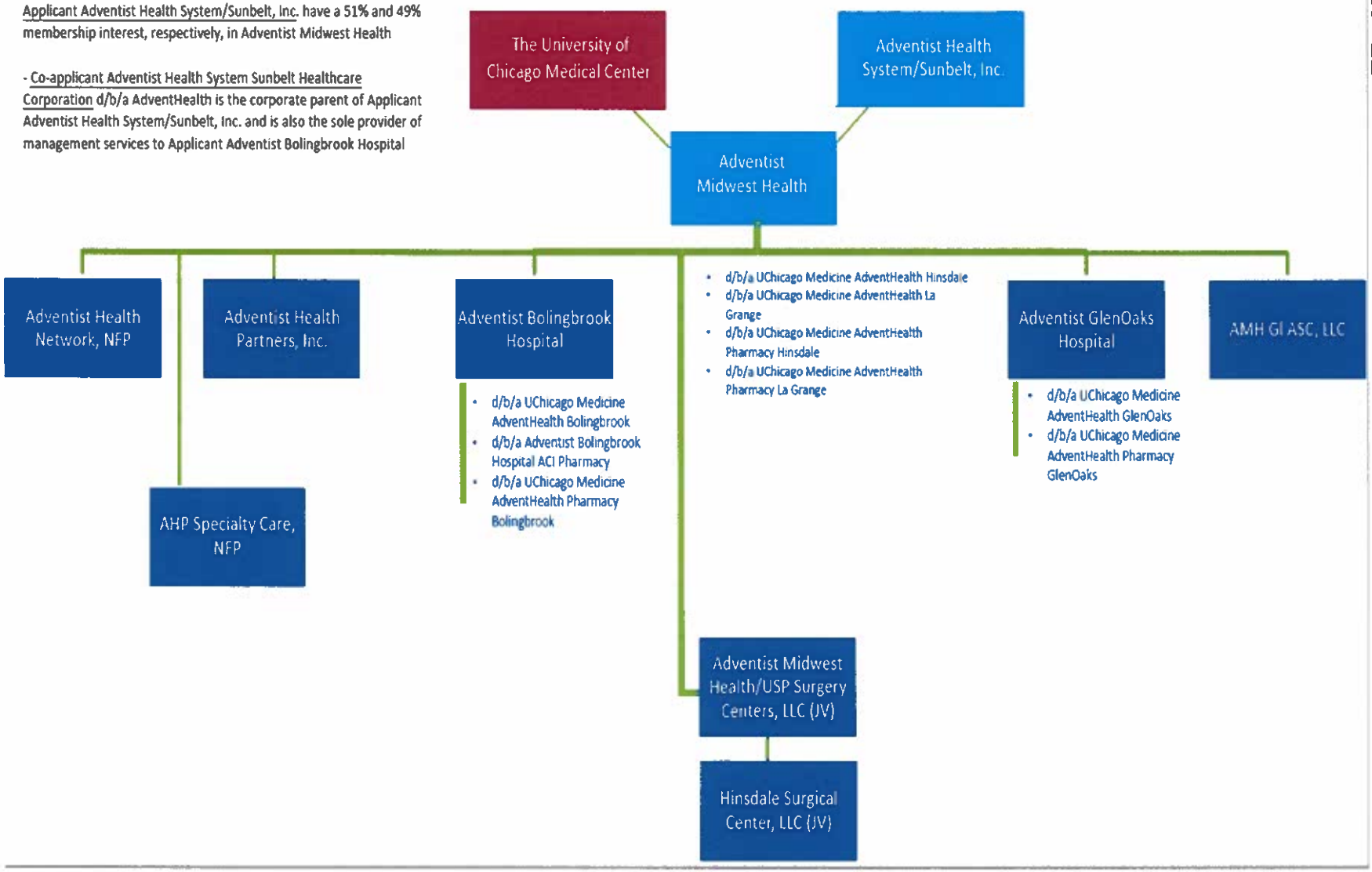
A copy of the organizational chart for UCMAH Bolingbrook is attached.

ATTACHMENT 4

- Adventist Midwest Health is the sole corporate member of Applicant Adventist Bolingbrook Hospital d/b/a UChicago Medicine AdventHealth Bolingbrook

- Co-applicant The University of Chicago Medical Center and Co-Applicant Adventist Health System/Sunbelt, Inc. have a 51% and 49% membership interest, respectively, in Adventist Midwest Health

- Co-applicant Adventist Health System Sunbelt Healthcare Corporation d/b/a AdventHealth is the corporate parent of Applicant Adventist Health System/Sunbelt, Inc. and is also the sole provider of management services to Applicant Adventist Bolingbrook Hospital



Section I. Flood Plain Requirements

Attachment 5

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

ATTACHMENT 5

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 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: UChicago Medicine AdventHealth Bolingbrook (Name) 500 Remington Blvd (Address)
   Bolingbrook (City) IL (State) 60440 (ZIP Code) (Telephone Number)

2. Project Location: 500 Remington Blvd (Address) Bolingbrook, IL (City) (State)
   Will (County) T37N Sec 22 (Township) (Section)

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

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

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

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

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

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

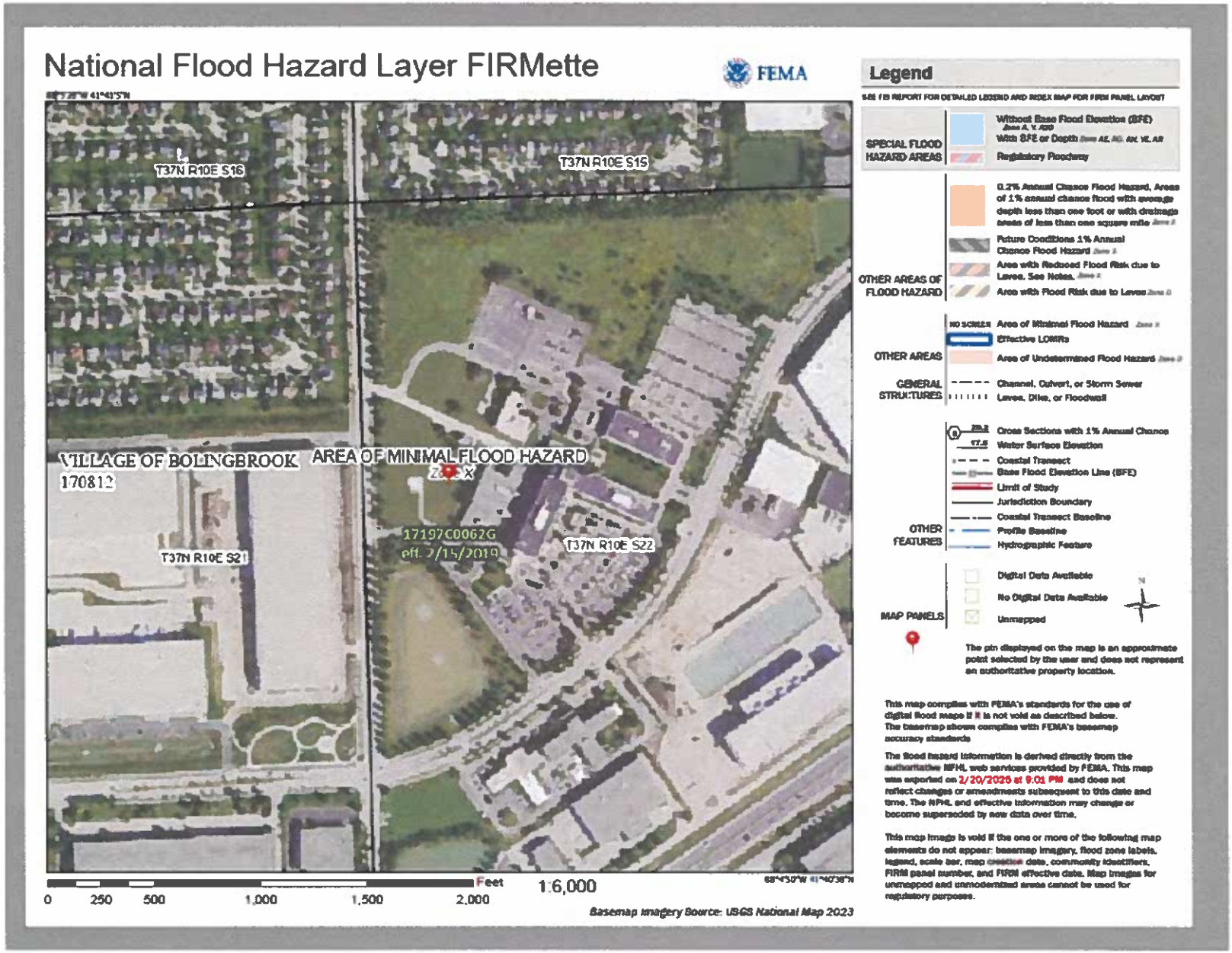
_____
(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date: _____

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

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

ATTACHMENT 5



ATTACHMENT 5

Section I. Historic Resources Preservation Act Requirements

Attachment 6

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

ATTACHMENT 6

SAUL EWING

Anna Pawlik
Phone: (312) 876-6958
anna.pawlik@saul.com
www.saul.com

March 10, 2025

VIA EMAIL

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer
Illinois Department of Natural Resources
One Natural Resources Way
Springfield, Illinois 62701-1271
E-mail: SHPO.Review@Illinois.gov

RE: Review to Determine Impact Upon Historic Resources
500 Remington Boulevard, Bolingbrook, Illinois 60440
Certificate of Need Application

Dear Ms. Mayer:

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

The Project will be to construct a new addition to increase its cardiac catheterization capacity and for other non-clinical space. The new construction will be a 15,558 gsf addition that will include the relocated and addition catherization lab plus needed administrative, storage, circulation and other non-clinical space

The proposed project is for the establishment of a cardiac catherization service within an existing acute care hospital and Level II Trauma Center surgery center located at 500 Remington Boulevard, Bolingbrook, Illinois 60440. Enclosed please find a map showing the property together with a street view and satellite photos.

We would appreciate a letter in response that we can include as part of the CON application. If you have questions or comments, or need additional information, please contact me at (312) 876-6958. I appreciate your assistance.

Very truly yours,

Anna Pawlik

Anna Pawlik

ATTACHMENT 6

ATTACHMENT 6

ATTACHMENT 6

ATTACHMENT 6

ATTACHMENT 6

External Link

Project Details

Project Information

Project ID	002031225	Title	CON - Addition to Hospital
County	WI	General Location	Bolingbrook
Law	State	Ownership	Private
Received Date	3/12/2025	Completion Date	
Acres	0	Surveyed By	
Structural Sites	1	Archeological Sites	0
Comments			

List of Properties

HARGIS Ref Number	Property Type	Address	City	State Site Number	STR	Determination Of Eligibility
	Structural	500 Remington Blvd.	Bolingbrook			undetermined

No Project Property Found

Project Status History

Status	Remarks	Date
Application Received		3/12/2025

List of IN Correspondence

Correspondence Name	Received Date	Remarks	Archaeology Survey ID

No In Correspondence Found

List of OUT Correspondence

Correspondence Name	Date	Correspondence

No OUT Correspondence Found

ATTACHMENT 6

Section I. Project Costs and Source of Funds

Attachment 7

Section 1120.110, Project Costs and Sources of Funds

Project Costs and Sources of Funds

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	$ 45,900	$ 21,600	$ 67,500
Site Survey and Soil Investigation	$ 6,256	$ 2,944	$ 9,200
Site Preparation	$ 301,155	$ 141,720	$ 442,875
Off Site Work	$ -	$ -	$ -
New Construction Contracts	$ 7,530,820	$ 3,546,245	$ 11,077,065
Modernization Contracts	$ -	$ -	$ -
Contingencies	$ 1,470,553	$ 692,025	$ 2,162,578
Architectural/Engineering Fees	$ 760,689	$ 357,971	$ 1,118,660
Consulting and Other Fees	$ 1,351,526	$ 626,600	$ 1,978,126
Movable or Other Equipment (not in construction contracts)	$ 3,231,914	$ 431,814	$ 3,663,728
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	$ 752,114	$ 353,936	$ 1,106,050
Acquisition of Building or Other Property (excluding land)	$ -	$ -	$ -
TOTAL USES OF FUNDS	**$ 15,450,927**	**$ 6,174,855**	**$ 21,625,782**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 15,450,927	$ 6,174,855	$ 21,625,782
Pledges	$ -	$ -	$ -
Gifts and Bequests	$ -	$ -	$ -
Bond Issues (project related)	$ -	$ -	$ -
Mortgages	$ -	$ -	$ -
Leases (fair market value)	$ -	$ -	$ -
Governmental Appropriations	$ -	$ -	$ -
Grants	$ -	$ -	$ -
Other Funds and Sources	$ -	$ -	$ -
TOTAL SOURCES OF FUNDS	**$ 15,450,927**	**$ 6,174,855**	**$ 21,625,782**

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

ATTACHMENT 7

Clinical	6748	57%	
Non-Clinical	8365	43%	
Total	15113		
Use of Funds - ASC Only	**TOTAL**	**Clinical**	**Non-Clinical**
Preplanning Costs - Include A/E Fees	$ 67,500	$ 38,475	$ 29,025
Site Survey & Soil Investigation	$ 9,200	$ 5,244	$ 3,956
Site Preparation	$ 965,880	$ 550,552	$ 415,328
Off Site Work	$ -	$ -	$ -
New Construction Contracts	$ 10,554,060	$ 6,056,050	$ 4,498,010
Modernization Contracts	$ -	$ -	$ -
Contingencies	$ 2,162,578	$ 1,232,669	$ 929,909
A/E Fees	$ 1,118,660	$ 637,636	$ 481,024
Consulting & Others Fees	$ 1,931,926	$ 1,109,798	$ 822,128
City Permit Fees	$ 400,000	$ 228,000	$ 172,000
IDPH Fees	$ 46,177	$ 26,321	$ 19,856
CON Related Fees	$ 50,000	$ 28,500	$ 21,500
Test & Balance	$ 50,000	$ 28,500	$ 21,500
Legal	$ 20,000	$ 11,400	$ 8,600
Commissioning	$ 100,000	$ 57,000	$ 43,000
Equipment Planning	$ 75,375	$ 42,964	$ 32,411
Graphics / Wayfinding Design	$ 50,000	$ 28,500	$ 21,500
Building Permit	$ 75,000	$ 42,750	$ 32,250
Program Management Representation	$ 485,829	$ 276,923	$ 208,906
Materials Testing	$ 55,000	$ 31,350	$ 23,650
Low Voltage / IT Design	$ 55,000	$ 31,350	$ 23,650
Use Tax	$ 144,545	$ 82,391	$ 62,154
Helipad Coordination and Design Consultant	$ 30,000	$ 17,100	$ 12,900
ADA Consulting	$ 10,000	$ 5,700	$ 4,300
Arc Flash / Breaker Study	$ 20,000	$ 11,400	$ 8,600
Sewer / Domestic Tap Fees	$ 30,000	$ 17,100	$ 12,900
Envelop Commissioning	$ 40,000	$ 22,800	$ 17,200
Transition Planning & Activation	$ 75,000	$ 42,750	$ 32,250
Builders Risk Insurance	$ 100,000	$ 57,000	$ 43,000
Physicist Testing	$ 20,000	$ 20,000	$ -
	TOTAL	**Clinical**	**Non-Clinical**
Movable Or Other Equipment (not in Construction Contracts)			
Total	**$ 3,709,928**	**$ 3,225,528**	**$ 484,400**
Furniture	$ 220,458	$ 125,661	$ 94,797
Signage	$ 123,200	$ 70,224	$ 52,976
Artwork	$ -	$ -	$ -
Major Medical Equipment	$ 3,366,270	$ 3,029,643	$ 336,627

ATTACHMENT 7

	TOTAL	Clinical	Non-Clinical
Other Costs to Be Capitalized	$ 1,106,050	$ 630,449	$ 475,602
Security	$ 136,400	$ 77,748	$ 58,652
IT Cabling	$ 441,100	$ 251,427	$ 189,673
IT Equipment	$ 528,550	$ 301,274	$ 227,277
Acquisition of Building or Other Property (excluding land)			
TOTAL USE OF FUNDS	**$ 21,625,782**	**$ 13,486,401**	**$ 8,139,381**
Sources of Funds			
Cash and Securities	$ 21,625,782	$ 13,486,401	$ 8,139,381
Pledges			
Gifts & Bequests			
Bond Issue			
Mortgages			
Leases			
Govt Appropriations			
Grants			
Other Funds			
TOTAL SOURCE OF FUNDS	$ 21,625,782	$ 13,486,401	$ 8,139,381

ATTACHMENT 7

Section I. Cost Space Requirements

Attachment 9

Cost Space Requirements

COST SPACE REQUIREMENTS

		Gross Square Feet		Amount of Proposed Total Gross Square Feet			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
CATH LAB	7,003,013.39	935	3,304	3,304	-	-	935
PACU/PREP	6,483,389.25	829	3,244	3,244	-	-	829
TOTAL CLINICAL	13,486,400.64	1,764	6,748	6,748			1,764
NON-REVIEWABLE							
ADMINISTRATION & STAFF	735,609.36	185	756	603	153	-	185
INTERDEPARTMENTAL CIRCULATION	2,739,074.54		2,813	2,813			
MEP/IT	386,292.22		397	397			
STORAGE	4,278,403.24		4,397	4,397			
TOTAL NON-CLINICAL	8,139,381.36		8,365	8,212	153	-	
TOTAL	21,625,782.00	1,764	15,113	14,960	153	-	1,764

Section III. Background of Applicant

Attachment 11

Section 1110.230, Background, Purpose of the Project and Alternatives

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

   Co-Applicants The University of Chicago Medical Center ("UCMC") and Adventist Health System/Sunbelt, Inc. ("Adventist Health") are parties to a joint venture. That joint venture entity, Adventist Midwest Health, either directly operates or is the sole corporate member of the following four Illinois hospitals, which are each separately accredited by The Joint Commission:

   - Applicant Adventist Bolingbrook Hospital d/b/a UChicago Medicine AdventHealth Bolingbrook (IDPH Hospital License #0005496)
   - Adventist GlenOaks Hospital d/b/a UChicago Medicine AdventHealth GlenOaks (IDPH Hospital License #0003814)
   - Adventist Midwest Health d/b/a UChicago Medicine AdventHealth La Grange (IDPH Hospital License #0005967)
   - Adventist Midwest Health d/b/a UChicago Medicine AdventHealth Hinsdale (IDPH Hospital License #0000976).

   UCMC owns and operates its medical center in Chicago with IDPH license number 0003897. UCMC also owns and operates Ingalls Memorial Hospital with license number 0001099 and Ingalls Same Day Surgery Center, license number 0001043.

   In addition, Co-Applicant Adventist Health System Sunbelt Healthcare Corporation (d/b/a AdventHealth) is the corporate parent of Co-Applicant Adventist Health System/Sunbelt, Inc. and maintains ultimate control of 51 hospitals in 8 other states.

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

   With the signatures on the Certification pages of this Certificate of Need Application, each of the applicants attests that, to the best of its knowledge, no adverse action has been taken against any Illinois health care facility owned and/or operated by it during the three years prior to the filing of this CON Application. Further, with the signatures provided on the Certification pages of this CON application, each of the applicants authorizes the Health Facilities and Services Review Board and the Illinois Department of Public Health access to any documents which it finds necessary to verify any information submitted, including but

not limited to official records of IDPH or other States agencies and records of nationally recognized accreditation organizations.

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

   By its signature to this permit application each of the Applicants hereby grants the Review Board and the IDPH access to information to verify information in this application.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF132377

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

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
1/10/2026		0005496

General Hospital

Effective: 01/11/2025

Adventist Bolingbrook Hospital
dba UChicago Medicine AdventHealth Bolingbrook
500 Remington Blvd

Bolingbrook, IL 60440

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 1/10/2026

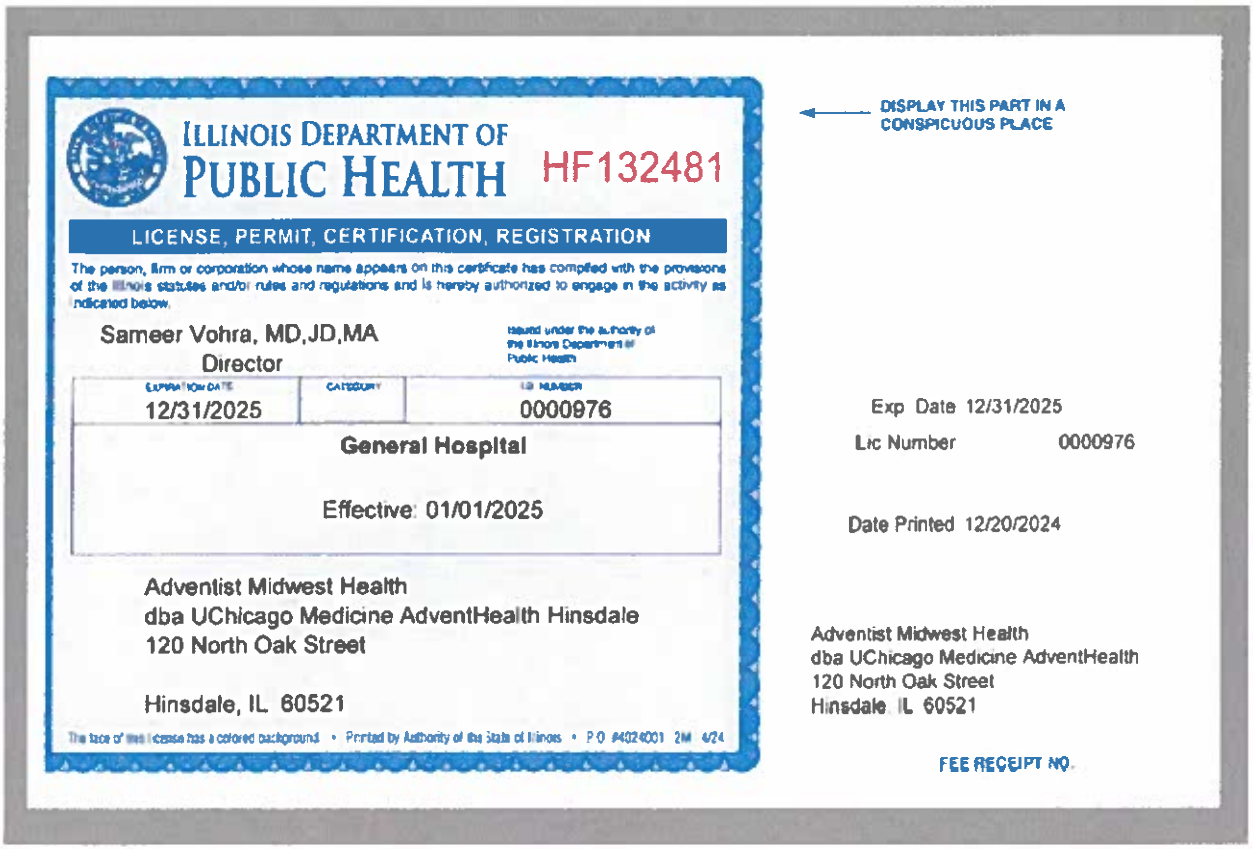
Lic Number 0005496

Date Printed 12/6/2024

Adventist Bolingbrook Hospital
dba UChicago Medicine AdventHealth
500 Remington Blvd
Bolingbrook, IL 60440

FEE RECEIPT NO.

ATTACHMENT 11



ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF132481

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.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2025		0000976

General Hospital

Effective: 01/01/2025

Adventist Midwest Health
dba UChicago Medicine AdventHealth Hinsdale
120 North Oak Street

Hinsdale, IL 60521

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp Date 12/31/2025

Lic Number 0000976

Date Printed 12/20/2024

Adventist Midwest Health
dba UChicago Medicine AdventHealth
120 North Oak Street
Hinsdale, IL 60521

FEE RECEIPT NO.

ATTACHMENT 11

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF132482

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.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
1/31/2026		0005967

General Hospital

Effective: 02/01/2025

Adventist Midwest Health
dba UChicago Medicine AdventHealth La Grange
5101 South Willow Springs Road

La Grange, IL 60525

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp Date 1/31/2026

Lic Number 0005967

Date Printed 12/20/2024

Adventist Midwest Health
dba UChicago Medicine AdventHealth
5101 South Willow Springs Road
La Grange, IL 60525

FEE RECEIPT NO.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF130438

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.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
6/30/2025		0003814

General Hospital

Effective: 07/01/2024

Adventist GlenOaks Hospital
dba UChicago Medicine AdventHealth GlenOaks
701 Winthrop Ave

Glendale Heights, IL 60139

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4422001 10M 3/22

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 6/30/2025

Lic Number 0003814

Date Printed 3/27/2024

Adventist GlenOaks Hospital
dba UChicago Medicine AdventHealth
701 Winthrop Ave
Glendale Heights, IL 60139

FEE RECEIPT NO.

The Joint Commission

April 17, 2023

Herbert Buchanan
VP Chief Executive Officer
Adventist Bolingbrook Hospital
500 Remington Boulevard
Bolingbrook, IL 60440

Joint Commission ID #: 454359
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 3/29/2023

Dear Mr. Buchanan:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning January 21, 2023 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.
Please note, if your survey was conducted off-site (virtually): Your organization may be required to undergo an on-site survey once The Joint Commission has determined that conditions are appropriate to conduct on-site survey activity.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

ATTACHMENT 11

April 29, 2024

Adam Maycock
CEO
Adventist Midwest Health
120 North Oak Street
Hinsdale, IL 60521-3890

Joint Commission ID #: 7359
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 4/17/2024

Dear Mr. Maycock:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 10, 2024 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations

ATTACHMENT 11

The Joint Commission

May 6, 2024

Adam Maycock
CEO
Adventist Midwest Health
5101 South Willow Springs Road
La Grange, IL 60525

Joint Commission ID #: 7370
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 5/1/2024

Dear Mr. Maycock:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning February 24, 2024 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations

ATTACHMENT 11

The Joint Commission

October 26, 2023

Vladimir Radivojevic
VP, CEO
AdventHealth GlenOaks Hospital
701 Winthrop Avenue
Glendale Heights, IL 60139

Joint Commission ID #: 5192
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 10/13/2023

Dear Mr. Radivojevic:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning August 12, 2023 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations

ATTACHMENT 11

Section III. Purpose of Project

Attachment 12

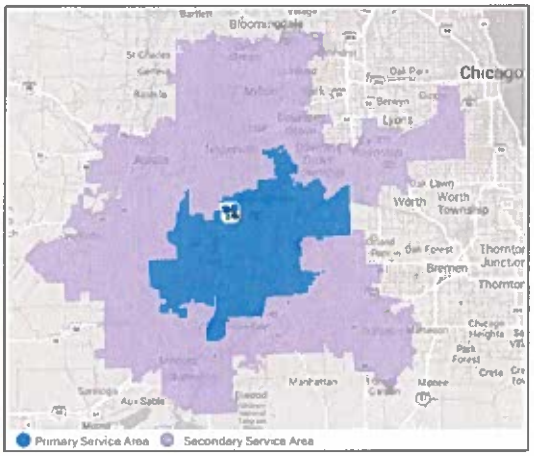
Overview of Purpose

Description of how the project will provide health services that improve health care or well-being of the market area population to be served;

Cath Lab Expansion Project: Enhancing Healthcare and Well-being

The expansion of our catheterization lab (CL) is a significant step towards improving healthcare and well-being in our primary service area. The robust emergency services that we provide to our community regularly require CL services, and this expansion will ensure that we can continue to meet the growing needs of our community.

Primary Service Area (PSA)



The Bolingbrook Primary Service Area (PSA) is experiencing significant growth in demand for cardiovascular services, with outpatient demand projected to increase by 20% and inpatient demand by 4.9% between 2025 and 2032. This growth is driven by rising prevalence of key cardiac conditions, including congestive heart failure (CHF) and heart valve anomalies, which are expected to see notable increases in both inpatient and outpatient settings.

Diagnostic and procedural volumes are also anticipated to follow this upward trend, underscoring the need for expanded capacity to meet the evolving needs of the population. Establishing a modern catheterization laboratory in this region will not only address the growing demand for cardiovascular care but also enhance access to critical diagnostic and interventional services, improving patient outcomes. This strategic investment aligns with our mission to deliver high-quality, accessible care to the communities we serve.

Our primary service area encompasses a diverse population with varying healthcare needs. The expansion of the CL will allow us to better serve this population by providing timely and efficient cardiac care, which is crucial for emergency situations.

Improved Access to Emergency and Chronic Cardiovascular Care

The community need for cardiovascular services, is well stated in the amount of coronary heart disease,[1] which has a rate of 5.6%.[2] This rate is higher than Will County (4.9%) and Illinois

[1] Centers for Disease Control and Prevention (CDC). (n.d.). **PLACES: Sub-County data (zip codes, tracts)**. Retrieved from https://www.cdc.gov/places.

[2] Centers for Disease Control and Prevention (CDC). (n.d.). **PLACES: Sub-County data (zip codes, tracts)**. Retrieved from https://www.cdc.gov/places.

(5.4%). These statistics highlight the need for enhanced healthcare services in our area, as do our steady emergency room (ER) volumes, which brings approximately 107 patients per day to our ER seeking care.

Improved Access to Cancer Care

The added capacity from the CL expansion will allow patients to receive cancer care closer to their homes, without the need to travel to other communities. This is particularly important for patients who require regular treatments and follow-ups. The increased capacity will also enable our interventional radiologists to complete biopsies and cancer treatments more efficiently, providing better outcomes for our patients. At our hospital, the cancer diagnosis rate is 7.09%,[3] which is slightly higher than Will County (6.7%)[4] and the US (6.88%).[5] This illustrates a current demand that is expected to increase over time.

Identify the issues and problems that project seeks to address or solve; Detail how the project will address or solve these issues or problems.
There are several problems and/or issues that will be addressed and/or remedied with the proposed project, including the following:

- Access – Currently, there are no other hospitals within a 10-mile radius of our hospital, which means patients have to travel significant distances to receive care. Patients who need complex biopsies or certain cancer treatments are not able to get those services in their community today. The expansion will provide these essential services locally, reducing the need for travel and ensuring timely care. Bolingbrook Hospital serves a community with diverse socioeconomic backgrounds. Many of these patients are challenged with access to affordable care. In 2024, nearly 23% of its patients were on a Medicaid plan or uninsured.[6] During the same time period, nearly 50% of patients coming through the Emergency Department were on Medicaid plan or uninsured.[7] Bolingbrook Hospital is committed to care for all of its community, contributing considerable charity care for patients unable to afford the cost of care. By adding new services and expanding service lines, the hospital is increasing access to affordable care for its community.

- Quality of Care: With only one CL available today, if there is an emergent need for interventional procedures while a patient is already being treated on the table, the patient would have to be stabilized and moved off the table. This can delay critical care and

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[3] Centers for Disease Control and Prevention (CDC). (n.d.). **PLACES: Sub-county data (zip codes, tracts)**. Retrieved from https://www.cdc.gov/places.

[4] Centers for Disease Control and Prevention (CDC). (n.d.). **Behavioral Risk Factor Surveillance System (BRFSS): County and state level data**. Retrieved from https://www.cdc.gov/brfss.

[5] Centers for Disease Control and Prevention (CDC). (n.d.). **Behavioral Risk Factor Surveillance System (BRFSS): County and state level data**. Retrieved from https://www.cdc.gov/brfss.

[6] Centers for Disease Control and Prevention (CDC). (n.d.). **Behavioral Risk Factor Surveillance System (BRFSS): County and state level data**. Retrieved from https://www.cdc.gov/brfss.

[7] U.S. Census Bureau. (n.d.). **American Community Survey (ACS): Tables S2704, S2701, and B27010**. Retrieved from https://www.census.gov/programs-surveys/acs.

potentially compromise patient outcomes. The expansion will add capacity, allowing for simultaneous treatments and improving the overall quality of care.

Section III. Alternatives

Attachment 13

Alternatives

Provide alternatives to the proposed project. The comparison shall address issues of cost, patient access, quality, and financial benefits in both the short term (within 1-3 years after project completion) and in the long term.

UCMAH Bolingbrook considered the following alternatives before selecting the proposed project:

1. Proposing a project of lessor scope and cost

One alternative considered involved adding one additional cardiac catheterization lab ("CL") next to the current lab. However, adding a new CL in existing space would displace the endoscopy rooms. The primary advantage of this approach is the reduced expenditure. However, because the hospital is essentially land-locked, there are limitations to future expansion. Additionally, this alternative would displace crucial endoscopy space, creating a negative operational impact for endoscopy. In addition to the impact to the adjacent clinical spaces, the Sterile Processing Department supporting the campus is located below the area of the proposed expanded cardiac lab department. The construction of a second lab and supporting spaces would result in a significant impact to the Sterile Processing Department, causing operational hardships and substantial enabling costs to the project.

2. Retain the Current State

An alternative option is to maintain the current setup without any changes. This approach retains the existing setup with only one CL, requiring no additional financial investment and avoiding any operational disruption associated with construction or relocation. However, it also means a lack of capacity to serve more patients, leading to operational challenges when multiple patients are present and no redundancy in the event of equipment failure. Consequently, there would be a need to transfer patients to other hospitals or risk patients leaving their home area to get the required treatments elsewhere.

3. Build a Full Outpatient CL Center

The most comprehensive solution is to construct a full outpatient (OP) CL center on or near the hospital campus. This option would follow the trends of these procedures moving to the outpatient setting and could potentially allow for some physician investment and partnership. However, this approach would not address the inpatient (IP) capacity issue created by a busy emergency room and growing community. Moreover, it would be more costly and time-consuming to find and build the suitable space needed for the OP CL center.

4. Construct Proposed Project

UCMAH needs a second cath lab to ensure patient access, and to provide redundancy, particularly in emergency situations. As a Level II Trauma Center, UCMAH has an active Emergency Department with over 36,600 ED visits in 2023. The most common reason for a patient to present in the ED is chest pains. A second cath lab will minimize the need to displace non-emergency procedures when the cath lab is needed for emergencies. For efficiency, the cath lab is also used for interventional radiology procedures. The second lab will for additional capacity for treating patients that need interventional radiology and allow for more advanced procedures to be performed.

Because of the hospital site and location, there is only one practical location for hospital expansion. The hospital is essentially land-locked and the proposed 15,000 square footage expansion is likely the sole opportunity for future expansion. Consequently, in addition to adding a second cath UCMAH also proposes adding additional non-clinical administrative and storage space.

Project	Summary	Pros	Cons
Project of lessor scope/cost	Add one CL next to current lab and displace endoscopy rooms Cost: $5,850,000	• Less money	• Land locked solution • Displaces crucial endoscopy space • Negative operational impact to sterile processing department underneath
Current State "Do Nothing"	Continue current situation of only having one CL Cost: $0	• Less money • No operational disruption	• Lack of capacity • Operational challenges • Transfer of patients out of the hospital • Patients leaving the market
Building full OP CL Center	Build an outpatient CL on or near the hospital campus $45,000,000	• More procedures moving to OP setting • Physician investment and partnership would be possible	• Does not solve IP capacity issue • More costly • More time consuming
Expand building to allow for 1 additional CL's and space for	Add 15,000 square feet to the building that will allow for	• Allows for all services to be combined in one	• Best Alternative

administrative and storage purposes	pre-operative, post-operative and catheterization rooms all in one area $21,625,782	convenient area • Allows for faster, easier access to the ER	

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

Attachment 14

Project Scope, Utilization and Unfinished/Shell Space

UCMAH Bolingbrook proposes a 15,113 square foot addition to its Bolingbrook Hospital, specifically targeting Cath Lab capabilities and volumes, and other non-clinical space.

The expansion would be located at the southernmost building of the hospital campus, jetting off the building towards the northwest by the current Emergency Department and Surgery Department. The new Cath Lab space will host two new 675 square foot Cath Labs, one new Cath Lab space that will host the relocated Cath Lab equipment currently in use at the Bolingbrook Hospital, and the other with all new equipment. The Cath Labs will be supported by a centralized control room with component equipment rooms to the outside of each lab space. To the north of the Cath Labs is a clean supply with egress to the east. The total space allocation for the Cath Lab Department is 3,504 square feet, which falls within the state standards for Cath Labs in Illinois.

The Cath Labs would have a unit with eight dedicated preparation and post-anesthesia care unit (PACU) rooms to the south of the labs, supported by two nurse stations that provide maximum visibility to patients and circulation in the department. The space includes a shared clean room and medication space, equipment alcoves, equipment room, a soiled utility space and two patient toilets, plus one for an isolation room. The PACU/Prep Department space makes up 3,244 square feet, which exceeds the state standard by approximately five hundred square feet. Several components add to the additional square footage as indicated below:

- The PACU/Prep space is dedicated to the new Cath Labs and not shared with other departments.
- Each PACU/Prep room is an individual room with sliding doors, which are larger than bays with cubicle curtains. Private rooms lead to greater patient satisfaction and better infection prevention.
- Universal PACU/Prep rooms are planned for operational efficiency and flexibility.
- Each PACU/Prep includes a handwash sink in per FGI Standards as best practice. IDPH only requires handwashing sinks at central nurse stations.
- There is one dedicated isolation PACU/Prep room with dedicated toilet for infection prevention.

The new department also includes several dedicated staff spaces including men's and women's locker rooms, staff toilet, staff break room and a separate reading room. Included in this square

footage allocation is the patient family waiting room as well. Altogether, this space totals 756 square feet.

Circulation throughout the space makes up 2,815 square feet, allowing for back of house movement, patient movement, and sterile supply movement throughout the department. Circulation also provides the required life safety egress from the building by continuing existing corridors.

To the southwest of expansion is a 397 square foot space specifically serving the mechanical, electrical, plumbing, and low voltage needs for the Cath Lab. And lastly, the expansion has adequate storage for the Cath Lab and hospital use totaling 4,397 square feet. The full scope of all departmental construction square footage is 15,113 square feet.

The exterior of the building would keep with the existing hospital aesthetic by tying in the same design elements seen throughout the campus. Specific design elements include composite metal systems, aluminum storefront and curtain wall, concrete wall systems with accent headers, and concrete foundation wall by the loading dock area. The overall building square feet including the exterior construction is 15,558 square feet.

Section IV. Project Services Utilization

Attachment 15

Appendix B, Project Services Utilization

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

Document that in the 2nd year of operation, the annual utilization of the service shall meet or exceed the utilization standards.

Section IV. Project Services Utilization

Attachment 15

15) Project Services Utilization

Document that in the second year of operation, the annual utilization of the service shall meet or exceed the utilization standards.

UCMAH Bolingbrook has historically operated a single swing IR/Cardiac Cath Lab, which supports a robust Interventional Cardiology program, Interventional Radiology program, and Vascular Surgeons requiring image guided technology for interventional work. Given the growth of the UChicago Medicine AdventHealth Cardiovascular Service Line across the AdventHealth Great Lakes region and the specific cardiovascular needs of the UCMAH Bolingbrook primary service area (PSA), expanding from one to two cardiac catheterization labs is essential. This expansion will ensure the continuation of current services without disruption and meet the increased demand identified in the community assessment.

The community assessment indicates a significant demand for cardiovascular services, with outpatient demand projected to increase by 20% and inpatient demand by 4.9% between 2025-2032. Additionally, a rise in cancer diagnoses has necessitated enhanced support for oncology patients through innovative, minimally invasive interventional radiology procedures for diagnosis and treatment.

The current single Cardiac Cath/IR lab limits UCMAH Bolingbrook's ability to provide seamless, uninterrupted, and safe care for patients facing life-threatening emergencies. Patients experiencing emergencies such as a STEMI (ST-Elevation Myocardial Infarction), cardiac arrest, cardiogenic shock, acute pulmonary embolism, or vascular emergencies often require the intervention of interventional cardiologists, radiologists, or vascular surgeons using image-guided therapeutic interventions available only in a cath lab/IR setting with fluoroscopic imaging. All these emergencies are time sensitive and require immediate intervention. UChicago Medicine AdventHealth is adherent to the American College of Cardiology (ACC) and American Heart Association (AHA) guidelines for STEMI care. These guidelines aim to reduce total ischemic time and improve survival rates for STEMI patients by ensuing timely and coordinated care. For patients undergoing primary percutaneous coronary intervention (PCI), the goal is to achieve a door-to-balloon time of 90 minutes or less. A cardiac cath program should have the redundancy of a second lab if there is an on-going procedure or lab downtime.

The planned expansion includes the addition of one cardiac cath lab and eight prep and recovery bays. The expansion is supported by historical procedural volumes at UCMAH Bolingbrook and the growth at other UChicago Medicine AdventHealth facilities in the region. The table below illustrates the number of cardiac catheterizations and other interventional procedures performed by UChicago Medicine AdventHealth Interventional Cardiologists, Electrophysiologists, Vascular Surgeons, and Interventional Radiologists at Bolingbrook and three other UChicago AdventHealth facilities in the region. A large, employed cardiology practice covers Hinsdale, LaGrange, and Bolingbrook. Cumulative regional volumes are considered from both quality and

quantity perspectives. The same Interventional Radiology group also covers the three UChicago Medicine AdventHealth facilities listed below.

The UChicago Medicine AdventHealth Cardiovascular Service Line adopts a regional approach, monitoring patient needs across each hospital's PSA. This includes ensuring patient access, timely procedure scheduling, safe and uninterrupted care during procedures, availability of emergent services, and achieving high-quality outcomes for every patient.

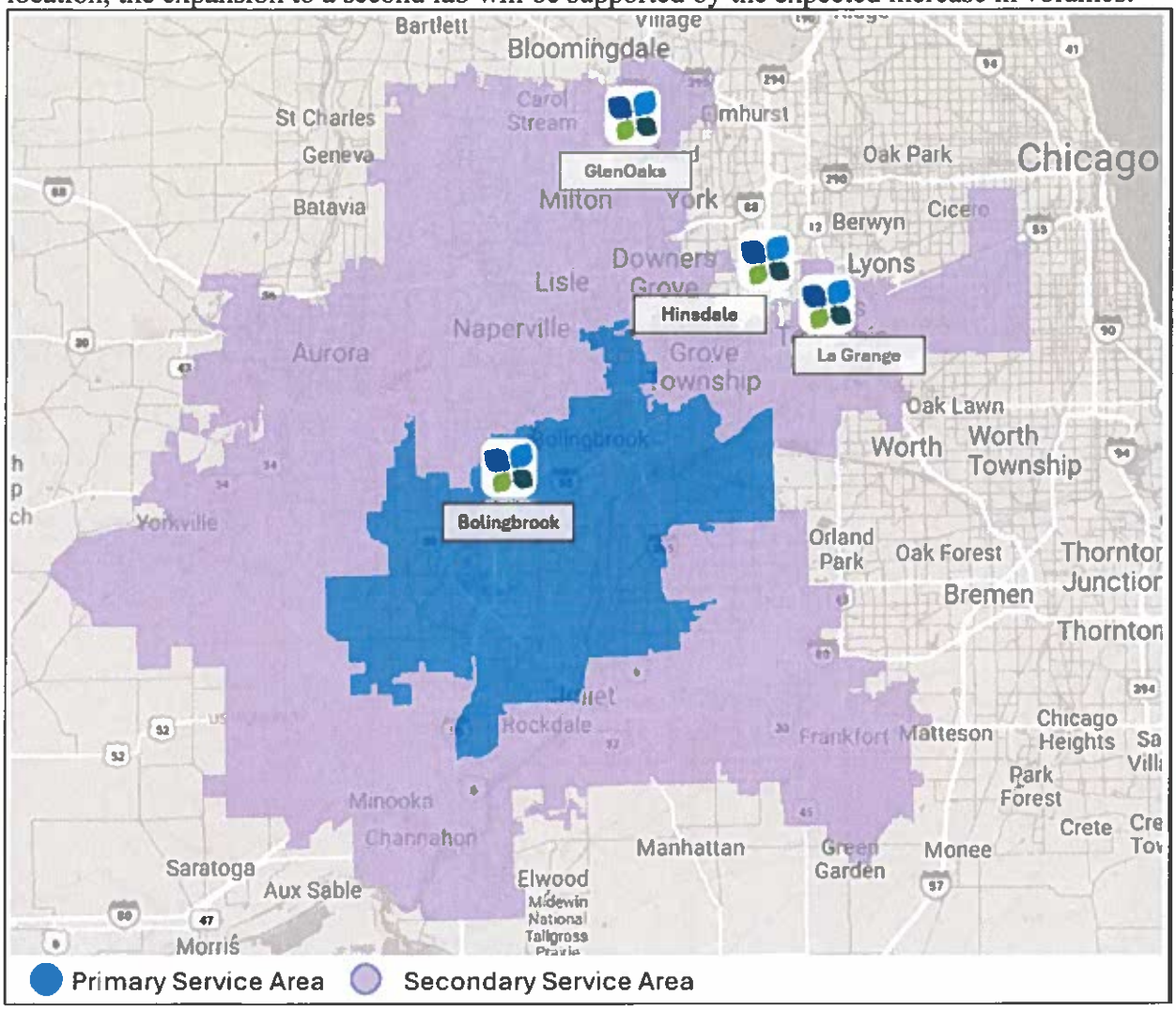
The table below demonstrates that the cardiac cath and/or cardiac cath/IR labs in the region meet or exceed current state standards of 200 cardiac caths. Expanding UCMAH Bolingbrook from one to two cardiac cath labs will be required to support the continued growth of cardiac and interventional radiology services in a safe and effective manner. UCMAH Bolingbrook will be able to support the community it serves by providing access to care utilizing two labs versus the constraints of one lab. Two cath labs reduces the risk of delay to care by creating redundancy and availability of a lab when a medical emergency arises requiring therapeutic intervention that can only be provided in a Cardiac Cath and/or Interventional Radiology Lab. The lack of redundancy creates on-going risk if at the time of an emergency there is a concurrent patient already receiving necessary care in the single lab or if there is equipment downtime due to equipment failure and/or preventive maintenance is on-going.

Procedures Performed in the Cardiac Cath Lab Department (Bolingbrook is a Cardiac Cath/ Interventional Radiology Swing Lab)					
Year	**UChicago Medicine AdventHealth Hinsdale**	**UChicago Medicine AdventHealth LaGrange**	**UChicago Medicine AdventHealth Bolingbrook**		
	Cardiac Cath/EP/Vascular	Cardiac Cath/EP/Vascular	Cardiac Cath/Vascular	Interventional Radiology	**Total**
2021	723	301	359		1383
2022	1112	206	373	991	2682
2023	2132	667	375	839	4013
2024	3566	326	290	873	5055
	3 labs 2021-9/2023. 4th lab opened 9/14/23	2 labs	1 lab		

*Catheterization Procedures reported in the annual AHQ provided by IDPH.

The table above demonstrates the current labs exceed the 200 cases annually. As a cardiovascular service line, UChicago Medicine AdventHealth desires to provide the services for the Bolingbrook community at our Bolingbrook facility. In the current state, due to the lack of cath lab redundancy at UCMAH Bolingbrook, it frequently schedules Bolingbrook outpatients at the Hinsdale facility to reduce risk of case interruption. As demonstrated in the table above, Hinsdale volumes are growing exponentially with the increase in EP volumes and TAVR volumes. Therefore, to allow Hinsdale to take on the continued growth and to provide patient satisfaction to the patients that travel from the Bolingbrook PSA, UChicago Medicine AdventHealth has determined the necessity to expand the Bolingbrook facility to provide care to the patients in the community it serves. The additional lab will also serve the growing needs

determined in the community assessment. Based on growth projections in the community and the service line allowing patients to schedule at the Bolingbrook location versus the Hinsdale location, the expansion to a second lab will be supported by the expected increase in volumes.



ATTACHMENT 15

Attachment 22

Cardiac Catheterization

1. Criterion 1110.225(a) Peer Review

UCMAH Bolingbrook Peer Review program is included as part of this Attachment 22.

Peer Review Plan

AdventHealth, Bolingbrook

And

Medical Staff

Approval:
Peer Review Committee: 11/21/16; 9/23/19, 10/26/2022
Medical Executive Committee: 12/9/16; 10/11/19, 11/11/2022
Board of Directors: 12/14/16; 10/24/19, 12/14/2022

ATTACHMENT 22

Cardiac Cath Peer Review

Physician Peer Review Committee and Process

Purpose: The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence. (Standard MS.09.01.01, *2022 Hospital Accreditation Standards* The Joint Commission)

Responsibilities of the Peer Review Committee are to:

- Oversee the Peer Review process, including the timeliness of the process, as delineated in the attached Flow Charts, Narrative Description and Recommendations document

Attachment #1: Performance Management Decision Guide for Medical Staff
Attachment #2: Peer Review Process Narrative Description
Attachment #3: Peer Review Process Flow charts

- Address cases that are referred to the Committee by Department Chairs or Medical Directors, following initial identification, screening, and review
- Evaluate cases using appropriate specialist peer input and physician response
- Determine actions required for all cases that are addressed by the Committee. All recommendations for focused review and external review are reviewed by MEC. Attachment #3: Peer Review Committee Action Choices
- Recommend follow-up action, as appropriate, to the Medical Executive Committee (MEC) Recommend to the MEC cases which may require external peer review:

1. When conflict of interest issues exist or internal expertise to complete the review is not available.
2. When the recommendation of the Peer Review Committee regarding actions is not preliminarily supported by the MEC.
3. When a Chief Medical Officer or the President of the Medical Staff requests an expedited review.

Focused professional practice evaluation (FPPE) is performed when concerns or issues arise regarding a practitioner's competence or performance.

The purpose of FPPE for a medical staff member experiencing performance issues is to evaluate current competence through intense review.

1. FPPE may be recommended by the Peer Review Committee in response to a single case in which findings indicate that intense review of the physician's practice is deemed appropriate by the Committee.
2. It may be recommended when trended data indicates that a medical staff member has a practice pattern which requires evaluation.
3. The department chairman will review Premier physician profiles semiannually; drill down will occur as needed for any measure two or more standard deviations from the mean.

The Peer Review Committee shall make this recommendation for FPPE to the Medical Executive Committee for action and approval.

The Medical Executive Committee is responsible for overseeing the process for individual case review, which may include establishment of a medical review panel and time-frames for review.

When concurrent review is recommended the timeframe for review shall be no less than 3 months or 10 cases. Upon completion of the initial review period, the number of cases reviewed and outcomes, will be reported to the Medical Executive Committee. The MEC will determine if an adequate number of cases has been reviewed to draw a conclusion; monitoring may be concluded or continued at that time. The physician will be notified in writing of the outcome of the initial monitoring period.

When case numbers are low, retrospective chart review may be utilized to reach a valid sample size (generally no less than 10 cases). The guidelines for focused review may be modified by the Medical Executive Committee in a specific case to achieve timely closure of issues.

Membership:

- Vice President of the Medical Staff
- Secretary/Treasurer of the Medical Staff
- Vice Chairs of the Departments of the Medical Staff will act as members for the period of their office
- Minimum of Three "at-large" members will be chosen on the recommendation of the Peer Review Committee
- One member from the hospitalist physician group
- Definition of Peer: a "Peer" for the purpose of the Peer Review process shall be considered a member of the organized medical staff within the same professional designation; (e.g. MD or DO; DDS; Podiatrist); however, specialty-specific members of the medical staff will be utilized to provide consultation, as needed
- A quorum shall be present when 3 members of the Committee are present.
- The Chief Medical Officer will act as an Advisory Member to the Committee
- The Chief Nursing Officer will act as an Advisory Member to the Committee
- The Quality Coordinator will act as staff support for the Chair of the Committee

Committee Support:
The Quality Coordinator will:

- Maintain the case identification process
- Provide initial case screening services
- Facilitate the timely referral and review of cases to the Department Chairs and or Medical Directors and to the Peer Review Committee
- Assure that a database is maintained for cases in the peer review process.
- Maintain the Peer Review Profile system
- Provide initial screening of Premier physician profiles

Reporting:

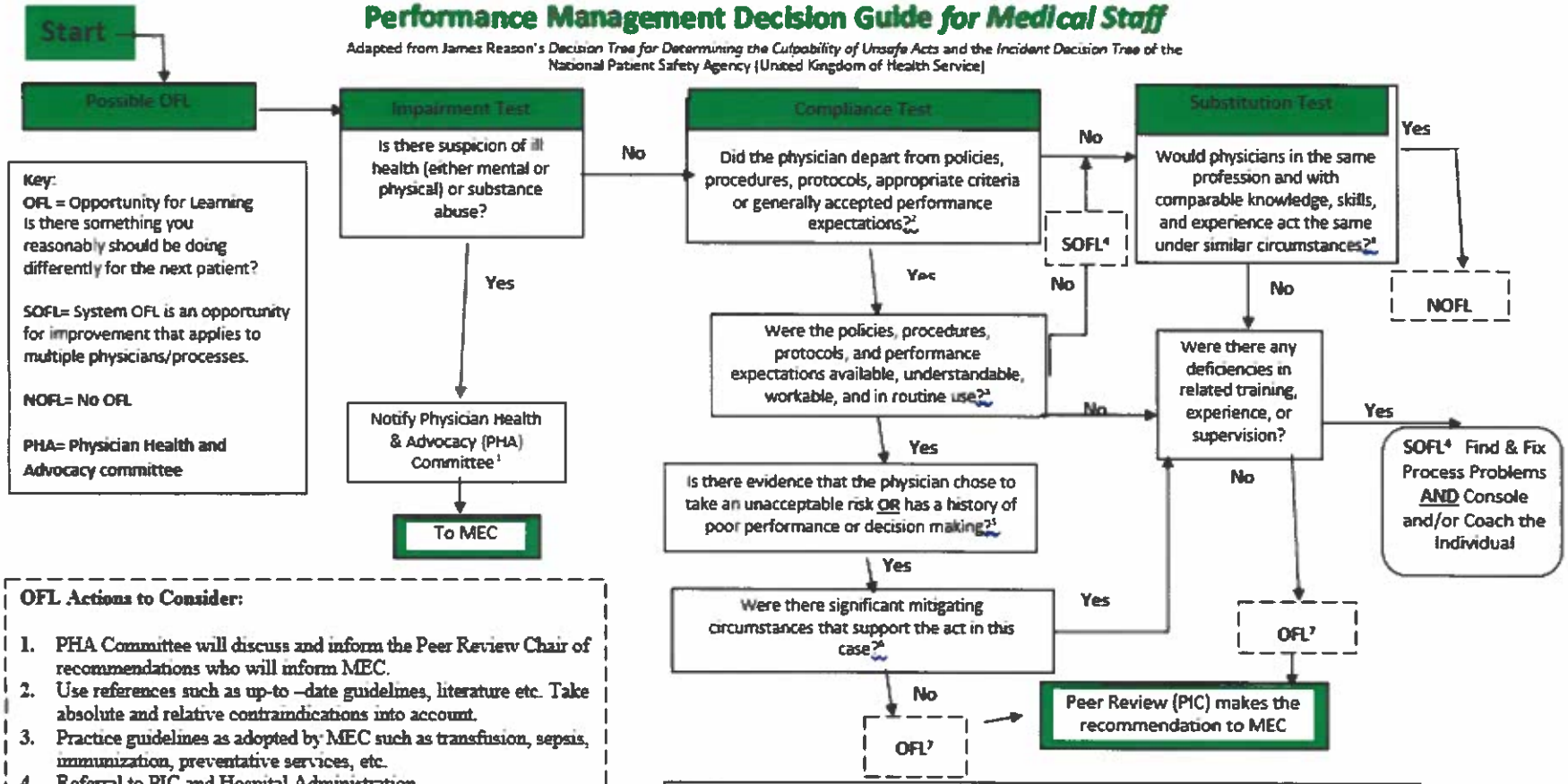
- The Peer Review Committee reports to the Medical Executive Committee

Schedule:

- The Peer Review Committee shall meet, at a minimum, once a month and at the discretion of the Chair. The Committee may meet more often in order to address cases in a timely manner. The Chair has the authority to cancel a monthly meeting.

Performance Management Decision Guide *for Medical Staff*

Adapted from James Reason's *Decision Tree for Determining the Culpability of Unsafe Acts* and the *Incident Decision Tree* of the National Patient Safety Agency (United Kingdom of Health Service)



OFL Actions to Consider:

1. PHA Committee will discuss and inform the Peer Review Chair of recommendations who will inform MEC.
2. Use references such as up-to –date guidelines, literature etc. Take absolute and relative contraindications into account.
3. Practice guidelines as adopted by MEC such as transfusion, sepsis, immunization, preventative services, etc.
4. Referral to PIC and Hospital Administration.
5. Was this on purpose?
6. There are circumstances where a violation is warranted because the alternative is worse.
7. OFL can result in a range of learning actions:
   a. Educational letter
   b. "Cup of coffee" conversation
   c. In person educational meeting with informal corrective action.
   d. In person formal corrective action with FPPE to monitor for change.
   e. Refer repeat OFLs, patters of OFLs or a single egregious OFL to Peer Review
8. Community standard applies: Would you expect a similar provider with a similar patient under similar circumstances to treat the patient similarly?

#7 Detail	OFL Learning Action	
Action		Responsibility
a.	Educational Letter	Chair
b.	"Cup of coffee" conversation	Vice Chair
c.	In person educational meeting with informal corrective action with/without FPPE	Dept. Chair and Provider Expert(s) if appropriate
d.	In person meeting with formal corrective action with FPPE to monitor for change	PIC Chair and Dept. Chair
e.	Refer repeat OFLs, patterns of OFLs or a single egregious OFL to Peer Review	Chair and Peer Review

The Peer Review Process Narrative Description Summary

Case Identification:

Cases may be identified through, but not limited to:

- Occurrence Screens specific to a function/department
- Referrals from other Medical Staff or Hospital Committees, Task Force groups, or other bodies, etc.
- Referrals from Perinatal Mortality & Morbidity, and, Robotics Committee, Cardiovascular Committee, Radiology Peer Review Committee, Pathology QA Committee
- Referrals from Medical Staff members
- Referrals from Hospital Staff
- Referrals from Risk Management
- Referrals from external review bodies (QIO, etc.,)
- Referrals based on patient complaints

Initial Screening:

Cases will be screened by the Quality Coordinator to determine:

- If the documented circumstances of the case meet the intent of peer review
- If adequate information exists to review the case
- If the case should be "Fast-Tracked" (see below)

The Manager of Medical Data Outcomes and Peer Review will seek the input of the Chief Medical Officer, as necessary, to make these determinations

Note: Perinatal Committee, PCCs, Robotics Committee, Cardiovascular Committee, Radiology Peer Review Committee, Pathology QA Committee, do Initial & Final Screening in their respective areas

"Fast-Track" Referral:

Cases identified for immediate review will be referred to the Department Chair by the Quality Coordinator

A) Possible Sentinel Event cases, as defined by the Medical Staff Sentinel event policy/procedure
   - Dept. Chair participates in Sentinel Event process and the case may be referred to Peer Review, if warranted.

B) Cases where it is felt that an immediate patient clinical-safety issue is involved. Cases in this category may be identified through the work of a critical incident review team.
   - Dept. Chair reviews and immediately addresses with the responsible physician(s) and then refers to the Peer Review Committee for retrospective review, as warranted.

C) Any issue where the physician(s) involved is/are identified as displaying behavior that is disruptive to the clinical process or the hospital organization.
   - Dept. Chair/CMO reviews and refers to Code of Conduct Committee

D) Issues where the "citizenship" of the medical staff member is in question; e.g. not responding to an on-call assignment, not documenting medical record information in a timely or appropriate manner to facilitate patient care.

- Department Chair reviews and addresses as soon as possible with responsible physician(s).

For cases involving a Conflict of Interest:
No Peer Review Committee member, Committee Chair, Department Chair, and/or Department Vice Chair may:

- Conduct the Screening or Review steps of the peer review process, or
- Vote in the Evaluation step of the peer review process

for any case in which they, or a business partner, participated in the clinical care of the patient. (i.e. Radiology, Emergency, Pathology)

Quality Coordinator, in consultation with the Chair of the Peer Review Committee and/or the Chief Medical Officer will determine an appropriate alternative medical staff member in a position of leadership with appropriate clinical expertise, to participate in the Peer Review process steps.

Alternative External Review Process:
The Peer Review Committee may refer cases to another Advent Great Lakes Region Hospital or an External Review Service when:

- Committee members agree that there is a conflict of interest for multiple committee members,
- The case review requires a specific specialty's expertise which is beyond the scope of committee members, or
- The physician involved in the case review requests an external review with Peer Review Committee approval.

Alternative Screening and Review process for Obstetrics Performance Improvement, Robotics Committee, Cardiovascular Committee, Radiology Peer Review Committee, Pathology QA Committee

- The Medical Executive Committee has determined that these Committees will conduct the Screening and Review steps within the Peer Review process for any identified case.
- The committee will discuss the case at the peer review session after a regularly scheduled meeting and determine if the issues identified involve the clinical judgment and/or technique of a particular physician(s). If it is determined that clinical judgment and/or technique quality of care issues are involved, the members will follow the process outlined for the Peer Review Committee and assign a recommendation.
- The Chair of these Committees will refer cases to the Peer Review Committee and participate in any further discussion and evaluation of the case, including the formulation of recommendations, as required, to the Medical Executive Committee.
- The Chairs of these Committees will present an annual summary to the Peer Review Committee, including the number of cases reviewed, a breakdown by specialty and final recommendations.

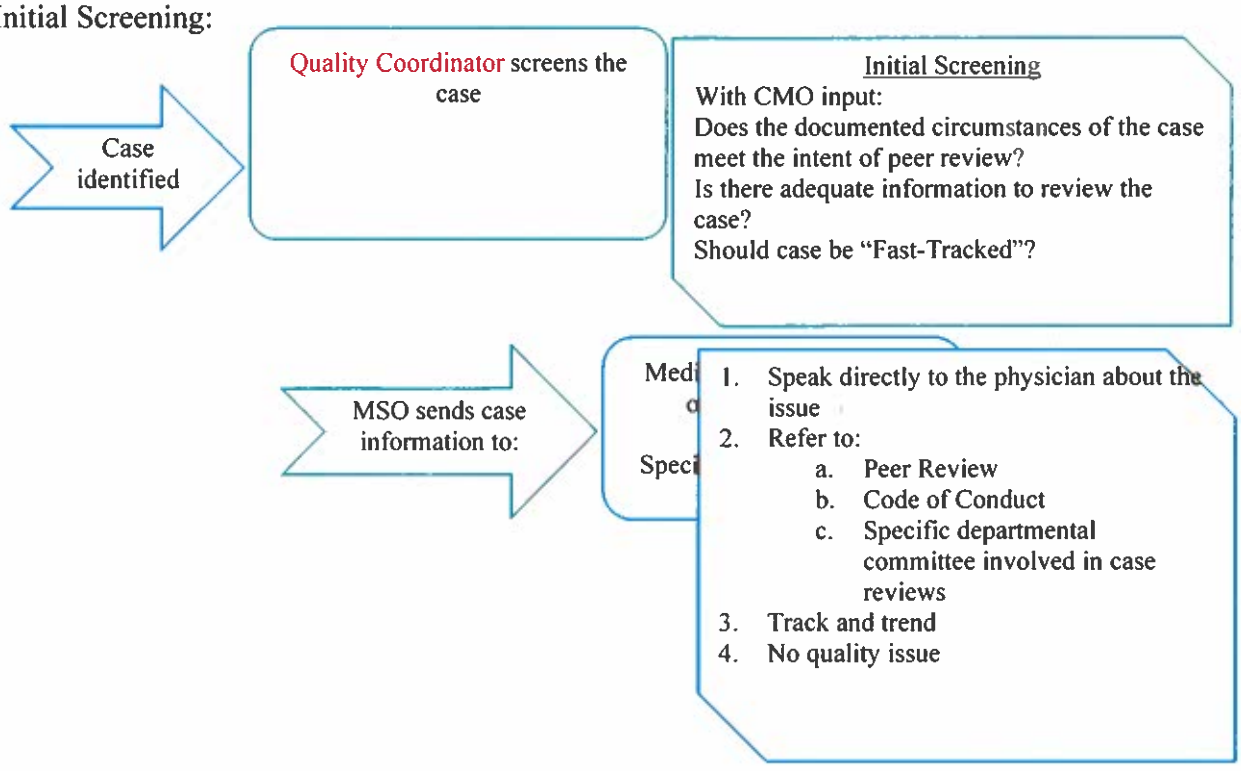
Peer Review Process Flow Charts

Case Identification:

Examples of internal referrals: safety huddle, word of mouth, Patient safety officer, referrals from hospital lawyers. Risk masters, letters of complaint, daily chart review, leader rounding visits,

Examples of external referrals: QIO=Quality Improvement Organizations (external review bodies) i.e.; Joint commission, CMS, IDPH, HIS=Health and Safety Institute-OSHA

Initial Screening:



ATTACHMENT 22

Attachment 22

Cardiac Catheterization

2. Criterion 1110.225(b) Establishment or Expansion of Cardiac Catheterization Services

Section 1110.225 provides that "there shall be no additional adult or pediatric catheterization categories of services started in a health planning areas unless…"

The applicant has existing cardiac cath services and is not starting an additional service.

The Applicant meets utilization of 1100.620. See the utilization table in this Attachment 22, item 4.

For informational purposes, we note the Clinicians below have privileges at the two hospitals at UChicago Medicine AdventHealth Bolingbrook, Hinsdale and LaGrange hospital locations.

Name	Title	Role	UChicago AdventHealth Bolingbrook	UChicago AdventHealth Hinsdale	UChicago AdventHealth LaGrange
LAWRENCE, ANDREW THOMAS	Physician	Cardiology: Electrophysiology	X	X	X
SHAH, SAURABH	Physician	Cardiology: Electrophysiology	X	X	X
AGUILAR, FRANCISCO GUILLERMO	Physician	Cardiology: Electrophysiology	X	X	X
ADIB, KEENAN	Physician	Cardiology: Interventional Cardiology	X	X	X
KUNCHITHAPATHAM, SELVAKUMAR	Physician	Cardiology: Interventional Cardiology	X	X	X
TESSALEE, MEECHAI	Physician	Cardiology: Interventional Cardiology	X	X	X
RYAN, PAUL DAMIEN	Physician	Cardiology: Interventional Cardiology	X	X	X
CARELL, EDGAR STEELE	Physician	Cardiology: Interventional Cardiology	X	X	X
MCMAHON, JAMES R	Physician	Cardiology: Noninvasive	X	X	X
SHIHABI, AHMAD HASAN	Physician	Cardiology: Noninvasive	X	X	X
DABBOUSEH, NOURA MUHAMAD	Physician	Cardiology: Noninvasive	X	X	X
PATEL, MAYUR P	Physician	Cardiology: Noninvasive	X	X	X
LEWIS, GREGORY M	Physician	Cardiology: Noninvasive	X	X	X
ALI, AHMED G	Physician	Cardiology: Noninvasive	X	X	X
DOBACZEWSKI, MARCIN PIOTR	Physician	Cardiology: Noninvasive	X	X	X
KRAUSS, DANIEL E	Physician	Cardiology: Noninvasive	X	X	X
ALVI, NAZIA	Physician	Cardiology: Noninvasive	X	X	X
FOLLMAN, DUANE F	Physician	Cardiology: Noninvasive	X	X	X
LAMBERT, KAREN L	Physician	Cardiology: Noninvasive	X	X	X
PATEL, HIREN SANJAY	Physician	Cardiology: Noninvasive	X	X	X
PEREZ, MARIA LATZ	Physician	Cardiology: Noninvasive	X	X	X
GIBBS, GEORGE GARING	Physician	Cardiology: Noninvasive	X	X	X
WATTICKS, VERONICA	APP	Cardiology: Noninvasive	X	X	X
KNEIP, MELISSA J	APP	Cardiology: Noninvasive	X	X	X
LOSURDO, JUNE R	APP	Cardiology: Noninvasive	X	X	X
MURPHY, KRISTINE	APP	Cardiology: Noninvasive	X	X	X
CROSS, PATRICE M	APP	Cardiology: Noninvasive	X	X	X
THOMAS, TREESA JAMES	APP	Cardiology: Noninvasive	X	X	X
OREN, ANDREA C	APP	Cardiology: Noninvasive	X	X	X

Attachment 22

Cardiac Catheterization

3. Criterion 1110.225(c) Unnecessary Duplication of Services

UCMAH Bolingbrook currently has a cardiac catheterization category of service and 1110.225(c) does not apply.

Attachment 22

Cardiac Catheterization

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

UCMAH Bolingbrook meets – see minimum utilization standard of 200 procedures. See table below and also see Attachment 15 additional discussion of utilization. **Attachment 22**

Cardiac Catheterization

5. Criterion 1110.225(e) Support Services

Because UCMAH Bolingbrook is not establishing a new service, 1110.225(e) does not apply. Nevertheless, available support services are outlined below. The following support services are available at UCMAH Bolingbrook:

- ✓ Nuclear Medicine Laboratory
- ✓ Echocardiography service
- ✓ Electrocardiography services, including stress testing and continuous cardiogram monitoring
- ✓ Pulmonary function unit
- ✓ Blood bank
- ✓ Hematology laboratory - coagulation laboratory
- ✓ Microbiology laboratory

Procedures Performed in the Cardiac Cath Lab Department (Bolingbrook is a Cardiac Cath/Interventional Radiology Swing Lab)					
Year	UChicago Medicine AdventHealth Hinsdale	UChicago Medicine AdventHealth LaGrange	UChicago Medicine AdventHealth Bolingbrook		
	Cardiac Cath/EP/Vascular	Cardiac Cath/EP/Vascular	Cardiac Cath/Vascular	Interventional Radiology	Total
2021	723	301	359		1383
2022	1112	206	373	991	2682
2023	2132	667	375	839	4013
2024	3566	326	290	873	5055
	3 labs 2021-9/2023. 4th lab opened 9/14/23	2 labs	1 lab		

Outpatient Cardiac Rehab programs when necessary. UCMAH Bolingbrook is ACR accredited in vascular studies with RVT (Registered Vascular Technologist) registered sonographers.

UCMAH Bolingbrook has a laboratory that includes the departments of Chemistry, Immunochemistry, Hematology, Blood Banking, Microbiology, Serology, Immunology and Urinalysis. Lab Services include ABGs (Arterial Blood Gas). The Laboratory Medical

Director is knowledgeable and educated on the requirements of a Laboratory offering transfusions and operating a blood bank. Professional pathology services at the Hospital are contracted through DuPage Pathology Associates. S.C.

Attachment 22

Cardiac Catheterization

6. Criterion 1110.225(f) Laboratory Location

The proposed expansion will have two cath labs and will be located immediately adjacent to each other in accordance with Review Board regulations.

Attachment 22

Cardiac Catheterization

7. Criterion 1110.225(g) Staffing

Because UCMAH Bolingbrook is not establishing a new service, this staffing section does not apply. Nevertheless, the staffing details are provided.

Staffing – Applicant must document that the following personnel will be available:

1. Cath lab Director Board-Certified in Internal Medicine, Pediatrics or Radiology with subspecialty training in Cardiology or Cardiovascular Radiology
    - Dr. Selvakumar Kunchithapatham MD, FACC
2. A physician with training in cardiology and/or radiology present during examination with extra physician backup personnel available.
    - All physicians performing procedures will have appropriate, verified training and privileges commensurate.
3. Nurse specially trained in critical care of cardiac patients, knowledge of cardiovascular medication, and understanding of catheterization equipment.
    - Nurses will be hired in the cath lab who have verified experience and training in cath lab procedures, working with critical care patients, cardiac recovery experience, moderate sedation procedures, ACLS/BLS certification, and competency with cath lab equipment and safety. Any nursing staff hired that do not present with experience in any of these categories will receive adequate training and orientation before providing independent care.
4. Radiologic technologist highly skilled in conventional radiographic techniques and angiographic principles, knowledgeable in every aspect of catheterization instrumentation, and with thorough knowledge of the anatomy and physiology of the cardiovascular system.
    - Radiologic technologists currently working in the cardiac cath lab have verified experience and training in cath lab procedures, ACLS/BLS certification, and competency with cath lab equipment and safety. Any Radiologic technologists hired into the cath lab will be expected to have the same and/or receive adequate training and orientation to meet these needs.
5. Cardiopulmonary technician for patient observation, handling blood samples and performing blood gas evaluation calculations.
    - The UCMAH Bolingbrook Lab and Respiratory Therapy team will be providing these services. Blood drawn in the cath lab will be handled in accordance with hospital policies and by staff who demonstrate competency in these processes.
6. Monitoring and recording technician for monitoring physiologic data and alerting physician to any changes.
    - All nursing staff and Radiologic technologists have or will be trained to utilize the hemodynamic recording system, record all case activity, recognize physiologic/rhythm changes, report/alert any changes to the physician immediately, maintain ACLS/BLS certification, and activate any emergency response appropriately when necessary.

7. Electronic radiologic repair technician to perform systematic tests and routine maintenance; must be immediately available in the event of equipment failure during a procedure.
    - UCMAH Bolingbrook has a contract with the GE HealthCare biomedical team that supports all hospital equipment by providing all preventive maintenance, routine maintenance, and emergent support at all times.
8. Darkroom technician well trained in photographic processing
    - This is non-applicable. All images are digital and saved on the enterprise picture archiving and communication system (PACS)

Attachment 22

Cardiac Catheterization

8. Criterion 1110.225(h) Continuity of Care

UCMAH Bolingbrook has established a comprehensive transfer agreement to ensure the safe and efficient transfer of patients when necessary. When a patient transfer is indicated, and after a thorough review of the relative risks and benefits, UCMAH Bolingbrook personnel will facilitate a timely transfer to an alternate hospital. This process is carried out in accordance with established procedures. Additionally, the Emergency Medical Treatment and Active Labor Act (EMTALA) applies to the transfer of patients with emergency medical conditions that have not yet been stabilized. EMTALA requirements will be strictly followed to ensure the safety and well-being of these unstabilized patients. Attached is the UChicago Medicine AdventHealth Adult Transfer Guidelines for Non-Behavioral Patients that would be followed for patients for patients requiring transfer to a facility with open-heart surgical services for continuity of care. UChicago Medicine AdventHealth provides open-heart surgical services at the UChicago Medicine AdventHealth Hinsdale facility and/or UChicago Medicine Hyde Park Campus.

Attached is a copy of the Transfer Agreement with the UChicago Medicine AdventHealth Hinsdale.

UCMAH Hinsdale operates an open heart program.

HOSPITAL TRANSFER AGREEMENT

THIS HOSPITAL TRANSFER AGREEMENT ("**Agreement**") is entered into and effective March 5, 2025 (the "**Effective Date**") by and between Adventist Bolingbrook Hospital ("**Transferring Facility**") and Adventist Midwest Health d/b/a Adventist Hinsdale Hospital ("**Receiving Hospital**"). Transferring Facility and Receiving Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

PURPOSE OF AGREEMENT

1. Transferring Facility is a licensed and Medicare certified acute care hospital providing health care services to the community.

2. Patients of Transferring Facility ("**Patients**") may require transfer to a hospital for a variety of health care services including, but not limited to, **cardiovascular surgery services**.

3. Receiving Hospital is a licensed and Medicare certified acute care hospital in reasonable proximity to Transferring Facility and desires to cooperate in the transfer of Patients from Transferring Facility, when and if such transfer may, from time to time, be deemed necessary by the respective Patient's physician.

4. The Parties desire to establish a transfer arrangement to ensure continuity of care for Patients and to specify the procedure for ensuring the timely transfer of Patients from Transferring Facility to Receiving Hospital.

NOW, THEREFORE, in consideration of the foregoing, and the terms and conditions set forth herein, the Parties agree as follows:

ARTICLE 1
TRANSFER OF PATIENTS

1.1 Recommendation of Transfer. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, if a Patient needs acute inpatient or emergency care and has either requested to be taken to Receiving Hospital, or is unable to communicate a preference for hospital services at a different Hospital, and a timely transfer to Receiving Hospital would best serve the immediate medical needs of Patient, a designated staff member of Transferring Facility will contact the admitting office or emergency department of Receiving Hospital (the "**Emergency Department**") to facilitate admission.

1.2 Patient Admitting. Provided Receiving Hospital has the capacity to treat the Patient, Receiving Hospital will accept and, as appropriate, admit a Patient as promptly as possible in accordance with applicable federal, state and local laws, the rules and standards of all applicable accreditation organizations such as The Joint Commission (each, an "**Accrediting Organization**"), and reasonable policies and procedures of Receiving Hospital.

1.3 Confirmation of Transfer. After receiving a transfer request, Receiving Hospital will give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital's responsibility for patient care will begin when Patient is

admitted to Receiving Hospital. Communication and Quality Improvement measures between Transferring Facility and Receiving Hospital will be noted, as related to patient stabilization, treatment prior to and subsequent to transfer and patient outcome.

ARTICLE 2
RESPONSIBILITIES OF TRANSFERRING FACILITY

2.1 Ambulance Service. Transferring Facility will arrange for ambulance or other appropriate transportation service to Receiving Hospital

2.2 Transfer Coordinator. Transferring Facility will designate a person who has authority to represent Transferring Facility and coordinate the transfer of Patient to Receiving Hospital.

2.3 Notice of Transfer. Transferring Facility will notify Receiving Hospital's designated representative prior to transfer to alert him or her of the impending arrival of Patient and provide information on Patient to the extent allowed pursuant to Article 4. Such notice will be as far in advance as possible and in any event prior to the Patient leaving the Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care.

2.4 Notice of Arrival Time. Transferring Facility will notify Receiving Hospital of the estimated time of arrival of the Patient.

2.5 Physician's Order to Transfer. The Patient's medical record will contain a physician's order to transfer the Patient. The attending physician recommending the transfer will communicate directly with Receiving Hospital's patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

2.6 Patient Information. In addition to a Patient's medical records and the physician's order to transfer, Transferring Facility will provide Receiving Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

2.7 Personal Effects of Patient. Personal effects of any transferred Patient will be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include, but are not limited to money, jewelry, personal papers and articles for personal hygiene.

ARTICLE 3
RESPONSIBILITIES OF RECEIVING HOSPITAL

3.1 Receiving Coordinator. Receiving Hospital will designate a person who has authority to represent and coordinate the transfer and receipt of Patients into the Emergency Department.

3.2 Patient Admitting. Receiving Hospital will timely admit Patient to Receiving Hospital when transfer of Patient is medically appropriate as determined by Receiving Hospital attending physician subject to hospital capacity and patient census issues, provided that all usual conditions of admission to Receiving Hospital are met.

3.3 Billing and Collection. Receiving Hospital will be responsible for the billing and collection of charges for all services provided by Receiving Hospital. Transferring Facility will in no way share in the revenue generated by services delivered to Patients at Receiving Hospital.

ARTICLE 4
PROVISION AND PROTECTION OF PATIENT INFORMATION

4.1 Patient Information. To meet the needs of Patients with respect to timely access to emergency care, Transferring Facility will provide information on Patients to Receiving Hospital, to the extent approved in advance or authorized by law and to the extent Transferring Facility has such information available. Such information may include: Patient Name, Social Security Number, Date of Birth, insurance coverage and/or Medicare beneficiary information (if applicable), known allergies or medical conditions, treating physician, contact person in case of emergency and any other relevant information Patient has provided Transferring Facility in advance, to be given in connection with seeking emergency care.

4.2 Provision of Records. The Transferring Facility will send a copy of all Patient medical records and information set forth in Section 2.6 that are available at the time of transfer to the Receiving Hospital. Other records will be sent as soon as practicable after the transfer. The Patient's medical record will contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations.

4.3 HIPAA Compliance. Each Party will and will cause its employees and agents to protect the confidentiality of all patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information) in accordance with all applicable state and federal laws, rules and regulations protecting the confidentiality, privacy and/or security of such information, including the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated pursuant thereto ("**HIPAA**"), each as may be amended.

ARTICLE 5
COMPLIANCE

5.1 Regulatory and Accreditation Standards. Each Party will perform its duties under this Agreement in compliance with all applicable federal, state and local laws and the rules and standards of any Accrediting Organization.

5.2 Government Program Participation. Each Party certifies that it has not been excluded from participation in or sanctioned by Medicare, Medicaid or any other federal or state funded health care program. Each Party will promptly deliver to the other Party written notice if it becomes excluded from participation in or sanctioned by Medicare, Medicaid or any other federal or state funded health care program.

5.3 No Referrals Requirement. The Parties agree that nothing contained in this Agreement will require any Party to refer or admit patients to, or order or make arrangements for the ordering of, any goods or services from another Party to this Agreement. Notwithstanding any unanticipated effect of any provision of this Agreement, no Party will knowingly or intentionally conduct its behavior in such a manner as to violate the prohibitions against fraud and abuse in connection with the Medicare and Medicaid programs.

5.4 Non-Exclusivity. This Agreement in no way gives Receiving Hospital an exclusive right of transfer of Patients of Transferring Facility. Transferring Facility may enter into similar agreements with other acute care hospitals, and Patients will continue to have complete autonomy with respect to choice of hospital service providers, as further described in Section 5.5.

5.5 Patient Freedom of Choice. In entering into this Agreement, Transferring Facility is not acting to endorse or promote the services of Receiving Hospital. Rather, Transferring Facility intends to coordinate the timely transfer of Patients for emergency care. Patients are in no way restricted in their choice of emergency care providers.

5.6 Books and Records. Upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States, or any of their duly authorized representatives, each Party will make available to the Secretary or to the Comptroller General those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing its services under this Agreement. Such inspection will be available for up to four (4) years after the rendering of such service. The Parties agree that any attorney-client, accountant-client or other legal privileges will not be deemed waived by virtue of this Agreement.

5.7 Communication and Quality Improvement. Transferring Facility and Receiving Hospital will each designate a representative who shall meet as often as necessary to discuss quality improvement measures related to patient stabilization and/or treatment prior to and subsequent to transfer and patient outcome. The parties agree to reasonably cooperate with each other to oversee performance improvement and patient safety applicable to the activities under this Agreement to the extent permissible under applicable laws. All information obtained and any materials prepared pursuant to this section and used in the course of internal quality control or for the purpose of reducing morbidity and mortality, or for improving patient care, will be privileged and strictly confidential for use in evaluation and improvement of patient care according to 735 ILCS 5/8-2101 et seq., as may be amended from time to time.

ARTICLE 6
INSURANCE AND HOLD HARMLESS

6.1 Insurance. Both Parties will maintain, at no cost to the other Party, professional liability insurance with limits of at least One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate. Each Party will provide evidence of the coverage required herein to the other Party prior to the commencement of this Agreement and as requested thereafter. In the event of insufficient coverage as required by this Section 6.1, or lapse of coverage, each Party reserves the right to terminate this Agreement immediately. Such insurance may be provided by a captive or self-insured program.

6.2 Hold Harmless. Neither Party to this Agreement shall be liable for any negligent or wrongful acts, either of commission or omission, chargeable to the other unless such liability is imposed by law, and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligation or duty owed by one party against the other or against a third party.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Agreement will commence on the Effective Date and will continue in effect for one (1) year (the "**Initial Term**"). **Thereafter, this Agreement will automatically renew for successive one (1) year terms unless terminated pursuant to this Section.** The Initial Term and all renewal terms will collectively be the "**Term**" of this Agreement.

7.2 Termination Without Cause. Either Party may terminate this Agreement at any time, without cause or penalty, by providing sixty (60) days' prior written notice of termination to the other Party.

7.3 Immediate Termination. Notwithstanding anything to the contrary herein, this Agreement will be terminated immediately upon the following events:

(a) the suspension or revocation of a Party's license, certificate or other legal credential necessary to render patient care services and meet the terms and conditions of this Agreement;

(b) termination of a Party's participation in or exclusion from any federal or state health care program for any reason;

(c) the cancellation or termination of a Party's insurance required under Article 6 of this Agreement without replacement coverage having been obtained; and/or

(d) a Party determines that the continuation of this Agreement would endanger Patient care.

7.4 Termination Due to Change in or Violation of Law. Either Party will have the unilateral right to terminate or amend this Agreement, without liability, to the extent necessary to comply with any legal order issued to such Party by a federal or state department, agency or commission, or Accrediting Organization, or if it is reasonably determined that continued participation in this Agreement would jeopardize such Party's status as a Medicare or Medicaid participant or would be inconsistent with its status as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. Prior to termination of this Agreement pursuant to this Section, the Parties will first reasonably attempt to amend this Agreement in a manner that will achieve the business purposes hereof. If either Party proposes an amendment to this Agreement in order to comply with applicable law or accreditation standards, and such amendment is unacceptable to the other Party, either Party may choose to terminate this Agreement immediately upon written notice at any time thereafter.

ARTICLE 8
RELATIONSHIP OF PARTIES

This Agreement evidences an independent contractor relationship, and nothing in this Agreement is intended nor will be construed to: a) create a partnership or joint venture relationship between Receiving Hospital and Transferring Facility; or b) allow either Party to exercise control or direction over the manner or method by which the other Party and its representatives perform this Agreement. Transferring Facility will neither have nor exercise any direction or control over the methods, techniques or procedures by which Receiving Hospital or its employees, agents or representatives perform their professional responsibilities and functions. The sole interest of Transferring Facility is to coordinate the timely transfer of Patients to Receiving Hospital for emergency care.

ARTICLE 9
GENERAL PROVISIONS

9.1 Non-Discrimination. The Parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either Party in the Patient transfer process as set forth in this Agreement based on age, race, sex, religion, national origin, handicap, veteran's status, sexual orientation or any other protected class.

9.2 Amendment. This Agreement may be amended only by a writing signed by both Parties.

9.3 Successors and Assigns. The terms of this Agreement will be binding on and inure to the benefit of and be enforceable by the respective successors and permitted assigns of the Parties.

9.4 Assignment. No Party may assign this Agreement or any right or duty hereunder without the prior written consent of the other Party. Any attempt at assignment without such written consent is void. Notwithstanding the foregoing, each Party has the right to assign any duties, rights and benefits under this Agreement to its successors or affiliates without the written consent of the other Party.

9.5 Third Party Beneficiary. None of the provisions in this Agreement are intended by the Parties, nor will be deemed, to confer any benefit on any person not a party to this Agreement.

9.6 Governing Law and Exclusive Jurisdiction. This Agreement will be governed and interpreted by Illinois law. Any legal action pertaining to this Agreement must be brought in the state or federal courts located in (or closest to) the Illinois county in which the Receiving Hospital is located.

9.7 Severability. The invalidity or unenforceability of any particular provision of this Agreement, or the application of the provision to any party or circumstance, will not affect the other provisions hereof or the applicability of such provision to other persons or circumstances other than those as to whom or which it is held to be invalid or unenforceable, and this Agreement will be construed in all respects as if such invalid or unenforceable provision were omitted.

9.8 Waiver. No term, covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waiving Party. The subsequent acceptance of performance by a Party will not be deemed to be a waiver of any preceding breach by any other Party of any term, covenant or condition of this Agreement and the waiver of any term, covenant or condition will not be construed as a waiver of any other term, covenant or condition of this Agreement.

9.9 Notices. All notices that may be given under this Agreement will be in writing, addressed to the receiving Party's address set forth below or to such other address as the receiving Party may designate by notice hereunder. Notices will be given: (i) by delivery in person; (ii) by traceable courier delivery (such as Federal Express); (iii) by certified or registered U.S. mail, return receipt requested; or (iv) by electronic mail in accordance with the terms set forth in this Section.

Transferring Facility: Adventist Bolingbrook Hospital
500 Remington Blvd.
Bolingbrook, Illinois 60440
Attn: **CEO**

Receiving Hospital: Adventist Hinsdale Hospital
120 N. Oak Street
Hinsdale, Illinois 60521
Attn: **CEO**

Notices will be deemed to have been given as follows: (i) if by hand or traceable courier delivery, at the time of the delivery; (ii) if sent by certified or registered mail, on the second business day after such mailing; or (iii) if sent by electronic mail, upon confirmation of receipt by personal confirmation (i.e. electronic mail or verbal confirmation from recipient).

9.10 Headings. The section titles and other headings contained in this Agreement are for reference only and will not in any way affect the meaning or interpretation of this Agreement.

9.11 Gender, Number. Whenever the context of the Agreement so requires, the masculine gender will include the feminine or neuter, the singular number will include the plural and reference to one or more Parties will include all successors or assignees of the Party.

9.12 Entire Agreement. This Agreement, together with all addenda, attachments, schedules and exhibits hereto, constitutes the entire agreement between the Parties relating to the subject matter hereof, and supersedes all prior and contemporaneous agreements and understandings, whether written or oral, regarding such subject matter.

9.13 **Survival**. Those terms of the Agreement that by their terms are intended to survive termination will survive termination.

9.14 **Counterparts**. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all such counterparts together will constitute one and the same instrument. Facsimile copies and copies delivered by electronic email in a ".pdf" format data file will be deemed to be originals.

IN WITNESS THEREOF, the Parties have caused this Agreement to be executed by their duly authorized officers hereto to be effective as of the Effective Date.

Transferring Facility:
Adventist Bolingbrook Hospital

DocuSigned by:
By: Kenneth Rose
84AF102B3991474...

Printed Name: Kenneth Rose

Title: President/CEO

Receiving Hospital:
Adventist Hinsdale Hospital

Signed by:
By: Elise MacCarroll-Wright
2EC55Z2DAA5T4A8...

Printed Name: Elise MacCarroll-Wright

Title: President and CEO

AdventHealth

POLICY

Policy # GLR.NUR.084	**Policy Name** Adult Transfer Guidelines for Non-behavioral Health Patients
Policy Location AH Hinsdale, AH Bolingbrook, AH GlenOaks, AH LaGrange	**Responsible Department** Executive
Policy Owner or Executive Owner Wendi Hix (GL-Asst-Executive)	**Original Creation Date** 11/01/2017
Policy Effective Date 03/26/2024	**Policy Review Date** 03/26/2024

I. SCOPE:

This policy is applicable to UChicago Medicine | AdventHealth Great Lakes Region Bolingbrook, GlenOaks, Hinsdale and La Grange ("UChicago Medicine AdventHealth Hospitals").

II. PURPOSE:

To facilitate the transfer of non-behavioral health patients who require a higher level of care or otherwise request transfer from one UChicago Medicine AdventHealth Hospital to another, or to any other appropriate hospital.

III. POLICY:

Where patient transfer has been indicated and following an appropriate review of relative risks and benefits, UChicago Medicine AdventHealth personnel will facilitate timely transfer to an alternate hospital, consistent with the procedures set forth below. The Emergency Medical Treatment and Active Labor Act (EMTALA) applies to transfer of patients with Emergency Medical Conditions that have not yet been Stabilized, and EMTALA requirements will be followed with respect to such unstabilized patients. See AdventHealth EMTALA Policy, CW CR 500.

A. **Transfer to another UChicago Medicine AdventHealth Hospital.** The following process should be utilized for transferring non-stroke patients within the regional system:

1. The patient's condition will be stabilized within the capabilities of the transferring Facility prior to the transfer.
2. The transferring physician in charge of the patient's care needs to have a receiving physician at the receiving facility prior to the transfer (transferring physician may also be the receiving physician).
3. The transferring physician will contact the receiving Facility's House Director or Bed Placement, when available, to communicate a need for

a patient transfer.

UChicago Medicine AdventHealth Hinsdale House Director: 630-856-3701 (available 24/7)

UChicago Medicine AdventHealth La Grange House Director: 708-245-6830 (available 24/7)

UChicago Medicine AdventHealth GlenOaks: 630-545-6152 (nights and weekends); other times please call the respective clinical coordinator.

UChicago Medicine AdventHealth Bolingbrook House Director: 630-312-2600 (available 24/7); other times please call the respective clinical coordinator.

4. The receiving physician in charge of the patient will provide the receiving Facility's House Director the required information. A new FIN will be created and provided for placing new/additional orders.
5. The receiving Facility's House Director or when available Bed Placement shall facilitate the transfer process by contacting the appropriate nursing unit to obtain a bed assignment based on the care needs of the patient.
6. The receiving Facility's House Director or Bed Placement will communicate to the transferring facility the new patient bed assignment and receiving nurse contact information so a complete report can be provided.
7. The "Consent for Interfacility Transfer" must be completed by the transferring facility and accompany the patient to the receiving facility.
8. The "Physician Certification Statement for Ambulance Transportation" (PCS) form, when appropriate, for specific ambulance services, should be completed by the transferring facility and given to the ambulance crew.

B. **Transfer of Higher-Need Patients to University of Chicago Medical Center.** For any non-stroke patients requiring a higher level of care beyond UChicago Medicine AdventHealth Hospitals, recommend transfer to University of Chicago Medical Center unless circumstances warrant transfer elsewhere, *e.g.*, due to patient's condition or terms of applicable Emergency Medical System Regional Plan. Notwithstanding the foregoing, patient choice in Receiving Hospital will be honored wherever possible.

Non-Stroke patient transfer to UChicago Medicine

1. Online UCM Provider Directory **http://bit.ly/UCMDocs** can be used to locate a UChicago Medicine provider by specialty, clinical interests, or location.
2. Contact UChicago Medicine Transfer Center at 855-834-4782 to begin transfer process and provide the following information:
    i. Identify as an AdventHealth contact/provider.

ii. Contact information on current attending physician.
iii. Patient demographics (name and date of birth)
iv. Patient diagnosis & current clinical condition.
v. Current patient location.
vi. Medical services required.

3. UCM Transfer Center will remain single point of contact for all urgent & emergent transfer requests.
4. The "Consent for Interfacility Transfer" must be completed by the transferring facility and accompany the patient to the receiving facility.
5. The "Physician Certification Statement for Ambulance Transportation" (PCS) form, when appropriate, for specific ambulance services, should be completed by the transferring facility and given to the ambulance crew.

Stroke Transfer process to UChicago Medicine

1. Contact UChicago Medicine Aeromedical Network (UCAN) Line at 773-702-3222 to begin the transfer process and provide the following information:
   i. Identify as an AdventHealth contact/provider.
   ii. Contact information on current attending physician.
   iii. Patient demographics (name and date of birth)
   iv. Patient diagnosis & current clinical condition.
   v. Last Known Normal
   vi. Current patient location.
   vii. Medical services required.
2. UCM UCAN line will remain the single point of contact for all urgent & emergent STROKE transfer requests.
3. The "Consent for Interfacility Transfer" must be completed by the transferring facility and accompany the patient to the receiving facility.
4. The "Physician Certification Statement for Ambulance Transportation" (PCS) form, when appropriate, for specific ambulance services, should be completed by the transferring facility and given to the ambulance crew.
5. Two Copies of the patient chart and CD of brain imaging should be given to the ambulance crew.

C. **Patient Transfer to Other Hospitals**. Process for patients requesting or requiring transfer for outside the UChicago Medicine AdventHealth Hospitals or University of Chicago Medical Center:

1. Physician of the transferring facility will identify the physician accepting

patient for transfer.

2. Contact transfer center of receiving facility and provide requested information necessary for transfer.
3. Document room assignment information and contact information of receiving unit when bed placement is available.
4. The "Consent for Interfacility Transfer" must be completed by the transferring facility and accompany the patient to the receiving facility.
5. The "Physician Certification Statement for Ambulance Transportation" (PCS) form, when appropriate, for specific ambulance services, should be completed by the transferring facility and given to the ambulance crew.

IV. PROCEDURE/GUIDELINES:

V. DEFINITION(S):

VI. EXCEPTION(S):

VII. REFERENCE(S):

The Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the "Patient Anti-Dumping" statute, is a federal statute intended to prevent Medicare-participating hospitals with dedicated emergency departments from refusing to treat people based on their insurance status or ability to pay. AdventHealth Company Wide EMTALA Policy CW CR 500.

VIII. RELATED DOCUMENT(S) / ATTACHMENT(S):

Appendix A: Non- Stroke UChicago Medicine transfer center information

IX. PRIOR APPROVALS

Regional Executive Council (Date): 04/21/15

Clinical Practice Council (Regional): 1/28/14; 11/28/17; 3/19/19; 10/27/2020; 3/15/2022

Legacy Adventist Chief Nursing Officers: 7/29/19; 1/27/2021; 7/27/2022

Quality Steering Committee (AHH/ALMH): 1/31/14

Medical Executive Committee (AHH/ALMH): 4/11/14; 9/13/2023

Performance Improvement Committee (AGO): 4/24/14

Medical Executive Committee (AGO): 6/12/14; 12/14/2023
Performance Improvement Committee (BOL): 6/13/14
Medical Executive Committee (BOL): 6/20/14; 12/8/2023
AHH/ALMH/AGH Quality & Patient Safety: 12/7/17

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Cardiac Catheterization

9. Criterion 1110.225(i) Multi-Institution Variances

The cardiac catheterization program at UCMAH Bolingbrook as part of an integrated program with its UCMAH hospitals in Hinsdale and Lagrange. Because UCMAH already has a cardiac cath service, the variance is not applicable. The UChicago Medicine AdventHealth Cardiovascular Service Line adopts a regional approach, monitoring patient needs across each hospital's PSA. This includes ensuring patient access, timely procedure scheduling, safe and uninterrupted care during procedures, availability of emergent services, and achieving high-quality outcomes for every patient.

Section VII. 1120.120 Availability of Funds

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The Project will be funded entirely from cash on hand. As the Chicago Medicine AdventHealth Joint Venture is owned at 51% by UChicago Medicine, the financials consolidate into UChicago Medicine's financials. UChicago Medicine's most recently audited financials have been provided.

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Bond Ratings: UChicago Medicine holds a strong AA-bond rating from Fitch while AdventHealth holds a strong AA rating. Both ratings affirmations are included in this attachment.

FitchRatings

RATING ACTION COMMENTARY

Fitch Affirms University of Chicago Medicine (IL) at 'AA-'; Outlook Stable

Fri 24 Jan, 2025 - 11:56 AM ET

Fitch Ratings - Chicago - 24 Jan 2025: Fitch Ratings has affirmed University of Chicago Medicine's (UCM) Issuer Default Rating (IDR) at 'AA-'. Fitch has also affirmed the ratings assigned to revenue bonds issued by the Illinois Finance Authority (IFA) on behalf of UCM at 'AA-'.

The Rating Outlook is Stable.

RATING ACTIONS

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

VIEW ADDITIONAL RATING DETAILS

The 'AA-' reflects UChicago Medicine's strong financial profile in the context of the system's broad and growing reach for high-acuity services throughout the Chicago metro area and into northwest Indiana. While UCM's cash-to-adjusted debt percentage is relatively

ATTACHMENT 35

modest for a 'AA-' health system, the ratio should improve in the coming years, even under Fitch's forward-looking stress case. UCM's operating margins rebounded in FY 2024 after a soft FY 2023.

The Stable Outlook reflects Fitch's expectation that margins will continue to improve in the coming years to levels more consistent with a strong operating profile assessment, despite UCM's recent track record of more modest operating results. The system continues to benefit considerably from its high degree of integration with the University of Chicago (UChicago).

SECURITY

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

KEY RATING DRIVERS

Revenue Defensibility - 'bbb'

Broad Reach for High-Acuity Services in Competitive Market; Strong Link with UChicago

UChicago Medicine achieves a midrange revenue defensibility despite the degree of competition from other AMCs and high-acuity providers in the Chicago area. The UCMC flagship is the leading provider for certain quaternary services, particularly in UCM's primary service area that covers the southside of Chicago, the south and southwestern suburbs, and northwest Indiana. This reach is bolstered by UCM's AdventHealth assets in the western suburbs. UCM's revenue defensibility is enhanced by its strong relationship with UChicago.

While UCM's payor mix is somewhat modest, this is common for an AMC, especially those like UCM whose operations include a large children's hospital. The broader service area economy is considered to be generally stable, and the inclusion of the AdventHealth assets should improve UCM's payor mix over time given its higher levels of commercial and Medicare patients in the western suburbs.

Operating Risk - 'a'

Track-Record of Good Operations, Improved Results in FY 2024 After Compressed Margins in FY 2023

UCM's operating risk profile remains strong. UCM has a track-record of sound operating EBITDA margins, which averaged 6.3% between FY 2019 and FY 2024 treating transfers to the University as an operating expense (8.7% without the transfers) (the transfer to the University has been essentially flat at about $71.8 million for years). More recently, the operating EBITDA margin compressed to 4.6% in FY 2023 (6.5% excluding the transfer), but rebounded to 5.9% in FY 2024 (7.4% excluding the transfer).

Improved results in FY 2024 were driven by: volume gains in key areas, including admissions (up 3.7% over FY 2023, and up 3.6% including observations), surgeries (up 5.1%), and outpatient visits (up 3.5%), due in part to the AdventHealth joint venture; a decline in average length of stay (ALOS) from 6.8 days in FY 2023 to 6.5 days in FY 2024; and continued efforts to flex expenses to revenue despite macro labor and inflationary pressures that lingered into FY 2024.

Expense management efforts have included per unit supply cost savings, reducing overhead, position controls, and continued limited use of contract labor. Management also notes that operating margins at the Ingalls affiliate are now in-line with the rest of the system, after years of focused improvements. FY 2024 also benefited from $58 million of 340B settlement funds.

Fitch expects that UCM should sustain operating margins, with the potential to improve in the coming years. Performance improvements include continued ramp up of the Northwest Indiana market, enhanced use of artificial intelligence in revenue cycle, reduced Medicare Advantage denials, and continued focus on LOS. Through unaudited Q1FY25 the obligated group recorded an operating EBITDA margin of 7.1% (treating transfers to UChicago as an operating expense) (compared to 5.0% in Q1FY24).

Capital Spending

Capex plans are manageable in the context of UCM's cash flow generation, balance sheet, and fundraising. Continued outpatient/ambulatory investments are expected. The highlighted ongoing project is construction of a major $815 million cancer center on the UCMC main campus, which is to be financed in part with fundraising (UCM and the University have a track-record of strong philanthropy) among other sources.

The cancer center project has received certificate of need (CON) approval and the majority of the build is expected by FY 2026. Recent capital expenditures were highlighted by a large outpatient center in Crown Pointe, IN that opened in April 2024. The system does not have new money debt plans in the near term.

Financial Profile - 'aa'

Capital-Related Ratios Should Remain Strong through a Stress Case

UCM's financial profile is strong and capital-related ratios should remain reasonably strong even in a forward-looking stress case.

At FYE 2024 UCM had nearly $1.7 billion of unrestricted cash and investments and debt measured just over $1.4 billion (including operating leases), translating to cash-to-total debt of about 115%. Cash on hand exceeded 135 days at FYE 2024 and is not an asymmetric risk to UCM's financial profile.

UCM participates in the University's defined benefit (DB) pension. The DB plan was 99% funded at FYE 2024 compared to a projected benefit obligation of about $662 million (UCM accounts for roughly 40% of the DB plan). Because the DB is more than 80% funded it is not included in adjusted debt and therefore cash-to-adjusted debt is the same as cash-to-total debt.

Based on FY 2024 results, UCM's net adjusted debt-to-adjusted EBITDA was favorably negative at -0.7x and cash-to-adjusted debt was 115%. In Fitch's forward-looking scenario analysis stress case, net adjusted debt-to-adjusted EBITDA returns favorably negative by year three and cash-to-adjusted debt exceeds 120% by year four.

Asymmetric Additional Risk Considerations

There are no asymmetric risks associated with UCM's rating.

UCM has $325 million of variable rate demand obligation (VRDO) bonds and approximately $48 million of commercial paper (CP). The VRDOs are supported by letters of credit (LOC) from five banks with staggered expiration dates between May 2025 and May 2029. Maximum annual debt service (MADS) is $76.8 million, and MADS coverage based on FY 2024 results was 4.1x and does not pose an asymmetric risk.

RATING SENSITIVITIES

Factors that Could, Individually or Collectively, Lead to Negative Rating Action/Downgrade

--Failure to sustain operating results such that the operating EBITDA margin is expected to remain below 6% for an extended period (treating transfers to the University as an operating expense, or below 7%-8% without the transfers);

--Expectation that cash-to-adjusted debt will remain below 120% in the out years of Fitch's forward-looking stress case.

Factors that Could, Individually or Collectively, Lead to Positive Rating Action/Upgrade

--Expectation that UCM's operating EBITDA is sustained at 9% or better (treating transfers to UChicago as an operating expense);

--Material growth in unrestricted liquidity levels leading to much stronger cash-to-adjusted debt in excess of 200% even in a stress scenario.

PROFILE

UCM is a major AMC whose flagship UCMC is located on the campus of UChicago. While UChicago is not obligated on UCM's bonds, UCM is a component unit of the University and there is very tight alignment between the two (UChicago would be required to assume certain UCMC debt only if the University terminated its affiliation agreement or lease with the medical center). UCM's total operating revenue exceeded $4.6 billion in FY 2024.

Sources of Information

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

The highest level of ESG credit relevance is a score of '3', unless otherwise disclosed in this section. A score of '3' 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. Fitch's ESG Relevance Scores are not inputs in the rating process; they are an

observation on the relevance and materiality of ESG factors in the rating decision. For more information on Fitch's ESG Relevance Scores, visit https://www.fitchratings.com/topics/esg/products#esg-relevance-scores.

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APPLICABLE CRITERIA

U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria (pub. 12 Nov 2024) (including rating assumption sensitivity)

U.S. Public Sector, Revenue-Supported Entities Rating Criteria (pub. 10 Jan 2025) (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), v2.0.0 (1)

ADDITIONAL DISCLOSURES

Dodd-Frank Rating Information Disclosure Form

Solicitation Status

Endorsement Policy

ENDORSEMENT STATUS

Illinois Finance Authority (IL)	EU Endorsed, UK Endorsed

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Fitch Ratings

RATING ACTION COMMENTARY

Fitch Rates AdventHealth, FL Series 2024A, B and C bonds 'AA'; Affirms IDR; Outlook Stable

Fri 24 May, 2024 - 3:55 PM ET

Fitch Ratings - New York - 24 May 2024: Fitch Ratings has assigned a 'AA' rating to approximately $250 million tax exempt fixed-rate hospital revenue bonds consisting of series 2024A and 2024B issued by Colorado Health Facilities Authority and the series 2024 C issued by the Highlands County Health Facilities Authority on behalf of the AdventHealth Obligated Group (FL).

Fitch has also affirmed the Issuer Default Rating (IDR) and the rating on various series of bonds issued by and on behalf of AdventHealth at 'AA'. Fitch additionally affirmed the short-term rating supported by AdventHealth's self-liquidity at 'F1+', which is mapped to AdventHealth's long-term 'AA' rating and supported by the system's sufficient liquidity reserves.

The Rating Outlook is Stable.

The bonds will be issued as fixed rate. Bond proceeds will fund capital projects and refund debt. Bonds are expected to price the week of June 3 via negotiation.

RATING ACTIONS

ENTITY / DEBT	RATING	PRIOR
AdventHealth (FL)	LT IDR AA Rating Outlook Stable Affirmed	AA Rating Outlook Stable

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AdventHealth (FL) /General Revenues/1 LT	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable
AdventHealth (FL) /Self-Liquidity/1 ST	ST	F1+	Affirmed	F1+

VIEW ADDITIONAL RATING DETAILS

The 'AA' rating is based on AdventHealth's competitive market position, especially in its core Florida markets, and its financial profile, characterized by a long history of strong operating EBITDA margins, adequate levels of liquidity, and a manageable debt burden. The financial performance improved materially in FY23 with an 11.7% operating EBITDA margin up from 7.7% in FY22, and that performance has carried over into 2024, with a 12.6% operating EBITDA margin in Q1.

The lower performance in FY22 was driven by the sector's staffing challenges and inflationary pressures. The improved performance in FY23 reflects the easing of some of these pressures, a robust $300 million margin recovery plan implemented by AdventHealth, and the affiliation with the University of Chicago Medicine, which removed the results of AdventHealth's greater Chicagoland operations, composed of four hospitals and related facilities, from the operating income statement. The operating results of this affiliation are now accounted for under the equity method.

Fitch's forward look shows AdventHealth maintaining the improved operating performance while absorbing the additional 2024 debt. Capital spending is expected to remain above depreciation. Key adjusted leverage metrics show resiliency through Fitch's moderate stress scenario, supporting the Stable Outlook.

SECURITY

The bonds are secured by a pledge of the obligated group's (OG) gross revenues and notes under the 2014 MTI.

KEY RATING DRIVERS

Revenue Defensibility - 'bbb'

Strong Presence in Growing Markets; Good Payor Mix

The midrange revenue defensibility is based on AdventHealth's geographic diversity, its growing presence in several markets with highly favorable demographics, and a good payor mix, with Medicaid and self-pay accounting for a relatively modest 17% of FY23 gross revenues. AdventHealth has a market presence in nine states: Florida, Colorado, Kansas, Texas, Illinois, Wisconsin, Kentucky, North Carolina and Georgia. Within these service areas, AdventHealth's hospitals are generally located in areas with favorable demographics, particularly in Florida, Kansas, Colorado and Texas, with projected population growth in these markets ranging from 5% to 7% over the next five years.

Florida continues to account for a significant portion of revenue (78.6% in FY23), and in FY23 accounted for almost all of the system's operating EBITDA. AdventHealth operates in three distinct regions in Florida, which allows for a measure of geographic diversity helping to offset concerns about the concentration of operations in the state. Central Florida centered on the greater Orlando area, with eight hospitals, covers areas north and east of Orlando in Flagler, Lake and Volusia counties, with six hospitals.

The region also includes Tampa and includes Polk, Highlands and Marion counties, with 13 hospitals. The multistate division, which includes four hospitals in Kansas, five hospitals in Colorado and five hospitals in the Southeast account for the remaining revenues, with the Colorado Rocky Mountain region generating 8.9% of revenues and about 1% of operating EBITDA of the consolidated system.

In Central Florida AdventHealth holds a leading 43.3% market share, trailed by Orlando Health at 36.8%, and 12.3% held by HCA and is anchored by AdventHealth Orlando (AHO) with 1,400 staffed beds. AHO provides high-end tertiary and quaternity care, including transplants, and operates the largest cancer center in the state, as well as a women's and children's hospital. AdventHealth opened a 120-bed hospital on the Winter Garden campus in 2022, and constructed a 100-bed hospital in Flagler County, both of which have deepened AdventHealth's market presence, along with its interest in Health First.

The West Florida market is the system's fastest growing market, generating 20.5% of the system revenues, up from 18% in 2022. Its 23.6% inpatient market share trails BayCare's 25.9%, but leads with 28.1% of ED visits. The West Florida strategy is focused on expansion of existing acute care and ambulatory and ED (both hospital based and freestanding) coverage, and the current plan calls for a $252 million project to build a hospital in South Hillsborough County, slated to open in 4Q24.

Operating Risk - 'aa'

Strong and Stable Operating Performance; Robust Capital Spending

AdventHealth's operating risk has historically been very strong, with operating EBITDA margins averaging 12.5% and EBITDA margins averaging 13.7% in the four years preceding 2022. In FY22 (year-end December 31, audited) operating EBITDA margin declined as the system faced various headwinds, including higher use of agency staffing, heightened turnover and general industry inflationary pressures. The $283.7 million operating income in FY22 included $384 million spent of Epic implementation in several markets and the effect on Florida operations from two hurricanes; excluding the Epic expense, the operating EBITDA margin would have been 10.2%.

In FY23, management focused on returning the organization to performance more in line with the historical trend, launching a $300 million improvement plan partially aimed at supply costs and overhead. The success of that plan along with good growth in patient volumes (total admissions, surgeries, outpatient emergency room visits were all up), a drop in the length of stay, and the EPIC instillation, completed in Q4 2023, pushed the operating EBITDA up to 11.7%, which exceeded AdventHealth's 2023 budget.

The good performance was maintained in Q1 2024, with operating income of $341.4 million compared to operating income of $172 million in Q1 2023. Management is also focusing on balance sheet recovery, with the target of returning the system to minimum 200% cash to debt by 2024, which will be aided by the improved operating performance, as well as the strategic adjustments to the system's portfolio, including the sale of eight skilled nursing facilities in Florida that was completed in 2023. Cash-to-adjusted debt was at 197.1% at March 31, 2024.

Capital spending averaged a robust 161% of depreciation over the last five years and the system's average age of plant is a low 9.3 years; the system invested more than $5.8 billion in capex between 2019 and 2023. The system has been able to fund this level of capital largely through cash flow, as evidenced by Debt to EBITDA averaging 2.3x over this five-year period. A major information technology conversion to EPIC begun in 2021 was finished in 2023 and that contributed to the capex spending, as well as to one-time operating expenses ($156 million in 2023).

AdventHealth has a formulaic approach to capital spending, using adherence to a capital model tied to 75% of operating EBITDA. In 2023, AdventHealth scaled that back to 60%, but spending according to the formula will resume thereafter. As such, Fitch expects the level of capital spending to remain consistent with historical levels, especially given the system's continued growth. As part of the capital spending over the next three to four

years, new hospitals are expected to be built in Riverview, Lenexa City Center, Lake Nona, Minneola, and hospital expansions are expected in Wesley Chapel, Littleton, and Winter Garden.

Financial Profile - 'aa'

Financial Profile Resilient Through Fitch's Stress Scenario

Fitch's forward-look shows AdventHealth's financial metrics remaining consistent with a strong financial profile assessment, reflecting a sustained operating performance, adequate liquidity and a moderate debt burden, even after applying Fitch's revenue and liquidity stresses. Key adjusted leverage metrics remain above the 'aa' thresholds through Fitch's stress case scenario.

At YE 2023, AdventHealth reported unrestricted cash and investments of $8.2 billion. This liquidity position (as calculated by Fitch) translated to 189% cash-to-adjusted debt, up from 156.2% in the prior fiscal year, and days cash on hand of 201 days, also up from 166 days at YE 2022. The consolidated system's net adjusted debt to adjusted EBITDA (NADAE) stayed negative over the last five years and was at a negative 1.9x in 2023 (the negative NADAE indicates AdventHealth could pay down all its debt within a year). Debt service coverage (as calculated by Fitch) was very strong at 9x in FY24, and Fitch notes that coverage remained very good in FY22 at 5.8x despite the challenging operating environment, which further highlights AdventHealth's manageable debt burden, even as it continued to invest in growth.

Fitch's forward-look assumes operating EBITDA margins maintained above 10%, consistent with the strong operating risk assessment, incorporates the additional 2024 debt, and assumes capital spending remaining above depreciation. For the stress scenario, Fitch applied the standard operating and investment stresses in the early years. AdventHealth's relatively conservative asset allocation results in a very modest 5.4% decline in liquidity reserves initially for the investment stress.

Fitch's moderate stress scenario, show that AdventHealth's key adjusted leverage metrics (cash-to-adjusted debt and NADAE) remain consistent with the 'aa' financial profile, within the context of AdventHealth's midrange revenue defensibility and strong operating risk assessments.

Asymmetric Additional Risk Considerations

No asymmetric risks informed the rating assessment outcomes.

RATING SENSITIVITIES

Factors that Could, Individually or Collectively, Lead to Negative Rating Action/Downgrade

--A prolonged decline in financial performance, such that operating EBITDA margins stabilize in the 8% to 9% range;

--Declines in unrestricted liquidity such that cash-to-adjusted debt is expected to remain well below 190%.

Factors that Could, Individually or Collectively, Lead to Positive Rating Action/Upgrade

--Given the 'AA' rating, an upgrade is not anticipated in the near term.

PROFILE

AdventHealth is a large, multistate healthcare organization with 50 hospitals, operates 8,600 beds, 56 urgent care centers, 22 offsite emergency departments, 16 home health and hospice agencies, and various health-related businesses located in nine states: Florida, Colorado, Kansas, Texas, Illinois, Wisconsin, Kentucky, North Carolina and Georgia.

The system is structured into four operating divisions: Central Florida, West Florida, the Multi State Division, and the Primary Health Division, with each division having its own management structure but a number of services provided on a centralized basis. The consolidated system had total operating revenues of $16.8 billion in FY23, a 41.2% increase in five years with a significant portion of the increase from organic growth. The OG represented 96.5% of the consolidated system's revenues and 87.8% of assets in FY23. Fitch analyzes the performance of the consolidated system.

The Multi-State division includes a number of partnerships that were entered into both to support AdventHealth's own facilities in competitive markets and to participate in high growth markets. Under the system's continuous strategic evaluation of its markets, effective April 1, 2022, AdventHealth dissolved the joint operating company (JOC) AMITA Health in Illinois, which combined four of AdventHealth's Chicago-area hospitals with hospitals operated by Ascension Health. Recognizing that AdventHealth needs a partner for its Chicago presence, the system entered into an affiliation with UChicago Medicine (UCM) on a 49%/51% ownership basis, but 50%/50% governance structure. Fiscal 2024 was the first full year of the affiliation.

Similarly, AdventHealth and CommonSpirit Health have opted to terminate their 27-year old JOC, Centura Health, in June 2023. AdventHealth now operates its five hospitals under its own governance and plans to continue to build its Denver market presence. Following the initial acquisition of a minority interest in Health First, in 2020, AdventHealth has made an additional payment of $125 million in 2021 and made the last payment of $100 million in June 2023, for a total investment of $350 million, equal to a 27% ownership of the four hospitals in Brevard County, a market adjacent to its Orlando presence.

Sources of Information

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.

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PARTICIPATION STATUS

The rated entity (and/or its agents) or, in the case of structured finance, one or more of the transaction parties participated in the rating process except that the following issuer(s), if any, did not participate in the rating process, or provide additional information, beyond the issuer's available public disclosure.

APPLICABLE CRITERIA

U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria - Effective Nov. 20, 2020 to Nov. 12, 2024 (pub. 18 Nov 2020) (including rating assumption sensitivity)

U.S. Public Sector, Revenue-Supported Entities Rating Criteria – Effective from January 12, 2024 to January 10, 2025 (pub. 12 Jan 2024) (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), v2.0.0 (1)

ADDITIONAL DISCLOSURES

Dodd-Frank Rating Information Disclosure Form

Solicitation Status

Endorsement Policy

ENDORSEMENT STATUS

AdventHealth Obligated Group (FL)	EU Endorsed, UK Endorsed

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SOLICITATION STATUS

ATTACHMENT 35

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

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Section VIII. 1120.130 – Financial Viability

Attachment 36 – Audited Financial Statements

The Project will be funded entirely from cash on hand. As the UChicago Medicine AdventHealth joint venture is owned at 51% by UChicago Medicine, the financials consolidate into UChicago Medicine's financials. UChicago Medicine's most recently audited financials are attached.

ATTACHMENT 36

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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ATTACHMENT 36

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

Independent Auditors' Report

The Board of Trustees
The University of Chicago Medical Center:

Opinion

We have audited the consolidated financial statements of The University of Chicago Medical Center (the System), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and changes in net assets without donor restrictions, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the System as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

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

Responsibilities of Management for the Consolidated Financial Statements

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

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

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2022 supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Chicago, Illinois
November 1, 2022

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Balance Sheets

June 30, 2022 and 2021

(In thousands)

Assets		2022	2021
Current assets:			
Cash and cash equivalents	$	60,997	184,639
Patient accounts receivable		471,321	437,141
Current portion of investments limited to use		67,796	247,395
Current portion of malpractice self-insurance receivable		21,904	16,809
Current portion of pledges receivable		3,543	2,289
Prepaids, inventory, and other current assets		203,353	195,394
Total current assets		828,914	1,083,667
Investments limited to use, less current portion		1,604,017	1,722,327
Property, plant, and equipment, net		1,531,898	1,509,150
Pledges receivable, less current portion		4,604	5,708
Malpractice self-insurance receivable, less current portion		96,919	90,598
Other assets, net		113,005	122,867
Total assets	$	4,179,357	4,534,317
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	289,214	282,219
Current portion of long-term debt		22,313	22,875
Current portion of other long-term liabilities		10,664	4,775
Estimated third-party payor settlements and Medicare Advance		275,805	454,530
Current portion of malpractice self-insurance liability		21,904	16,809
Due to University of Chicago		33,645	29,809
Total current liabilities		653,545	811,017
Other liabilities:			
Workers' compensation self-insurance liabilities, less current portion		8,124	8,604
Malpractice self-insurance liability, less current portion		178,013	168,640
Long-term debt, less current portion		903,182	937,757
Interest rate swap liability		83,440	147,362
Other long-term liabilities, less current portion		128,393	145,633
Total liabilities		1,954,697	2,219,013
Net assets:			
Without donor restrictions		2,088,996	2,169,780
With donor restrictions		135,664	145,524
Total net assets		2,224,660	2,315,304
Total liabilities and net assets	$	4,179,357	4,534,317

See accompanying notes to consolidated financial statements.

ATTACHMENT 36

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Years ended June 30, 2022 and 2021

(In thousands)

	2022	2021
Operating revenues:		
Patient service revenue	$ 2,548,487	2,331,509
Other operating revenues and net assets released from restrictions used for operating purposes	436,961	457,645
Total operating revenues	2,985,448	2,789,154
Operating expenses:		
Salaries, wages, and benefits	1,294,763	1,134,205
Supplies and other	1,030,114	944,587
Physician services	316,946	303,435
Insurance	21,413	39,603
Interest	36,904	39,743
Medicaid provider tax	69,756	75,683
Depreciation and amortization	133,271	132,707
Total operating expenses	2,903,167	2,669,963
Operating revenue in excess of expenses	82,281	119,191
Nonoperating gains and losses:		
Investment return, net	(154,282)	387,316
Change in fair value of nonhedged derivative instruments	4,229	2,637
Derivative ineffectiveness on hedged derivative instruments	(1,427)	695
Other, net	(2,760)	(251)
Revenue and gains in excess (deficient) of expenses and losses	(71,959)	509,588
Other changes in net assets without donor restrictions:		
Net asset transfers to University of Chicago	(71,750)	(71,750)
Change in accrued pension benefits other than net periodic benefit costs	4	2,781
Effective portion of change in valuation of derivatives	62,885	44,967
Net assets released from restriction for capital purposes	36	125
Distributions and other, net	—	(24)
Increase (decrease) in net assets without donor restrictions	$ (80,784)	485,687

See accompanying notes to consolidated financial statements.

ATTACHMENT 36

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2022 and 2021

(In thousands)

		2022	2021
Net assets without donor restrictions:			
Revenue and gains in excess (deficient) of expenses and losses	$	(71,959)	509,588
Net asset transfers to University of Chicago, net		(71,750)	(71,750)
Change in accrued pension benefits other than net periodic benefit cost		4	2,781
Effective portion of change in valuation of derivatives		62,885	44,967
Net assets released from restrictions for capital purposes		36	125
Distributions and other, net		—	(24)
Increase (decrease) in net assets without donor restrictions		(80,784)	485,687
Net assets with donor restrictions:			
Contributions		10,944	12,513
Net assets released from restrictions used for operating purposes		(9,456)	(8,358)
Investment return, net		(11,312)	29,809
Net assets released from restrictions for capital purposes		(36)	(125)
Increase (decrease) in temporarily restricted net assets		(9,860)	33,839
Change in net assets		(90,644)	519,526
Net assets at beginning of year		2,315,304	1,795,778
Net assets at end of year	$	2,224,660	2,315,304

See accompanying notes to consolidated financial statements.

ATTACHMENT 36

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended June 30, 2022 and 2021

(In thousands)

	2022	2021
Cash flows from operating activities:		
Change in net assets	$ (90,644)	519,526
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Net change in unrealized gains and losses on investments	232,738	(312,323)
Net asset transfers to University of Chicago	71,750	71,750
Restricted contributions and investment return	368	(42,322)
Realized gains on investments	(61,140)	(63,889)
Net change in valuation of derivatives	(63,922)	(46,545)
Change in accrued pension benefits other than net period benefit cost and other	(4)	(2,781)
Loss on refinancing of long-term debt	(7,764)	(832)
Loss on disposal of assets	393	235
Net assets released from restrictions for operations	9,456	8,358
Payment of lease obligations	(4,795)	(10,814)
Depreciation and amortization	133,271	132,707
Changes in assets and liabilities:		
Patient accounts receivable	(34,180)	(103,465)
Other assets, net	(4,868)	(38,892)
Accounts payable and accrued expenses	12,553	21,828
Due to University of Chicago	3,836	(7,840)
Estimated settlements with third-party payors and Medicare Advance	(178,725)	(82,317)
Self-insurance liabilities	13,988	25,142
Other liabilities	(3,735)	36,767
Net cash provided by operating activities	28,576	104,293
Cash flows from investing activities:		
Purchases of property, plant, and equipment	(156,412)	(83,744)
Change in construction payables	(5,558)	4,022
Purchases of investments	(274,809)	(944,485)
Sales of investments	389,808	637,099
Net cash used in investing activities	(46,971)	(387,108)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt, including bond premium	—	47,270
Additional repayment of long-term debt	(27,373)	(72,642)
Payments of finance/long-term lease obligation	(7,612)	(8,113)
Net asset transfers to University of Chicago, net	(71,750)	(71,750)
Net assets released from restriction for operations	(9,456)	(8,358)
Proceeds from restricted contributions	10,944	42,322
Net cash used in financing activities	(105,247)	(71,271)
Net (decrease) increase in cash and cash equivalents	(123,642)	(354,086)
Cash and cash equivalents:		
Beginning of year	184,639	538,725
End of year	$ 60,997	184,639
Noncash transactions:		
Other assets included for right-of-use assets – operating leases as a result of adopting ASU No. 842, Leases	$ 60,050	60,148

See accompanying notes to consolidated financial statements.

(1) Organization and Basis of Presentation

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

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

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

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

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

(b) COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted. Various policies were implemented by federal, state, and local governments in response to the COVID-19 pandemic.

During fiscal year 2022 and 2021, the System received approximately $4,740 and $11,136, respectively, in general and targeted Provider Relief Fund (PRF) distributions, as provided for under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Generally, these distributions from the PRF are not subject to repayment, provided the recipient is able to attest to and comply with the

terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the PRF and the impact of the pandemic on operating results through June 30, 2022, the System recognized through June 30, 2022 and 2021, $5,386 and $61,802, respectively. The unrecognized amount of general distributions and targeted distributions are recorded as estimated third-party payor settlements and Medicare Advance in the consolidated balance sheets as of June 30, 2022 and 2021 of $311 and $949, respectively. The System will continue to monitor compliance with the PRF and the impact of the pandemic on our revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, the ability to retain some or all of the distributions received may be impacted.

In addition, during the fourth quarter of fiscal year 2020, the System received $214,500 of accelerated Medicare payments under the Medicare Advanced Payment Program (APP). After 120 days of receipt, claims for services provided to Medicare beneficiaries will be applied against the advance payment balance. Any unapplied advance payment amounts must be paid for the advance payments for acute care hospitals. As of June 30, 2022 and 2021, the System has recorded the APP payments as estimated third-party payor settlements and Medicare advance on the consolidated balance sheets of $36,248 and $183,259. On September 30, 2020, federal legislation extended the terms of APP payments such that any claims for services provided to Medicare beneficiaries will be applied against the advance payment balance beginning April 2021.

The CARES Act also provides for a deferral of payments of the employer portion of social security payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021 and the remaining half until December 2022. The System has deferred payroll taxes and recorded the deferral under the caption of accrued expenses on the consolidated balance sheets at June 30, 2022 and 2021 for $18,645 and $36,800, respectively.

(c) Use of Estimates

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

(d) Community Benefits

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

The System developed a Financial Assistance Policy (the Policy) under which patients are offered discounts of up to 100% of charges on a sliding scale. The Policy is based both on income as a percentage of the Federal Poverty Level guidelines and the charges for services rendered. The Policy also contains provisions that are responsive to those patients subject to catastrophic healthcare expenses. Since the System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing care under this Policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2022 and 2021, are reported in note 6.

(e) Fair Value of Financial Instruments

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

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

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

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

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

(f) Cash and Cash Equivalents

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

(g) Inventory and Supplies

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

(Continued)

(h) Investments

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

Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by an entity and an active market with quoted prices exists, the market price of an identical security is used as reported fair value. Reported fair values for shares in mutual funds are based on share prices reported by the funds as of the last business day of the fiscal year. The System's interests in alternative investment funds, such as private debt, private equity, real estate, natural resources, and absolute return, are generally reported at the net asset value (NAV) reported by the fund managers, which is used as a practical expedient to estimate the fair value, unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2022 and 2021, the System had no plans to sell investments at amounts different from NAV.

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

A summary of the inputs used in valuing the System's investments as of June 30, 2022 and 2021 is included in note 7.

(i) Investments Limited as to Use

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

(j) Derivative Instruments

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

For hedging relationships, the System formally documents the hedging relationship and its risk management objective and strategy for understanding the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging investment's effectiveness in offsetting the hedged risk will be

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assessed, and a description of the method for measuring ineffectiveness. This process includes linking all derivatives that are presented as cash flow hedges to specific assets and liabilities in the consolidated balance sheets.

(k) Property, Plant and Equipment

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

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

The System periodically assesses the recoverability of long-lived assets (including property, plant, and equipment) when indications of potential impairment based on estimated, undiscounted future cash flows exist. Management considers factors, such as current results, trends, and future prospects, in addition to other economic factors, in determining whether there is an impairment of the asset. There were no impairments of long-lived assets during 2022 or 2021.

(l) Leases

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

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

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

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

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

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

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

The System monitors for events or changes in circumstances that require a reassessment of one of its leases. Leases having an initial term of 1 year or less are expensed as incurred.

(m) Net Assets

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

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

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

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

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(In thousands)

The description of amounts classified as donor restricted net assets (endowments only) as of June 30, 2022 and 2021 is as follows:

	Perpetual	Time restricted by law	2022 Total
Restricted for pediatric healthcare	$ 3,506	18,719	22,225
Restricted for adult healthcare	3,482	60,036	63,518
Restricted for educational and scientific programs	13,311	3,373	16,684
	$ 20,299	82,128	102,427

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

The endowment component of net assets without donor restrictions comprises of amounts designated by the Board to function as endowment, which amounted to $1,242,517 and $1,339,160 included within investments limited to use as of June 30, 2022 and 2021, respectively.

In addition to endowments, the System has $33,237 and $30,834, respectively, of other restricted net assets at June 30, 2022 and 2021.

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

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

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

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

(i) Patient Service Revenues

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

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

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

(ii) Charity Care

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

(Continued)

(iii) Third-Party Settlements

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions, and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change by material amounts.

The System has an estimation process for recording Medicare patient service revenue and estimated cost report settlements. As a result, the System records accruals to reflect the expected final settlements on our cost reports.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments from the finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in patient service revenues of $16,997 and $4,035, for the years ended June 30, 2022 and 2021, respectively.

(p) Hospital Assessment Program/Medicaid Provider Tax

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital (collectively referred to herein as HAP) have been approved by CMS through December 31, 2022. Under HAP, the state receives additional federal Medicaid funds for the state's healthcare system administered by the Illinois Department of Healthcare and Family Services. In 2022, reimbursement under the HAP resulted in a net increase of $123,000 in operating income, which includes $192,755 in Medicaid payments included in patient service revenue offset by $69,755 in Medicaid provider tax expense. In 2021, reimbursement under the HAP resulted in a net increase of $83,757 in operating income, which includes $159,439 in Medicaid payments included in patient service revenue offset by $75,682 in Medicaid provider tax expense.

(q) Other Revenue

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

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Premium and capitation revenues are received and recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The System has no material contract assets or liabilities at June 30, 2022 relating to premium and capitation revenue.

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

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

(r) Income Taxes

The System applies ASC Topic 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in a company's financial statements. ASC Topic 740 prescribes a more likely than not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under ASC Topic 740, tax positions are evaluated for recognition, derecognition, and measurement using consistent criteria and provide more information about the uncertainty in income tax assets and liabilities. As of June 30, 2022 and 2021, the System does not have an asset or liability recorded for unrecognized tax positions.

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

Deferred income taxes on the taxable entities of the Non-Obligated Groups are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the consolidated financial statement carrying amounts and the tax bases of existing assets and liabilities. As of June 30, 2022 and 2021, the UCMC and CHHD Non-Obligated groups have deferred tax assets primarily relating to net operating losses (NOL) of $19,234 and $17,763, respectively; however, it has a full valuation allowance as management believes that it was not more likely than not that the results of future operations would generate sufficient taxable income to realize the NOL.

(s) Subsequent Events

On September 13, 2022, UCMC and AdventHealth entered into a definitive agreement to enter into an affiliation under which UCMC will acquire a controlling interest in AdventHealth's Greta Lakes Region – which includes its four Illinois hospitals in Bolingbrook, Glendale Heights, Hinsdale and LaGrange, Illinois along with ambulatory and related assets and an associated medical group (Advent Midwest Health) – with AdventHealth retaining the remaining interest and continuing to manage daily operations

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(In thousands)

of the facilities with shared governance and certain reserve powers for UCMC. UCMC and AdventHealth will each retain their current system-level governance and administrative structures, and UCMC anticipates consolidating the financials of Advent Midwest Health into UCMC financial reporting. The affiliation is expected to close in early 2023, subject to regulatory approvals.

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, the System evaluated events and transactions through November 1, 2022, the date the consolidated financial statements were issued.

(3) Financial Assets and Liquidity Resources

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

	2022	2021
Financial assets:		
Cash and cash equivalents and investments limited to use	$ 128,793	425,799
Patient accounts receivable	471,321	437,141
Total financial assets available within one year	600,114	862,940
Liquidity resources:		
Bank lines of credit	100,000	100,000
Total financial assets and liquidity resources available within one year	$ 700,114	962,940

Included in cash and cash equivalents as presented above, as of June 30, 2022, the System has $67,677 of cash held in current portion of investment, limited to use. In addition, $1,242,517 is held in funds functioning as endowment and $212,761 of CHHD investments, all available for general expenditure upon Board approval, of which $752,482 is liquid within 12 months. As of June 30, 2021, the System had $241,160 of cash held in current portion of investment, limited to use. In addition, $1,339,160 in funds functioning as endowment and $248,687 of CHHD investments, all available for general expenditure upon Board approval, of which $880,953 is liquid within 12 months.

(4) Agreements and Transactions with the University

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

(Continued)

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

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

UCMC purchases various services from the University, including certain employee benefits, utilities, security, telecommunications, and insurance. In addition, certain UCMC accounting records are maintained by the University. During the years ended June 30, 2022 and 2021, the University charged UCMC $38,661 and $34,857, respectively, for utilities, security, telecommunications, insurance, and overhead.

The University's Division of Biological Sciences provides physician services to UCMC. In 2022 and 2021, UCMC recorded $283,001 and $271,561, respectively, in expense related to these services.

UCMC's Board adopted a plan of support under which it would provide annual net asset transfers to the University for support of academic programs in biology and medicine. All commitments under this plan are subject to the approval of UCMC's Board and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board are reflected as current liabilities. UCMC recorded net asset transfers of $71,750 in both 2022 and 2021 for this support.

(5) Patient Service Revenue and Patient Receivables

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

(a) Medicare

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

Other services rendered to Medicare beneficiaries are reimbursed based on a combination of prospectively determined rates and cost reimbursement methodologies. For the cost reimbursement, the System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits by the Medicare fiscal intermediary. UCMC's Medicare reimbursement reports through June 30, 2017 have been audited by the Medicare fiscal intermediary. CHHD's Medicare reimbursement reports through June 30, 2018 have been audited by the Medicare fiscal intermediary.

(Continued)

(In thousands)

(b) Medicaid

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

(c) Blue Cross

The System also participates as a provider of healthcare services under reimbursement agreements with Blue Cross under its indemnity program. The provisions of the agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the System and a review by Blue Cross. UCMC's and CHHD's Blue Cross reimbursement reports for 2021 and prior years have been reviewed by Blue Cross.

(d) Other

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

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

		2022	2021
Medicare	$	723,757	675,959
Medicaid		650,874	580,336
Managed care		1,164,292	1,066,617
Patients and other		9,564	8,597
Patient service revenue	$	2,548,487	2,331,509

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

		2022	2021
Inpatient	$	1,387,427	1,248,492
Outpatient/Ambulatory care		1,043,374	984,841
Physician services		117,686	98,176
	$	2,548,487	2,331,509

(Continued)

(In thousands)

The mix of receivables from patients and third-party payors as of June 30, 2022 and 2021 is as follows:

	2022	2021
Medicare	20.7 %	22.5 %
Medicaid	28.8	31.7
Managed care	49.2	44.4
Patients and other	1.3	1.4
	100.0 %	100.0 %

(6) Community Benefits

The following is a summary of the System's unreimbursed cost of providing care, as defined under its Financial Assistance Policy, along with the unreimbursed cost of government-sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2022 and 2021:

		2022	2021
Uncompensated care:			
Medicaid sponsored indigent healthcare	$	67,218	110,336
Medicare sponsored indigent healthcare – cost report		131,939	139,660
Medicare sponsored indigent healthcare – physician services		138,746	87,584
Total uncompensated care		337,903	337,580
Charity care		34,500	31,282
		372,403	368,862
Unreimbursed education and research:			
Education (unaudited)		71,880	66,774
Research (unaudited)		48,000	48,000
Total unreimbursed education and research		119,880	114,774
Total community benefits	$	492,283	483,636

The System determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries, wages and benefits, supplies, and other operating expenses, to determine a cost-to-charge ratio. The cost to charge ratio is applied to the charity care gross charges to calculate the charity care amount reported above. The System has not amended its financial assistance policies in 2022.

(Continued)

(In thousands)

(7) Investments Limited as to Use

The composition of investments limited as to use is as follows at June 30, 2022 and 2021:

	2022				
	Separately invested	TRIP	Other	Total	2021
Investments carried at fair value:					
Cash equivalents	$ 204	20,406	68,469	89,079	268,927
Global public equities	41,528	354,837	—	396,365	538,244
Private debt	—	55,200	—	55,200	61,525
Private equity:					
U.S. venture capital	128	131,004	—	131,132	151,685
U.S. corporate finance	—	69,441	—	69,441	70,791
International	—	162,929	—	162,929	168,427
Real assets:					
Real estate	—	73,054	—	73,054	72,146
Natural resources	—	76,451	—	76,451	70,406
Absolute return:					
Equity oriented	—	127,911	—	127,911	155,678
Multistrategy	—	78,880	—	78,880	86,199
Credit oriented	—	71,430	—	71,430	71,734
Protection oriented	—	37,129	—	37,129	36,193
Fixed income:					
U.S. Treasuries, including TIPS	—	83,041	—	83,041	76,315
Other fixed income	165,058	—	—	165,058	105,846
Other:					
Beneficial interests in trust	—	—	9,074	9,074	10,715
Funds in trust	—	—	45,639	45,639	24,891
Total investments	$ 206,918	1,341,713	123,182	1,671,813	1,969,722

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

	2022	2021
Current portion of investments limited to use	$ 67,796	247,395
Investments limited to use, less current portion	1,604,017	1,722,327
Total investments limited to use	$ 1,671,813	1,969,722

(Continued)

(In thousands)

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

	2022			
	UCMC	CHHD	Total	2021
Investments limited as to use:				
By the Board for capital improvements/restrictions by donors	$ 193,022	23,762	216,784	164,458
Funds held by custodian/trustee under indenture agreements	112	—	112	115
Funds held by trustee for self-insurance	6,424	39,103	45,527	18,656
Collateral for interest rate swap	—	—	—	6,120
Working capital account – not limited as to use	67,677	—	67,677	241,180
TRIP investments	1,143,640	198,073	1,341,713	1,539,213
Total investments limited to use	$ 1,410,875	260,938	1,671,813	1,969,722

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

	2022			
	UCMC	CHHD	Total	2021
Interest and dividend income, net	$ 14,884	2,453	17,317	11,104
Realized gains on sales of securities, net	50,699	10,441	61,140	63,689
Change in unrealized gains and losses on securities, net	(198,579)	(34,160)	(232,739)	312,323
	$ (133,016)	(21,266)	(154,282)	387,316

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2022, UCMC has commitments of $1,681 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

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

(Continued)

authorized by the University Board of Trustee's Investment Committee, which oversees the University's investment program in accordance with established guidelines.

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

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

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

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

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

(In thousands)

Funds in trust investments consist primarily of project construction funds and workers' compensation trust funds. Funds in trust comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2022 and comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2021.

The System believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2022 and 2021. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed. Assets and liabilities recorded at fair value as of June 30, 2022 and 2021 were as follows:

Assets	Quoted prices in active markets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	2022 Total fair value
Cash and cash equivalents	$ 60,997	—	—	60,997
Investments:				
Cash equivalents	89,079	—	—	89,079
Global public equities	86,130	—	—	86,130
Real assets:				
Real estate	11,625	—	—	11,625
Fixed income:				
U.S. Treasuries, including TIPS	83,041	—	—	83,041
Other fixed income	165,058	—	—	165,058
Restricted investments		—	9,074	9,074
Funds in trust	6,536	39,103	—	45,639
Investments measured at net asset value[1]				1,182,167
Total investments at fair value	502,466	39,103	9,074	1,732,810
Other assets	10,913	—	—	10,913
Total assets at fair value	$ 513,379	39,103	9,074	1,743,723
Liabilities				
Interest rate swap payable	$ —	83,440	—	83,440
Total liabilities at fair value	$ —	83,440	—	83,440

(Continued)

(In thousands)

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

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

During 2022, there were no transfers between investment between Levels 2 and 3. The interest rate swap arrangement has inputs, which can generally be corroborated by market data and is, therefore classified within Level 2.

The following table presents activity for the year ended June 30, 2022 for assets measured at fair value using unobservable inputs classified in Level 3:

	Level 3 rollforward
Beginning fair value	$ 10,715
Change in unrealized gains and losses, net	(1,641)
Ending fair value	$ 9,074

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

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

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

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

(Continued)

(In thousands)

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

(Continued)

	Remaining life	Redemption terms	Redemption restrictions and terms
Fixed income:			
Commingled funds	N/A	Weekly to monthly with notice periods of 5 to 10 days	None
Separate accounts	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Funds in trust	N/A	Daily	None

(8) Endowments

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

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

The System has beneficial interests in trusts. The System has recorded its share of the principal of the trusts as net assets with donor restrictions. Distributions from the trusts are recorded within net assets without restrictions if unrestricted; otherwise, they are classified as net assets with donor restrictions until appropriated for expenditure. In some instances, the historical costs basis of the funds is not available as the System received the shares in 1929. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies at June 30, 2022 and 2021, respectively.

(Continued)

(In thousands)

The System has the following donor-restricted endowment activities during the years ended June 30, 2022 and 2021 delineated by net asset class:

	2022		
	Without Donor Restrictions	With Donor Restrictions	Total
Changes in the fair value of endowment investments:			
Investment return:			
Endowment yield (interest and dividends)	$ 14,863	955	15,818
Net appreciation (realized and unrealized) on investments	(147,879)	(12,270)	(160,149)
Investment return, net of payout	(133,016)	(11,315)	(144,331)
Endowment payout	(57,852)	(3,961)	(61,813)
Net investment return	(190,868)	(15,276)	(206,144)
Other changes in endowment investments:			
Gifts and pledge payments received in cash	88,719	3,013	91,732
Other changes	5,506	—	5,506
Total other changes in endowment investments	94,225	3,013	97,238
Net change in endowment investments	(96,643)	(12,263)	(108,906)
Endowment investments at:			
Beginning of year	1,339,160	114,690	1,453,850
End of year	$ 1,242,517	102,427	1,344,944
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	20,299	20,299
Appreciation	—	82,128	82,128
Board-designated "funds functioning as endowment"	1,242,517	—	1,242,517
Total – as above	$ 1,242,517	102,427	1,344,944

(Continued)

(In thousands)

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

Investment and Spending Policies

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

ATTACHMENT 36

(In thousands)

For endowments invested in TRIP, the Board of the System has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula. The University utilizes the total return concept in allocating endowment income. In accordance with the University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board with the objective of a 5% average payout over time, was 5.5% for the fiscal years ended June 30, 2022 and 2021. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

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

(9) Property, Plant, and Equipment

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

	2022	2021
Land and land rights	$ 60,748	55,610
Buildings and improvements	1,964,500	1,941,958
Equipment	810,242	779,917
Construction in progress	125,350	35,712
	2,960,840	2,813,197
Less accumulated depreciation	(1,428,943)	(1,304,047)
Total property, plant, and equipment, net	$ 1,531,897	1,509,150

The cost of buildings that are jointly used by the University and the System is allocated based on the lease provisions. In addition, land and land rights include $13,600 and $15,400 for 2022 and 2021, respectively, which represents the unamortized portion of initial lease payments made to the University.

Capitalized interest costs in 2022 and 2021 were approximately $658 and $751, respectively. Construction in progress consists of various routine capital improvements and renovation projects. As of June 30, 2022, the System had total contractual commitments associated with ongoing capital projects of approximately $5,306.

(10) Long-Term Debt

The long-term debt of both UCMC and CHHD is issued pursuant to the second Amended and Restated Master Trust Indenture (MTI) dated as of June 1, 2019, as subsequently amended and supplemented. The Obligated Group Members are UCMC, CHHD, Ingalls Memorial Hospital, Ingalls Home Care, and Ingalls

ATTACHMENT 36

(In thousands)

Development Foundation. Each series of bonds is collateralized by the unrestricted receivables of the obligated Group Members and subject to certain restrictions under the MTI.

Long-term debt at June 30, 2022 and 2021 consists of the following:

	Fiscal year maturity	Interest rate	2022	2021
University of Chicago Medical Center:				
Fixed rate:				
Illinois Finance Authority:				
Series 2009A (2009B bonds paid off 08-15-20)	2022	5.0 %	$ —	12,795
Series 2009D1 and 2009D2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E1 and 2009E2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010A and 2010B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011A and 2011B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2015A	2030	5.0	21,895	21,895
Series 2016A	2027	5.0	22,830	22,830
Series 2016B	2042	5.0	164,490	164,490
Series 2020A	2027	2.5	47,270	47,270
Teachers Insurance and Annuity Association of America (TIAA):				
Series 2017A	2047	4.4	30,000	30,000
New York Life:				
Series 2019E fixed rate taxable	2042	2.7	57,565	60,645
Unamortized premium			13,935	15,276
Total fixed rate			682,985	700,201
Variable rate:				
Series 2013A	2050	1.9/2.5	65,480	66,963
Illinois Educational Facilities Authority (IEFA)	2038	1.1/1.1	55,341	59,028
Total variable rate			120,821	125,991
Unamortized debt issuance costs			(4,302)	(4,607)
Less current portion of long-term debt			(18,543)	(17,358)
Total UCMC long-term portion of debt, less current portion			780,961	804,227
UCMC Title Holding Corporation:				
Fixed rate:				
Brownfield Revitalization 40 – Promissory note A	2024	1.5	—	4,850
Urban Development Fund XLVI – Promissory note A	2024	1.5	—	4,576
Urban Development Fund LI – Promissory note A	2024	1.8	6,500	6,500
Citi NMTC – QLICI	2032	1.2	3,476	3,476
Citi NMTC – QLICI	2032	1.2	1,620	1,620

(Continued)

(In thousands)

	Fiscal year maturity	Interest rate	2022	2021
URP QLICI – Loan A	2047	1.0 %	$ 7,334	7,334
URP QLICI – Loan B	2047	1.0	2,666	2,666
SCORE QLICI – Loan A	2047	1.0	4,176	4,176
SCORE QLICI – Loan B	2047	1.0	1,704	1,704
CNI QLICI – Loan A	2047	1.0	3,455	3,455
CNI QLICI – Loan B	2047	1.0	1,545	1,545
Total UCMC Title Holding Corporation debt			32,476	41,902
Less current portion			—	(1,862)
Title holding company LT portion			32,476	40,040
Total UCMC debt, excludig current portion			$ 813,437	844,267
CHHD:				
Fixed Rate: Series 2017	2034	2.5	$ 32,390	34,325
Fixed rate: Series 2019	2042	2.7	61,445	63,165
Unamortized debt issuance costs			(320)	(345)
Total debt and unamortized premiums (discount)			93,515	97,145
Less current portion of long-term debt			(3,770)	(3,655)
Total CHHD debt, excluding current portion			$ 89,745	93,490
Total notes and bonds payable			$ 925,495	960,632
Less current portion			(22,313)	(22,875)
Long-term debt, excluding current portion			$ 903,182	937,757

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

Year ending June 30:	
2023	$ 22,313
2024	23,293
2025	25,349
2026	26,103
2027	27,248
Thereafter	791,876
	$ 916,182

(Continued)

(In thousands)

(a) Letters of Credit

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

Payment on each of the variable rate demand revenue bonds is also collateralized by a letter of credit. The letters of credit that support the Series 2009D and 2009E bonds expire in June 2023 and June 2026, respectively. The letters of credit that support the Series 2010A and 2010B bonds expire in May 2025 and July 2024, respectively. The letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2025 and May of 2026, respectively. Payment of each of the IEFA bonds is collateralized by a letter of credit maturing May 2022. The letters of credit are subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1:35:1.

Included in UCMC's debt is $55,341 of commercial paper revenue notes and $325,000 of variable rate demand bonds. In the event that UCMC's remarketing agents are unable to remarket the bonds, the trustee of the bonds will tender them under the letters of credit. Scheduled repayments under the letters of credit are between one and three years, beginning after a grace period of at least one year from the event, and bear interest rates different from those associated with the original bond issue. Any bonds tendered are still eligible to be remarketed. Bonds subsequently remarketed would be subject to the original bond repayment schedules.

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

Year ending June 30:	
2023	$ 22,313
2024	171,726
2025	127,532
2026	155,827
2027	27,248
Thereafter	411,536
	$ 916,182

(b) Lines of Credit

At June 30, 2021, UCMC had a $100,000 line of credit from a commercial bank. As of June 30, 2022, UCMC has a $100,000 line of credit from a commercial bank that expires March 2, 2023.

As of June 30, 2022 and 2021, no amount was outstanding under the lines.

(c) Interest Payments

The System paid interest, net of capitalized interest, of approximately $31,200 and $31,300 in 2022 and 2021, respectively.

(d) UCMC Title Holding Corporation

During fiscal years 2017 and 2018, UCMC entered into New Markets Tax Credit (NMTC) financing agreements for the purposes of financing various projects at UCMC, including the financing of equipment and the construction of a new emergency department and adult trauma center. UCMC's NMTC consists of NMTC investors (Investors) who provide qualified equity investments to community development entities (CDE's) who in turn provide debt financing to separate not for profit tax-exempt entities, which are qualified active low income community businesses (QALICB). UCMC Title Holding Corporation and UCMC Title Holding Corporation II NFP, the QALICB's, have been consolidated into the financial statements.

In May 2022, the tax compliance period ended for one of the NMTC financing agreements made for UCMC Title Holding Corporation. The Investor of USBCDC Investment Fund 147, LLC exercised their Put Option and UCMC purchased the investment fund for $1. At this time, UCMC recognized a gain of $1,079 related to the investment fund, and the loans in the amount of $7,977 from UCMC to the investment fund, as well as the outstanding principal from the investment fund to UCMC Title Holding Corporation in the amount of $7,763, were extinguished. As of June 30, 2022 UCMC Title Holding Corporation and UCMC Title Holding Corporation II NFP have remaining active financing agreements in the amount of $6,500 and $25,976, respectively.

(11) Derivative Instruments

The System has interest rate related derivative instruments to manage its exposure on debt instruments. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk; however, the System is required to post collateral to the counterparty when certain thresholds as defined in the derivative agreements are met. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. System management also mitigates risk through periodic reviews of their derivative positions in the context of their total blended cost of capital.

The System is required to post collateral under the specific terms and conditions for the various interest rate swap agreements as described below. At June 30, 2022 and 2021, $0 and $6,120 was held as collateral, respectively, and was recorded in current portion of investments limited to use and included in Note 7 as funds in trust for disclosure. Collateral postings are primarily driven by the value of the swap as measured at the reset date. Collateral requirements increase if credit ratings were to be downgraded.

(Continued)

ATTACHMENT 36

(In thousands)

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

UCMC Interest Rate Swap Agreement

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

Management has determined that the interest rate swaps are effective and have qualified for hedge accounting. The fair value of the UCMC swap agreement liabilities was $78,870 and $138,563 at June 30, 2022 and 2021, respectively, and has been included in other long-term liabilities in the accompanying consolidated balance sheets. The net effective portion of the change in fair value on the UCMC swap agreements of $62,885 and $44,967 in 2022 and 2021, respectively, has been included in the change in net assets without donor restrictions in the accompanying 2022 and 2021 consolidated statements of operations and changes in net assets without donor restriction. Management has recognized ineffectiveness of approximately $1,427 in 2022 and an ineffectiveness of $695 in 2021 in nonoperating gains and losses. This movement reflects the spread between tax-exempt interest rates and LIBOR during the period. The effective portion of these swaps is included in other changes in net assets without donor restrictions. The interest rate swaps terminate on February 1, 2044. Cash settlement payments related to the swaps are recorded in interest expense.

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

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

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

(Continued)

(In thousands)

CHHD Swap Agreement

CHHD entered into an interest rate swap agreement on June 28, 2004 to lock in long-term fixed rates on the Series 2004 variable-rate debt issuance, with a maturity date of May 15, 2034. This agreement was amended on March 1, 2013. Under the amended agreement, the notional amount and maturity did not change, and CHHD receives, on a monthly basis, 67% of one-month LIBOR plus 47.5 basis points and makes payments on a monthly basis, an annualized fixed rate of 4.61%. The swap is not designated as a hedging instrument, and therefore, the change in fair value of the 2004 interest rate swap agreement of $4,229 and $2,637 in 2022 and 2021, respectively, was recognized as a component of nonoperating gains in the accompanying consolidated statements of operations and changes in net assets without donor restriction. The fair value of the Series 2004 interest rate swap agreement liability of $4,570 and $8,799 at June 30, 2022 and 2021, respectively, is included as a component of other long-term liabilities in the accompanying consolidated balance sheets. The differential to be paid or received under the Series 2004 interest rate swap agreement is recognized monthly and has been included as a component of interest expense in the accompanying consolidated statements of operations and changes in net assets without donor restriction.

A summary of outstanding positions under the interest rate swap agreements for CHHD at June 30, 2022 is as follows:

Series	Notional amount	Maturity date	Rate received	Rate paid
2004 Interest rate swap Agreement:	$ 34,450	May 15, 2034	% of LIBOR	Fixed 4.61%

(12) Leases

The components of lease cost for the years ended June 30, 2022 and 2021 reported as part of other expenses in the consolidated statements of operations and changes in net assets without donor restrictions, were as follows:

	2022	2021
Operating lease expense	$ 14,477	10,814
Finance lease expense:		
Amortization of right-of-use assets	6,138	5,802
Interest on lease liabilities	1,115	1,146
Total finance lease expense	7,253	6,948
Total lease expense	$ 21,730	17,762

(Continued)

(In thousands)

Amounts reported in the consolidated balance sheets as of June 30, 2022 and 2021 were as follows:

		2022	2021
Operating Leases:			
Right-of-use assets – operating leases	$	66,269	64,323
Accumulated amortization		6,219	4,175
Other assets, net	$	60,050	60,148
Current portion of other long-term liabilities	$	5,831	4,626
Other long-term liabilities, less current portion		54,219	55,522
Total operating lease liabilities	$	60,050	60,148
Finance Leases:			
Right-of-use assets – finance leases	$	49,270	37,818
Accumulated amortization		12,107	7,643
Other assets, net	$	37,163	30,175
Current portion of other long-term liabilities	$	5,859	3,329
Other long-term liabilities, less current portion		32,553	28,055
Total finance lease liabilities	$	38,412	31,384

Other information related to leases as of June 30, 2022 and 2021 was as follows:

Supplemental cash flow information:

		2022	2021
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flow from operating leases	$	4,795	10,814
Financing cash flow from finance leases		7,612	8,113
ROU assets obtained in exchange for lease obligations:			
Operating leases		4,384	14,318
Finance leases		12,151	2,202
Reductions to ROU assets resulting from reductions to lease obligations:			
Operating leases		6,624	4,175
Finance leases		3,463	8,058

(Continued)

(In thousands)

	2022	2021
Weighted average remaining lease term:		
Operating leases	13.3 years	12.7 years
Finance leases	10.1 years	13.4 years
Weighted-average discount rate:		
Operating leases	2.2 %	2.2 %
Finance leases	5.6	3.5

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

Maturities of lease liabilities under non-cancelable leases as of June 30, 2022 are as follows:

	Operating	Finance
2023	$ 7,080	6,813
2024	5,706	6,801
2025	5,358	5,411
2026	5,287	5,241
2027 and thereafter	45,559	23,614
	68,988	47,880
Less amount representing interest	8,938	9,468
Present value of net minimum lease payments	$ 60,050	38,412

(13) Insurance

Professional and General Liability

The System maintains separate self-insurance programs for UCMC and CHHD. UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2022 and 2021 were $10,000 and $5,000, respectively, per claim and unlimited in the aggregate. Claims in excess of $10,000 are subject to an additional self-insurance retention limited to $7,500 per claim and $15,000 in aggregate. There are no assurances that the University will be able to renew existing policies or procure coverage on similar terms in the future.

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

(In thousands)

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

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and assets available for claims for the combined University and UCMC self-insurance program as of June 30, 2022 and 2021 is presented below:

	2022	2021
Actuarial present value of self-insurance liability for medical malpractice	**$ 239,308**	**202,419**
Total assets available for claims	**305,422**	**344,879**

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately $39,047 higher at June 30, 2022. The interest rate assumed in determining the present value was 4.50% and 2.75% for 2022 and 2021, respectively. UCMC has recorded its pro rata share of the malpractice self-insurance liability in the amount of $107,689 and $96,204 at June 30, 2022 and 2021, respectively, with an offsetting receivable from the malpractice trust to cover any related claims. The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense its negotiated pro rata share of the actuarially determined normal contribution, with gains and losses amortized over five years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2022, UCMC's expense is estimated to be approximately $11,000 related to malpractice insurance.

On April 30, 2019, CHHD entered into a loss portfolio transfer for the Ingalls Memorial Hospital medical malpractice program by obtaining an occurrence-based policy for claims through June 30, 2018. At June 30, 2022, there was no additional liability calculated by the programs actuaries that would require additional reserves by CHHD or the Captive. Accruals for CHHD professional and general liabilities are recorded on a discounted basis consistent with the University's insurance program.

On October 1, 2020 a new tax-exempt Cayman domiciled captive, Trulen Insurance SPC Limited ("Trulen"), was incorporated to operate as the new medical malpractice framework for CHHD. Trulen was organized as a Segregated Portfolio Company, which consists of a "core" company and 3 segregated portfolios, or "cells", which allow segregation of risk and assets between the Hospital and General Liability, employed community physicians, and non-employed contracted provider liabilities. The insurance business of Ingalls Casualty Insurance Limited ("ICIL"), the previous insurer of professional liability insurance for CHHD, was transferred and novated to the three separate portfolios by issuing three separate Deeds of Novation and Business Transfer between Trulen and ICIL. After the completion of the business transfer, ICIL ceased underwriting operations. As of June 30, 2022 the total assets of Trulen were $93,404 and total liabilities were $88,334. Total claim expense as of June 30, 2022 was $13,618.

(In thousands)

(14) Pension Plans

Active Plans

A majority of UCMC's personnel participate in the University's defined-benefit and contribution pension plans, which are considered multiemployer pension plans. Under the defined-benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last ten years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding based on the guidelines set forth by the Employee Retirement Income Security Act of 1974, on an actuarially determined basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of net assets without donor restrictions. The adjustment to net assets without donor restrictions was $4 and $2,781 for the years ended June 30, 2022 and 2021. UCMC expects to make contributions not to exceed $3,200 for the fiscal year ending June 30, 2022.

Effective January 1, 2017, the 401(a) defined-benefit pension plan was frozen for UCMC employees participating in the plan and was replaced with an enhanced defined-contribution plan. Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately $28,400 and $11,700 for the years ended June 30, 2022 and 2021, respectively.

UCMC's expense related the multiemployer University's defined-benefit plans included in the University's consolidated financial statements for the years ended June 30, 2022 and 2021 was $0, respectively.

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

		2022	2021
Projected benefit obligation	$	767,140	1,006,857
Fair value of plan assets		673,813	871,372
Deficit of plan assets over benefit obligation	$	(93,327)	(135,485)

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

	2022	2021
Discount rate	5.0 %	3.2 %
Expected return on plan assets	5.8	6.0
Rate of compensation increase	3.5	3.5

(Continued)

(In thousands)

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

	2022	2021
Domestic equities	29 %	26 %
International equity	20	21
Fixed income	51	53
	100 %	100 %

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

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

Expected future benefit payments excluding plan expenses are as follows:

Fiscal year:	
2023	$ 75,297
2024	50,528
2025	50,608
2026	49,817
2027	50,486
2028-2032	254,148

UCMC and CHHD also maintain additional defined-contribution retirement plans for employees. The System's pension expense under these distinct defined-contribution retirement plans for UCMC was $9,900 and $700 for the years ended June 30, 2022 and 2021, respectively.

CHHD expense under these distinct defined-contribution retirement plans was $2,900 and $800 for the years ended June 30, 2022 and 2021, respectively.

(Continued)

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(In thousands)

(15) Functional Expenses

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

	2022			
	Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$ 1,165,697	127,257	1,809	1,294,763
Supplies and other	916,851	112,140	1,124	1,030,115
Physician services	312,825	4,121	—	316,946
Insurance	21,191	222	—	21,413
Interest	35,075	1,831	—	36,906
Medicaid provider tax	69,756	—	—	69,756
Depreciation and amortization	131,949	1,321	—	133,270
Total	$ 2,653,344	246,892	2,933	2,903,169

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

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

(Continued)

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(16) Contingencies

(a) Litigation

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

(b) Regulatory Investigation and Other

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

(c) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the governor of Illinois signed into law, Public Act 97-0688, which created new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. The System certified in 2022 and 2021 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

Schedule 1

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Balance Sheet Information

June 30, 2022

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Heath System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Eliminations	Consolidated total
	$ 43,473	4,971	28	1,439	—	—	49,912	7,079	4,006	—	60,997
	425,893	—	39,299	—	2,398	—	467,371	2,289	1,661	—	471,321
T	67,774	22	—	—	—	—	67,796	—	—	—	67,796
e receivable	21,904	—	—	—	—	—	21,904	—	—	—	21,904
	3,543	—	—	—	—	—	3,543	—	—	—	3,543
	128,980	2,393	100,500	295	11,152	(49,511)	193,809	2,981	14,076	(210,866)	—
ts	148,866	1,055	11,208	248	121	—	161,304	2,118	41,161	(1,290)	203,353
	849,033	8,441	151,017	1,982	13,677	(49,511)	965,639	14,527	60,904	(212,156)	828,914
tion	1,343,101	8,221	132,560	68,111	19,073	(3,215)	1,565,851	—	38,166	—	1,604,017
	1,304,718	6,925	196,156	—	—	—	1,506,899	18,393	6,607	(1)	1,531,898
	4,604	—	—	—	—	—	4,604	—	—	—	4,604
rent portion	96,919	—	—	—	—	—	96,919	—	—	—	96,919
	411,715	(5,803)	(2)	—	—	(293,220)	80,690	57,543	1,547	(26,774)	113,005
	$ 4,001,090	18,884	479,731	68,093	32,750	(377,946)	4,220,602	90,462	107,224	(238,931)	4,179,357
nts											
	$ 232,137	(37,148)	96,109	1,128	3,119	—	295,345	5,882	36,696	(48,889)	289,214
	18,543	—	3,770	—	—	—	22,313	—	—	—	22,313
	10,482	—	—	—	—	—	10,482	1,496	—	(1,294)	10,684
l Medicare Advance e liability	236,982	—	36,882	—	400	—	274,164	—	1,640	1	275,805
	21,904	—	—	—	—	—	21,904	—	—	—	21,904
	—	50,627	15,713	58	88	(49,511)	16,970	83,268	81,948	(162,176)	—
	33,645	—	—	—	—	—	33,645	—	—	—	33,645
	553,573	13,479	152,474	1,186	3,607	(49,511)	674,803	90,646	100,282	(212,358)	653,545
less current portion	8,124	—	—	—	—	—	8,124	—	—	—	8,124
portion	96,919	—	—	—	—	—	96,919	—	81,094	—	178,013
	780,961	—	89,745	—	—	—	870,706	32,476	—	—	903,182
	78,870	—	4,570	—	—	—	83,440	—	—	—	83,440
	129,521	4,599	10,738	—	184	(2,358)	142,574	22,283	52	(36,516)	128,393
	1,647,988	17,983	257,527	1,186	3,771	(51,869)	1,876,566	145,377	181,428	(248,874)	1,954,697
	2,218,841	(1,099)	218,994	54,824	28,974	(309,740)	2,209,794	(54,915)	(74,228)	9,743	2,088,996
	136,481	—	3,210	12,283	5	(16,337)	135,642	—	72	—	135,664
	2,353,122	(1,099)	222,204	66,907	28,979	(326,077)	2,344,036	(54,915)	(74,204)	9,743	2,224,660
	$ 4,001,090	16,884	479,731	68,093	32,750	(377,946)	4,220,602	90,462	107,224	(238,931)	4,179,357

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ATTACHMENT 36

Schedule 2

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Year ended June 30, 2022

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Heath System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Eliminations	Consolidated total
	$ 2,164,585	—	325,487	—	9,687	—	2,499,719	24,280	26,302	(1,824)	2,548,487
assed from restrictions	407,166	6,763	10,302	1,743	443	(6,208)	420,209	3,156	37,285	(23,889)	436,961
	2,571,751	6,763	335,789	1,743	10,110	(6,208)	2,919,928	27,448	63,587	(25,513)	2,985,448
	1,070,188	2,169	151,902	369	9,282	—	1,242,930	18,083	35,059	(1,309)	1,294,763
	883,190	3,047	120,287	1,168	1,845	(900)	1,007,637	11,373	15,582	(4,478)	1,030,114
	275,449	1,400	23,278	21	241	(4,251)	296,138	6,339	16,660	(2,191)	316,946
	4,360	1,127	16,208	—	221	(1,057)	20,859	1,550	14,876	(15,872)	21,413
	33,483	—	4,131	—	—	—	37,614	943	3	(1,656)	36,904
	51,932	—	17,924	—	—	—	69,756	—	—	—	69,756
	113,917	534	15,370	—	9	—	129,830	2,416	1,025	—	133,271
	2,432,419	7,297	359,100	1,558	10,598	(6,208)	2,804,764	40,704	83,205	(25,506)	2,903,167
ncial) of expenses	139,332	(534)	(23,311)	185	(488)	—	115,184	(13,256)	(19,618)	(7)	82,291
	(133,016)	(500)	(13,484)	(5,950)	(1,455)	—	(154,383)	—	—	—	(154,383)
e instruments	—	—	4,229	—	—	—	4,229	—	—	—	4,229
ative instruments	(1,427)	—	—	—	—	—	(1,427)	—	—	—	(1,427)
	(9,570)	(466)	(574)	(259)	(86)	—	(10,955)	7,767	(498)	930	(2,756)
	(144,013)	(966)	(9,805)	(6,209)	(1,541)	—	(162,435)	7,767	(498)	930	(154,290)
ietirement) of expenses	(4,781)	(1,500)	(33,117)	(5,804)	(2,029)	—	(47,271)	(5,495)	(20,116)	923	(71,959)
ination											
net	(71,750)	—	—	—	—	—	(71,750)	—	—	—	(71,750)
han net periodic											
	4	—	—	—	—	—	4	—	—	—	4
erivatives	82,885	—	—	—	—	—	82,885	—	—	—	82,885
tal purposes	38	—	—	—	—	—	38	—	—	—	38
	(5,000)	(2)	13,914	(1,513)	—	—	1,400	—	(1,405)	5	—
ts without donor	$ (18,528)	(1,502)	(19,203)	(13,526)	(3,570)	—	(54,698)	(5,495)	(21,521)	928	(80,784)

Schedule 3

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2022

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Heath System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CMHD Entities	Eliminations	Consolidated total
xpenses and losses	$ (4,701)	(1,500)	(33,117)	(5,924)	(2,029)	—	(47,271)	(5,485)	(20,118)	923	(71,953)
, net	(71,750)	—	—	—	—	—	(71,750)	—	—	—	(71,750)
ian net periodic											
	4	—	—	—	—	—	4	—	—	—	4
ivatives	62,885	—	—	—	—	—	62,885	—	—	—	62,885
al purposes	36	—	—	—	—	—	36	—	—	—	36
	(5,090)	(1)	10,913	(7,517)	—	—	1,400	—	(1,405)	5	—
s without donor restrictions	(18,526)	(1,501)	(19,204)	(13,438)	(2,029)	—	(54,696)	(5,485)	(21,523)	928	(80,784)
	10,546	—	—	398			10,944	—	(3)	3	10,944	
	—	—	50	—	—	(50)	—	—	—	—	—
or operating purposes	(8,106)	—	—	(348)	—		(8,458)	—	—		(8,458)
or capital purposes	(36)	—	—	—	—	—	(36)	—	—		(36)
	(8,811)	—	—	(1,841)	—	—	(11,312)	—	—	—	(11,312)
s with donor restrictions	(8,289)	—	50	(1,591)	—	(50)	(9,880)	—	(3)	3	(9,880)
	(26,795)	(1,501)	(19,154)	(15,029)	(2,029)	(50)	(64,568)	(5,485)	(21,524)	931	(80,844)
	2,379,917	402	241,358	81,934	31,008	(326,027)	2,408,593	(49,429)	(52,680)	8,812	2,315,304
	$ 2,353,122	(1,099)	222,204	66,905	28,979	(326,077)	2,344,025	(54,914)	(74,204)	9,743	2,224,660

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Financial Statements

June 30, 2024 and 2023

(With Independent Auditors' Report Thereon)

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Independent Auditors' Report

The Board of Trustees
The University of Chicago Medical Center:

Opinion

We have audited the consolidated financial statements of The University of Chicago Medical Center (the System), which comprise the consolidated balance sheets as of June 30, 2024 and June 30, 2023, and the related consolidated statements of operations and changes in net assets without donor restrictions, statements of changes in net assets, and statement of cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the System as of June 30, 2024 and June 30, 2023, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

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

Responsibilities of Management for the Consolidated Financial Statements

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

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

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2024 supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Chicago, Illinois
November 7, 2024

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Balance Sheets

June 30, 2024 and 2023

(In thousands)

Assets		2024	2023
Current assets:			
Cash and cash equivalents	$	183,072	176,546
Patient accounts receivable		691,974	525,670
Current portion of investments limited to use		19	58,638
Current portion of malpractice self-insurance receivable		25,193	22,754
Current portion of pledges receivable		19,131	3,543
Due from affiliate		15,924	66,397
Prepaids, inventory, and other current assets		261,681	268,673
Total current assets		1,196,994	1,122,221
Investments limited to use, less current portion		1,527,487	1,572,137
Property, plant, and equipment, net		2,094,663	2,009,957
Pledges receivable, less current portion		79,043	4,802
Malpractice self-insurance receivable, less current portion		81,899	93,434
Other assets, net		301,092	171,740
Total assets	$	5,281,178	4,974,291
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	388,452	356,024
Current portion of long-term debt		28,143	23,293
Current portion of other long-term liabilities		6,413	8,929
Estimated third-party payor settlements and Medicare Advance		311,651	282,121
Current portion of malpractice self-insurance liability		25,193	22,754
Due to University of Chicago		33,033	29,280
Total current liabilities		792,885	722,401
Other liabilities:			
Workers' compensation self-insurance liabilities, less current portion		11,921	11,267
Malpractice self-insurance liability, less current portion		164,516	190,815
Long-term debt, less current portion		1,227,091	1,266,194
Interest rate swap liability		42,660	57,511
Other long-term liabilities, less current portion		188,872	137,355
Total liabilities		2,427,945	2,385,543
Net assets:			
Without donor restrictions		2,285,840	2,135,831
Non-controlling interest in consolidated joint venture		310,750	305,185
Total net assets without donor restrictions		2,596,590	2,441,016
With donor restrictions		256,643	147,732
Total net assets		2,853,233	2,588,748
Total liabilities and net assets	$	5,281,178	4,974,291

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Years ended June 30, 2024 and 2023

(In thousands)

	2024	2023
Operating revenues:		
Patient service revenue	$ 3,996,033	3,260,498
Other operating revenues and net assets released from restrictions used for operating purposes	629,140	508,677
Total operating revenues	4,625,173	3,769,175
Operating expenses:		
Salaries, wages, and benefits	1,966,480	1,614,475
Supplies and other	1,703,990	1,427,559
Physician services	403,201	355,593
Insurance	70,511	42,065
Interest	47,816	41,945
Medicaid provider tax	137,502	86,093
Depreciation and amortization	184,722	151,344
Total operating expenses	4,514,222	3,719,074
Operating revenue in excess of expenses	110,951	50,101
Nonoperating gains and losses:		
Investment return, net	101,050	41,190
Change in fair value of nonhedged derivative instruments	(3,110)	1,888
Derivative ineffectiveness on hedged derivative instruments	—	3,296
Other, net	1,799	(3,142)
Revenue and gains in excess of expenses and losses	210,690	93,333
Less revenue and gains in excess (deficit) of expenses and losses attributable to non-controlling interest	(5,565)	2,806
Revenue and gains in excess of expenses and losses	205,125	96,139
Other changes in net assets without donor restrictions:		
Net asset transfers to University of Chicago	(71,750)	(71,750)
Effective portion of change in valuation of derivatives	17,961	20,745
Contribution of AdventHealth joint venture net assets	—	231,483
Additional working capital from AdventHealth	—	70,896
Distributions and other, net	(1,327)	7,313
	150,009	354,826
Net income (loss) attributed to non-controlling interest in consolidated joint venture	5,565	(2,806)
Increase in net assets without donor restrictions	$ 155,574	352,020

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2024 and 2023

(In thousands)

	2024	2023
Net assets without donor restrictions:		
Revenue and gains in excess of expenses and losses	$ 205,125	96,139
Net asset transfers to University of Chicago	(71,750)	(71,750)
Effective portion of change in valuation of derivatives	17,961	20,745
Contribution of AdventHealth joint venture net assets	—	231,483
Additional working capital from AdventHealth	—	70,896
Distributions and other, net	(1,327)	7,313
Increase in net assets without donor restrictions before non-controlling interest	150,009	354,826
Net income (loss) attributed to non-controlling interest in consolidated joint venture	5,565	(2,806)
Increase in net assets without donor restrictions	155,574	352,020
Net assets with donor restrictions:		
Contributions	113,392	13,950
Contribution of AdventHealth net assets with donor restrictions	—	8,713
Net assets released from restrictions used for operating purposes	(13,918)	(7,641)
Investment return, net	11,237	(2,954)
Net assets released from restrictions for capital purposes	(1,800)	—
Increase in net assets with donor restrictions, net	108,911	12,068
Change in net assets	264,485	364,088
Net assets at beginning of year	2,588,748	2,224,660
Net assets at end of year	$ 2,853,233	2,588,748

See accompanying notes to consolidated financial statements.

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THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended June 30, 2024 and 2023

(In thousands)

	2024	2023
Cash flows from operating activities:		
Change in net assets	$ 264,485	364,088
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Net change in unrealized gains and losses on investments	(56,860)	(3,440)
Net asset transfers to University of Chicago	71,750	71,750
Restricted contributions and investment return	(124,629)	(10,996)
Realized gains on investments	(44,190)	(24,077)
Net change in valuation of derivatives	(14,851)	(25,929)
Contribution of AdventHealth Joint Venture net assets	—	(241,629)
Additional working capital from AdventHealth	—	(70,896)
Net assets released from restrictions for operations	13,918	7,641
Payment of lease obligations	(22,099)	(6,728)
Depreciation and amortization	184,722	151,344
Amortization of bond premium/discount/cost of issuance	(1,103)	(1,148)
Changes in assets and liabilities:		
Patient accounts receivable	(166,304)	(54,349)
Other assets, net	(86,235)	(130,923)
Accounts payable and accrued expenses	26,431	51,920
Due to University of Chicago	3,753	(4,365)
Estimated settlements with third-party payors and Medicare Advance	29,530	6,316
Self-insurance liabilities, net	(23,208)	16,795
Other liabilities	(1,562)	(14,934)
Net cash provided by operating activities	53,548	80,440
Cash flows from investing activities:		
Purchases of property, plant, and equipment	(259,188)	(172,421)
Investment in joint venture	—	(250,000)
Net assets released from restriction for capital purposes	1,800	—
Purchases of investments	(507,706)	(291,943)
Sales of investments	712,025	357,544
Net cash used in investing activities	(53,069)	(356,820)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt, including bond premium	—	393,825
Repayment of long-term debt	(33,150)	(28,685)
Payments of finance/long-term lease obligation	(3,964)	(6,355)
Net asset transfers to University of Chicago, net	(71,750)	(71,750)
Additional working capital from AdventHealth and acquired cash	—	98,585
Net assets released from restriction for operations	(13,918)	(7,641)
Net assets released from restriction for capital purposes	(1,800)	—
Proceeds from line of credit	6,000	—
Proceeds from restricted contributions	124,629	13,950
Net cash provided by financing activities	6,047	391,929
Net increase in cash and cash equivalents	6,526	115,549
Cash and cash equivalents:		
Beginning of year	176,546	60,997
End of year	$ 183,072	176,546

See accompanying notes to consolidated financial statements.

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(1) Organization and Basis of Presentation

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

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

On January 1, 2023, UCMC acquired a controlling interest in AdventHealth Great Lakes Region through a member substitution becoming the sole Class A member and Advent Health becoming the sole Class B member of this 501c3 corporation and affiliation agreement. As a result of this transaction, AdventHealth Great Lakes Region is included in the consolidated financial statements of UCMC with distinguishing of net assets deemed controlling interest versus non-controlling interest.

The University of Chicago (the University), as the sole corporate member of UCMC, elects UCMC's Board of Trustees (the Board) and approves its bylaws. The UCMC president reports to the University's executive vice president for Medical Affairs. The relationship between UCMC and the University is defined in the Medical Center bylaws, an affiliation agreement, an operating agreement, and several leases. See note 5 for agreements and transactions with the University.

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

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

(b) Accounting Standards Adopted

In June 2016, the Financial Accounting Standards Board issued Accounting Standards Update (ASU) 2016-13, Financial Instruments – Credit Losses (topic 326) Measurement of Credit Losses on Financial Instruments commonly referred to as the Current Expected Credit Losses (CECL) model. Under the

CECL model, UCMC is required to estimate expected credit losses over the contractual term of financial assets, including receivables. The estimation of the expected credit losses involves considering relevant information about past events, current conditions and forecasts that effect the collectability of the financial assets. UCMC adopted ASU 2016-13 in fiscal year 2024 with no material impact on the consolidated financial statements.

(c) Use of Estimates

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

(d) Community Benefits

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

The System developed a Financial Assistance Policy (the Policy) under which patients are offered discounts of up to 100% of charges on a sliding scale. The Policy is based both on income as a percentage of the Federal Poverty Level guidelines and the charges for services rendered. The Policy also contains provisions that are responsive to those patients subject to catastrophic healthcare expenses. Since the System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing care under this Policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2024 and 2023, are reported in note 7.

(e) Fair Value of Financial Instruments

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

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

(Continued)

developed based on the best information available. The three-tier hierarchy of inputs is summarized in the three broad levels as follows:

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

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

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

(f) Cash and Cash Equivalents

Cash equivalents include U.S. Treasury notes, commercial paper, and corporate notes with original maturities of three months or less, excluding investments whose use is limited. The system has deposits at financial institutions that exceed the Federal Deposit Insurance Corporation ("FDIC") limits. Cash equivalents held by investment managers are treated as investing activity in the consolidated statements of cash flows.

(g) Inventory and Supplies

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

(h) Investments Limited as to Use

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

Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by an entity and an active market with quoted prices exists, the market price of an identical security is used as reported fair value. Reported fair values for shares in mutual funds are based on share prices reported by the funds as of the last business day of the fiscal year. The System's interests in alternative investment funds, such as private debt, private equity, real estate, natural resources, and absolute return, are generally reported at the net asset value (NAV) reported by the fund managers, which is used as a practical expedient to estimate the fair value, unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2024 and 2023, the System had no plans to sell investments at amounts different from NAV.

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

A summary of the inputs used in valuing the System's investments as of June 30, 2024 and 2023 is included in note 8.

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

(i) Derivative Instruments

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

As of June 30, 2024, the System has discontinued hedge accounting. Prospectively, the change in fair value of derivatives will be reported as a single number in non-operating income. The amount that remains in net assets without donor restrictions will be amortized to interest expense consistent with the underlying related bonds being paid off.

(j) Property, Plant and Equipment

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

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

(k) Recoverability of Assets

The System periodically assesses the recoverability of long-lived assets (including property, plant, and equipment) when indications of potential impairment based on estimated, undiscounted future cash flows exist. Management considers factors, such as current results, trends, and future prospects, in addition to other economic factors, in determining whether there is an impairment of the asset. There were no impairments of long-lived assets during 2024 or 2023.

(Continued)

(l) Leases

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

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

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

Key estimates and judgments include how the System determines (1) the discount rate it uses to discount the unpaid lease payments to present value, (2) lease term, and (3) lease payments. The System uses the internal weighted average cost of capital when no explicit interest rate is available for a period comparable to the lease term. Lease expense is recognized on a straight-line basis over the lease term.

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

The System monitors for events or changes in circumstances that require a reassessment of one of its leases. Leases having an initial term of 1 year or less are expensed as incurred.

(m) Net Assets

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

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

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(In thousands)

whose donor-imposed restrictions were met during the fiscal year, as well as previously restricted gifts and grants for buildings and equipment that have been placed in service.

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

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

The description of amounts classified as donor restricted net assets (endowments only) as of June 30, 2024 and 2023 is as follows:

	Perpetual	Time restricted by law	2024 Total
Restricted for pediatric healthcare	$ 3,728	18,585	22,311
Restricted for adult healthcare	5,993	60,003	65,996
Restricted for educational and scientific programs	14,002	3,510	17,512
	$ 23,721	82,098	105,819

	Perpetual	Time restricted by law	2023 Total
Restricted for pediatric healthcare	$ 3,964	19,822	23,786
Restricted for adult healthcare	918	55,865	56,783
Restricted for educational and scientific programs	15,681	4,325	20,006
	$ 20,563	80,012	100,575

(Continued)

The endowment component of net assets without donor restrictions is comprised of amounts designated by the Board to function as endowment, which amounted to $1,175,567 and $1,216,476 included within investments limited to use as of June 30, 2024 and 2023, respectively.

In addition to endowments, the System has $150,824 and $47,157, respectively, of other restricted net assets at June 30, 2024 and 2023.

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

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

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

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

(i) Patient Service Revenues

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

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

The System has agreements with governmental and other third-party payors that provide for payments to the System at amounts different from established charges. Payment arrangements for

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

(ii) Charity Care

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

(iii) Third-Party Settlements

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions, and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change by material amounts.

The System has an estimation process for recording Medicare patient service revenue and estimated cost report settlements. As a result, the System records accruals to reflect the expected final settlements on our cost reports.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments from the finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in patient service revenues of $69,148 and $25,780, for the years ended June 30, 2024 and 2023, respectively. For the year

ended June 30, 2024, includes a $57,500 Medicare Settlement made to 340b hospitals underpaid during 2018 thru 2022.

(p) Hospital Assessment Program/Medicaid Provider Tax

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital (collectively referred to herein as HAP) have been approved by CMS through December 31, 2023. Under HAP, the state receives additional federal Medicaid funds for the state's healthcare system administered by the Illinois Department of Healthcare and Family Services. In 2024, reimbursement under the HAP resulted in a net increase of $188,387 in operating income, which includes $325,889 in Medicaid payments included in patient service revenue offset by $137,502 in Medicaid provider tax expense. In 2023, reimbursement under the HAP resulted in a net increase of $160,223 in operating income, which includes $267,963 in Medicaid payments included in patient service revenue offset by $107,740 in Medicaid provider tax expense.

(q) Other Revenue

Other operating revenue includes revenue from non-patient care services, of which a substantial portion includes revenue from the 340b program, clinical space rental revenue, contributions both unrestricted in nature and those released from restriction to support operating activities, related grant income, premium and capitation revenues, and other miscellaneous income.

Premium and capitation revenues are received and recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The System has no material contract assets or liabilities at June 30, 2024 and 2023 relating to premium and capitation revenue.

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

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

(r) Income Taxes

The System applies ASC Topic 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in a company's financial statements. ASC Topic 740 prescribes a more likely than not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under ASC Topic 740, tax positions are evaluated for recognition, de-recognition, and measurement using consistent criteria and provide more information about the uncertainty in income tax assets and liabilities. As of June 30, 2024 and 2023, the System does not have an asset or liability recorded for unrecognized tax positions.

UCM Obligated Group is comprised of subsidiaries that are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and, therefore, exempt from federal income

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taxes on related income pursuant to Section 501(a) of the Code. UCM Non-Obligated Groups consist of several not-for-profit and taxable entities. The taxable entities include University of Chicago Medicine Care Network, LLC; Trulen Insurance SPC Limited; Medcentrix, Inc.; Ingalls Same Day Surgery; and Ingalls Provider Group, which are taxable entities under applicable sections of the Code.

Deferred income taxes on the taxable entities of the Non-Obligated Groups are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the consolidated financial statement carrying amounts and the tax bases of existing assets and liabilities. As of June 30, 2024 and 2023, the UCM Non-Obligated Groups have deferred tax assets primarily relating to net operating losses; however, it has a full valuation allowance as management believes that it was not more likely than not that the results of future operations would generate sufficient taxable income to realize the NOL.

(s) Subsequent Events

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, the System evaluated events and transactions through June 30, 2024, the date the consolidated financial statements were issued.

(i) Line of Credit

The System obtained a line of credit on September 5, 2024 for $75,000 with JPMorgan Chase Bank, National Association due to expire on September 4, 2025. There is currently no outstanding balance on the line of credit.

(t) Reclassifications

Certain amounts in the 2023 consolidated financial statements have been reclassified to conform to the 2024 presentation. The reclassifications had no impact to total assets, liabilities, revenues, expenses or net assets.

(3) Advent Joint Venture

On January 1, 2023, the System acquired a controlling interest in AdventHealth Great Lakes Region (AdventHealth GLR) through a member substitution becoming the sole Class A member and Advent Health becoming the sole Class B member of this 501c3 corporation and affiliation agreement. As a result of this transaction, AdventHealth Great Lakes Region is included in the consolidated financial statements of UCMC for the six-month period from January 1, 2023 through June 30, 2023 with distinguishing of net assets deemed controlling interest versus non-controlling interest. This affiliation positions the System, under the University of Chicago Medical Center brand (UChicago Medicine), to expand its integrated academic health delivery system to the Southwest and Western suburbs of Chicago, providing patients access to care at the forefront of medicine where patients live and work.

The affiliation was effected through a member substitution with consideration contributed by UCMC of $250,000 for a controlling interest of the AdventHealth GLR. AdventHealth GLR's noncontrolling interest, as well as subsequent working capital infusions, were recorded as direct additions to net assets.

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(In thousands)

The acquisition-date fair value of identifiable assets and liabilities of AdventHealth GLR at January 1, 2023 consisted of the following:

Fair value of identifiable net assets:		
Cash and cash equivalents	**$**	**27,689**
Prepaids, inventory, and other current assets		**19,199**
Property, plant and equipment, net		**456,982**
Other assets, net		**37,893**
Accounts payable and accrued expenses		**(14,890)**
Other long-term liabilities		**(35,244)**
	$	**491,629**

The valuation of the fair value of identifiable assets and liabilities has been completed. In valuing these assets and liabilities, fair values were based on, but not limited to, independent appraisals, discounted cash flows, replacement costs, and actuarially determined values.

Operating expenses for the year ended June 30, 2024 include costs related to the integration of AdventHealth GLR into the System in accordance with the affiliation agreement and terms of the joint venture including costs of the valuation, transaction related costs, marketing and other operating programs for the benefit of patients. At June 30, 2024 and June 30 2023, respectively, AdventHealth GLR had a receivable due from the non-controlling interest of $15,924 and $66,397 that is deemed collectible.

Operating results and changes in net assets attributable to AdventHealth GLR since the date of acquisition in the accompanying consolidated financial statement of operations and changes in net assets for the year ended June 30, 2023 are as follows:

Total operating revenue	**$**	**512,626**
Revenue deficient of expense		**5,727**

The following unaudited information presents the System's results for the years ended June 30, 2023, had the acquisition date been July 1, 2021:

		2023
		(Unaudited)
Total operating revenues	**$**	**4,238,549**
Total operating expenses		**4,173,819**

(Continued)

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(In thousands)

(4) Financial Assets and Liquidity Resources

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

		2024	2023
Financial assets:			
Cash and cash equivalents and investments limited to use	**$**	**183,091**	**235,184**
Patient accounts receivable		**691,974**	**525,670**
Total financial assets available within one year		**875,065**	**760,854**
Total financial assets and liquidity resources available within one year	**$**	**875,065**	**760,854**

Included in cash and cash equivalents as presented above, as of June 30, 2024, the System has $19 of cash held in current portion of investment, limited to use. In addition, the System maintains $1,175,567 in funds functioning as endowment and $207,471 of other long-term investments, all available for general expenditure upon Board approval, of which $641,229 is liquid within 12 months. As of June 30, 2023, the System had $58,638 of cash held in current portion of investment, limited to use. In addition, the System maintains $1,216,476 in funds functioning as endowment and $201,267 of other long-term investments, all available for general expenditure upon Board approval, of which $664,969 is liquid within 12 months.

(5) Agreements and Transactions with the University

The affiliation agreement with the University provides, among other things, that all members of the medical staff will have academic appointments in the University. The affiliation agreement has an initial term of 40 years ending October 1, 2026 unless sooner terminated by mutual consent or as a result of a continuing breach of a material obligation therein or in the operating agreement. The affiliation agreement automatically renews for additional successive 10-year terms following expiration of the initial term, unless either party provides the other with at least 2 years' prior written notice of its election not to renew.

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

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

The System has a relationship with the University Investment Office by which the System investments are managed. The System owns shares within the University Investment TRIP, known as Total Return Investment Portfolio. Changes in share price are recognized on the books and records of the System.

(Continued)

UCMC purchases various services from the University, including certain employee benefits, utilities, security, telecommunications, and insurance. In addition, certain UCMC accounting records are maintained by the University. During the years ended June 30, 2024 and 2023, the University charged UCMC $43,601 and $38,153, respectively, for utilities, security, telecommunications, insurance, and overhead.

The University's Division of Biological Sciences provides physician services to UCMC. In 2024 and 2023, UCMC recorded $355,424 and $305,316, respectively, in expense related to these services.

UCMC's Board adopted a plan of support under which it would provide annual net asset transfers to the University for support of academic programs in biology and medicine. All commitments under this plan are subject to the approval of UCMC's Board and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board are reflected as current liabilities. UCMC recorded net asset transfers of $71,750 in both 2024 and 2023 for this support.

(6) Patient Service Revenue and Patient Receivables

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

(a) Medicare

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

Other services rendered to Medicare beneficiaries are reimbursed based on a combination of prospectively determined rates and cost reimbursement methodologies. For the cost reimbursement, the System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits by the Medicare fiscal intermediary. UCMC's Medicare reimbursement reports through June 30, 2019 have been audited by the Medicare fiscal intermediary. CHHD's Medicare reimbursement reports through June 30, 2018 have been audited by the Medicare fiscal intermediary.

(b) Medicaid

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

(In thousands)

(c) Blue Cross

The System also participates as a provider of healthcare services under reimbursement agreements with Blue Cross under its indemnity program. The provisions of the agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the System and a review by Blue Cross. UCMC's and CHHD's Blue Cross reimbursement reports for 2023 and prior years have been reviewed by Blue Cross. Advent Joint Venture does not participate in Blue Cross reimbursement report.

(d) Other

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

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

		2024	2023
Medicare	$	1,269,580	966,491
Medicaid		870,690	786,454
Managed care		1,832,058	1,489,351
Patients and other		23,705	18,202
Patient service revenue	$	3,996,033	3,260,498

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

		2024	2023
Inpatient	$	1,894,094	1,646,561
Outpatient/Ambulatory care		1,837,583	1,436,532
Physician services		264,356	177,405
	$	3,996,033	3,260,498

(Continued)

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(In thousands)

The mix of receivables from patients and third-party payors as of June 30, 2024 and 2023 is as follows:

	2024	2023
Medicare	23.4 %	24.9 %
Medicaid	18.8	26.0
Managed care	55.3	41.9
Patients and other	2.5	7.2
	100.0 %	100.0 %

(7) Community Benefits

The following is a summary of the System's unreimbursed cost of providing care, as defined under its Financial Assistance Policy, along with the unreimbursed cost of government-sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research, and other community programs for the years ended June 30, 2024 and 2023:

		2024	2023
Uncompensated care:			
Medicaid sponsored indigent healthcare	$	120,024	115,169
Medicare sponsored indigent healthcare – cost report		191,045	188,114
Medicare sponsored indigent healthcare – physician services		166,065	123,437
Total uncompensated care		477,134	426,720
Charity care		46,434	40,689
		523,568	467,409
Unreimbursed education and research:			
Community benefits (unaudited)		8,157	—
Education (unaudited)		98,432	79,619
Research (unaudited)		56,757	48,229
Total unreimbursed education and research		163,346	127,848
Total community benefits	$	686,914	595,257

The System determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries, wages and benefits, supplies, and other operating expenses, to determine a cost-to-charge ratio. The cost to charge ratio is applied to the charity care gross charges to calculate the charity care amount reported above. The System has not amended its charity care policies in 2024.

(Continued)

(In thousands)

(8) Investments Limited as to Use

The composition of investments limited as to use is as follows at June 30, 2024 and 2023:

	2024				
	Separately Invested	TRIP	Other	Total	2023
Investments carried at fair value:					
Cash and cash equivalents	$ 490	25,624	—	26,114	8,002
Global public equities	24,900	362,460	—	387,360	429,422
Private debt	—	—	—	—	58,038
Private equity	—	401,872	—	401,872	365,067
Real assets	—	137,237	—	137,237	128,457
Diversifying	—	196,920	—	196,920	162,955
Absolute return:					
Equity oriented	—	130,152	—	130,152	132,875
Fixed income	94,821	86,411	—	181,232	213,868
Other:					
Beneficial interests in trust	—	—	10,140	10,140	9,325
Funds in trust	5,670	—	50,809	56,479	122,748
Total investments	$ 125,881	1,340,676	60,949	1,527,506	1,630,775

Investments classified as other consist of construction and debt proceeds to pay interest, donor restricted investments in beneficial interests in trusts, workers' compensation, self-insurance, and trustee-held funds.

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

	2024	2023
Investments limited as to use:		
By the board for capital improvements/restrictions by donors	$ 130,352	199,194
Funds held by custodian/trustee under indenture agreements	19	63,402
Funds held by trustee for self-insurance	56,459	59,345
TRIP investments	1,340,676	1,308,834
Total investments limited to use	$ 1,527,506	1,630,775

(Continued)

(In thousands)

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

	2024	2023
Interest and dividend income, net	$ 19,089	13,673
Realized gains on sales of securities, net	31,896	24,077
Change in unrealized gains and losses on securities, net	56,860	3,440
Investment Management Fees	(6,795)	—
	$ 101,050	41,190

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2024, UCMC has commitments of $9 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

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

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

(Continued)

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

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

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

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

Funds in trust investments consist primarily of project construction funds and workers' compensation trust funds. Funds in trust comprise 1% cash and cash equivalents, 25% equities, and 74% fixed income investments at June 30, 2024. Funds in trust comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2023.

(In thousands)

The System believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2024 and 2023. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed. Assets and liabilities recorded at fair value as of June 30, 2024 and 2023 were as follows:

	(Level 1)	(Level 2)	(Level 3)	2024 Total fair value
Assets:				
Cash and cash equivalents	$ 183,072	—	—	183,072
Investments:				
Cash equivalents	26,114	—	—	26,114
Global public equities	58,157	—	—	58,157
Private Equity – U.S.				
Venture Capital	21	—	6,130	6,151
Real assets:	—	—	11	11
Real estate	3	—	1,001	1,004
Fixed Income:				
U.S. Treasuries, including TIPS	86,411	—	—	86,411
Other fixed income	94,821	—	—	94,821
Restricted investments	10,140	—	—	10,140
Funds in trust	5,838	50,641	—	56,479
Investments measured at net asset value[1]				1,188,218
Total investments at fair value	464,577	50,641	7,142	1,710,578
Other assets	12,236	—	—	12,236
Total assets at fair value	$ 476,813	50,641	7,142	1,722,814
Liabilities:				
Interest rate swap payable	$ —	42,660	—	42,660
Total liabilities at fair value	$ —	42,660	—	42,660

(Continued)

(In thousands)

	(Level 1)	(Level 2)	(Level 3)	2023 Total fair value
Assets:				
Cash and cash equivalents	$ 176,546	—	—	176,546
Investments:				
Cash equivalents	8,000	—	—	8,000
Global public equities	82,218	—	—	82,218
Real assets:				
Real estate	20	—	—	20
Fixed income:				
U.S. Treasuries, including TIPS	89,043	—	—	89,043
Other fixed income	147,713	—	—	147,713
Restricted investments	—	—	9,325	9,325
Funds in trust	5,143	117,603	—	122,746
Investments measured at net asset value[1]				1,171,710
Total investments at fair value	508,683	117,603	9,325	1,807,321
Other assets	12,572	—	—	12,572
Total assets at fair value	$ 521,255	117,603	9,325	1,819,893
Liabilities:				
Interest rate swap payable	$ —	57,511	—	57,511
Total liabilities at fair value	$ —	57,511	—	57,511

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

During 2024, there were no transfers between investments between Levels. The interest rate swap arrangement has inputs, which can generally be corroborated by market data and is, therefore, classified within Level 2.

(Continued)

(In thousands)

The following table presents activity for the year ended June 30, 2024 & 2023 respectively for assets measured at fair value using unobservable inputs classified in Level 3

	2024	2023
Beginning fair value	$ 9,325	9,074
Change in unrealized gains and losses, net	(2,183)	251
Ending fair value	$ 7,142	9,325

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

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

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

	Remaining life	Redemption terms	Redemption restrictions and terms
Global public equities:			
Commingled funds	N/A	Daily to triennial with notice periods of 6 to 122 days	Lock up provisions for up to 1 remaining year; some investments have a portion of capital held in side pockets with no redemptions permitted
Partnerships	N/A	Monthly to triennial with notice periods of 7 to 184 days	Lock up provisions for up to 1 remaining year; some investments have a portion of capital held in side pockets with no redemptions permitted
Separate accounts	N/A	Daily with notice periods of 1 to 90 days	None

(Continued)

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	Remaining life	Redemption terms	Redemption restrictions and terms
Private debt:			
Drawdown partnerships	1 to 11 years	Redemptions not permitted	N/A
Private equity:			
Drawdown partnerships	1 to 31 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 5 days	None
Partnerships	N/A	Semiannual with notice period of 90 days	Lock up provisions for up to 3 years; some investments have a portion of capital held in side pockets with no redemptions permitted
Direct investments	N/A	Redemptions not permitted	N/A
Real estate:			
Drawdown partnerships	1 to 13 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 5 days	None
Natural resources:			
Drawdown partnerships	1 to 13 years	Redemptions not permitted	N/A
Absolute return:			
Commingled funds	N/A	Monthly to triennial with notice periods of 30 to 90 days	Some investments have a portion of capital held in side pockets with no redemptions permitted
Drawdown partnerships	1 to 9 years	Redemptions not permitted	N/A
Partnerships	N/A	Daily to annual with notice periods of 1 to 90 days	Some investments have a portion of capital held in side pockets with no redemptions permitted

(9) Endowments

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

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

(Continued)

(In thousands)

The System has beneficial interests in trusts. The System has recorded its share of the principal of the trusts as net assets with donor restrictions. Distributions from the trusts are recorded within net assets without restrictions if unrestricted; otherwise, they are classified as net assets with donor restrictions until appropriated for expenditure. In some instances, the historical costs basis of the funds is not available as the System received the shares in 1929. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies at June 30, 2024 and 2023, respectively.

The System has the following donor-restricted endowment activities during the years ended June 30, 2024 and 2023 delineated by net asset class:

	2024		
	Without donor restrictions	With donor restrictions	Total
Changes in the fair value of endowment investments:			
Investment return:			
Endowment yield (interest and dividends)	$ 12,173	688	12,861
Net appreciation (realized and unrealized) on investments	77,045	7,444	84,489
Investment management fees	(5,708)	(503)	(6,211)
Net investment return	83,510	7,629	91,139
Endowment payout	(50,685)	(4,530)	(55,215)
Investment return, net of payout	32,825	3,099	35,924
Other changes in endowment investments:			
Gifts and pledge payments received in cash	474	2,343	2,817
Other changes	(74,208)	(198)	(74,406)
Total other changes in endowment investments	(73,734)	2,145	(71,589)
Net change in endowment investments	(40,909)	5,244	(35,665)
Endowment investments at:			
Beginning of year	1,216,476	100,575	1,317,051
End of year	$ 1,175,567	105,819	1,281,386
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	23,721	23,721
Appreciation	—	82,098	82,098
Board-designated "funds functioning as endowment"	1,175,567	—	1,175,567
Total – as above	$ 1,175,567	105,819	1,281,386

(Continued)

(In thousands)

	2023		
	Without donor restrictions	With donor restrictions	Total
Changes in the fair value of endowment investments:			
Investment return:			
Endowment yield (interest and dividends)	$ 12,109	608	12,717
Net appreciation (realized and unrealized) on investments	25,243	1,341	26,584
Investment management fees	(5,427)	(475)	(5,902)
Net investment return	31,925	1,474	33,399
Endowment payout	(51,767)	(4,276)	(56,043)
Investment return, net of payout	(19,842)	(2,802)	(22,644)
Other changes in endowment investments:			
Gifts and pledge payments received in cash	—	13	13
Other changes	(6,199)	937	(5,262)
Total other changes in endowment investments	(6,199)	950	(5,249)
Net change in endowment investments	(26,041)	(1,852)	(27,893)
Endowment investments at:			
Beginning of year	1,242,517	102,427	1,344,944
End of year	$ 1,216,476	100,575	1,317,051
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	20,563	20,563
Appreciation	—	80,012	80,012
Board-designated "funds functioning as endowment"	1,216,476	—	1,216,476
Total – as above	$ 1,216,476	100,575	1,317,051

Investment and Spending Policies

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

For endowments invested in TRIP, the Board of the System has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula.

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(In thousands)

The University utilizes the total return concept in allocating endowment income. In accordance with the University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board with the objective of a 5% average payout over time, was 5.36% and 5.5% for the fiscal years ended June 30, 2024 and 2023. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

(10) Property, Plant, and Equipment

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

		2024	2023
Land and land rights	$	81,326	81,325
Buildings and improvements		2,383,283	2,342,288
Equipment		1,050,200	922,964
Construction in progress		338,627	238,054
		3,853,436	3,584,631
Less accumulated depreciation		(1,758,773)	(1,574,674)
Total property, plant, and equipment, net	$	2,094,663	2,009,957

The cost of buildings that are jointly used by the University and the System is allocated based on the lease provisions. In addition, land and land rights include $10,000 and $33,157 for 2024 and 2023, respectively, which represents the unamortized portion of initial lease payments made to the University.

Capitalized interest costs in 2024 and 2023 were approximately $6,085 and $3,100, respectively. Construction in progress consists of various routine capital improvements and renovation projects. As of June 30, 2024, the System had total contractual commitments associated with ongoing capital projects of approximately $402,440.

(Continued)

(In thousands)

(11) Pledges

Pledges receivable at June 30, 2024 and 2023 are shown as follows:

	2024	2023
Unconditional promises expected to be collected in:		
Less than one year	$ 75	3,543
One year to five years	105,827	4,802
More than five years	11,100	—
	117,002	8,345
Less:		
Valuation allowance	(18,827)	—
Total	$ 98,175	8,345

The System's 5 largest pledges comprise approximately 90% and 96% percent of pledges receivable at June 30, 2024 and 2023, respectively. Included in this amount is a pledge receivable from a single donor, net of current year pledge payments and amortization of the discount, of $70,800 at June 30, 2024. The discount used for pledges was 5.6%.

(12) Long-Term Debt

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

(In thousands)

Long-term debt at June 30, 2024 and 2023 consists of the following:

	Fiscal year maturity	Interest rate	2024	2023
University of Chicago Medical Center:				
Fixed rate:				
Illinois Finance Authority:				
Series 2008D1 and 2008D2 (Synthetically fixed rate)	2044	3.9 %	$ 70,000	70,000
Series 2008E1 and 2008E2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010A and 2010B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011A and 2011B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2015A	2030	5.0	21,895	21,895
Series 2016A	2027	5.0	14,360	18,705
Series 2016B	2042	4.4	163,045	163,785
Series 2020A	2027	2.5	29,015	38,250
Series 2022A	2053	5.0	207,600	207,600
Series 2022B1	2053	5.0	83,700	83,700
Series 2022B2	2053	5.0	83,700	83,700
Teachers Insurance and Annuity Association of America				
Series 2017A	2047	4.4	30,000	30,000
New York Life:				
Series 2019E taxable	2037	2.7	51,150	54,400
Unamortized premium			31,011	31,678
Total fixed rate			1,040,476	1,058,711
Variable rate:				
Series 2013A	2050	1.9	62,379	63,952
Illinois Educational Facilities Authority (IEFA)	2038	3.7	47,578	51,526
Total variable rate			109,957	115,478
Unamortized debt issuance costs			(7,066)	(6,948)
Less current portion of long-term debt			(23,893)	(19,143)
Total UCMC long-term portion of debt, less current portion			$ 1,119,474	1,148,098

(Continued)

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(In thousands)

	Fiscal year maturity	Interest rate	2024	2023
UCMC Title Holding Corporation:				
Fixed rate:				
Urban Development Fund LI – Promissory note A	2031	1.8 %	$ —	4,701
Urban Development Fund LI – Promissory note B	2031	1.8	—	1,799
Citi NMTC – QLICI	2032	1.2	3,476	3,476
Citi NMTC – QLICI	2032	1.2	1,620	1,620
URP QLICI – Loan A	2048	1.0	7,334	7,334
URP QLICI – Loan B	2048	1.0	2,666	2,666
SCORE QLICI – Loan A	2048	1.0	4,176	4,176
SCORE QLICI – Loan B	2048	1.0	1,704	1,704
CNI QLICI – Loan A	2048	1.0	3,455	3,455
CNI QLICI – Loan B	2048	1.0	1,545	1,545
Total UCMC Title Holding Corporation debt			25,976	32,476
Less current portion			(250)	(250)
Title Holding Corporation LT portion			25,726	32,226
Total UCMC debt, excluding current portion			$ 1,145,200	1,180,324
Community Health and Hospital Division:				
Fixed rate:				
Illinois Finance Authority:				
Series 2017 Bonds	2034	2.5	$ 28,665	30,570
New York Life:				
Series 2019E taxable	2042	2.7	57,500	59,495
Unamortized debt issuance costs			(274)	(295)
Total debt and unamortized premiums (discount)			85,891	89,770
Less current portion of long-term debt			(4,000)	(3,900)
Total CHHD debt, excluding current portion			$ 81,891	85,870
Total notes and bonds payable:				
Less current portion			$ 1,256,234	1,289,487
Long-term debt, excluding current portion			(28,143)	(23,293)
			$ 1,227,091	1,266,194

(Continued)

(In thousands)

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

Year ending June 30:	
2025	$ 28,602
2026	31,053
2027	31,097
2028	32,385
2029	33,340
Thereafter	1,075,086
	$ 1,231,563

(a) Letters of Credit

Included in UCMC's debt is $47,578 of commercial paper revenue notes and $325,000 of variable rate demand bonds. Under its various credit agreements, UCMC is subject to certain financial covenants, including maintaining a minimum debt service coverage ratio; maintaining minimum levels of days' cash on hand, maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise, disposing of UCMC property; and certain other nonfinancial covenants.

Payment on each of the variable rate demand revenue bonds is also secured by a letter of credit. The letters of credit that support the Series 2009D and 2009E bonds expire in June 2028 and June 2026, respectively. The letters of credit that support the Series 2010A and 2010B bonds expire in May 2029. The letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2025 and May of 2026, respectively. Payment of each of commercial paper revenue notes is secured by a letter of credit maturing April 2026. The letters of credit are subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.25:1.

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

(Continued)

(In thousands)

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

Year ending June 30:		
2025	$	24,514
2026		202,948
2027		155,266
2028		81,178
2029		24,535
Thereafter		743,122
	$	1,231,563

(b) Lines of Credit

UCMC has a $100,000 line of credit from a commercial bank, which expires March 4, 2025. As of June 30, 2024 and 2023, there was $6,000 and $0 outstanding, respectively, included in Accounts Payable and Accrued Expenses in the accompanying consolidated balance sheets.

(c) Interest Payments

The System paid interest, net of capitalized interest, of approximately $46,875 and $38,000 in 2024 and 2023, respectively.

(13) Derivative Instruments

The System uses interest rate swaps as a part of its risk management strategy to manage exposure to fluctuations in interest rates and to manage the overall cost of its debt. The interest rate swaps are not used for speculative purposes and are measured at fair value in the accompanying consolidated balance sheets

The fair value of each swap is the estimated amount UCMC would receive or pay to terminate the swap agreement at the reporting date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value is included in interest rate swap liability on the consolidated balance sheets, while the change in fair value is recorded in other changes in net assets without donor restrictions for the effective portion of the change and in non-operating gains and losses for the ineffective portion of the change. The inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Effective July 1, 2023, the London Interbank Offered Rate (LIBOR) reference rate associated with the swaps has been replaced with the Secured Overnight Funding Rate (SOFR). The System effected the transition to SOFR by adhering to the ISDA 2020 Interbank Offered Rates Fallback Protocol, thereafter with no significant impact based on this adoption.

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(In thousands)

During the years ended June 30, 2024 and 2023, UCMC was party to several swap agreements as described further below.

UCMC Swap Agreements

In February and May 2024, respectively, UCMC simultaneously entered into (a) a total return swap whereby UCMC receives a fixed rate and pays a variable rate (percentage of SOFR plus a spread) and (b) an interest rate swap whereby UCMC pays a fixed rate and receives a variable rate (percentage of SOFR plus a spread), with the intent of creating a fixed cost of funding and lowering its basic rent payments in connection with two lease agreements with a third-party leasing company for two properties in Chicago, Illinois. The respective swap agreements entered into in February and May 2024 terminate on May 15, 2034. Settlements are made semi-annually.

In 2006, UCMC entered into a floating-to-fixed rate swap agreement to manage the interest rate risk associated with outstanding variable rate debt. The original agreement was subsequently amended in 2011 to, among other things, divide the notional amount between two counterparties resulting in two floating-to-fixed swap agreements—each with notional amount of $162,500. Under the floating-to-fixed agreements, UCMC receives a percentage of SOFR and pays a fixed rate. The floating-to-fixed rate swap agreements terminate on February 1, 2044. On July 1, 2020, UCMC entered into a novation of the two floating-to-fixed swap agreements for a five-year term. The novation to the new parties is under like-kind terms and arrangements that do not require designation of the hedging relationship and related accounting. Settlements are made monthly.

The floating-to-fixed swap agreements are no longer designated as a hedging instrument, and therefore, the change in fair value will prospectively be recognized as a component of non-operating gains in the accompanying consolidated statements of operations. Management has recognized change in fair value of approximately ($3,784) and $3,296 in 2024 and 2023, respectively in non-operating gains and losses. This movement reflects the spread between tax-exempt interest rates and SOFR during the period. Management has determined that the interest rate swaps are effective, and the effective portion of these swaps is included in other changes in net assets without donor restrictions. Cash settlement payments related to the swaps are recorded in interest expense. The fair value of the UCMC swap agreement liabilities was $40,652 and $54,829 at June 30, 2024 and 2023, respectively, and has been included in other long-term liabilities in the accompanying consolidated balance sheets.

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

Effective date	Associated debt series	Original term	Current notional amount	UCMC pays	UCMC receives
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	$ 162,500,000	3.89 %	68% of SOFR
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	162,500,000	3.97 %	68% of SOFR
February 29, 2024	Total Return Swap	10 Years	7,200,000	60% of SOFR + spread	5.13 %
February 29, 2024	Interest Rate Swap	10 Years	7,200,000	4.26%	60% of SOFR + spread
May 8, 2024	Total Return Swap	10 Years	34,435,000	60% of SOFR + spread	5.25 %
May 8, 2024	Interest Rate Swap	10 Years	34,435,000	4.46 %	60% of SOFR + spread

(Continued)

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(In thousands)

CHHD Swap Agreement

In June 2004, CHHD entered into a floating-to-fixed rate swap agreement to lock in long-term fixed rates on the Series 2004 variable-rate debt (which was subsequently refunded by the Series 2017 Bonds), with a maturity date of May 15, 2034. This agreement was amended on March 1, 2013. Under the amended agreement, the notional amount and maturity did not change, and CHHD receives a percentage of SOFR plus 47.5 basis points and makes payments at an annualized fixed rate of 4.61%. Settlements are made monthly.

The swap is not designated as a hedging instrument, and therefore, the change in fair value of $674 and $1,888 in 2024 and 2023, respectively, was recognized as a component of non-operating gains in the accompanying consolidated statements of operations. The fair value of the floating-to-fixed swap agreement liability of $2,008 and $2,682 at June 30, 2024 and 2023, respectively, is included as a component of other long-term liabilities in the accompanying consolidated balance sheets. The differential to be paid or received under the floating-to-fixed swap agreement is recognized monthly and has been included as a component of interest expense in the accompanying consolidated statements of operations and changes in net assets without donor restriction.

A summary of outstanding positions under the interest rate swap agreements for CHHD at June 30, 2024 is as follows:

Effective date	Associated debt series	Original term	Current notional amount	CHHD pays	CHHD receives
June 28, 2004	N/A	30 Years	$ 30,775,000	4.61 %	67% of SOFR + spread

By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk; however, the System is required to post collateral to the counterparty when certain thresholds as defined in the derivative agreements occur. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. System management also mitigates risk through periodic reviews of their derivative positions in the context of their total blended cost of capital.

To manage the credit risk of the swap agreements, the System is required to provide collateral under specific terms and conditions for each of the swap agreements when the combined fair value exceeds a predetermined threshold. Collateral posting requirements are driven by the value of the swap as measured at the reset date and are based upon the System's credit rating. Collateral requirements increase if the System's credit ratings were to be downgraded. At June 30, 2024 and 2023, no collateral was posted.

(Continued)

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(In thousands)

(14) Leases

The components of lease cost for the years ended June 30, 2024 and 2023 reported as part of other expenses in the consolidated statements of operations and changes in net assets without donor restrictions, were as follows:

		2024	2023
Operating lease expense	$	17,096	18,882
Finance lease expense:			
Amortization of right-of-use assets		7,809	5,682
Interest on lease liabilities		1,369	1,015
Total finance lease expense		9,178	6,697
Total lease expense	$	26,274	25,579

Amounts reported in the consolidated balance sheets as of June 30, 2024 and 2023 were as follows:

		2024	2023
Operating Leases:			
Right-of-use assets – operating leases	$	150,518	60,884
Accumulated amortization		17,560	6,728
Other assets, net	$	132,958	54,156
Current portion of other long-term liabilities	$	10,925	4,560
Other long-term liabilities, less current portion		125,290	49,596
Total operating lease liabilities	$	136,215	54,156
Finance Leases:			
Right-of-use assets – finance leases	$	61,056	50,815
Accumulated amortization		20,042	18,094
Other assets, net	$	41,014	32,721
Current portion of other long-term liabilities	$	5,009	6,411
Other long-term liabilities, less current portion		40,121	25,989
Total finance lease liabilities	$	45,130	32,400

(Continued)

(In thousands)

Other information related to leases as of June 30, 2024 and 2023 was as follows:

Supplemental cash flow information:

	2024	2023
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flow from operating leases	$ 20,730	6,728
Operating cash flow from finance leases	1,369	—
Financing cash flow from finance leases	3,964	6,355
ROU assets obtained in exchange for lease obligations:		
Operating leases	66,385	—
Finance leases	10,241	—
Reductions to ROU assets resulting from reductions to lease obligations:		
Operating leases	—	—
Finance leases	—	5,690
Weighted average remaining lease term:		
Operating leases	10.8 years	12.7 years
Finance leases	10.3 years	10.2 years
Weighted-average discount rate:		
Operating leases	1.4 %	2.2 %
Finance leases	2.4	5.5

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

Maturities of lease liabilities under non-cancelable leases as of June 30, 2024 are as follows.

	Operating	Finance
2025	$ 19,748	7,525
2026	18,982	7,410
2027	18,393	4,473
2028	15,375	4,499
2029 and thereafter	95,689	31,773
	168,187	55,680
Less amount representing interest	31,972	10,550
Present value of net minimum lease payments	$ 136,215	45,130

(Continued)

(In thousands)

(15) Insurance

Professional and General Liability

The System maintains separate self-insurance programs for UCMC and CHHD. UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2024 and 2023 were $15,000 and $10,000, respectively, per claim and unlimited in the aggregate. Claims in excess of $10,000 are subject to an additional self-insurance retention limited to $10,000 per claim and $20,000 in aggregate. There are no assurances that the University will be able to renew existing policies or procure coverage on similar terms in the future.

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

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

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and assets available for claims for the combined University and UCMC self-insurance program as of June 30, 2024 and 2023 is presented below:

		2024	2023
Actuarial present value of self-insurance liability for medical malpractice	**$**	**234,984**	**235,305**
Total assets available for claims		**286,090**	**286,771**

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately $40,364 higher at June 30, 2024. The interest rate assumed in determining the present value was 5.5% and 5.00% for 2024 and 2023, respectively. UCMC has recorded its pro rata share of the malpractice self-insurance liability in the amount of $107,092 and $105,887 at June 30, 2024 and 2023, respectively, with an offsetting receivable from the malpractice trust to cover any related claims. The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense it's negotiated pro rata share of the actuarially determined normal contribution, with gains and losses amortized over five years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2024 and 2023, UCMC's expense is estimated to be approximately $15,700 and $19,000, respectively, related to malpractice insurance.

ATTACHMENT 36

On April 30, 2019, CHHD entered into a loss portfolio transfer for the Ingalls Memorial Hospital medical malpractice program by obtaining an occurrence-based policy for claims through June 30, 2018. At June 30, 2024, there was no additional liability calculated by the programs actuaries that would require additional reserves by CHHD or the Captive. Accruals for CHHD professional and general liabilities are recorded on a discounted basis consistent with the University's insurance program.

On October 1, 2020, a new tax-exempt Cayman domiciled captive, Trulen Insurance SPC Limited ("Trulen"), was incorporated to operate as the new medical malpractice framework for CHHD. Trulen was organized as a Segregated Portfolio Company, which consists of a "core" company and 3 segregated portfolios, or "cells", which allow segregation of risk and assets between the Hospital and General Liability, employed community physicians, and non-employed contracted provider liabilities. The insurance business of Ingalls Casualty Insurance Limited ("ICIL"), the previous insurer of professional liability insurance for CHHD, was transferred and novated to the three separate portfolios by issuing three separate Deeds of Novation and Business Transfer between Trulen and ICIL. After the completion of the business transfer, ICIL ceased underwriting operations. As of June 30, 2024 and 2023, the total assets of Trulen were $101,660 and $127,454, respectively; and total liabilities were $91,862 and $113,046, respectively. Total claim expense as of June 30, 2024 and 2023 was $13,037 and $11,340, respectively.

(16) Pension Plans

Active Plans

A majority of UCMC's personnel participate in the University's defined-benefit and contribution pension plans, which are considered multiemployer pension plans. Under the defined-benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last 10 years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding based on the guidelines set forth by the Employee Retirement Income Security Act of 1974, on an actuarially determined basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of net assets without donor restrictions.

Effective January 1, 2017, the 401(a) defined-benefit pension plan was frozen for UCMC employees participating in the plan and was replaced with an enhanced defined-contribution plan. Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately $26,703 and $31,500 for the years ended June 30, 2024 and 2023, respectively.

UCMC's expense related the multiemployer University's defined-benefit plans included in the University's consolidated financial statements for the years ended June 30, 2024 and 2023 was $0.

(Continued)

(In thousands)

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

		2024	2023
Projected benefit obligation	$	662,287	708,494
Fair value of plan assets		658,154	683,480
Deficit of plan assets over benefit obligation	$	(4,133)	(25,014)

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

	2024	2023
Discount rate	5.6 %	5.5 %
Expected return on plan assets	5.8	5.8
Rate of compensation increase	3.5	3.5

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

	2024	2023
Domestic equities	19 %	24 %
International equity	17	18
Fixed income	64	58
	100 %	100 %

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

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

(Continued)

(In thousands)

Expected future benefit payments excluding plan expenses are as follows:

Fiscal year:		
2025	$	73,914
2026		48,447
2027		48,492
2028		48,214
2029		47,867
2030–2034		230,455

UCMC and CHHD also maintain additional defined-contribution retirement plans for employees. The System's pension expense under these distinct defined-contribution retirement plans for UCMC was $13,433 and $13,200 for the years ended June 30, 2024 and 2023, respectively.

CHHD expense under these distinct defined-contribution retirement plans was $5,738 and $2,845 for the years ended June 30, 2024 and 2023, respectively.

(17) Functional Expenses

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

		2024			
		Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$	1,755,121	211,005	354	1,966,480
Supplies and other		1,540,152	163,052	786	1,703,990
Physician services		403,201	—	—	403,201
Insurance		64,509	6,002	—	70,511
Interest		47,816	—	—	47,816
Medicaid provider tax		137,502	—	—	137,502
Depreciation and amortization		184,464	258	—	184,722
Total	$	4,132,765	380,317	1,140	4,514,222

(Continued)

(In thousands)

	2023			
	Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$ 1,485,230	129,191	54	1,614,475
Supplies and other	1,288,039	138,935	585	1,427,559
Physician services	347,338	8,255	—	355,593
Insurance	37,491	4,574	—	42,065
Interest	41,175	770	—	41,945
Medicaid provider tax	86,093	—	—	86,093
Depreciation and amortization	150,583	761	—	151,344
Total	$ 3,435,949	282,486	639	3,719,074

Functional classifications have been determined based on their relationship to major program services and supporting activities. For support functions directly related to major program services, an allocation has been applied based on the percentage of time and effort devoted to the program service. For overhead expenses such as utilities and interest expense, an allocation based on square footage has been applied. The costs related to support functions not directly related to program activities have been fully classified as supporting activities.

(18) Contingencies

(a) Litigation

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

(b) Regulatory Investigation and Other

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

(Continued)

(c) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the governor of Illinois signed into law, Public Act 97-0688, which created new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital's estimated property tax liability. The System certified in 2024 and 2023 and has not recorded a liability for related property taxes based upon management's current determination of qualified services provided.

ATTACHMENT 36

Schedule 1

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Balance Sheet Information

June 30, 2024

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Obligated Group Eliminations	Obligated Group Consolidation	Advent	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Non-Obligated Group Eliminations	Consolidated total
	$ 7,103	9,077	33	1,013	1	—	17,227	140,939	1,888	23,018	—	183,072
	526,869	—	36,229	—	1,325	—	564,423	118,313	7,128	2,110	—	691,974
	20	—	—	—	—	—	19	—	—	—	—	19
ceivable	25,193	—	—	—	—	—	25,193	—	—	—	—	25,193
	19,131	—	—	—	—	—	19,131	—	—	—	—	19,131
	298,858	12,580	64,666	1,046	9,087	(77,022)	249,223	15,923	193,160	2,683	(445,063)	15,924
	180,521	773	12,136	—	—	—	193,430	66,460	3,694	1,651	(3,544)	261,691
	997,695	22,430	113,064	2,058	10,413	(77,022)	1,068,646	341,635	205,860	29,462	(448,609)	1,196,994
	1,271,425	5,864	117,337	67,499	16,772	—	1,478,897	—	—	48,590	—	1,527,487
	1,418,529	4,956	202,545	—	—	—	1,626,030	449,610	13,413	5,610	—	2,094,663
	79,043	—	—	—	—	—	79,043	—	—	—	—	79,043
t portion	81,899	—	—	—	—	—	81,899	—	—	—	—	81,899	
	788,935	(8,498)	2,721	211	—	(325,008)	458,361	42,026	40,106	14,602	(254,005)	301,092
	$ 4,637,526	24,760	435,667	69,768	27,185	(402,030)	4,792,876	833,273	259,379	98,264	(702,614)	5,281,178
	$ 270,921	3,173	27,609	137	1,543	—	303,383	69,675	7,136	11,726	(3,468)	388,452
	23,893	—	4,000	—	—	—	27,893	—	250	—	—	28,143
	6,413	—	—	—	—	—	6,413	—	—	—	—	6,413
ederal Advance ority	219,271	—	21,786	—	448	—	241,505	68,502	—	1,644	—	311,651
	25,193	—	—	—	—	—	25,193	—	—	—	—	25,193
	15,301	21,553	25,039	530	2,117	(77,022)	(12,582)	—	297,110	160,614	(445,142)	—
	33,033	—	—	—	—	—	33,033	—	—	—	—	33,033
	593,925	24,726	78,434	667	4,108	(77,022)	624,838	138,177	304,496	173,984	(448,610)	792,885
t current portion rtion	9,505	2,416	—	—	—	—	11,921	—	—	—	—	11,921
	81,899	—	—	—	—	—	81,899	—	—	82,617	—	164,516
	1,119,474	—	81,891	—	—	—	1,201,365	—	25,726	—	—	1,227,091
	40,652	—	2,008	—	—	—	42,660	—	—	—	—	42,660
	160,134	—	15,998	—	—	—	176,132	29,996	14,707	1,473	(32,436)	189,872
	2,005,589	27,142	178,331	667	4,108	(77,022)	2,138,815	167,173	344,929	258,074	(481,046)	2,427,945
	2,391,025	(2,382)	255,155	58,939	23,077	(309,739)	2,416,115	336,674	(85,550)	(159,831)	(221,568)	2,285,840
	—	—	—	—	—	—	—	310,750	—	—	—	310,750
	240,912	—	2,181	10,162	—	(15,269)	237,946	18,676	—	21	—	256,643
	2,631,937	(2,382)	257,336	69,101	23,077	(325,008)	2,654,061	666,100	(85,550)	(159,810)	(221,568)	2,853,233
	$ 4,637,526	24,760	435,667	69,768	27,185	(402,030)	4,792,876	833,273	259,379	98,264	(702,614)	5,281,178

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ATTACHMENT 36

Schedule 2

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

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

Year ended June 30, 2024

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Obligated Group Eliminations	Obligated Group Consolidation	Advent	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Non-Obligated Group Eliminations	Consolidated total
	$ 2,593,285	—	376,735	—	5,834	—	2,975,854	938,308	56,457	27,971	(2,507)	3,996,033
no donor restrictions	481,715	6,833	9,358	2,132	313	(5,310)	495,041	108,494	857	46,729	(21,981)	629,140
	3,074,950	6,833	386,093	2,132	6,147	(5,310)	3,470,895	1,046,802	57,314	74,700	(24,488)	4,625,173
	1,205,234	1,868	151,387	309	8,030	—	1,366,828	524,494	33,502	41,727	(71)	1,966,480
	1,102,667	3,220	133,935	1,889	895	(961)	1,241,645	408,065	33,220	53,122	(32,052)	1,703,990
	360,968	—	25,500	16	341	(2,733)	384,092	—	9,343	13,973	(4,207)	403,201
	24,275	1,745	15,916	—	369	(1,616)	40,689	18,737	1,974	24,007	(14,896)	70,511
	46,448	—	2,286	—	—	—	48,734	—	281	—	(1,199)	47,816
	68,674	—	23,741	—	—	—	92,415	45,087	—	—	—	137,502
	117,550	535	18,020	—	—	—	136,105	44,587	3,117	913	—	184,722
	2,925,816	7,368	370,785	2,214	9,635	(5,310)	3,310,508	1,040,970	81,437	133,742	(52,435)	4,514,222
):t) of expenses	149,134	(535)	15,308	(82)	(3,488)	—	160,337	5,832	(24,123)	(59,042)	27,947	110,951
	81,861	394	8,102	4,023	1,183	—	95,563	5,487	—	—	—	101,050
nstruments	(3,784)	—	674	—	—	—	(3,110)	—	—	—	—	(3,110)
	—	(575)	—	—	—	—	(575)	—	1,799	90	485	1,799
	78,077	(181)	8,776	4,023	1,183	—	91,878	5,487	1,799	90	485	99,739
ication) of expenses	227,211	(716)	24,084	3,941	(2,305)	—	252,215	11,319	(22,324)	(58,952)	28,432	210,690
f expenses erest	—	—	—	—	—	—	—	(5,565)	—	—	—	(5,565)
ication) of expenses rations	227,211	(716)	24,084	3,941	(2,305)	—	252,215	5,754	(22,324)	(58,952)	28,432	205,125
ion ft ratives)	(71,750) 17,961 (2,704)	— — (1)	— — 5,862	— — (2)	— — 1	— — —	(71,750) 17,961 3,156	— — —	— — —	— — (6,483)	— — —	(71,750) 17,961 (1,327)
	170,718	(717)	29,946	3,939	(2,304)	—	201,582	5,754	(22,324)	(65,435)	28,432	150,009
	—	—	—	—	—	—	—	5,565	—	—	—	5,565
without donor	$ 170,718	(717)	29,946	3,939	(2,304)	—	201,582	11,319	(22,324)	(65,435)	28,432	155,574

Schedule 3

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2024

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Obligated Group Eliminations	Obligated Group Consolidation	Advent	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CNHD Entities	Non-Obligated Group Eliminations	Consolidated total
s and losses	$ 227,211	(716)	24,084	3,941	(2,305)	—	252,215	5,754	(22,324)	(58,952)	28,432	206,125
	(71,750)	—	—	—	—	—	(71,750)	—	—	—	—	(71,750)
t	17,961	—	—	—	—	—	17,961	—	—	—	—	17,961
	(2,704)	(1)	5,862	(2)	1	—	3,156	—	—	(4,483)	—	(1,327)
ncl ons before non-controlling interest	170,718	(717)	29,946	3,939	(2,304)	—	201,582	5,754	(22,324)	(63,435)	28,432	150,009
	—	—	—	—	—	—	—	5,565	—	—	—	5,565
n ctions	170,718	(717)	29,946	3,939	(2,304)	—	201,582	11,319	(22,324)	(63,435)	28,432	155,574
	108,237	—	—	732	—	—	108,969	4,423	—	—	—	113,392
ng purposes	(12,863)	—	—	(1,050)	(5)	—	(13,918)	—	—	—	—	(13,918)
	6,815	—	—	815	—	—	7,630	3,607	—	—	—	11,237
l purposes	—	—	—	(1,800)	—	—	(1,800)	—	—	—	—	(1,800)
onor restrictions	102,189	—	—	(1,303)	(5)	—	100,881	8,030	—	—	—	108,911
	272,907	(717)	29,946	2,636	(2,308)	—	302,463	19,349	(22,324)	(63,435)	28,432	264,485
	2,359,030	(1666)	227,390	66,465	25,386	(325,008)	2,351,998	646,751	(63,226)	(96,375)	(250,000)	2,589,748
	$ 2,631,937	(2382)	257,336	69,101	23,077	(325,008)	2,654,461	666,100	(85,550)	(159,810)	(221,568)	2,853,233

Section IX. 1120.140 - Economic Feasibility

Attachment 37

Economic Feasibility

A. Reasonableness of Financing Arrangements.

By their signatures on the application, the Applicants attest that the Project will be funded through cash on hand.

B. Conditions of Debt Financing.

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

C. Reasonableness of Project and Related Costs.

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		Gross Square Foot		Gross Square Foot		Const. $	Mod. $	
	New	Mod.	New	Circ*	Mod.	Circ.	(AxC)	(BxE)	
Cath Labs	$ 900.00		3504				$ 3,153,600.00		$ 3,153,600.00
Prep/PACU	$ 729.00		3244				$ 2,351,900.00		$ 2,351,900.00
Admin	$ 420.00		756				$ 317,520.00		$ 317,520.00
Circulation	$ 443.00			2813			$ 1,252,675.00		$ 1,252,675.00
MEP/IT	$ 1,970.00		397				$ 782,090.00		$ 782,090.00
Storage	$ 395.00		4397				$ 1,736,815.00		$ 1,736,815.00
Contingency									$ 959,460.00
TOTALS			12298	2813					$ 10,554,060.00

*Circulation is -

All construction contracts will be managed with a Guaranteed Maximum Price

D. Project Operating Costs.

Cath Lab 2 Estimated Costs, Procedures, and Cost per Procedure

	2027	
Operating Costs	$	1,791,114
Number of Procedures		600
Annual Operating Cost Per Unit	$	2,985.19

E. Total Effect of Project on Capital Costs.

Total Project Capital Cost	$21,625,782
Annual Depreciation	$540,645
Estimated Annual procedures	545
Capital Cost per Procedure	$992.01

Section X. Safety Net Impact Statement

Attachment 38

The proposed Project is classified as "non-substantive" under the Review Board's rules. Consequently, Safety Net Impact statements are not applicable.

Section X. Charity Care

Attachment 39

Shown below is the amount of charity care provided by UCMAH Bolingbrook.

Charity Care - Bolingbrook Hospital				
	CY 21	CY 22	CY 23	FY 24
Net Patient Revenue	**196,865,975**	**199,601,332**	**216,543,366**	**228,831,240**
Amount of Charity Care (Charges)	**20,197,345**	**20,197,345**	**22,360,094**	**26,368,641**
Cost of Charity Care	**5,105,430**	**5,502,968**	**6,222,115**	**7,473,102**
Ratio of Charity Care Cost to Net Patient Rev.	2.59%	2.76%	2.87%	3.27%

ADVENTHEALTH ACCOUNTS PAYABLE
902 INSPIRATION AVE
STE 9100
ALTAMONTE SPRINGS, FL 32714
844/259-3977

AdventHealth

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525 W JEFFERSON ST 4TH FLOOR
CENTRAL OFFICE OPERATIONS SECTION (COOS)
SPRINGFIELD IL 62761-0001

Invoice Number	Invoice Date	Vendor ID	Gross Amount	Discount Taken	Paid Amount
03/07/2025-AHBH	3/7/25	0000048494	2,500.00	0.00	2,500.00

Attn: Donna Czekaj - IDPH Con Filing Fee 12300 1230 URG RTF

25-013
INITIAL

Check Number	Date	Total Gross Amount	Total Discounts	Total Paid Amount
1002874098	3/11/25	$2,500.00	$0.00	$2,500.00

THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

AdventHealth
902 INSPIRATION AVE STE 9100
ALTAMONTE SPRINGS, FL 32714-1519

AdventHealth

64-1278/611

Number 1002874098
Date 3/11/25

Pay ****TWO THOUSAND FIVE HUNDRED AND XX/100 DOLLAR ****

$2,500.00***

To The Order Of

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525 W JEFFERSON ST 4TH FLOOR
CENTRAL OFFICE OPERATIONS SECTION (COOS)
SPRINGFIELD IL 62761-0001

Bank of America
900 Hope Way
Altamonte Springs FL 32714

Authorized Signature

⑈1002874098⑈ ⑆063111278⑆ 335988626 7⑈