

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Advocate Christ Medical Center – 22 Medical Surgical Inpatient Bed Addition		
Street Address: 4440 W. 95 th Street		
City and Zip Code: Oak Lawn 60453		
County: Cook	Health Service Area: 7	Health Planning Area: A-04

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center		
Street Address: 4440 W. 95 th Street		
City and Zip Code: Oak Lawn 60453		
Name of Registered Agent: The Corporation Company		
Registered Agent Street Address: 600 S. 2 nd Street Suite 104		
Registered Agent City and Zip Code: Springfield, IL 62704		
Name of Chief Executive Officer: Dia Nichols		
CEO Street Address: 2025 Windsor Drive		
CEO City and Zip Code: Oak Brook, IL 60523		
CEO Telephone Number:		

Type of Ownership of Applicants

☒ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
○ Corporations and limited liability companies must provide an Illinois certificate of good standing. ○ Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Mark Miller
Title: Hospital President - Advocate Christ Medical Center
Company Name: Advocate Christ Medical Center
Address: 4440 W. 95 th Street, Oak Lawn, IL 60453
Telephone Number: 708-684-8000
E-mail Address: mark.miller@aah.org
Fax Number:

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

Name: Myndee Gomberg Balkan
Title: Director, Health Facilities Planning
Company Name: Advocate Health
Telephone Number: 847-721-0376

E-mail Address: myndee.balkan@aah.org
Fax Number:

Additional Contact [Person to receive ALL correspondence or inquiries]

Name: Laura Parisi
Title: Director, Design and Construction
Company Name: Advocate Health
Address: 4440 W. 95th Street Oak Lawn, IL 60453
Telephone Number: 773-304-6068
E-mail Address: laura.parisi@aah.org
Fax Number:

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City and Zip Code: Oak Lawn 60453		
County: Cook	Health Service Area: 7	Health Planning Area: A-04

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

Exact Legal Name: Advocate Aurora Health Inc.
Street Address: 2025 Windsor Drive
City and Zip Code: Oak Brook, IL 60523
Name of Registered Agent: The Corporation Company
Registered Agent Street Address: 600 S. 2 nd Street Suite 104
Registered Agent City and Zip Code: Springfield, IL 62704
Name of President: Gabrielle Finley-Hazle
President Street Address: 2025 Windsor Drive
President City and Zip Code: Oak Brook, IL 60523
President Telephone Number:

Type of Ownership of Applicants

☒ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
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Name: Mark Miller
Title: Hospital President - Advocate Christ Medical Center
Company Name: Advocate Christ Medical Center
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Telephone Number: 708-684-8000
E-mail Address: mark.miller@aah.org
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Company Name: Advocate Health
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E-mail Address: myndee.balkan@aah.org
Fax Number:

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Street Address: 4440 W. 95 th Street		
City and Zip Code: Oak Lawn 60453		
County: Cook	Health Service Area: 7	Health Planning Area: A-04

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

Exact Legal Name: Advocate Health Inc.
Street Address: The Pearl, 915 Pearl Park Way, Suite 1400
City and Zip Code: Charlotte, NC 28204
Name of Registered Agent: The Corporation Company
Registered Agent Street Address: 600 S. 2 nd Street Suite 104
Registered Agent City and Zip Code: Springfield, IL 62704
Name of Chief Executive Officer: Eugene Woods
CEO Street Address: The Pearl, 915 Pearl Park Way, Suite 1400
CEO City and Zip Code: Charlotte, NC 28204
CEO Telephone Number:

Type of Ownership of Applicants

☒ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
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Name: Mark Miller
Title: Hospital President - Advocate Christ Medical Center
Company Name: Advocate Christ Medical Center
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Telephone Number: 708-684-8000
E-mail Address: mark.miller@aah.org
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Title: Director, Health Facilities Planning
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Telephone Number: 847-721-0376
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Additional Contact [Person to receive ALL correspondence or inquiries]

Name: Laura Parisi
Title: Director, Design and Construction
Company Name: Advocate Health
Address: 4440 W. 95th Street Oak Lawn, IL 60453
Telephone Number: 773-304-6068
E-mail Address: laura.parisi@aah.org
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: James Kokaska
Title: Vice President, Planning, Design & Construction
Company Name: Advocate Health, Inc
Address: 2025 Windsor Drive, Oak Brook, IL 60523
Telephone Number: 708-473-4692
E-mail Address: james.kokaska@aah.org

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation d/b/a/ Advocate Christ Medical Center
Address of Site Owner: 2025 Windsor Drive, Oak Brook, IL 60523
Street Address or Legal Description of the Site: 4440 W. 95 th Street Oak Lawn, IL 60453 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 <u>ATTACHMENT 2</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center			
Address: 4440 W. 95 th Street Oak Lawn, IL 60453			
☒	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.

Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center, Advocate Aurora Health, Inc. and Advocate Health, Inc., the applicants, seek approval from the Illinois Health Facilities and Services Review Board to add 22 medical surgical beds at Advocate Christ Medical Center. The site is located on the hospital campus at 4440 95th St. Oak Lawn, Illinois 60453.

This project will increase the number of CON authorized medical surgical beds from 437 to 459 medical surgical beds. The total hospital beds will increase from 794 to 816. This will include an all-private medical surgical unit to be developed on the 4th floor of the South Tower at Advocate Christ Medical Center in an area that will be vacated by 3 ancillary departments. The project will include the relocation of Cardio-diagnostics, Inpatient Dialysis and Inpatient Nuclear Medicine to the ground floor of the hospital in the area vacated by the cafeteria and kitchen from a previous project.

The total cost of the modernization project is \$40,011,558 with an anticipated completion date of October 31, 2028.

The project is classified as a non-substantive project, as the project does not establish a new category of service nor facility as defined in 20 IL CS 3690/3.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	☐ Yes	☒ No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
☐ Yes ☒ No		
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ _____ NA _____.		

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): October 31, 2028

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]

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Advocate Christ Medical Center			CITY: Oak Lawn, IL		
REPORTING PERIOD DATES: From: Jan 1, 2025, to: Dec. 31, 2025					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	437	25,669	168,916	+22	459
Obstetrics	44	5,156	14,419		44
Pediatrics	45	2,997	11,947		45
Intensive Care	170	7,063	52,937		170
Comprehensive Physical Rehabilitation	37	985	10,571		37
Acute/Chronic Mental Illness	0				0
Neonatal Intensive Care	61	165	16,246		61
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	794	42,035	275,036		816

CERTIFICATION

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

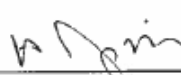
- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its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

This Application is filed on the behalf of Advocate Health and Hospitals Corporation d/b/a Advocate Christ 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

Dia Nichols
PRINTED NAME

President
PRINTED TITLE


SIGNATURE

Jim Slinkman
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13 day of January, 2026


Signature of Notary

Seal

*Insert the EXAG Declaration of the Applicant

Notarization:
Subscribed and sworn to before me
this 13 day of January, 2026


Signature of Notary

Seal


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


SIGNATURE

Dia Nichols
PRINTED NAME

Vice President
PRINTED TITLE

SIGNATURE

Brett J. Denton
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:

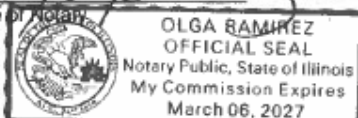
Subscribed and sworn to before me
this 22 day of January, 2020

Notarization:

Subscribed and sworn to before me
this ____ day of _____

Signature of Notary

Seal



Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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SIGNATURE

Dia Nichols
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this ____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

SIGNATURE

Brett J. Denton
PRINTED NAME

Secretary
PRINTED TITLE

Notarization: State of NC
County of Mecklenburg
Subscribed and sworn to before me
this 10th day of January, 2020

Wendy Ruth Parker
Signature of Notary

Seal

My Commission Expires
1-28-28

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.
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SIGNATURE

Brett J. Denton
PRINTED NAME

Secretary
PRINTED TITLE

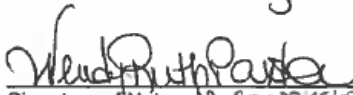
SIGNATURE

Bradley A. Clark
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization: State of NC
County of Mecklenburg
Subscribed and sworn to before me
this 10th day of January, 2006

Notarization:
Subscribed and sworn to before me
this ____ day of _____



Signature of Notary My Commission Expires 1-28-08

Seal

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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SIGNATURE

Brett J. Denton
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this ____ day of _____

Signature of Notary

Seal

SIGNATURE

Bradley A. Clark
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20 day of Jan. 2026

Samantha Jefferson
Signature of Notary

Seal

*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	MET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

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

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

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

- Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:
- Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Medical/Surgical	437	459
☐ Obstetric		
☐ Pediatric		
☐ Intensive Care		

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

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	
APPEND DOCUMENTATION AS <u>ATTACHMENT 19</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ IP Dialysis		
☒ Nuclear Medicine		
☒ Cardio diagnostics		

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
1APPEND DOCUMENTATION AS <u>ATTACHMENT 31</u> , 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]:**

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

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.



National Flood Hazard Layer FIRMette

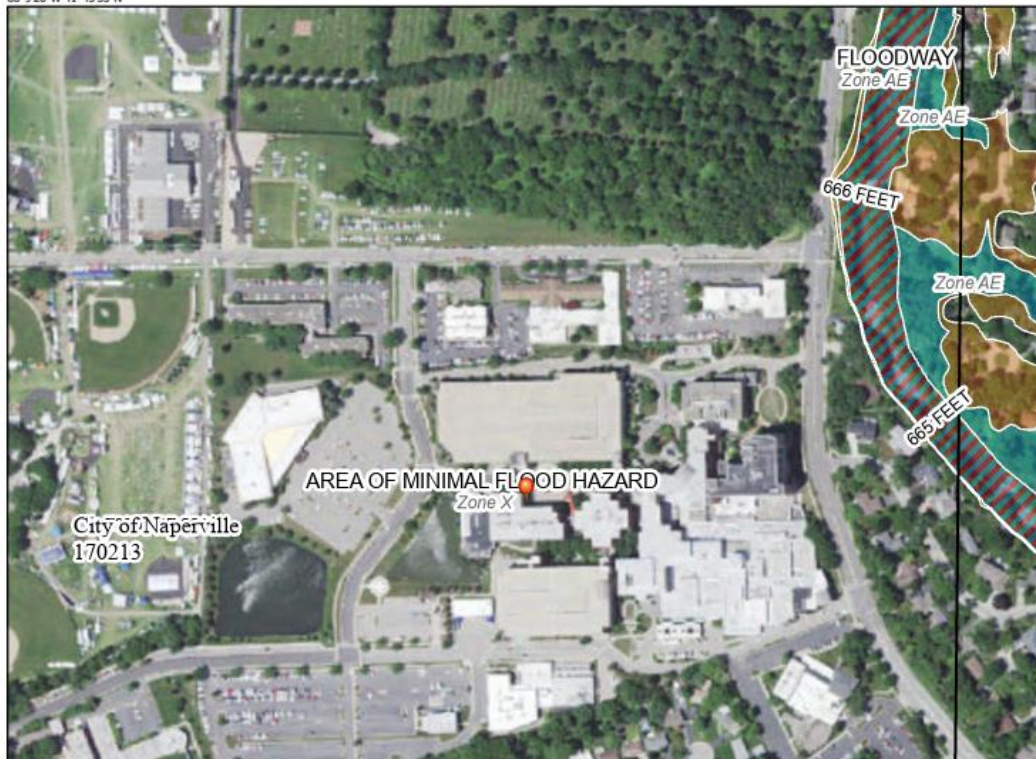
88°9'26"W 41°45'53"N



Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS		Without Base Flood Elevation (BFE) Zone A, V, A99
		With BFE or Depth Zone AE, AG, AH, VE, AR Regulatory Floodway
OTHER AREAS OF FLOOD HAZARD		0.2% Annual Chance Flood Hazard. Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile. Zone X
		Future Conditions 1% Annual Chance Flood Hazard Zone X
		Area with Reduced Flood Risk due to Levee. See Notes, Zone X
OTHER AREAS		Area of Minimal Flood Hazard Zone X
		Effective LOMRs
GENERAL STRUCTURES		Area of Undetermined Flood Hazard Zone D
		Channel, Culvert, or Storm Sewer
OTHER FEATURES		Levee, Dike, or Floodwall
		Cross Sections with 1% Annual Chance
MAP PANELS		Digital Data Available
		No Digital Data Available
		Unmapped
		The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.



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

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Type of Ownership of Applicants

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

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

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

Illinois Certificates of Good Standing for the applicants are provided as Attachment 1

Provided for Attachment #1:

Advocate Health and Hospitals Corporation

IL Certificate of Good Standing

Advocate Aurora Health, Inc.

IL Certificate of Good Standing

Advocate Health, Inc.

IL Certificate of Good Standing



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the

Department of Business Services. I certify that

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



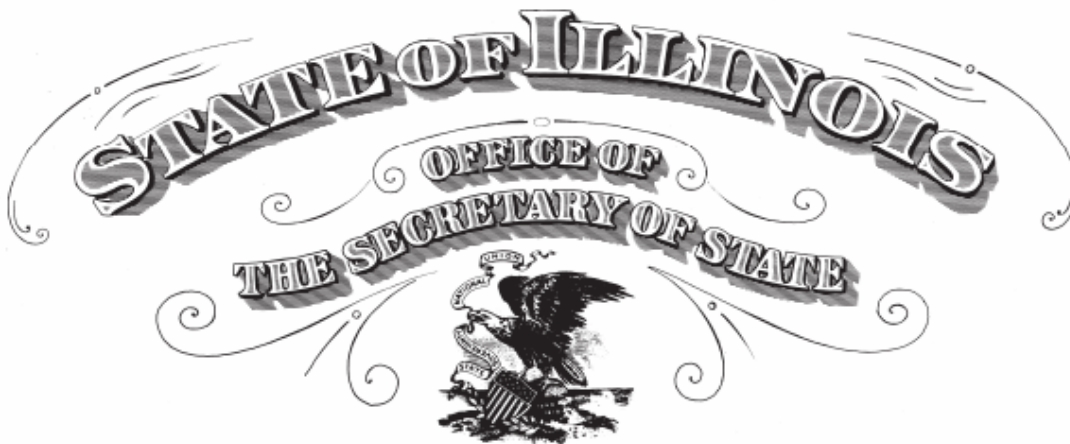
Authentication #: 2533503650 verifiable until 12/01/2026
Authenticate at: <https://www.ilsos.gov>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 1ST
day of DECEMBER A.D. 2025 .***

Alexi Giannoulis
SECRETARY OF STATE

File Number

7155-851-7



To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE AURORA HEALTH, INC., INCORPORATED IN DELAWARE AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON APRIL 03, 2018, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



Authentication #: 2609202454 verifiable until 04/02/2027
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 2ND day of APRIL A.D. 2026 .

Alexi Giannoulis
SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

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

ADVOCATE HEALTH, INC., INCORPORATED IN DELAWARE AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 28, 2022, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



Authentication #: 2533503720 verifiable until 12/01/2026
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 1ST day of DECEMBER A.D. 2025 .

Alexi Giannoulas
SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation d/b/a/ Advocate Christ Medical Center
Address of Site Owner: 2025 Windsor Drive, Oak Brook, IL 60523
Street Address or Legal Description of the Site: Advocate Christ Medical Center 4440 W. 95th Street, Oak Lawn, IL 60453 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 <u>ATTACHMENT 2</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The proposed site is at the Advocate Christ Medical Center located at 4440 W. 95th Street, Oak Lawn, IL 60453.

Please see Attachment #2 Exhibit 1.

January 22, 2026

Mr. John Kniery
Administrator
Illinois Health Facilities and Services Review
Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

**Re: Advocate Health and Hospitals Corporation d/b/a Christ Medical Center –
New 22 Bed Med Surg Project**

Dear Mr. Kniery:

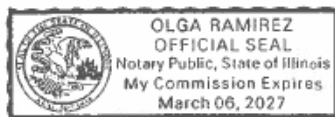
This attestation letter is submitted to indicate that Advocate Health and Hospitals d/b/a Advocate Christ Medical Center owns the site of the hospital located at 4440 W 95th St, Oak Lawn, Illinois 60453.

We trust this attestation complies with the State Agency Proof of ownership requirements indicated in the Permit application – June 2024 edition.

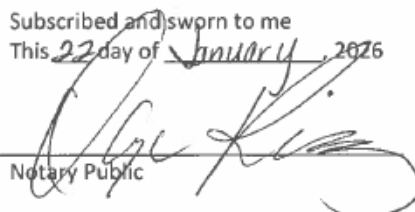
Respectfully,



Dia Nichols
President
Advocate Aurora Health, Inc.



Subscribed and sworn to me
This 22 day of January, 2026


Notary Public

Operating Identity/Licensee

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center	
Address: 4440 W. 95th Street, Oak Lawn, IL 60453	
☒ 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.	

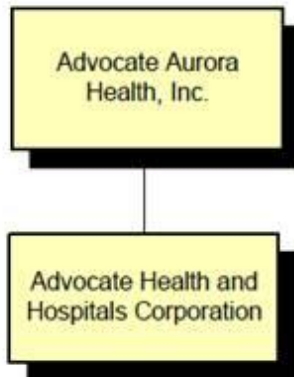
Illinois Certificates of Good Standing for the applicants are provided in Attachment 1 and are incorporated in Attachment 3 by reference.

Organizational Relationships

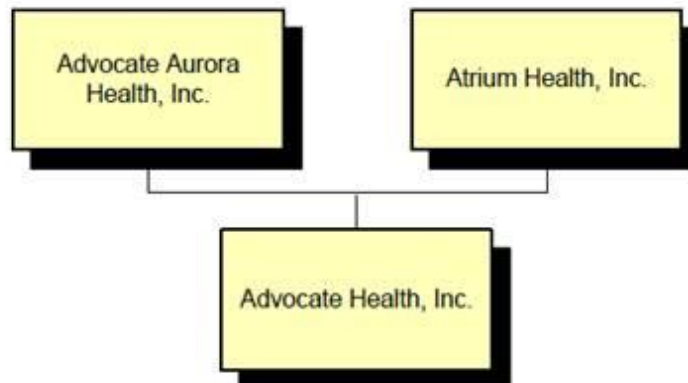
Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type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

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

See Attachment #4, Exhibit 1.



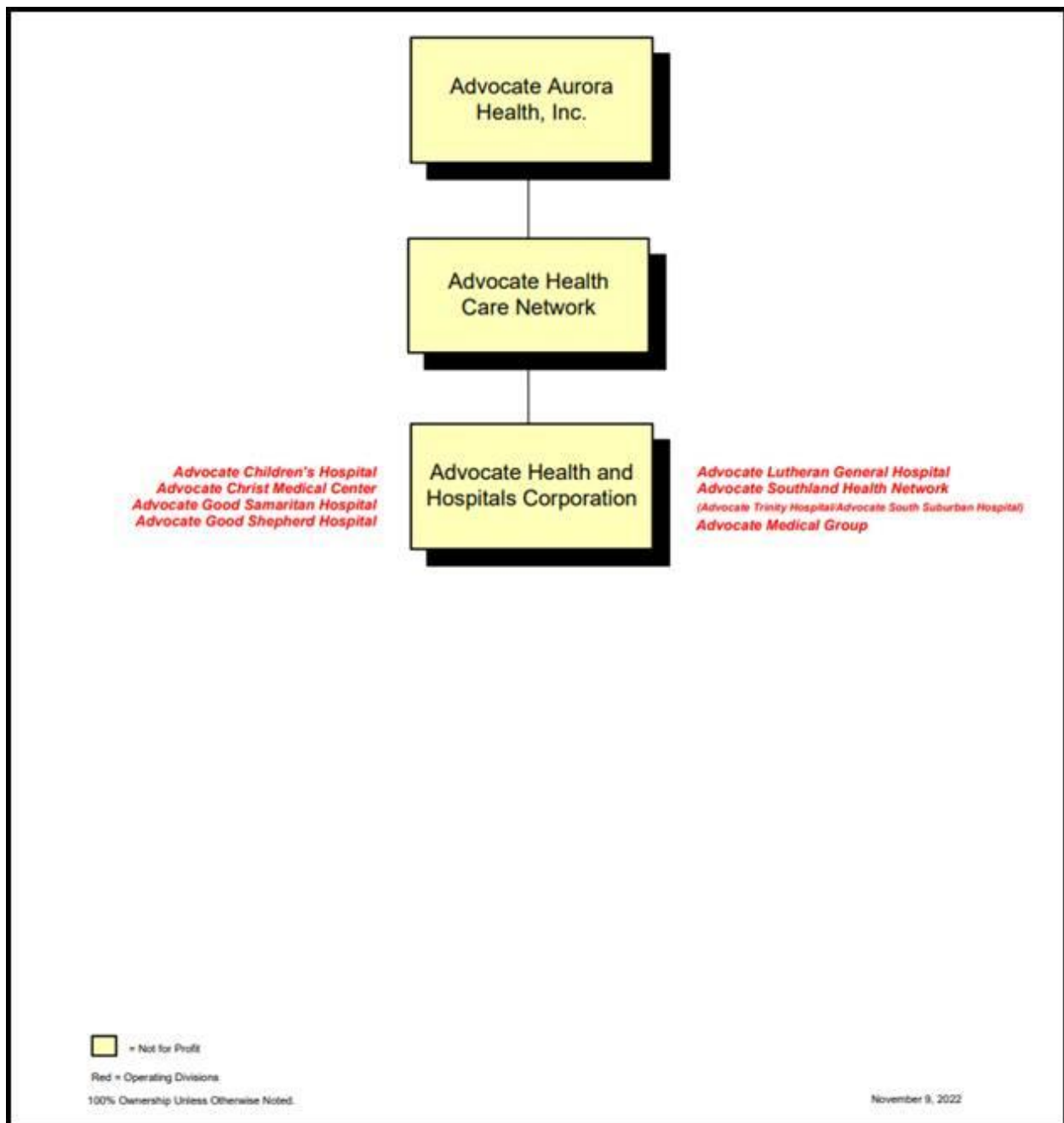
*Note because Advocate Health, Inc. has certain governance, management and operation oversight of Advocate Aurora Health, Inc. through a Joint Operating Agreement structure, it is also included as a co-applicant. Advocate Aurora Health, Inc. and Atrium Health, Inc. are the Corporate Members of Advocate Health, Inc.



 = Not for Profit

100% Ownership Unless Otherwise Noted.

January 25, 2023



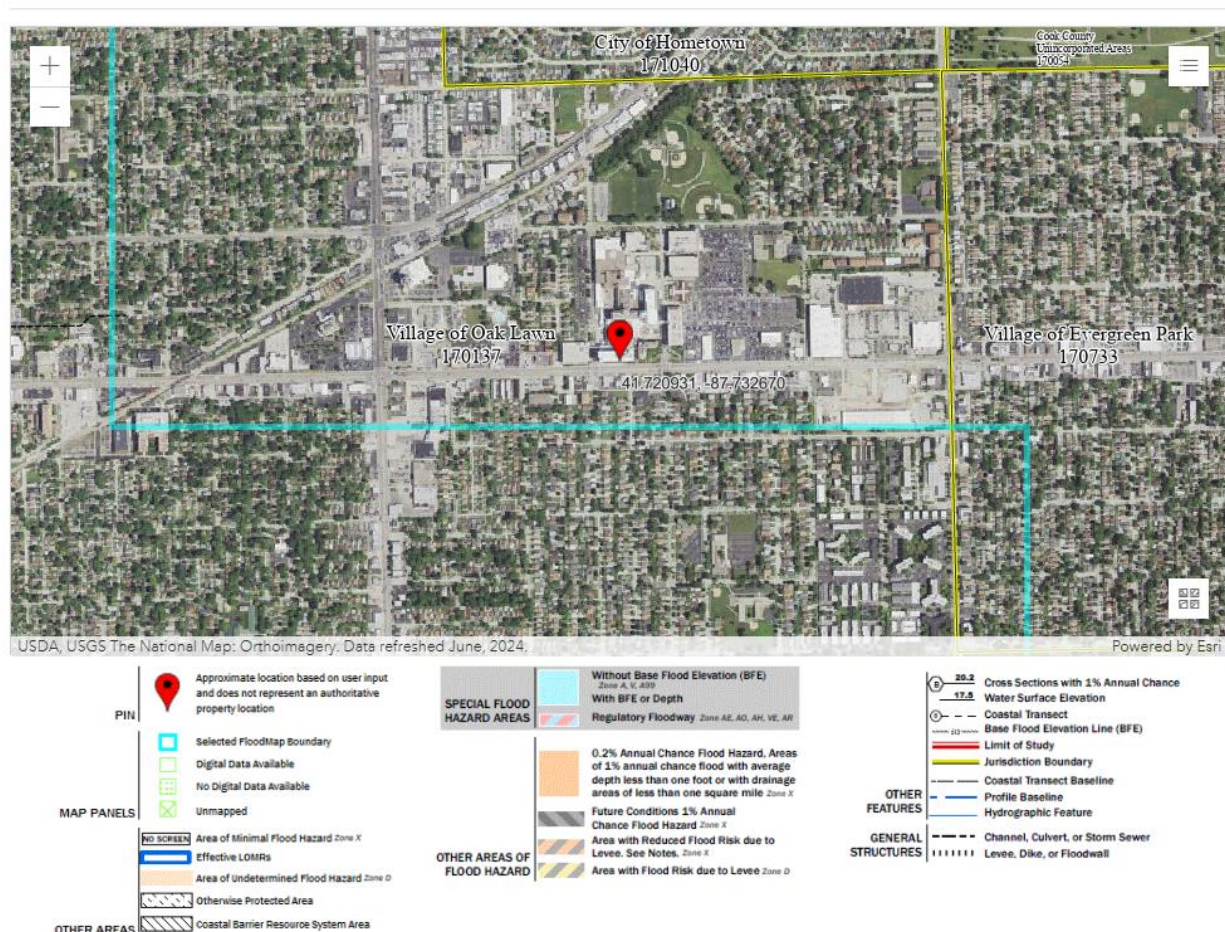
Flood Plain Requirements

[Refer to application instructions.]

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

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

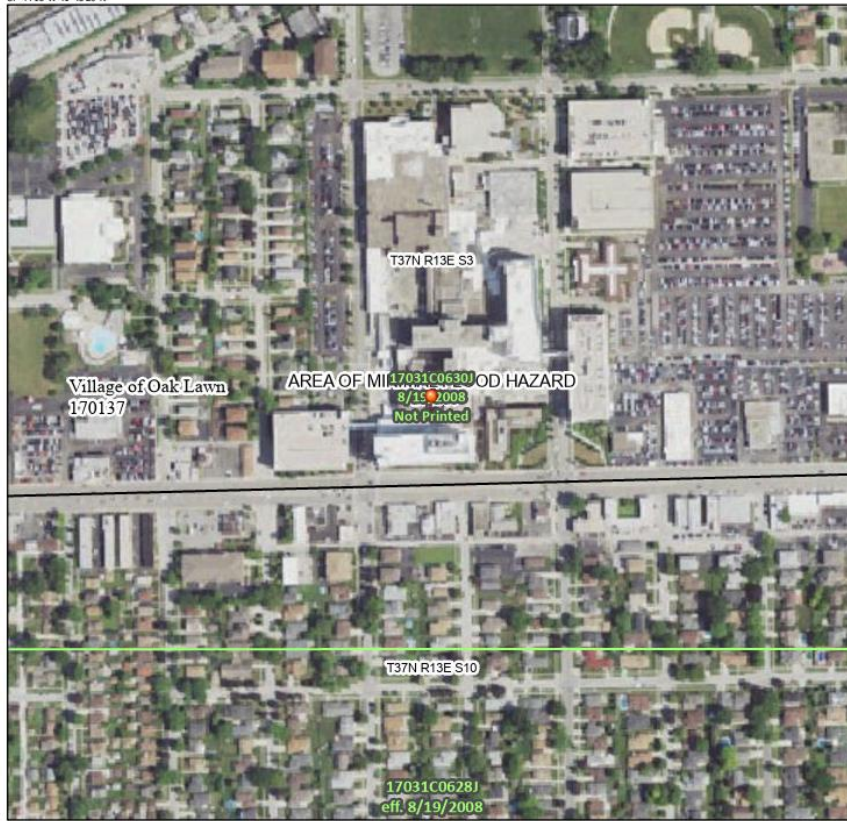
By their signatures on the Certification, the applicants certify that the site for the proposed project is not in a flood plain, as identified by the most recent FEMA flood plain hazard map for this area. This project is not in a special flood hazard area and therefore complies with Illinois Executive Order #2006-5. Please see Attachment 5, Exhibit 1.



National Flood Hazard Layer FIRMette



87°44'16"W 41°43'29"N



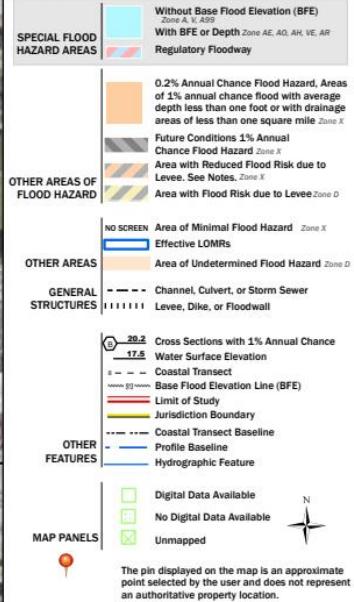
0 250 500 1,000 1,500 2,000 Feet

1:6,000

Basemap Imagery Source: USGS National Map 2023

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT



This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards.

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 9/5/2025 at 8:22 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

HISTORIC PRESERVATION ACT REQUIREMENTS

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

A letter was sent to the Illinois Department of Natural Resources (IDNR), the Historic Preservation Division on March 10, 2026, requesting a determination letter for this project. The IDNR, the Historic Preservation Division, is in the process of replying to that request. The Historic Preservation Letter request is provided as Attachment 6, Exhibit 1.

3/10/2026

Carey Mayer, Deputy State Historic Preservation Officer
Illinois State Historic Preservation Office
Attn: Review & Compliance
1 Old State Capital Plaza
Springfield, IL 62701

RE: Historic Preservation Act Determination
Advocate Christ Medical Center CON request to add 22 medical/surgical beds

Dear Ms. Mayer,

Per the Certificate of Need, the guidance is to provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act. Identified as Attachment 6 to the CON application form; below is the following information provided with supporting documentation:

1. Project's county, street address, and municipality.

The proposed project is located at Advocate Christ Medical Center, 4440 W 95th St, Oak Lawn, Cook County, Illinois 60453.

2. Complete description of your project, including any proposed ground-disturbing activity

Advocate Health seeks a certificate of need from the Illinois Health Facilities and Services Review Board to increase the number of CON authorized medical surgical beds from 437 to 459 medical surgical beds. The total hospital beds will increase from 794 to 816. This will include an all-private medical surgical unit to be developed on the 4th floor of the South Tower in an area that will be vacated by 3 ancillary departments. The project will include the relocation of Cardiodiagnostics, Inpatient Dialysis and Inpatient Nuclear Medicine to the ground floor of the hospital vacated by the cafeteria and kitchen from a previous project. The proposed project will involve modifications to the interior of the building.

3. Names of state and/or federal agencies and entities that are providing funding, licenses, permits, or approvals

Illinois Department of Public Health/HFSRB
Village of Oak Lawn

4. Name, email address, phone, and mailing address of the project contact

Jodi Feldheim, Jodi.feldheim@aah.org, 773-439-9949, 4440 West 95th Street, Oak Lawn, IL 60453.

5. Previously assigned SHPO log numbers associated with your project (if any)

Not applicable.

6. Total acreage involved in the project

Not applicable.

Page 1 of 2

7. Year of original construction for each structure on the project site

Physician Pavilion 1985
Outpatient Pavilion 2014
South Tower/Annex 1972
Main/West Tower 1958
East Tower 2016
North Office Building 1973
ED/Surgery Pavilion 1990
OR/ICU/Auditorium 2004
Hope Children's Hospital 1995

8. Description of any prior non-agricultural ground disturbance in the project area
Not applicable.

9. Any known historical information, architectural significance, significance to community, or association with a significant individual for any cultural resources within the project area

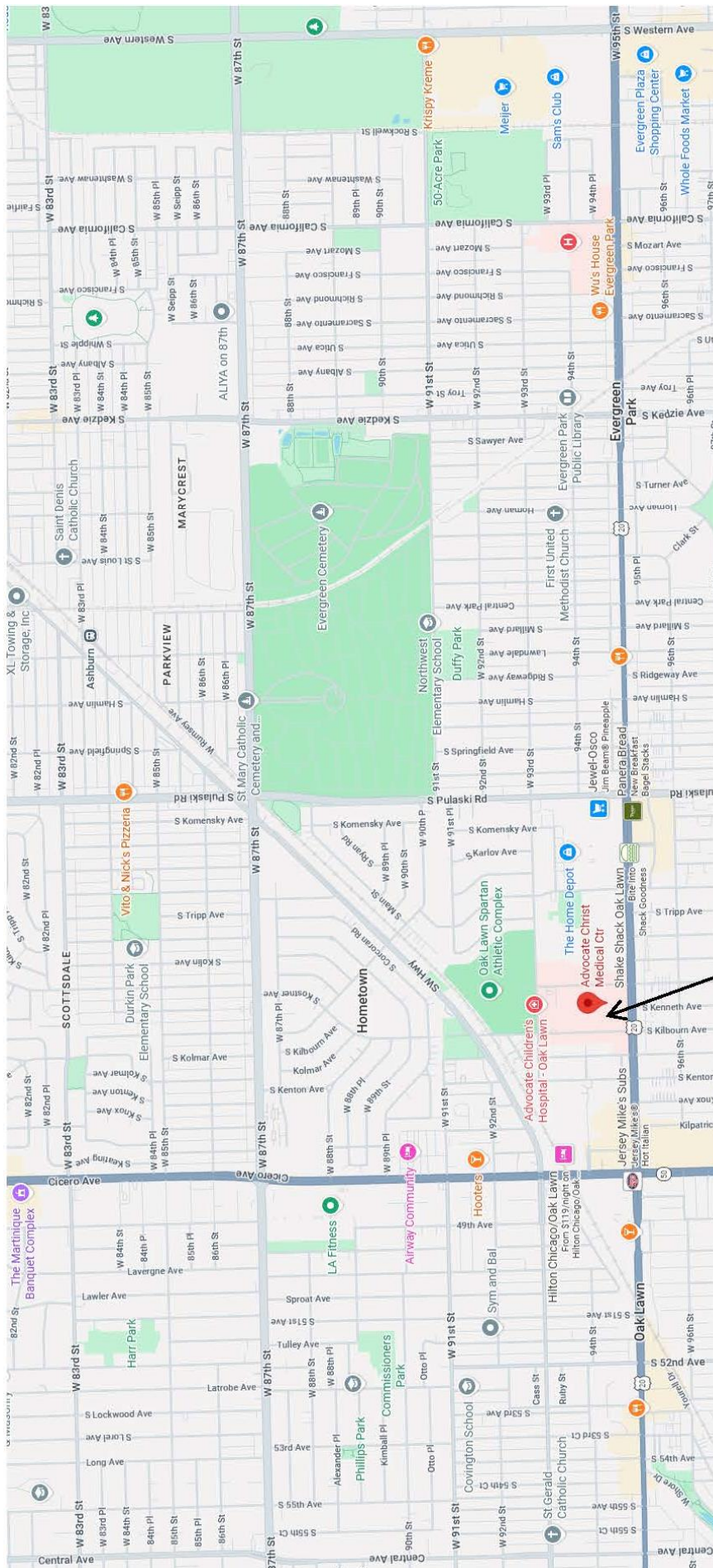
No significance previously noted.

Maps, Images, and Area of Potential Effects (APE) are provided in the Attachment.

Thank you for your time and consideration of our request for Historic Preservation Determination. If you have any questions, please contact me at Jodi.feldheim@aah.org

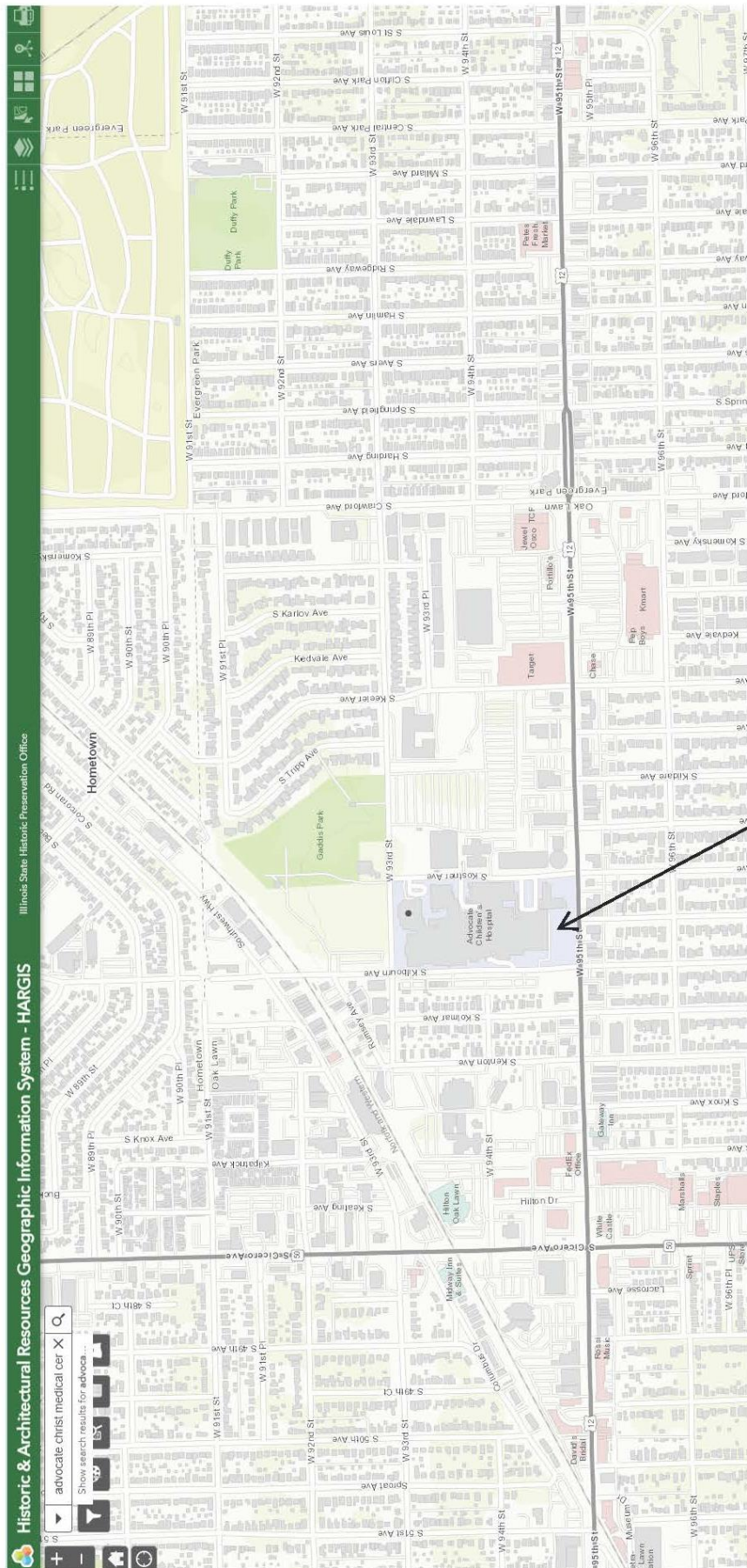
Sincerely,

Jodi Feldheim
Design Manager, Planning, Design and Construction
Advocate Health Care

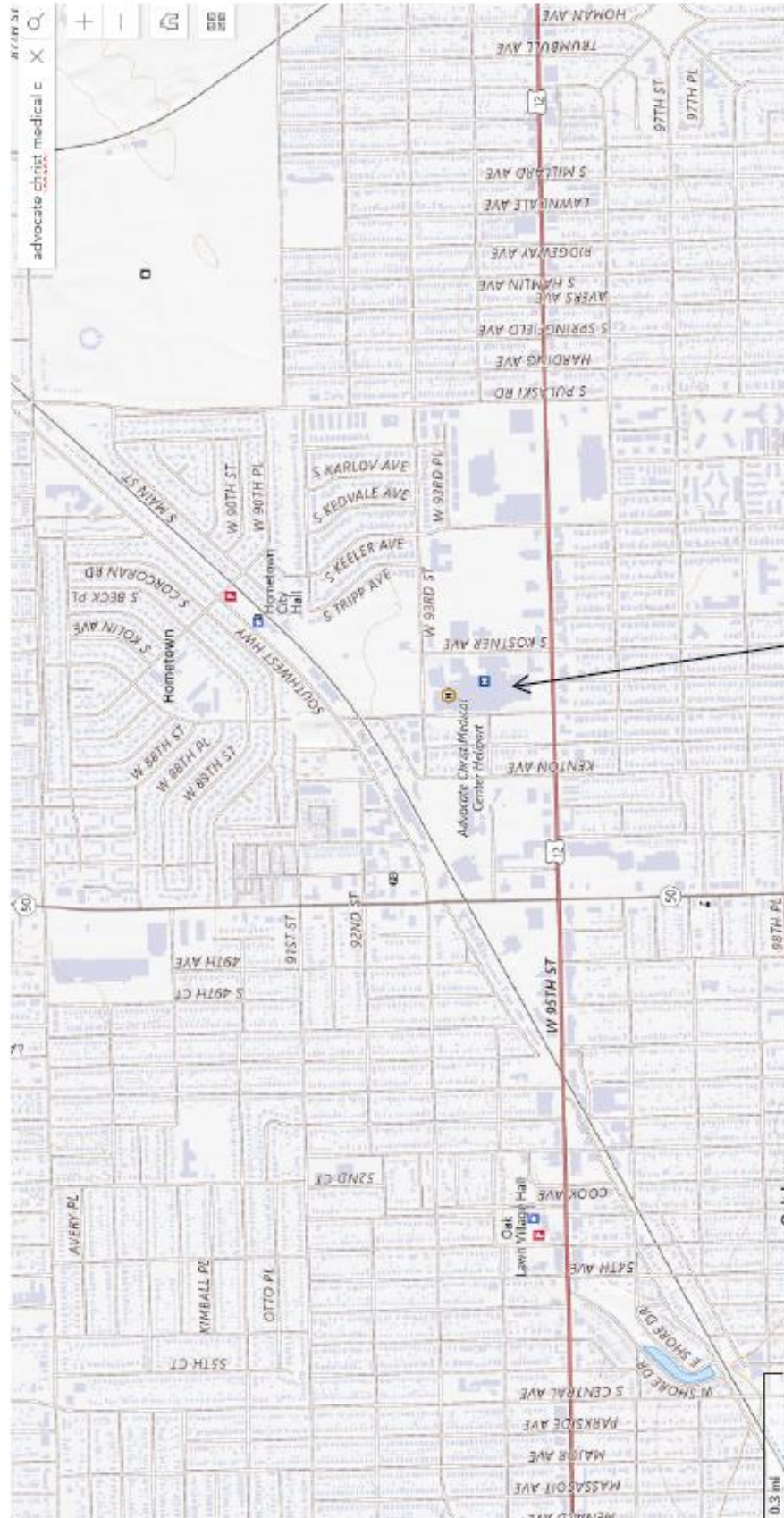


1000 ft

LOCATION OF HOSPITAL



LOCATION OF HOSPITAL



LOCATION OF HOSPITAL

SOURCE: USGS







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.

USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$ -	\$ -	\$ -
Site Survey and Soil Investigation	\$ -	\$ -	\$ -
Site Preparation	\$ -	\$ -	\$ -
Off Site Work	\$ -	\$ -	\$ -
New Construction Contracts	\$ -	\$ -	\$ -
Modernization Contracts	\$ 17,524,000	\$ 3,844,000	\$ 21,368,000
Contingencies	\$ 2,229,350	\$ 770,650	\$ 3,000,000
Architectural/Engineering Fees	\$ 1,595,339	\$ 551,482	\$ 2,146,821
Consulting and Other Fees	\$ 919,235	\$ 317,765	\$ 1,237,000
Movable or Other Equipment (not in construction contracts)	\$ 7,475,755	\$ 2,584,245	\$ 10,060,000
Bond Issuance Expense (project related)	\$ 256,571	\$ 70,194	\$ 326,765
Net Interest Expense During Construction (project related)	\$ 454,600	\$ 124,372	\$ 578,972
Fair Market Value of Leased Space or Equipment	\$ -	\$ -	\$ -
Other Costs To Be Capitalized	\$ 961,593	\$ 332,407	\$ 1,294,000
Acquisition of Building or Other Property (excluding land)	\$ -	\$ -	\$ -
TOTAL USES OF FUNDS	\$ 31,416,443	\$ 8,595,115	\$ 40,011,558
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$ 10,634,185	\$ 2,909,370	\$ 13,543,555
Pledges	\$ -	\$ -	\$ -
Gifts and Bequests	\$ -	\$ -	\$ -
Bond Issues (project related)	\$ 20,782,258	\$ 5,685,745	\$ 26,468,003
Mortgages	\$ -	\$ -	\$ -
Leases (fair market value)	\$ -	\$ -	\$ -
Governmental Appropriations	\$ -	\$ -	\$ -
Grants	\$ -	\$ -	\$ -
Other Funds and Sources	\$ -	\$ -	\$ -
TOTAL SOURCES OF FUNDS	\$ 31,416,443	\$ 8,595,115	\$ 40,011,558
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Project Cost and Sources of Funds - ITEMIZATION		
Preplanning Costs:	Total:	\$ 0
	Concept and Programming	\$ 0
	Pre-Construction Services	\$ 0
Site Survey and Soil Investigation:	Total:	\$ 0
Off Site Work:	Total:	\$ 0
Site Preparation:	Total:	\$ 0
New Construction Contracts:	Total:	\$ 0
Modernization Contracts:	Total:	\$ 21,368,000
	Construction Cost	\$ 18,638,457
	General Conditions / Temp Utilities	\$ 2,515,938
	Insurance	\$ 213,605
Contingencies:	Total:	\$ 3,000,000
Architectural/Engineering Fees:	Total:	\$ 2,146,821
Consulting and Other Fees:	Total:	\$ 1,237,000
	CON Application & Fees	\$ 90,000
	Project Audit	\$ 100,000
	IDPH Plan Review	\$ 40,000
	Commissioning	\$ 90,000
	Permits / Testing	\$ 390,000
	HVAC Pre-Testing	\$ 12,000
	Sustainability	\$ 30,000
	Medical Equipment Planning	\$ 85,000
	Low Voltage Design	\$ 400,000
Movable and Other Equipment:	Total:	\$ 10,060,000
(not in construction contracts)	Major Medical	\$ 9,200,000
	Television System/Clock System	\$ 195,000
	IT / Telecom System	\$ 420,000
	Headwalls	\$ 245,000
Bond Issuance Expense (project related):	Total:	\$ 326,765
Net Interest Expense During Construction (project related):	Total:	\$ 578,972
Other Costs to be Capitalized:	Total:	\$ 1,294,000
	Furnishings	\$ 830,000
	Signage/Wayfinding	\$ 80,000
	Artwork	\$ 40,000
	Pneumatic Tube Systems	\$ 100,000
	Window Treatments	\$ 22,000
	Cubicle and Shower Curtains	\$ 22,000
	Security Systems/Access Control	\$ 40,000
	Floor Prep Allowance	\$ 140,000
	Renderings/Models	\$ 20,000
	TOTAL:	\$ 40,011,558

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): <u>October 31, 2028</u>	
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 <u>ATTACHMENT 8</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

The following CON/COE applications have received permits from the HFSRB and are in process of development. These projects are expected to be completed on time and within budget without any changes in scope.

Advocate Illinois Masonic Medical Center	#22-009
Advocate Outpatient Center Westmont	#24-001
Advocate Naperville ASTC/Cath/Outpatient Center	#24-008
Advocate Lutheran General Hospital	#24-029
Advocate Good Shepherd Hospital	#24-015
Advocate Trinity Hospital	#25-002/25-003
Advocate Lutheran General Hospital CCC	#26-002
Advocate South Suburban Hospital Observation Unit	#26-010

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Total Cost*	Existing	Proposed	New Construction	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical-Surgical Services (22 beds)	\$15,821,230	0	14,000	0	14,000	0	0
Hemodialysis (12 stations)	\$5,650,439	0	5,000	0	5,000		
Cardio diagnostics (5)	\$4,520,352	0	4,000	0	4,000		
Nuclear Medicine (3 units)	\$5,424,422	0	4,800	0	4,800		
Total Clinical	\$31,416,443	0	27,800	0	27,800	0	0
NON-REVIEWABLE							
General Circulation	\$7,155,142	0	8,000	0	8,000	0	0
Administration	\$447,196	0	500	0	500		
Public Waiting	\$134,159	0	150	0	150		
Staff Respite, Staff Lounge	\$491,916	0	550	0	550		
EVS	\$89,439	0	100	0	100		
Electrical	\$143,103	0	160	0	160		
IS	\$134,159	0	150	0	150		
Total Non-clinical	\$8,595,115	0	9,610	0	9,610	0	0
TOTAL	\$40,011,558	0	37,410	0	37,410	0	0

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.

- 1. For the following questions, please provide a listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

Attachment 11, Exhibit 1, is the listing of all Illinois licensed health care facilities owned by the applicants. Exhibit 2 is the current state hospital license Advocate Christ Medical Center. Beyond those listed in Exhibit 1, there are no other Illinois hospitals owned by Advocate Aurora Health, Inc. in Illinois. Illinois Certificates of Good Standing for the applicants are provided in Attachment 1 and are incorporated in Attachment 11 by reference.

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

By the signatures on the Certification pages of this application, the applicants attest there has been no “adverse action” (as that term is defined in Section 1130.140 of the Illinois Health Facilities and Services Review Board (HFSRB) rules) against any Illinois health care facility owned and/or operated by the applicants, during the three-year period immediately prior to the filing of this application.

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

The applicants hereby authorize the HFSRB and the Illinois Department of Public Health to access information that may be required in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the HFSRB or Illinois Department of Public Health find pertinent to this subsection.

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

All licensure and accreditation information required with Attachment 11 is attached and the applicants are not relying on a previously filed application.

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

Illinois Hospitals owned and operated by the applicants.

Facility	Location	License No.	DNV Accreditation No.
Advocate Christ Medical Center	4440 West 95th St Oak Lawn, IL 60453	315	PRJC-435588-2012-MSL-USA
Advocate Condell Medical Center	801 South Milwaukee Ave Libertyville, IL 60048	5579	PRJC-492361-2013-AST-USA
Advocate Good Samaritan Hospital	3815 Highland Ave Downers Grove, IL 60515	3384	PRJC-369029-2012-MSL-USA
Advocate Good Shepherd Hospital	450 West Highway 22 Barrington, IL 60010	3475	PRJC-369027-2012-MSL-USA
Advocate Illinois Masonic Medical Center	836 West Wellington Ave Chicago, IL 60657	5165	PRJC-529782-2015-AST-USA
Advocate Lutheran General Hospital	1775 Dempster St Park Ridge, IL 60068	4796	PRJC-369033-2012-MSL-USA
Advocate Sherman Hospital	1425 North Randall Rd Elgin, IL 60123	5884	PRJC-496379-2013-MSL-USA
Advocate South Suburban Hospital	17800 South Kedzie Ave Hazel Crest, IL 60429	4697	PRJC-409982-2012-MSL-USA
Advocate Trinity Hospital	2320 East 93rd Street Chicago, IL 60617	4176	PRJC-408213-2012-MSL-USA

Additionally, AHHC has ownership interest of 50% or more in the following licensed health care facilities

Facility	Location	License No.	Joint Commission Accreditation No/ Accreditation Association for Ambulatory Health Care, Inc.
Dreyer Ambulatory Surgery Center	1220 N. Highland Ave, Aurora, IL	7001779	AAAHHC



January 23, 2026

Mark Miller, MD
President
Advocate Health and Hospitals Corp
4440 West 95th Street,
Oak Lawn, IL 60453

Joint Commission ID #: 7397
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 1/23/2026

Dear Mr. Miller:

We are pleased to share The Joint Commission's accreditation decision of Accredited for all services surveyed following your recent survey. For all services surveyed under the applicable manuals below, you have been **ACCREDITED**.

- Comprehensive Accreditation Manual for Hospitals

This accreditation award represents your commitment to upholding the highest standards of healthcare quality and safety for your patients, workforce and community. We share that commitment and value the collaboration between our organizations so that all people experience the safest, highest quality, best value healthcare across all settings.

This accreditation cycle is effective beginning November 22, 2025 and is customarily valid for up to 36 months, although, The Joint Commission may, in certain situations, shorten the duration of the cycle.

Knowing the power of the Gold Seal in inspiring confidence and trust in your community, we provide resources so that you can promote your accreditation decision. You can find information and tips in the "Publicity Kit" link located on your secure extranet site, The Joint Commission Connect.

To recognize your commitment and achievement to quality, The Joint Commission will update your accreditation decision on the Find Accredited Organizations page of our [website](#). Congratulations on your accomplishment.

Sincerely,

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



ILLINOIS DEPARTMENT OF
PUBLIC HEALTH

HF135431

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

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2026	Director	0000315
General Hospital		
Effective: 01/01/2026		

Advocate Health and Hospitals Corporation
dba Advocate Christ Medical Center
4440 W 95th Street

Oak Lawn, IL 60453

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4025001 2M 4/25

← **DISPLAY THIS PART IN A
CONSPICUOUS PLACE**

Exp. Date 12/31/2026

Lic Number 0000315

Date Printed 12/29/2025

Validation Num

Advocate Health and Hospitals Corpor
dba Advocate Christ Medical Center
4440 W 95th Street
Oak Lawn, IL 60453

FEE RECEIPT NO.

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

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

Criterion 1110.110 – Background, Purpose of the Project, and Alternatives

1110.110(b) – Purpose of Project

READ THE REVIEW CRITERION and provide the following required information:

PURPOSE OF PROJECT

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

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

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

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

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

Advocate Christ Medical Center (ACMC) needs to expand its medical/surgical capacity to maintain access to tertiary care services for residents of the Advocate Health Care's South Chicagoland Service Area. ACMC is the region's tertiary/quaternary referral center. It is the only Level I trauma center in the Advocate Health Care's South Chicagoland Service Area offering 24-hour in-house coverage by general surgeons, and prompt availability of care in specialties such as trauma and orthopedic surgery, cardiology, neurosurgery, oncology, anesthesiology, emergency medicine, radiology, internal medicine, plastic surgery, plastic surgery, oral and maxillofacial, pediatric, and critical care. These services are essential for:

- Open Heart surgeries
- Transplant procedures
- Traumatic brain injuries
- Blunt force trauma including falls

- Gun shot and stab wounds
- Serious auto accidents

Due to its Level I trauma status and the broad array of specialized tertiary/quaternary and advanced care services it offers, patients residing in the Advocate Health Care's South Chicagoland Service Area depend on APMC for such care and is the hospital in the Service Area that admits the most critically ill patients. As outlined in Attachment 19, Advocate Christ has continually operated above the State Board utilization standard for medical/surgical units, with average utilization at maximum in each of the last five years. APMC medical/surgical and intensive care beds operate at an average midnight occupancy of 98%.

These inpatient patient days are projected to increase over the next 5 years. Sg2 is forecasting inpatient growth of 9% for tertiary patient days and 25% for quaternary patient days.

As outlined in previous CON projects that added additional medical surgical beds, the projections showed that even with these additional beds, Christ Medical Center would continue to have an inpatient medical surgical census at or above 100%. The beds in the recently approved project have operated at an occupancy of 98% in 2025. The additional approved medical surgical beds have provided additional capacity, however, there continues to be a medical surgical bed deficit as the projections outline a need for medical surgical beds to be 528 in 2028 and 533 in 2029.

This project to add an additional 22 medical/surgical capacity at APMC will provide needed access for inpatient services. Additional medical/surgical beds will assist with managing patient flow from the point of admission to discharge. An increased number of beds will assist with moving patients out of the emergency room, creating capacity in the ED and assisting with bypass restrictions. Additional beds will also provide appropriate Medical Surgical capacity for patients prepared to be transitioned from more complex units, such as the ICU. The demand for inpatient services continues to increase resulting in boarding inpatients in the Emergency Department. The inpatient boarding census has averaged 45 inpatients in 2025.

The relocation of Inpatient Cardio-diagnostics, Dialysis and Nuclear Medicine to the former cafeteria which will include both construction and the replacement of the nuclear medicine department equipment. These relocated departments will benefit from complete redesign and updated equipment.

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

Advocate Christ Medical Center (APMC) is a tertiary/quaternary referral center and teaching hospital. APMC serves the southwest Chicago suburbs in Oak Lawn. The hospital is located in the State Board Planning Area A-04 as shown in Attachment 12, Exhibit 1.

The primary market area is very similar to State Board Planning Area A-04. The Advocate Health Care's South Chicagoland Service Area extends farther southwest into Will County to include

Mokena, Frankfort, and New Lenox, as well as northwest Indiana, including Dyer, Gary, Hammond, Merrillville, and Munster; and does not include City of Chicago proper as part of its service area. Attachment 12, Exhibit 2 is a map of all Trauma Center locations in Illinois. Attachment 12, Exhibit 3 provides a map of the Advocate Health Care South Chicagoland Service Area.

Population projections for the Service Area are provided in the table below. Over the next 5 years, the total population in the service area is expected to decrease (2.4%); however, the 65+ population is projected to grow nearly 8%, at an increase of 10,000+ additional older residents. ACMC is preparing for the increased demand of healthcare services that will accompany this demographic change.

Christ PSC Demographics					
Age Group	2025 Population	2030 Population	2025	Population Change	Population Change
			% of Total		
0-19	184,341	167,951	24.0%	(16,390)	-8.9%
20-44	256,139	251,983	33.4%	(4,156)	-1.6%
45-64	189,478	180,954	24.7%	(8,524)	-4.5%
65+	137,794	148,713	17.9%	10,919	7.9%
TOTAL	767,752	749,601	100.0%	(18,151)	-2.4%

The race and ethnicity projections provided below indicate that the Asian, Multiple Races, and Hispanic populations are expected to increase by 2.3%, 2.2%, and 1.7%, respectively. ACMC already has a strong focus of providing care with multilingual staff in many areas. As the multicultural aspects of the community change, ACMC is committed to meeting the social and medical needs of the population.

Christ PSC Demographics					
Ethnicity/Race	2025 Population	2030 Population	2025	Population Change	Population Change
			% of Total		
Asian	17,585	17,983	2.3%	398	2.3%
American Indian	753	723	0.1%	(30)	-4.0%
Black	159,819	155,282	20.8%	(4,537)	-2.8%
Pacific Islander	104	104	0.0%	-	0.0%
White	277,799	258,519	36.2%	(19,280)	-6.9%
Other Race	2,487	2,391	0.3%	(96)	-3.9%
Multiple Races	13,891	14,190	1.8%	299	2.2%
TOTAL	472,438	449,192	61.5%	(23,246)	-4.9%
Hispanic	295,314	300,409	38.5%	5,095	1.7%

Source: Esri 2025

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

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

Advocate Christ Medical Center has a long history of caring for people in the Chicago area. Its origin dates back to 1960. In 1995, Advocate Christ Medical Center became a member of Advocate Health Care. Advocate merged with Aurora Health Care in Wisconsin in 2018 to become Advocate Aurora Health.

In December 2022, Advocate Aurora Health combined with Atrium Health to create Advocate Health. Advocate Christ Medical Center is now part of Advocate Health, the third-largest nonprofit, integrated health system in the United States.

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

Additional M/S beds would permit APMC to:

- Accommodate increased projected patient days with higher levels of acuity
- Manage APMC's high patient census and appropriate patient placement into the right level of care
- Increase the number of private medical surgical rooms, improving throughput, patient flow, and ED access
- Modernize facilities for patients with increasing complexity
- Assist with transfer requests from community hospitals for higher level of care for the following service lines: Neurology, ENT, Orthopedics, Cardiovascular, General Medical and Trauma.

A Master Facility Plan to review the South Chicagoland area, and the Christ campus is ongoing and identified the continued need to provide additional M/S bed capacity. The ongoing investment in this campus is critical to provide access to current and future patients. The Master Planning process identified the need for more than previously approved.

The planned project will help address the issue of high utilization in specialty medical programs and the associated medical-surgical beds at APMC.

4. Cite the sources of the documentation.

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

Sources included:

- Clinical, administrative, and financial data from Advocate Health and Hospitals Corporation and Advocate Christ Medical Center
- Advocate Christ Medical Center Strategic Master Facility Plan
- Illinois Department of Public Health Hospital Licensing Code
- Illinois Health Facilities and Services Review Board (HFSRB) Administrative Rules
- IHA Compdata
- AIA/FGI Guidelines for Design and Construction of Health Care Facilities
- Illinois Administrative Code, Title 77, Chapter I, Subchapter b, Part 250, Section 250.2440 General Hospital Standards
- Advocate Christ Medical Center Financial Data
- Esri Population 2025 and the US Census Bureau
- Sg2 Market Estimates and Projections
- HFSRB Hospital Profiles
- HFSRB Inventories and Data
- HFSRB State Agency Reports
- Health care literature regarding current trends
- Village of Oak Lawn Building Codes including International Building Codes, National Electrical Code, State of Illinois Plumbing Code, Accessibility Code and State Hospital Licensing Standards

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

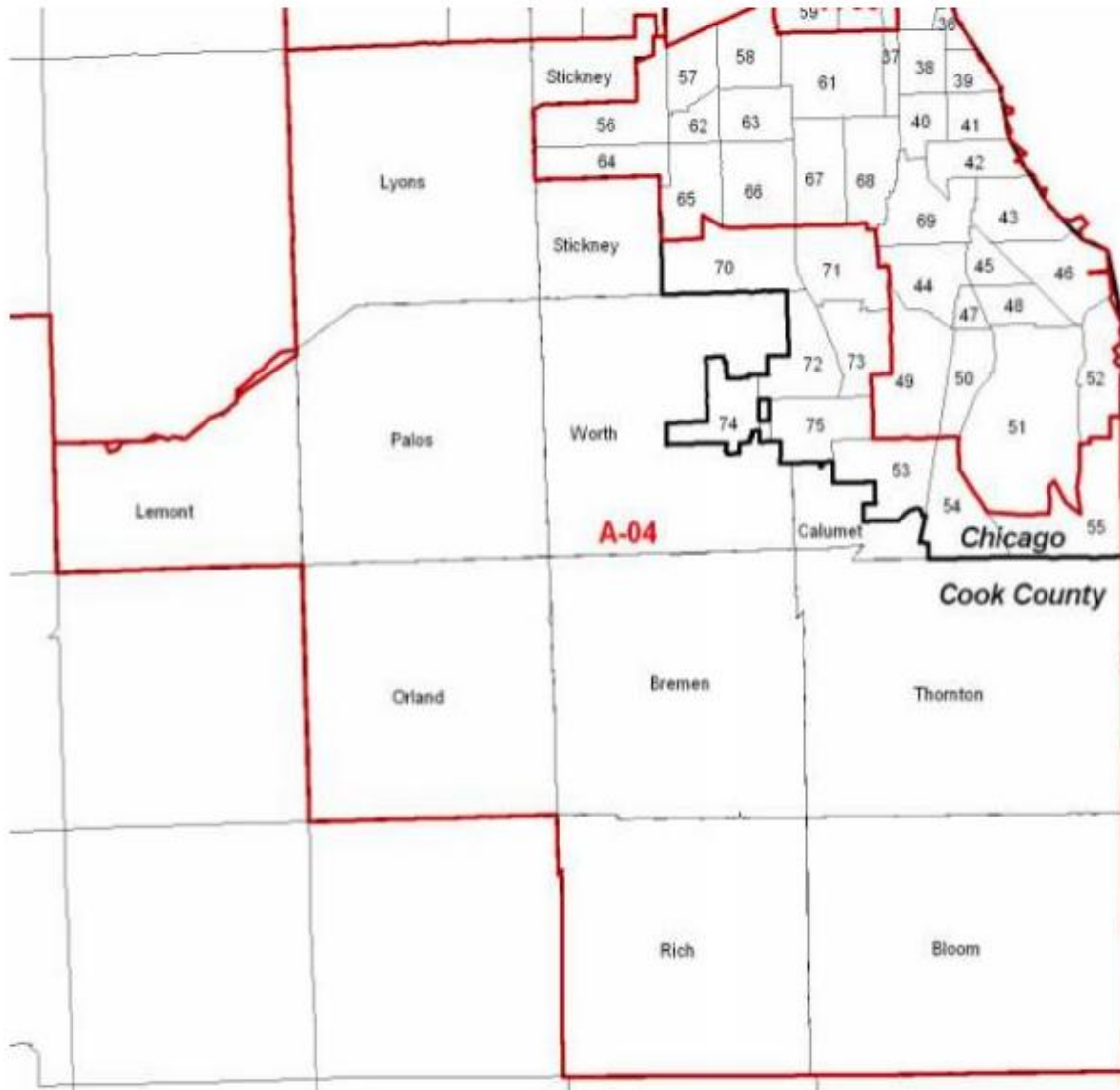
The primary purpose of the project is to provide additional medical surgical bed capacity to supports the population in the service area. The proposed project will improve access and provide additional capacity for specialized care at ACMC and provide increased availability of beds in the medical surgical category of service.

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

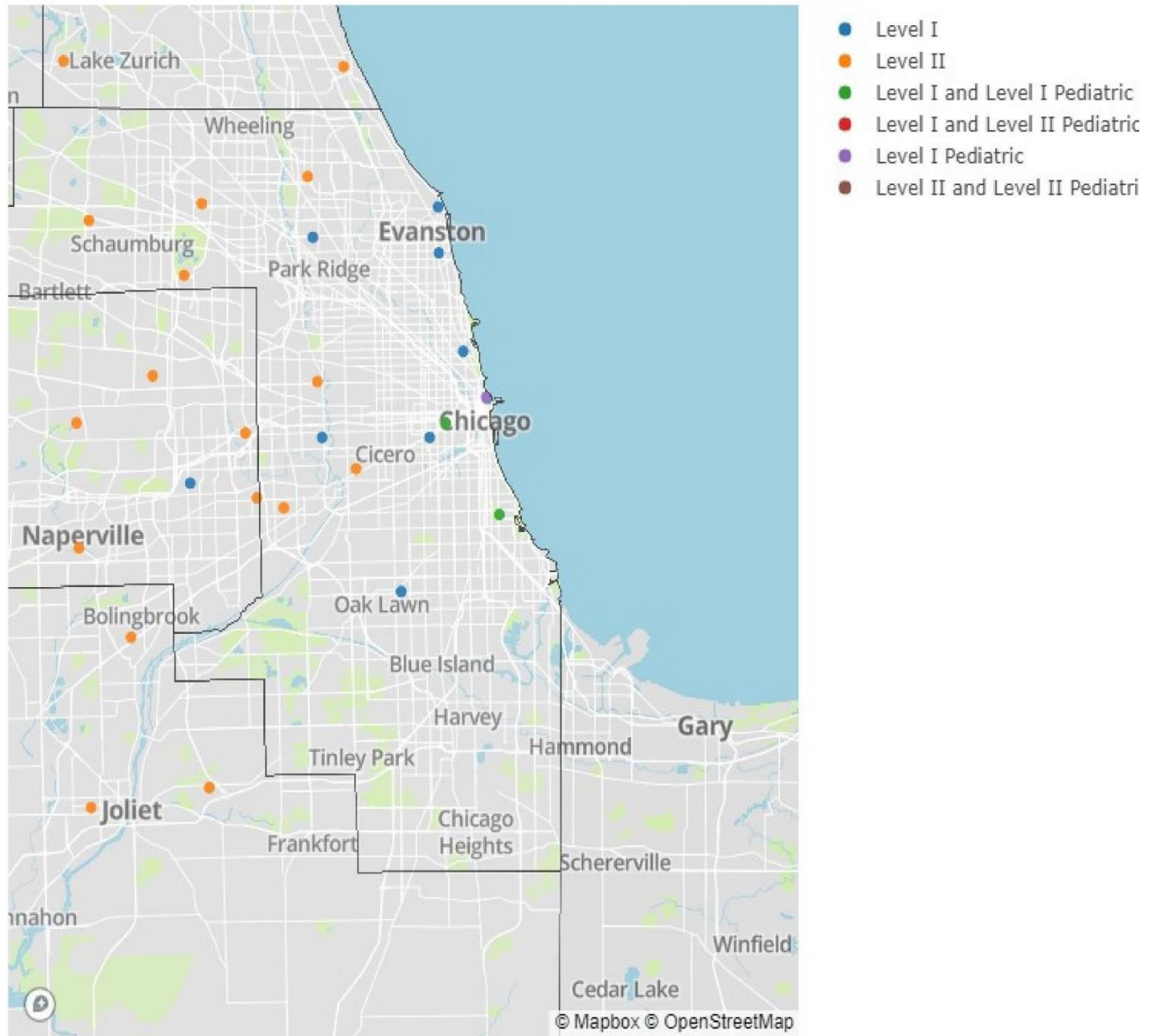
The principal goal for this project is to invest in the Advocate Christ campus by increasing capacity in the medical surgical category of service.

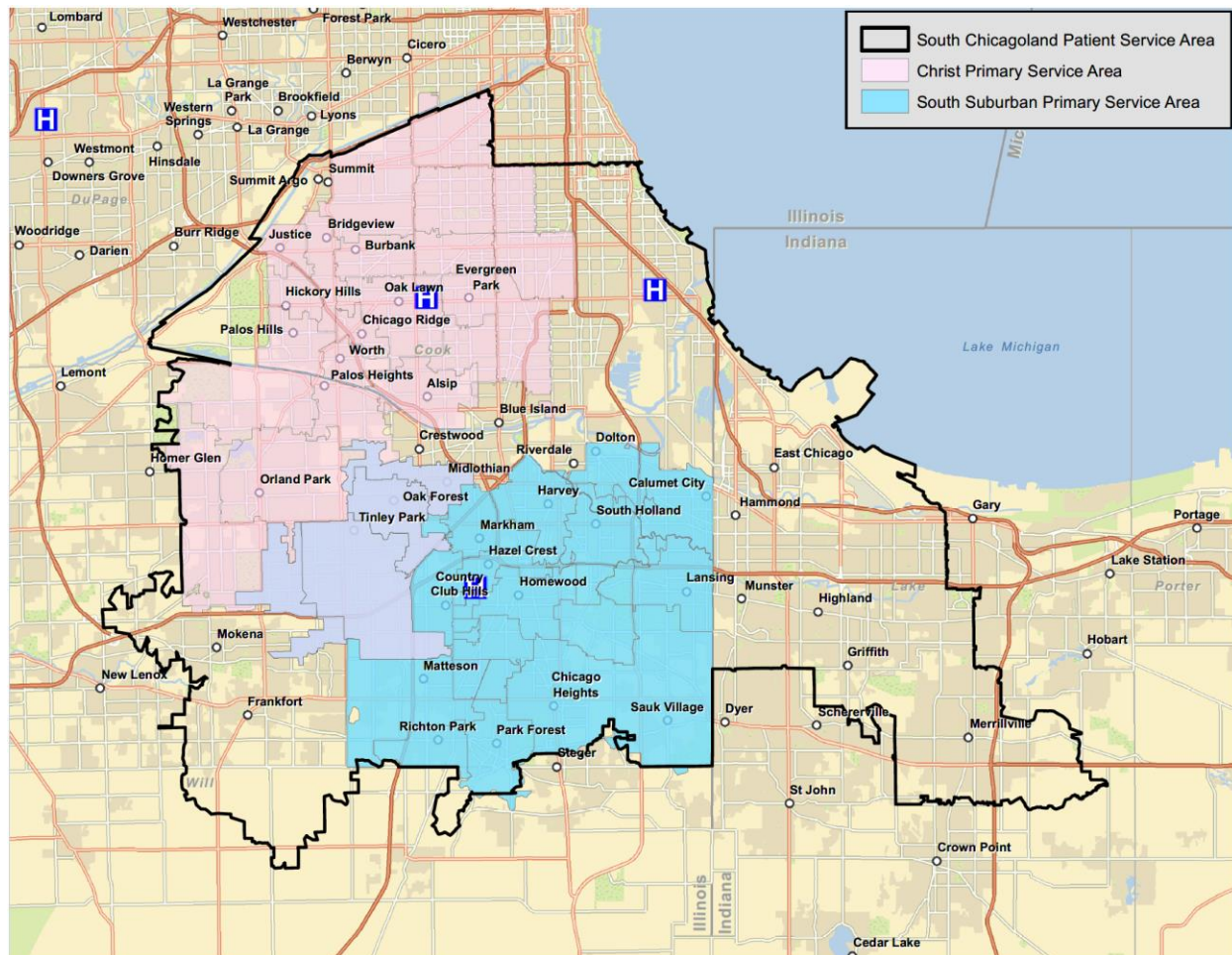
The modernization of this project was well thought out to provide the safest, high-quality care and minimized disruption to patients and clinicians. The phasing of this project includes relocating Inpatient Cardio-diagnostics, Dialysis and Nuclear Medicine to the former vacated cafeteria at the hospital. Once the relocation is complete, the construction of this new medical surgical unit will begin, creating a new 22 bed, all private adult medical surgical unit.

The project is expected to be completed and operational by October 31, 2028.



Illinois Trauma Centers





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.

As part of the overall Advocate Christ Medical Center (ACMC) Master Facility Planning process it was determined that there continues to be a critical need for additional medical surgical inpatient beds to address utilization and capacity issues across the hospital's campus. Recommendations were provided to continue to resolve the need for additional medical surgical beds at the current facility to enhance patient safety, health outcomes, and operational efficiency.

Several alternatives as outlined below were evaluated based on the recommendations of Advocate Health Care's Master Facility team and the Hospital's administration. The Applicants considered the following options in the evaluation to create an additional 22 medical surgical beds at Advocate Christ Medical Center.

Alternative One - Maintain Status Quo/Do Nothing

This option was to maintain the number of inpatient medical surgical beds at Advocate Christ. ACMC is a tertiary referral center, teaching hospital and is the only Level I trauma center in the Advocate Health Care South Chicagoland Service Area. Due to its tertiary/quaternary and Level I trauma status, ACMC is the only hospital in the service area that can admit the most critically ill patients.

Medical/Surgical units at ACMC continually operate above the State Board utilization standard with average utilization maximum capacity over the last five years. Occupancy is consistently

above 90% at the midnight census and is 11% higher mid-day. This does not account for the peak census in specific months and days of the week where census is considerably higher. Patient placement is challenged in units that include semi-private beds as cohorting these patients is not always an option.

Considering these factors, additional medical/surgical beds are needed to adequately address the acute care needs in the Advocate Health Care South Chicagoland Service Area. Maintaining the status quo would not address the growing need for tertiary/quaternary care services at ACHC.

There is no capital cost for this alternative.

Alternative Two - Add an addition to a hospital building to create an additional M/S unit

The most operationally efficient option to add new square footage on the Christ Medical Center campus for inpatient rooms would be to vertically expand the existing East Tower. Vertical expansion is a disruptive endeavor on an operational campus and would not be financially feasible to solely build out a single unit/floor. Due to this, the addition would be built to the maximum capacity planned for the existing structure consisting of 4 occupied floors and 1 mechanical floor. Only a single floor would be fitted out to accommodate the additional M/S unit, and all other floors would be left as shelled space in this Alternative.

The option to construct a vertical expansion to accommodate the additional medical surgical beds needed would address the capacity issue however, it was determined that the relocation of the 3 diagnostic and therapy services could provide the space needed to develop a new medical/surgical unit. These 3 units can be relocated to an area of the hospital formerly vacated with a lower construction cost.

The cost to add additional floors would be significantly higher than this project cost. As good financial stewards, it was determined that relocation of the ancillary departments to available space within the hospital and modernization of this area to a new medical surgical unit was a more appropriate option.

The cost of this alternative is \$173,570,000.

Alternative Three – Relocate the programs on 4 South to create an additional M/S unit

This option was determined to be the best alternative as there is a critical need for additional Medical Surgical beds at Christ Medical Center. The proposed project would include creating an additional Medical Surgical floor while maintaining the three required hospital-based diagnostic and therapy services currently located on 4 South for adult inpatients (Inpatient Dialysis, Inpatient Nuclear Medicine and Cardio-diagnostics). These services will be relocated into a vacant space on the ground floor of an existing hospital building that is more appropriately suited to these services and adjacent to the main campus's outpatient entrance and parking garage for improved patient access.

The option would address the medical surgical capacity issue and develop appropriately sized and compliant M/S rooms with the required clinical spaces and staff support for a new unit.

This project is designed to increase access while being fiscally responsible by using existing space with minimal patient disruption.

The cost of this alternative is \$40,011,558.

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative, and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

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

SIZE OF PROJECT				
DEPARTMENT/ SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Medical-Surgical Services (22 beds)	14,000	500-660 dgsf/Bed 660x22=14,520	520 SF	Yes
Hemodialysis Unit (12 stations)	5,000	N/A	N/A	N/A
Cardio diagnostics (5)	4,000	N/A	N/A	N/A
Nuclear Medicine (3)	4,800	1,600 dgsf/unit 1,600x3=4,800	0 SF	Yes
General Circulation	8,000	N/A	N/A	N/A
Administration	500	N/A	N/A	N/A
Public Waiting	150	N/A	N/A	N/A
Staff Lounge and Respite	550	N/A	N/A	N/A
EVS	100	N/A	N/A	N/A
Electrical	160	N/A	N/A	N/A
IS	150	N/A	N/A	N/A

Clinical Components

Medical/Surgical Unit

The Medical-Surgical Unit will be located within the existing bed tower and will utilize the space vacated by 3 ancillary services to create 22 private M/S patient rooms and the support space required for a new bed unit. In addition to creating a newly expanded M/S unit, the modernization scope includes creating the clinical support needed, team station workspace, offices and equipment storage.

The proposed 500-660 dgsf/Bed for the unit has been met and is below the State guidelines, for each M/S bed and the necessary support space for these services.

Inpatient diagnostic and therapy services

The proposed project includes relocating the following clinical services:

- IP Nuclear Medicine service - Relocating and replacing the 3 Nuclear Medicine with updated equipment - SPECT/CT imaging
- IP Dialysis - Relocating the IP Dialysis Service
- Cardio-Diagnostic Services - Relocating the Cardio-Diagnostic Services including TEE, Cardioversions and Stress Tests

The Nuclear Medicine service will continue to provide access for inpatients requiring this imaging service and replace with the most current technology to serve patients into the future. The proposed square footage of 4,800 DGSF for Nuclear Medicine meets the state guidelines of 4,800 DGSF for the 3 imaging units and the necessary support space for these services.

Cardiology Diagnostic services will continue to have 5 rooms. This space will include 2 rooms for TEE and 3 rooms for Stress Testing. The space is developed based on AAH guidelines to include 4,000 DGSF for these services. There are no State Guidelines for square footage of Cardio-Diagnostic services.

The Inpatient Dialysis Unit will be expanded to continue to provide access for inpatients requiring dialysis. A centralized location allows maximum patient care in a central location. There are no standards for an Inpatient Dialysis Unit.

Non-Clinical Components

The non-clinical components of the project total 9,610 DGSF of space. This includes administration, staff support space, public waiting, circulation, and building support.

There are no State Guidelines for the non-clinical components of the project.

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.

The proposed Project is to add 22 Medical Surgical beds for which the Illinois Health Facilities and Services Review Board has established standards.

The medical surgical utilization need has been projected to 2029 -the second year following completion of this project.

DEPT./SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS)	PROJECTED UTILIZATION		STATE STANDARD	MEET STANDARD?
	2025	Year 1- 2028	Year 2- 2029		
Med/Surg Patient Days	169,078	173,444	175,178	328.5 days/bed (90% occ) = 511	Yes

*Projected Utilization – 2 years post completion
Patient Days = IP and Obs Days

Medical-Surgical Projected Bed Need

The projected utilization for the Medical Surgical Projected Bed Need, as outlined in Attachment 19, was developed using the formula for the Need Determination Assessment in Part 1100 Narrative and Planning Policies Section 1100.520.

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

Christ Med Ctr	2021	2022	2023	2024	2025	% Change 2021-2025	Compound Annual Growth Rate
M/S Days	150,973	154,100	156,309	157,912	169,075	12.0%	2.9%

A conservative growth rate of 1% was used to project demand for the Medical Surgical units. This projected growth rate was applied to develop the trend line to 2029 (the second-year post completion of the project).

Projected Growth	2026	2027	2028	2029
1.0%	170,026	171,726	173,444	175,178

The current utilization has continually been above the State Board utilization standard for medical/surgical units, with average utilization exceeding the maximum capacity since 2021.

The state standard for M/S occupancy is calculated:

- 365 days per year x 90% = 328.5 days per bed
- In 2025, there were 169,075 patient days divided by 328.5 days per bed = 515 beds
- In 2029, there will be a projected need for 533 M/S beds

The inpatient M/S patient days are projected to increase by the second year after the proposed project is complete, the patient days are projected to be 169,433. With the additional M/S beds, the utilization will continue to remain above the state target occupancy of 90%. This projected occupancy supports the need for the project completion of 459 (437+22) medical surgical beds.

Patient days are projected to continue to increase due to increasing complexity of specialty patients requiring longer inpatient stays. As a Level 1 Trauma Center, the increase in trauma patients and the increased acuity of inpatients demonstrates the need for a greater number of inpatient patient days and need to increase Medical Surgical beds. The projected increased number of 65 and older population in the hospital's service area will further increase the number of Inpatients with co-morbidities that will require increasingly complex inpatient care to support the needs of patients living in service area.

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.

Not Applicable – no shell space.

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.

Not Applicable – no shell space.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

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

3. Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:
4. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Medical/Surgical	437	459

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (Formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110.200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

b) Planning Area Need – Review Criterion

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

2) Service to Planning Area Residents

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

Advocate Christ Medical Center is a tertiary/quaternary referral center and teaching hospital located in Oak Lawn, the southwest suburbs of Chicago in Cook County, with the surrounding communities including Alsip, Beverly, Bridgeview, Burbank, Evergreen Park, Hometown, Justice, Merrionette Park, Mt. Greenwood, Palos Heights, Palos Hills and Worth.

The proposed project will establish a 22 medical surgical bed unit. This will increase the medical surgical beds from 437 to 459.

These new rooms will be modernized with the current standard of care, supporting patient safety and quality, enhancing the patient experience, improving staff efficiency, and reducing unnecessary costs. The space will require renovation to comply with medical surgical code requirements. There continues to be a need for private rooms that address improved bed placement, effective throughput, and infection control needs.

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

In 2025, 93% of the Medical Surgical patients resided in the Hospital's service area. The table below provides the Med Surg IP patient origin.

Medical Surgical IP Patient Origin 2025	
Advocate Christ Patient Service Areas	
South Chicago	93.4%
Other	6.6%
TOTAL	100.0%

Medical Surgical patient origin by zip code for 2025 is shown in Attachment 19, Exhibit 1.

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

The Hospital expects that the additional Medical Surgical patients to have similar patient origin as shown in Attachment 19, Exhibit 1.

4) Service Demand – Expansion of Existing Category of Service

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

A) Historical Service Demand

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

As outlined in the Table below, the medical surgical occupancy had grown consistently year over year. The inpatient M/S patient days are projected to increase and by 2028, the first year the proposed project is complete, patient days are projected to be 173,444.

The current utilization has continually been above the State Board standard for medical/surgical units and is projected to continue to remain above the state target occupancy of 90% supporting the need for increased medical surgical beds.

Table 1110.11(b) Advocate Christ Medical Center Medical/Surgical Utilization 2021 – Projected 2028						
	2021	2022	2023	2024	2025	Projected 2028
Beds	394	394	394	425	437	437
Admissions	23,270	23,377	24,352	24,514	25,691	26,828
Inpatient Days	146,981	147,241	147,719	151,427	160,422	165,283
Observation Days	3,992	6,859	8,590	6,485	8,653	8,161
TOTAL Days	150,973	154,100	156,309	157,912	169,075	173,444
Average Length of Stay	6.5	6.6	6.4	6.4	6.6	6.5
Average Daily Census	413.6	422.2	428.2	431.5	462.8	473.9
Utilization	105.0%	107.2%	108.7%	101.5%	106.0%	108.7%
Beds Justified	460	469	476	481	515	528

Sg2 estimates that inpatient medical surgical days are projected to increase by 7% over the next 5 years, 10% over the next 10 years. Quaternary admissions will increase by 25% and tertiary admissions are projected to increase by 9% over the next 5 years. The 10-year Sg2 forecast for quaternary inpatient demand is forecasted at an increase of 47%, with tertiary inpatient demand at 16%. National trends project the acuity of inpatient admissions will continue to rise and result in an increase in average length of stay and patient days. Inpatient days are projected to continue to increase in part due to the growth of the aging population in the service area.

The population for the Advocate Christ service area illustrated a projected 8% growth in the 65+ population, expecting an increase of over 10,000 additional older residents. Due to the increased number of critically ill patients, Advocate Christ Medical Center has experienced an increase in patient acuity on the Medical Surgical units. The higher census on peak flow days over the past 3 years has highlighted the projected need for over 533 medical surgical beds over the next five years.

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

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

B) Projected Referrals

The applicant shall provide the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application.

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion.

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

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

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

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

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

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

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract.

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township, or community area, by the U.S. Census Bureau or IDPH.

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted.

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected.

v) Projections shall contain documentation of population changes in terms of births, deaths, and net migration for a period of time equal to or in excess of the projection horizon.
vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application; and
vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

d) Category of Service Modernization

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

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

This project includes modernization to create 22 M/S beds. The new project scope will bring additional medical surgical beds to the campus to address this care delivery need.

The newly assigned medical surgical rooms will be outfitted to follow industry standards and best practices including:

- Private patient space to accommodate families, patient care, and medical equipment at the patient's bedside
- Dedicated showers and toilet rooms in each room
- Enhanced infrastructure (headwall gases, digital display boards) and equipment to accommodate a range of patient care needs

The medical surgical floor will include staff support, MD dictation, team-work space, and staff respite areas.

The medical surgical unit will provide updated facilities and equipment. Technological demands have changed the way that nurses' access and use the patient information through systems in the room.

2) Documentation shall include the most recent:

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

There are no reports for the Medical/Surgical patient rooms.

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

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

The proposed modernization in this project is not related to maintenance or non-compliance with life safety codes or other code issues. The project is designed to create a new medical surgical unit in the area to be vacated by 3 ancillary departments. The project will include the relocation of Inpatient Cardio-diagnostics, Dialysis and Nuclear Medicine. The new inpatient

unit will be provided with current industry standards, technology, and infrastructure. Therefore, no reports are included.

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

Projected Bed Need

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

Advocate Christ Med Ctr	2021	2022	2023	2024	2025	% Change 2021-2025	Compound Annual Growth Rate
M/S Days	150,973	154,100	156,309	157,912	169,075	12.0%	2.9%

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

Patient days reported are reflective of the census at midnight. The average mid-day daily census at 1:00pm is about 11% higher in the medical surgical units.

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

To project demand for the Medical Surgical units, a projected growth rate of 1% was applied to the 2025 actual days to develop the trend line to 2028.

As shown in Table 1110.11(b), Inpatient medical surgical days had been increasing since 2021. A projection based on increases from the 2025 inpatient days would indicate the projected utilization in the following chart.

Projected Growth Rate	2026	2027	2028
1.0%	170,026	171,726	173,444

By the proposed project completion in 2028, the patient days are projected to increase year over year to 173,444. Based on the state target occupancy, the number of CON authorized medical surgical beds would outline a need for approximately 533 medical surgical beds by 2029.

The internal Master Planning process assessment supported this projected need for approximately 533 medical surgical beds to provide for current patient days and the projected clinical service growth and acuity increases. These additional 22 M/S beds will add needed M/S capacity by increasing the CON authorized M/S bed number to 459.

The analysis outlined the number of medical surgical beds needed, knowing that many of these patients will continue to have critical care needs and there will be increasing demand in higher acuity service lines. The medical surgical units are each designed for the specific service lines and the appropriate beds in each will support the destination clinical programs, the patient days at daytime census, privacy and infection control that will be needed by 2028.

The additional Medical Surgical beds in the project will alleviate the pressure at Advocate Christ Medical Center for appropriate inpatient placement to better serve the needs of the patients in the service area.

e) Staffing Availability – Review Criterion

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

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

The Advocate Health Care's system has a dedicated team of Recruiters and Sourcing Specialists. If there is a significant staff need anywhere in the system, resources are shifted quickly to address the situation. The staffing consultants at Advocate Health Care work in a collaborative manner.

An additional source for Advocate Christ Medical Center Medical Center's applicant pool comes from our active partnerships with local nursing programs. Advocate Christ has continually benefited from the strong reputation of Advocate Health Care's as an excellent place of employment, as evidenced by consistently being named as one of the Top 100 Places to work in Illinois.

f) Performance Requirements – Bed Capacity Minimum

1) Medical-Surgical

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

With the addition of the 22 M/S beds, the Hospital will have 459 Medical Surgical beds, exceeding the State minimum requirements.

g) Assurances

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

The letter is provided as Attachment 19 Exhibit 2.

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60453	3,482
60620	1,529
60629	1,509
60628	1,501
60459	1,393
60643	1,384
60652	1,318
60803	873
60455	829
60617	764
60655	700
60619	663
60415	620
60638	583
60805	575
60636	447
60827	403
60632	378
60406	365
60457	346
60462	305
60456	299
60465	279
60458	275
60621	267
60477	239

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60649	239
60418	233
60482	233
60452	232
60409	226
60609	203
60411	201
60463	191
60426	187
60419	174
60473	170
60478	166
60445	163
60429	153
60430	150
60466	133
60637	130
60428	127
60443	126
60487	126
60467	109
60653	101
60438	100
60472	97
60464	96
60633	83
60608	79
60491	77
60471	73
60423	71
60616	68
60623	66
60469	64
60615	63
60417	57
60451	48
60425	45
60475	45
60448	43
60422	42

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60804	40
60449	39
60461	39
60439	37
60501	35
60441	34
60624	32
60644	32
60651	32
60484	31
60440	29
60639	29
60901	28
60914	28
60525	26
60402	24
60641	24
46323	23
60618	22
60401	20
60431	20
60586	20
60612	20
60527	19
60640	19
60950	19
46368	18
46410	18
60435	18
60634	18
46408	17
60446	17
46307	16
60450	16
60504	16
60505	16
60559	16
46324	15
60047	15
60506	15

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60018	14
60130	14
60148	14
60515	14
60521	14
60532	14
60610	14
60625	14
60647	14
60120	13
60442	13
60480	13
60561	13
60657	13
60915	13
46304	12
46320	12
46375	12
60140	12
60447	12
60513	12
46311	11
46342	11
60016	11
60060	11
60061	11
60110	11
60432	11
60517	11
60544	11
60630	11
46312	10
46319	10
60123	10
60613	10
60645	10
46373	9
60014	9
60031	9
60085	9

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60087	9
60104	9
60156	9
60181	9
60403	9
60436	9
60468	9
60614	9
60626	9
60707	9
46321	8
60010	8
60051	8
60153	8
60177	8
60476	8
60964	8
60002	7
60030	7
60073	7
60101	7
60102	7
60131	7
60142	7
60185	7
60433	7
60565	7
60605	7
60607	7
60954	7
61021	7
61101	7
46322	6
46327	6
46385	6
46404	6
46405	6
60053	6
60084	6
60152	6

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60174	6
60424	6
60538	6
60560	6
60659	6
60714	6
60958	6
61704	6
46350	5
46356	5
60064	5
60067	5
60068	5
60069	5
60077	5
60099	5
60103	5
60126	5
60133	5
60139	5
60154	5
60171	5
60176	5
60410	5
60416	5
60420	5
60516	5
60534	5
60546	5
60548	5
60558	5
60601	5
60622	5
60660	5
61068	5
46407	4
49117	4
60015	4
60188	4
60301	4

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60304	4
60404	4
60421	4
60502	4
60526	4
60545	4
60585	4
60642	4
60646	4
60656	4
60953	4
33020	3
46303	3
46310	3
46360	3
46394	3
46403	3
46409	3
49203	3
60013	3
60056	3
60090	3
60098	3
60118	3
60124	3
60160	3
60162	3
60173	3
60434	3
60510	3
60543	3
60564	3
60706	3
61104	3
61701	3
28562	2
30349	2
32805	2
46341	2
46366	2

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
46383	2
46406	2
46530	2
47977	2
47978	2
49008	2
53705	2
60005	2
60042	2
60046	2
60050	2
60076	2
60107	2
60108	2
60115	2
60155	2
60164	2
60169	2
60178	2
60191	2
60192	2
60202	2
60302	2
60407	2
60408	2
60481	2
60490	2
60503	2
60542	2
60552	2
60631	2
60669	2
60680	2
60690	2
60912	2
60938	2
60940	2
60970	2
61008	2
61102	2

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
61103	2
61341	2
61350	2
61379	2
61447	2
61832	2
62522	2
78016	2
78521	2
85132	2
98011	2
0	1
840	1
11416	1
13905	1
14424	1
16001	1
17820	1
18610	1
19144	1
20748	1
22202	1
23704	1
24502	1
28304	1
28323	1
28630	1
29229	1
30032	1
30083	1
30214	1
30236	1
30238	1
30274	1
32206	1
32211	1
32227	1
32256	1
32811	1
32940	1

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
33322	1
33401	1
33558	1
33837	1
33914	1
33919	1
34219	1
34228	1
34614	1
34747	1
34748	1
34771	1
34788	1
36532	1
36744	1
37214	1
37217	1
37321	1
38016	1
38019	1
38109	1
38571	1
38732	1
39042	1
39097	1
39301	1
39437	1
40216	1
41011	1
42166	1
43065	1
44122	1
45044	1
45066	1
45805	1
46226	1
46391	1
46526	1
46534	1
46628	1

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
47906	1
47960	1
47963	1
48033	1
48134	1
49001	1
49010	1
49022	1
49056	1
49321	1
49507	1
50707	1
53083	1
53104	1
53105	1
53140	1
53147	1
53181	1
53188	1
53201	1
53205	1
53212	1
53215	1
53216	1
53218	1
53402	1
53528	1
53590	1
53704	1
53711	1
54914	1
55025	1
55403	1
55923	1
60004	1
60012	1
60021	1
60025	1
60041	1
60045	1

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
60062	1
60071	1
60074	1
60134	1
60157	1
60163	1
60172	1
60180	1
60184	1
60189	1
60190	1
60193	1
60201	1
60305	1
60444	1
60523	1
60540	1
60549	1
60551	1
60554	1
60563	1
60602	1
60603	1
60604	1
60611	1
60654	1
60911	1
60919	1
60921	1
60922	1
60948	1
60955	1
60959	1
60966	1
61030	1
61036	1
61054	1
61073	1
61074	1
61088	1

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
61107	1
61108	1
61109	1
61114	1
61301	1
61310	1
61348	1
61360	1
61364	1
61401	1
61485	1
61554	1
61761	1
61847	1
61853	1
61876	1
61920	1
61938	1
62301	1
62612	1
62703	1
62896	1
62931	1
63771	1
65043	1
65737	1
66503	1
70065	1
73701	1
74011	1
75070	1
75230	1
76002	1
76522	1
76574	1
77450	1
77583	1
78211	1
78233	1
78730	1

Advocate Christ Medical Center 2025 M/S Patient Origin	
M/S Patient Zip Code	M/S Patient Volume
80218	1
81007	1
81501	1
83814	1
85118	1
85202	1
85215	1
85924	1
89015	1
89103	1
89108	1
89146	1
89183	1
89447	1
90706	1
91340	1
92139	1
92336	1
92780	1
93535	1
93612	1
93618	1
93650	1
94591	1
95367	1
M4B 1	1
Grand Total	28,685

January 13, 2026

Mr. John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

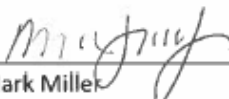
**Re: Advocate Health and Hospitals Corporation d/b/a Christ Medical Center – New
22 Bed Med Surg Project**

Dear Mr. Kniery:

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

Based on the information at this time, it is my understanding that by the second year of operation after project completion, Advocate Christ Medical Center reasonably expects to achieve and maintain the utilization standards for the Inpatient Bed Unit, as specified in // Ill. Administrative Code 1100.

Respectfully,



Mark Miller
President, Advocate Christ Medical Center and South Chicago Area
Advocate Health Care

Subscribed and sworn to me

This 13th day of JANUARY, 2026


Notary Public

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

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ IP Hemodialysis	11 stations	12 stations
☐ IP Nuclear Medicine	3 Nuclear Medicine units	3 Nuclear Medicine units (2x SPECT/CT and 1x SPECT)
☐ Cardio diagnostics	5 rooms (2 TEE, 3 Stress Test)	5 rooms (2 TEE, 3 Stress Test)

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

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

This project will include the relocation of the Inpatient Dialysis, Nuclear Medicine and Cardio diagnostic services for Inpatients at Advocate Christ Medical Center to vacant space located on the ground floor of the hospital.

Inpatient Dialysis

c) Service Modernization

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

- (c)(1) – Deteriorated Facilities OR
(c)(2) – Necessary Expansion

2) - Necessary Expansion

The proposed project will address the space needed for the Inpatient Hemodialysis service to be modernized and relocated to develop the space for the additional Medical Surgical Bed unit.

The Inpatient Hemodialysis Service at Advocate Christ Medical Center provides End Stage Renal Disease (ESRD) treatment to tertiary inpatients who require treatments during their inpatient admission for other medical care. The service is provided by Christ Medical Center nursing staff with special competency in dialysis services. The current inpatient dialysis unit/treatment room has 11 dedicated patient stations located on the 4th floor. A dedicated unit with 12 stations will be developed in area vacated by the former cafeteria and kitchen and relocate this service.

This modernized dialysis suite will be designed specifically for the Hemodialysis service, with a more centralized flow, and offering more structured storage. The increased capacity totaling 12 stations: 11 patient stations will be located in an open bay, and 1 private patient station to accommodate contact precaution patients, who cannot be treated within the open bay.

As outlined below, the number of patients at Christ Medical Center has followed the growing trend for dialysis treatments needed in the service area. The 65+ population in this service area is expected to increase by 8% over the next 5 years. This population has a higher incidence for kidney disease and with an increase of over 10,000 older adults in the area, there is a demonstrated need in the service area for dialysis treatment as this service supports these patients that require dialysis during their inpatient stay for other co-morbidities.

The centralized Inpatient Dialysis service will continue to provide access to inpatients that need this service during their hospital care, similar to the current unit. For these patients, they benefit with increased efficiencies for their dialysis care, a definitive scheduled time and earlier delivery of treatment to avoid conflict with other required medical care and testing. A centralized dialysis unit ensures the correct supplies are easily accessible and back up supplies are within close proximity to allow for minimal interruptions to care and treatment. This central dialysis service would allow multiple highly skilled dialysis nurses to be present to collaborate on their care and provide operational efficiencies for the nursing team.

The majority of inpatients that require dialysis are able to receive their treatment in the centralized dialysis suite. ICU patients and other isolation patients that require dialysis will continue to receive treatment at their bedside. This may be due to the need for isolation from other patients and the inability to co-mingle in this location due to high-risk infections or the patient's acuity.

3)(B) -Utilization – Major Equipment/Service or Facility

The volume for the Inpatient Dialysis service is provided below. The projected volume by year 2 was determined based on ratios inpatient volume to service.

The IP treatment volume is provided below. Over the last three years IP treatments have increased by 7.3%. This increase is due to increased patient volumes.

Based on conservative projections, utilization is estimated to continue to increase over the next five years. The projected growth outlined is due to an increased number of patients in the service area.

Historical Utilization					
DEPT/SERVICE	2022	2023	2024	2025	% Change 2022 -2025
IP Dialysis	9,857	9,796	10,335	10,574	7.3%

Projected Utilization		
DEPT/SERVICE	Year 1 - 2028	Year 2 - 2029
IP Dialysis	10,641	10,696

As there are no state utilization standards for inpatient dialysis, it was determined that 12 dialysis stations would provide continued access for the inpatients at Christ Medical Center.

Inpatient Nuclear Medicine

c) Service Modernization

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

(c)(1) – Deteriorated Facilities OR

(c)(2) – Necessary Expansion

2) - Necessary Expansion

The proposed project will address the space needed to continue to provide the Nuclear Medicine service at the Christ Medical Center by relocating this service, within the hospital, while developing the space for the additional Medical Surgical Bed unit. The new space will be of similar square footage, modernized with a more efficient configuration.

The Nuclear Medicine service at this location provides this critical imaging service primarily to inpatient admissions. The relocation of the service will include replacing the 3 Nuclear Medicine cameras with 3 units (2x SPECT/CT and 1xSPECT) to align with modern technology standards in Nuclear Medicine. The replacement equipment will enhance the overall quality of care by improving the diagnostic accuracy, and clinical efficiency. Spect CT combines functional imaging with anatomical imaging for more precise localization.

Outpatient nuclear medicine imaging will continue to be provided in the Hospital's Outpatient Pavilion's Imaging Department and is not included in this project.

3)(B) -Utilization – Major Equipment/Service or Facility

The volume for Nuclear Medicine procedures is provided below. The projected volume by year 2 was determined based on ratios of inpatient volume to service.

The Nuclear Medicine procedure volume is provided below. Total procedures have increased over the last year by 7% after a slight decline due to staffing constraints that have now been expanded.

The Nuclear Medicine volume is projected to increase as inpatient days increase and is supported by Advocate's focus on expanding the cardiac program and enhancing the delivery of timely exams. Nuclear Medicine is a key component in cardiac diagnostics, which directly supports this growth. Additionally, the hospital is experiencing increasing demand in oncology, further contributing to the upward trend in Nuclear Medicine utilization.

Historical Utilization					
DEPT/SERVICE	2022	2023	2024	2025	% Change 2022-2025
Nuclear Medicine	2,610	2,314	2,154	2,307	-11.6%

Projected Utilization		
DEPT/SERVICE	Year 1- 2028	Year 2-2029
Nuclear Medicine	2,352	2,370

The current 3 units will be replaced with 3 units to allow for optimal scheduling and minimal exam complexity. Continuing to provide the 3 units ensures patient access, allows for efficiency with multiphase studies, and considers the scheduling of preventative maintenance, along with future growth projected.

The increased utilization supports the need to maintain the 3 Nuclear Medicine units.

Cardio Diagnostics

c) Service Modernization

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

(c)(1) – Deteriorated Facilities OR

(c)(2) – Necessary Expansion

2) - Necessary Expansion

The proposed project will address the space needed for the Cardio-diagnostic Services located at the hospital to be modernized and relocated to develop the space for the additional Medical Surgical Bed unit.

The Cardio-diagnostics service at Advocate Christ Medical Center in the new space will continue to provide primarily inpatient cardiovascular services including TEE and Stress testing at this location. Similar to the Cardiac diagnostic service currently located at the hospital, some outpatient Transesophageal Echocardiograms (TEEs) and Cardioversions will also be performed at this location. The majority of outpatient services will continue to be performed at the outpatient locations that are not included in this project. This project will provide the upgraded space needed to continue to provide access to these services to inpatients during their admission.

According to Sg2, nearly 50% of Americans have some form of cardiovascular disease, and this population is growing in incidence, prevalence, and complexity. Increasing prevalence of chronic disease (e.g., CHF, heart valve, vascular) is driving inpatient admissions.

Sg2 is forecasting a 10% increase in inpatient cardiovascular volume over the next five years and 20% over the next ten years.

3)(B) -Utilization – Major Equipment/Service or Facility

The volume for Cardio Diagnostic procedures is provided below. The projected volume by year 2 was determined based on ratios inpatient volume to service.

Over the last three years, Cardio Diagnostic procedures have increased by 18.9% This increase is due to higher acuity patients and improved survivorship increasing the need for these Cardiovascular programs.

Based on conservative projections outlined, utilization is estimated to continue by 5% over the next five years. The projected growth outlined is due to an increased number of patients in the service area.

Historical Utilization					
DEPT/SERVICE	2022	2023	2024	2025	% Change 2022-2025
Cardio-diagnostics	103,031	108,689	115,584	122,509	18.9%

Projected Utilization		
DEPT/SERVICE	Year 1- 2028	Year 2-2029
Cardio-diagnostics	128,144	129,425

As there are no state utilization standards for Cardio-diagnostics, it was determined that 5 rooms would continue to provide the access needed for these important services.

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]:**

\$13,543,555	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.
\$26,468,003	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.
\$40,011,558	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

RATING ACTION COMMENTARY

Fitch Affirms Advocate Aurora Health (IL) at 'AA'; Outlook Stable

Wed 22 Oct, 2025 - 1:11 PM ET

Fitch Ratings - Chicago - 22 Oct 2025: Fitch Ratings has affirmed Advocate Aurora Health's (AAH) Issuer Default Rating (IDR) at 'AA'. Fitch has also affirmed the outstanding revenue bonds issued directly by AAH or by the Wisconsin Health and Educational Facilities Authority and Illinois Finance Authority on behalf of AAH/Advocate Health Care Network at 'AA'.

The Rating Outlook is Stable.

Fitch has also affirmed the Short-Term 'F1+' rating on AAH's variable rate debt and CP debt supported by AAH's self-liquidity.

RATING ACTIONS

ENTITY / DEBT ↕	RATING ↕		PRIOR ↕	
Advocate Aurora Health, Inc. (WI)	LT IDR	AA Rating Outlook Stable	AA Rating Outlook Stable	
	Affirmed			
Advocate Aurora Health, Inc. (WI) /General Revenues/1 LT	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable

Advocate Health Care Network (IL) /General Revenues/1 LT	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable
Advocate Aurora Health, Inc. (WI) /Self-Liquidity/1 ST	ST	F1+	Affirmed	F1+
Advocate Health Care Network (IL) /Self-Liquidity/1 ST	ST	F1+	Affirmed	F1+

[VIEW ADDITIONAL RATING DETAILS](#)

AAH and Atrium Health combined in December 2022 to form Advocate Health. The 'AA' long-term ratings for both AAH and Atrium reflect Advocate Health's very strong financial profile in the context of a sound operating profile, leading positions in markets across multiple states, and strong balance sheet metrics. Although AAH and Atrium remain separate obligated groups, most metrics and the financial profile reflect the full Advocate system.

Combined, Advocate treats approximately six million unique patients in more than 1,000 sites of care (including 69 hospitals) across six states in the Southeast (North Carolina, South Carolina, Georgia, and Alabama) and Midwest (Illinois and Wisconsin). The system also benefits from being the primary teaching affiliate of the Wake Forest University (WFU) School of Medicine.

Like most U.S. acute care providers, Advocate's operating metrics were compressed in fiscal 2022 amid macro labor and inflationary pressures, but margins have since rebounded. Fitch believes Advocate has the foundation to continue delivering good long-term operating results despite ongoing macro pressures, including HR 1. Advocate's combined capital-related metrics should remain strong in Fitch's forward-looking scenario analysis, including in a stress case.

SECURITY

Bonds are unsecured joint and several obligations of the obligated group, which consists of the vast majority of AAH hospitals, the AAH parent, and the Advocate Health Care

Network and AAH physician practices.

KEY RATING DRIVERS

Revenue Defensibility - bbb

Broad Reach Across Multiple Regions; Competition Present in Key Markets

Advocate operates across multiple markets in six states in distinct regions of the U.S. (the Southeast and Midwest). Key hospital markets include Charlotte and Winston-Salem in North Carolina; Macon, Georgia area; the Chicago area in Illinois; and Milwaukee and Green Bay in Wisconsin. Advocate maintains the market lead in most core service areas, though competition remains in many markets.

As a large, geographically diverse health system, Advocate operates in markets with varied demographic profiles. The Charlotte and Winston-Salem metro areas are growing faster than the national average, while Bibb County (Rome) and Floyd County (Macon) are in line with the national average. Population trends in the Chicago, Milwaukee, and Green Bay markets are more stagnant, though Advocate's Chicago assets are concentrated in more affluent suburban locations.

Advocate's combined Medicaid and self-pay share was 22% of gross revenue in fiscal 2025, below Fitch's 25% threshold for a midrange assessment. North Carolina recently expanded Medicaid under the ACA; Illinois expanded earlier. Wisconsin and Georgia did not expand. Given Advocate's payer mix, the system is somewhat less exposed to expected Medicaid cuts under HR 1, though longer-term provider tax and Medicaid directed payment program cuts will pressure top-line revenue. Even so, Fitch expects Advocate's revenue defensibility to remain reasonably resilient to federal healthcare policy changes.

Operating Risk - a

Track-Record Sound Operating Results; Margins Continue to Rebound

AAH and Atrium have a record of sound operating performance, and Advocate's margins continue to rebound from fiscal 2022 compression. In audited fiscal 2024, Advocate reported a 3.2% operating margin and a 7.4% operating EBITDA margin, adjusted to reclassify the portion of investment income included in operating revenue to non-operating. In fiscal 2023—the first full year post-merger—margins were 1.6% and 6.4%, respectively. On a combined basis per management's aggregation of audited results, fiscal

2022 showed a negative 0.8% operating margin and a 4.3% operating EBITDA margin, reflecting labor and inflationary pressures.

Factors driving improvement in fiscal 2024 include generally favorable volume trends—inpatient admissions up 7.1% in fiscal 2024 over fiscal 2023, or 3.1% including observation stays—and total surgeries up 2.6%; further integration synergies across supply chain, pharmacy optimization, revenue cycle, and IT, with management estimating \$1 billion in synergies over the 30 months post-merger; deployment of AI and other technologies to mitigate nurse and physician shortages; and the implementation of a Medicaid directed payment program in North Carolina to complement Medicaid expansion.

Interim fiscal 2025 results remain favorable. Through the unaudited fiscal 2025 six months ended June 30, Advocate posted a 4.4% operating margin and an 8.3% operating EBITDA margin, as the system has benefited from continued integration efficiencies and volume gains. Management reports that when excluding non-recurring revenue items—such as FEMA funding and employee retention tax credits—the operating margin was 3.4%. Management targets a sustainable margin over the long term despite HR 1, tariffs, and other headwinds.

Capital Spending

Advocate has maintained a steady capital spending pace. From fiscal 2021 to 2024, average capex was just over 130% of depreciation expense. The average age of plant was a sound 11.4 years at FYE 2024. Management plans to sustain capex in coming years but notes that capital spending is contingent on meeting EBITDA targets, and will flex capex accordingly.

In June 2025, Advocate opened the Pearl, a mixed-use project in Charlotte designed to accelerate biomedical research, innovation, and clinical care, which also houses the Wake Forest University School of Medicine-Charlotte. In 2025, Advocate also opened a new patient tower at Illinois Masonic Medical Center in Chicago and the Julie Ann Freischlag patient tower in Winston-Salem. Ongoing and planned projects include the new Carolina's Medical Center bed tower in Charlotte, slated to open in third-quarter 2027, and additional ambulatory access points. Given Advocate's scope and reach, Fitch expects regular market access, and management is considering about \$300 million of net new debt over the next year or so.

Financial Profile - aa

Very Strong Capital-Related Ratios

Advocate's financial profile is very strong. Capital-related metrics should remain robust in a forward-looking scenario analysis, including in a stress case.

At FYE 2024, Advocate had nearly \$24 billion of unrestricted cash and investments and \$8.7 billion of debt (including operating leases). Advocate sponsors six private defined benefit (DB) pension plans, each more than 85% funded. Fitch includes as a debt equivalent the portion of a FASB DB pension plan below 80% funded. Atrium also has the CMHA government DB pension, which was approximately 66% funded as of FYE 2024. Advocate's net adjusted debt (adjusted debt minus unrestricted cash and investments) is favorably negative and cash-to-adjusted debt exceeded 270% at FYE 2024.

Advocate's capital-related ratios should remain strong, even in a forward-looking stress scenario. In the stress case, Advocate's net adjusted debt-to-adjusted EBITDA remains favorably negative in every year and cash-to-adjusted debt never falls below 225% (and exceeds 280% by year four).

Short-Term Rating

The 'F1+' short-term rating is based on AAH maintaining a long-term rating of at least 'AA-'. AAH (and Advocate) maintains sufficient discounted internal liquid resources and has implemented written procedures to fund any un-remarketed put on the approximately \$1.1 billion of theoretical maximum potential AAH debt supported by self-liquidity. AAH's self-liquidity supported demand debt includes CP and puttable variable rate demand bonds (VRDB) not supported by standby bond purchase agreements (SBPAs) or letters of credit (LOC), which are adequately covered by internal liquidity (per Fitch's standard discounting of assets).

Asymmetric Additional Risk Considerations

There are no asymmetric risks affecting the rating.

Advocate's liquidity is robust and debt service coverage is strong, neither of which is an asymmetric risk. Cash on hand measured more than 265 days at FYE 2024. Maximum annual debt service (MADS) is \$458 million and MADS coverage in fiscal 2024 was strong at 9.6x.

RATING SENSITIVITIES

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

--Sustained compression in operating metrics, such that the operating EBITDA margin is expected to remain closer to 6%;

--Materially Weaker balance sheet and thinner capital-related ratios, leading to expectation that cash-to-adjusted debt were expected to remain below 200% in a forward-looking stress case, particularly if compounded with a weaker operating risk assessment.

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

--Combined Advocate Health operating EBITDA margin consistently at least in the 9% - 10% range;

--Considerable growth in unrestricted liquidity leading to superlative cash-to-adjusted debt expected to remain above 300% even throughout a forward-looking stress case.

PROFILE

Advocate Health is the result of the December 2022 combination of Atrium and AAH. The combined system operates 69 hospitals and more than 1,000 sites of care. The system maintains an academic affiliation with Wake Forest University and engages in considerable research efforts and has more than 250 GME programs.

Advocate is headquartered in Charlotte, NC and has acute care operations in six states: North Carolina, South Carolina, Georgia, Illinois, and Wisconsin. Core hospital operations are diversified, with particular penetration around Charlotte and Winston-Salem in North Carolina, Macon and Rome in Georgia, Milwaukee and Green Bay in Wisconsin, and the Chicago area in Illinois. Advocate Health treats approximately six million unique patients.

Advocate's total operating revenue measured nearly \$35 billion in FY 2024, making Advocate one of the five largest not-for-profit health systems in the U.S., and is the largest health system in North Carolina, Illinois, and Wisconsin. The system is structured as a Joint Operating Agreement (JOA). Advocate Health has a common board with 14 members (seven each from Atrium and AAH). While the AAH and Atrium have not yet combined debt obligations,, Advocate Health operates with a common management team and one board and the system is deeply integrated including with strategic development.

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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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 \(pub. 12 Nov 2024\)](#)
(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), v2.0.1 ([1](#))

ADDITIONAL DISCLOSURES

[Dodd-Frank Rating Information Disclosure Form](#)

[Solicitation Status](#)

[Endorsement Policy](#)

ENDORSEMENT STATUS

Advocate Health and Hospitals Corporation

EU Endorsed, UK Endorsed

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The complete span of best- and worst-case scenario credit ratings for all rating categories ranges from 'AAA' to 'D'. Fitch also provides information on best-case rating upgrade scenarios and worst-case rating downgrade scenarios (defined as the 99th percentile of rating transitions, measured in each direction) for international credit ratings, based on historical performance. A simple average across asset classes presents best-case upgrades of 4 notches and worst-case downgrades of 8 notches at the 99th percentile. For more details on sector-specific best- and worst-case scenario credit ratings, please see [Best- and Worst-Case Measures](#) under the Rating Performance page on Fitch's website.

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Advocate Health, North Carolina

September 16, 2025

This report does not constitute a rating action.

Credit Highlights

- S&P Global Ratings' long-term rating on various series of debt issued by Atrium Health (Charlotte-Mecklenburg Hospital Authority; CMHA), N.C., as well as various series of taxable debt issued by Advocate Aurora Health, Inc. (AAH), Ill. and various series of tax-exempt debt issued by the Illinois Finance Authority (IFA) and the Wisconsin Health & Education Facilities Authority for AAH is 'AA'.
- In addition, our long-term rating on various series of debt issued by the North Carolina Medical Care Commission for Wake Forest Baptist Obligated Group (WFB) is 'AA', and our long-term rating on WFB's series 2016 taxable bonds is 'AA'.
- Our dual rating on CMHA's series 2018F variable-rate demand bonds (VRDBs), supported by its self-liquidity, is 'AA/A-1+' and our short-term rating on its commercial paper (CP) program, also supported by self-liquidity, is 'A-1+'.
- Our dual rating on CMHA's series 2007B, 2007C, 2018G, and 2018H VRDBs is 'AA/A-1+'; all of these are supported by standby bond purchase agreements (SBPAs) from JPMorgan Chase Bank. In addition, our dual rating on its series 2007E VRDBs is 'AA+/A-1' and our underlying rating (SPUR) is 'AA'.
- Our dual rating on the IFA's series 2011B VRDBs issued for AAH and supported by AAH's self-liquidity is 'AA/A-1+' and our short-term rating on AAH's CP program, also supported by self-liquidity, is 'A-1+'.
- Our dual rating on IFA's series 2008C-1 and 2008C-2B VRDBs, which are supported by SBPAs from JPMorgan Chase Bank, is 'AA/A-1+'. In addition, our dual rating on IFA's series 2008C-3A VRDBs, which are supported by an SBPA from Northern Trust, is 'AA/A-1+'. These bonds were all issued for AAH.
- The outlook on all ratings, where applicable, is stable.

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Rationale

Security

CMHA bonds are secured by a revenue pledge of CMHA and the Atrium Health Foundation, and guarantees of the other members of the CMHA obligated group. Wake Forest Baptist Obligated Group bonds are general, unsecured obligations of its obligated group, which includes North Carolina Baptist Hospital, Wake Forest University Health Sciences, and Wake Forest University Baptist Medical Center; Wake Forest University is not a member of the obligated group; CMHA and WFB are part of the Atrium Health enterprise (Atrium Health). Lastly, Advocate Aurora Health bonds are general, unsecured obligations of its obligated group.

Although CMHA, Wake Forest Baptist, and Advocate Aurora Health currently maintain rated debt across separate obligated groups, all are part of the consolidated Advocate Health following the execution of a joint operating agreement in December 2022 between Atrium Health and Advocate Aurora Health. We rate the systems based on the group credit profile of Advocate Health per our group rating methodology criteria, with each affiliate considered core. As such, this analysis focuses on the enterprise and financial profile characteristics of Advocate Health as a whole, and all metrics cited are for the entire system unless stated otherwise. We understand management intends to consolidate its obligated group structure over the outlook period, which we would not expect to have an effect on the existing ratings, all else unchanged.

For VRDBs supported by SBPAs, the long-term rating reflects the 'AA' long-term rating on the health care obligor, and the short-term rating reflects the short-term rating on the respective bank. For CMHA's series 2007E VRDBs supported by a letter of credit (LOC) from TD Bank, we base the long-term rating on the application of low correlation joint criteria between TD Bank and the 'AA' SPUR on CMHA. The short-term rating reflects the 'A-1' short-term rating on TD Bank.

Credit overview

The rating reflects our view of the credit strength of the consolidated Advocate Health, namely an extremely broad and diverse service area spanning several noncontiguous states across the Midwest and Southeast and a robust and diverse medical staff with numerous academic relationships anchored by the full integration with Winston-Salem-based Wake Forest Baptist. In addition to its large and geographically diverse revenue base, Advocate Health maintains solid balance sheet metrics characterized by sound days' cash on hand and only moderate debt levels, which have improved further in recent years given a lack of new money borrowing activity. We understand management is contemplating some debt activity over the coming quarters and we believe this could be absorbed at the current rating given preliminary expectations from management.

System operating performance improved soundly in fiscal 2024 (ended Dec. 31), further recovering from a loss in fiscal 2022, aided by strong demand, above-budget integration synergies and cost savings, added revenue from North Carolina's Healthcare Access Stabilization Program (HASP), and \$200 million of FEMA funds. Within the consolidated Advocate Health, all three rated legacy entities produced positive operating results for the year, with the most pronounced improvement observed at Atrium Health. This progress has been enabled by successful integration efforts across the system, with management citing nearly \$1.1 billion in annual synergies already achieved, ahead of its initial three-year target. Performance metrics have improved further midway through fiscal 2025 due in part to rising supplemental funding and

Advocate Health, North Carolina

additional one-time items recognized, and we expect year-end results comparable to current levels.

We view the unified management team's integration efforts favorably, with further progress made since our last review. Key milestones include the consolidation of all vendor contracts and the system's investment platform, standardizing quality scorecards and charity care policies, and harmonizing IT systems, including a new holistic enterprise resource planning (ERP) system launched earlier in 2025. In addition, Advocate Health operates with a single CEO structure under Gene Woods (formerly of Atrium Health) and the remainder of the leadership team remains stable. The system is embarking on its next five-year strategic roadmap, called Rewire 2030, which aims to position Advocate Health as an integrated national health learning platform and leverage the inherent strengths of its size, scale, and clinical competencies. We anticipate strategic focus will shift from integration efforts to implementation of Rewire 2030 and management's new operating model. Advocate Health, like peers in the sector, retains exposure to the recently passed U.S. tax and spending bill partly due to its operations in Medicaid expansion states and participation in directed payment programs such as HASP. In subsequent reviews, we will monitor the system's response to these reforms, which most materially begin in fiscal 2028. Management believes its goals under Rewire 2030 align well with positioning Advocate Health to adapt to the expected reimbursement pressures.

The long-term rating is based on our view of the following Advocate Health credit strengths:

- Substantial geographic and revenue diversity, anchored around acute-care operations in Illinois, Wisconsin, North Carolina, and Georgia, generating operating revenue in excess of \$34 billion in its fiscal 2024;
- Healthy unrestricted reserves, with days' cash on hand above 250 and lighter debt load relative to net assets and revenue;
- Healthy operating performance in fiscal 2024 and interim 2025, aided in part by strong synergy realization and added HASP funds in North Carolina;
- Expansive and diverse clinical staff of about 18,000 active physicians, including faculty, employed and independent physicians, residents, and fellows; and
- Compelling and ambitious Rewire 2030 strategy to enhance Advocate Health's position in the sector, supported by a solidified leadership team that we view as well-qualified.

The strengths are partly offset, in our view, by the following credit weaknesses:

- Growing exposure to supplemental funding programs to support operating earnings, with HASP being especially meaningful; and
- Competitive markets and heightened expected capital spending, which we believe could pressure reserve growth, particularly if operating cash flow is not sustained or if investment market volatility occurs.

Environmental, social, and governance

We view favorably Advocate Health's social capital factors given the size and diversification of its multistate service area, including several markets with healthy demographic trends such as population and employment growth, though this is partially offset by markets with weaker growth prospects. In addition, the system, like its peers, remains subject to higher human capital risks tied to clinical labor supply, though workforce measures such as contract labor exposure have trended favorably in fiscal 2024 and interim 2025.

Advocate Health, North Carolina

We view Advocate Health's environmental and governance factors as neutral in our credit rating analysis. We believe the system's geographic diversity provides some hedge against the physical risks faced in each service area. In addition, the Advocate Health board is transitioning to a self-perpetuating structure following inaugural appointments. Atrium Health includes multiple governing boards with various levels of local authority and specific legacy appointment structures, but key reserve powers rest with the Advocate Health board. The Advocate Health board currently includes 14 members, reduced from the initial 20; Wake Forest Baptist controls two of the board seats by way of the same appointments at the Atrium Health level. Management believes the smaller size is more effective for the system, in addition to creating some capacity for new seats to be added over time via system growth. Per management, no material merger and acquisition plans are imminent at this time, following the integration of Elkin, N.C.-based Hugh Chatham Health into WFB in July 2025.

Outlook

The stable outlook reflects our view that Advocate Health's geographic diversity and scale, coupled with healthy balance sheet measures, lend stability to the rating amid general sector earnings pressure and uncertainty that will likely become more pronounced beyond the outlook period. The outlook is further supported by the system's strengthening performance in fiscal year 2024 and interim 2025, with management's integration execution positioning it well to sustain such progress, in our view.

Downside scenario

We consider there to be some cushion at the current rating, but believe below-expectation operating performance would be the most likely contributor to rating pressure over time. While we believe Advocate Health possesses numerous credit strengths, failure to sustain healthy earnings could eventually weaken the credit profile. Erosion of balance sheet measures, whether due to lighter earnings, continued system growth, or higher capital spending, could also pressure the rating.

Upside scenario

We do not expect to raise the rating over the outlook period. Over the longer-term, a higher rating would be predicated on sustained robust profitability with less exposure to supplemental funding, with continued accumulation of balance sheet cushion and successful realization of key components of its Rewire 2030 strategic vision.

Credit Opinion

Enterprise Profile--Very Strong

Broad, diverse, noncontiguous service area

As a whole, we view the system's footprint, among the largest nationally, favorably as we believe it lends considerable geographic diversity to Advocate Health. The system serves a large population of over 17 million based on the combined service areas of AAH (12.1 million) and Atrium Health (5.8 million). Demographics and growth projections contrast significantly across and within regions, with slight population decline projected in the large Illinois and Wisconsin markets

Advocate Health, North Carolina

(AAH) and smaller Georgia service area (Atrium Health Navicent and Atrium Health Floyd), rapid expansion in the Charlotte, N.C. metropolitan statistical area (Atrium Health), and growth in line with national averages in Winston-Salem, N.C. (WFB). Though the system is investing capital across all markets, spending is proportionally higher in North Carolina markets given the region's population growth and ongoing master facility plan at Carolinas Medical Center, the system's largest hospital.

Each system has maintained a sound payor mix, with a healthy 49% of 2024 net patient revenue coming from commercial insurers. AAH yields a slightly higher commercial mix despite the softer demographics, and we consider this a testament of its strong market position and clinical offerings, as well as Atrium Health's role as the major safety net provider in Charlotte. The system reports healthy conversations with national and regional payors, with an increased openness to partnership and shared-value arrangements enabled by Advocate Health's market reach.

Diverse portfolio of access points and robust medical staff support national market position

We view Advocate Health as having a relevant, though not always leading, market share across all its discrete service areas. The system competes directly with several strong regional systems and academic medical centers including NorthShore University Health System, Northwestern Memorial HealthCare, Novant Health, among many other well-regarded providers. In addition, many Advocate Health hospitals are in rural markets, which generally face lighter competitive dynamics but different demographics; addressing health disparities across rural and urban markets is a key goal of Rewire 2030.

In addition to robust coverage of the care continuum through both inpatient, outpatient, patient home, and digital access points, this view is further supported by the system's medical staff of nearly 18,000 active physicians, further supported by 45,000 nurses. Employed physician groups across the Midwest and Southeast regions report to a common leader with consistent compensation structures, and management reports strong clinical collaboration across legacy systems.

Clinical offerings are also enhanced by academic affiliations including several long-term teaching affiliations at AAH, as well as Wake Forest Baptist at Atrium Health. We expect the system will continue to integrate and leverage translational research and educational activities across its footprint as a means of market differentiation and innovation. Most notably, a new Wake Forest School of Medicine campus in Charlotte welcomed its first class in fall 2025, anchoring a new health care and innovation district called The Pearl, a multi-year development that is already home to several international healthcare corporations.

Advocate Health, North Carolina--Enterprise statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		
	2025	2024	2023	2022*
Inpatient admissions	287,323	538,779	494,640	447,734
Equivalent inpatient admissions	668,099	1,231,784	1,254,940	1,155,387
Emergency visits	1,180,131	2,276,741	2,184,381	2,048,726
Inpatient surgeries	63,793	127,853	124,544	117,263
Outpatient surgeries	161,694	324,814	316,577	298,967
Medicare case mix index	1.7700	1.7900	1.8100	N.A.
FTE employees	145,714	140,860	133,966	127,851
Active physicians	N.A.	17,592	15,800	15,400

Advocate Health, North Carolina

Advocate Health, North Carolina--Enterprise statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		
	2025	2024	2023	2022*
Based on net/gross revenues	Net	Net	Net	N.A.
Medicare (%)	31.2	31.0	32.4	N.A.
Medicaid (%)	16.2	16.0	15.7	N.A.
Commercial/Blues (%)	48.4	49.0	48.0	N.A.

*Based on S&P Global Ratings internal consolidation. Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. N.A.--Not available.

Financial Profile--Very Strong

Performance aided by operating synergies, supplemental funding, and one-time items; positive results expected to continue

Following a moderate loss in 2022 (calculated on a pro forma basis by S&P Global Ratings) driven by sector-wide labor challenges as well as broader inflationary expense pressures, earnings in fiscal 2023 (the system's first full year of operations following the joint operating agreement) recovered with a 1.8% operating margin. The 2023 budget targeted breakeven operations, but excluded the system's \$546 million net HASP gain as well as its \$238 million one-time 340B payment. Momentum continued in 2024 with results aided by synergy tailwinds, reduced corporate overhead, and improving workforce and productivity measures. Notably, 2024 results would be largely on-budget if excluding Atrium Health's FEMA funds recognized, as well as HASP revenue received related to the prior year, both items unbudgeted.

Fiscal 2025 operating results remain healthy midway through the year, ahead of management's operating target, supported by strong HASP funding and the receipt of about \$140 million one-time items, including FEMA funds and employee retention tax credits related to the pandemic. Other factors positively affecting performance include sustained patient demand and strong growth in retail and specialty pharmacy operations. We expect operating performance to remain consistent through year-end and into 2026.

Prior to 2023, both systems maintained solid operating results though Atrium Health's performance had trailed that of Advocate Aurora Health. This reversed in 2023 as added HASP funds accelerated earnings growth in North Carolina. The HASP program has been a material driver of system earnings in recent years, which we view as a risk over the medium term as new federal policies relating to directed payment programs are implemented. Both North Carolina and Illinois expanded Medicaid coverage under the Affordable Care Act, requiring a taper down of directed payment programs to 100% of Medicare beginning in 2028, with a similar phased implementation of a 3.5% provider tax cap. Management is quantifying the expected financial effect and views Advocate Health as having a sound foundation to address these concerns given the integration and operating efficiencies already achieved, as well as the further progress expected under Rewire 2030.

Our performance figures remove unrestricted contributions and investment activity from operating revenue and add non-controlling interest to operating expenses. In addition, fiscal 2023 results exclude a \$150 million impairment related to the system's divestment of Advocate Health Enterprises, namely its Senior Helpers and MobileHelp holdings, as well as an associated gain on sale of \$88 million in fiscal 2024. These entities were deemed non-core to the system

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strategy and carried an operating loss of around \$50 million in recent years. We consider this one example of management's approach of making critical decisions early in the integration process.

Healthy unrestricted reserve cushion should remain sound amid progress on major capital projects

The system's unrestricted reserve position has remained very sound and is supportive of the rating. The system expended a combined \$2.1 billion on capital items in 2024, near 170% of depreciation expense. We anticipate healthy capital spending over the outlook period given ongoing and contemplated growth projects, with management indicating an annual capital spending baseline near \$2.0 billion, with actual spending based on achieved operating cash flow. Meaningful ongoing projects include master campus plans and discrete growth projects across regions. Following the completion of the Julie Ann Freischlag Tower in Winston-Salem in mid-2025, the largest ongoing project is the expansion and renovation of its Charlotte flagship campus, Carolinas Medical Center, to be completed in late 2027. Despite its capital plans, which also include outpatient access points such as ambulatory surgical centers, we anticipate sustaining strong operating liquidity will remain a key pillar of management's plan, and expect strong cash flow will sufficiently support these plans over the outlook period. In addition, we understand forecasted capital capacity grows over the coming years, providing the system with added flexibility as Medicaid reforms come online.

We view the consolidated investment portfolio as appropriate for the system, and note the vast majority of unrestricted reserves are now under a unified investment management platform; this transition drove high realized investment earnings in 2024. The system has \$2.8 billion of alternative investment commitments over the coming nine years.

Ample liquidity support supplements balance sheet

The system retains ample liquidity within its unrestricted reserves, further supplemented by AAH's \$1.0 billion authorized CP program (\$270 million outstanding as of June 30, 2025) and \$950 million line-of-credit capacity, CMHA's \$800 million authorized CP program (upsized from \$400 million in May 2025; \$400 million outstanding), and \$300 million line of credit via WFB (\$200 million outstanding). CP balances and line of credit draws are deducted from unrestricted reserves and excluded from debt measures; Advocate Health's combined CP balance declined to \$470 million as of July 31, 2025.

Advocate Health has identified approximately \$2.6 billion in combined assets (market value discounted by S&P Global Ratings) as of July 31, 2025, to cover authorized CP programs and self-liquidity VRDBs including AAH's series 2011B VRDBs (\$70 million) and CMHA's series 2018F VRDBs (\$100 million). The identified assets are a subset of Advocate Health's unrestricted reserves and include cash and equivalents, money market funds, and U.S. government fixed-income securities. In the event of a failed remarketing, it is our opinion that the assets identified in the portfolio would provide sufficient liquidity. The system has also provided us with the operational procedures that will be followed to provide for timely payment in the event of a failed CP rollover or remarketing of the VRDBs. We monitor the credit quality, liquidity, and sufficiency of the assets identified by management on a monthly basis.

Lighter debt load and benefit exposure ahead of potential new borrowings

We view the system's leverage as sound for the rating, falling below 20% in 2024 with a low debt burden near 1.3x aided by the large total revenue base. Management is currently contemplating debt activity in early 2026, possibly inclusive of \$300 million in new money reimbursement debt

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and repayment of WFB's \$200 million line-of-credit draw with long-term debt. Given we exclude line of credit draws from unrestricted reserves and long-term debt, we would estimate a \$500 million increase in long-term debt concurrent with a \$500 million increase in reserves. We will fully evaluate Advocate Health's plan of finance once it is finalized, but believe the system has ample capacity for the preliminary transaction at the current rating. Borrowings presented in current liabilities given put, tender, or bank expiration dates within one year are moved into our long-term debt figures.

Just over 40% of long-term debt is considered contingent per S&P Global Ratings, inclusive of VRDBs, direct placement debt, and put bonds. All obligated groups and entities were compliant with financial covenants in fiscal 2024.

The system's interest rate swap portfolio includes five swaps from AAH (\$348 million notional value as of Dec. 31, 2024) and 10 swaps from Atrium Health (\$787 million notional value). Just \$750,000 in combined collateral was posted at year-end, related to WFB's lone swap. The swaps support a debt structure that is 65% fixed rate or synthetically fixed.

Advocate Health includes seven distinct defined-benefit pension plans of various legal classifications, with all closed to new participants with benefit accruals frozen. The combined net shortfall across all plans was about \$790 million as of Dec. 31, 2024, assuming an average discount rate of 5.7% (up from 5.1% in 2023), equating to moderate funded status of 81%. The most material pension exposure stems from the Atrium Health Charlotte Defined-Benefit Pension Plan, which carries a \$528 million shortfall. When viewed in the context of the system's consolidated financial profile, we anticipate pension exposure will remain manageable, with combined contributions of \$66 million in 2024.

Long-term operating lease liabilities were \$1.1 billion as of June 30, 2025, an amount we view as consistent with the system's overall debt load.

Advocate Health, North Carolina--Financial statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--			Medians for 'AA' rated health care systems
	2025	2024	2023	2022*	2024
Financial performance					
Net patient revenue (\$000s)	16,203,193	30,405,450	27,996,077	25,046,827	8,033,218
Total operating revenue (\$000s)	18,795,915	34,675,160	31,631,306	28,081,026	8,370,980
Total operating expenses (\$000s)	18,042,901	33,734,480	31,060,923	28,452,749	7,733,900
Operating income (\$000s)	753,014	940,680	580,383	(371,723)	204,345
Operating margin (%)	4.01	2.71	1.83	(1.32)	3.50
Net nonoperating income (\$000s)	978,353	1,645,394	389,982	613,386	418,034
Excess income (\$000s)	1,731,367	2,586,074	970,365	241,663	463,002
Excess margin (%)	8.76	7.12	3.03	0.84	7.80
Operating EBITDA margin (%)	7.96	6.94	6.61	3.76	8.10
EBITDA margin (%)	12.51	11.15	7.75	5.82	12.00
Net available for debt service (\$000s)	2,473,620	4,060,209	2,481,268	1,670,124	834,286
Maximum annual debt service (\$000s)	460,040	460,040	460,040	460,040	147,371
Maximum annual debt service coverage (x)	10.75	8.80	5.39	3.63	7.20
Operating lease-adjusted coverage (x)	7.01	5.80	3.68	2.62	5.70

Advocate Health, North Carolina

Advocate Health, North Carolina--Financial statistics

	--Six months ended June 30--	--Fiscal year ended Dec. 31--		Medians for 'AA' rated health care systems	
	2025	2024	2023	2022*	2024
Liquidity and financial flexibility					
Unrestricted reserves (\$000s)	24,254,027	23,988,702	21,542,090	19,440,700	7,354,302
Unrestricted days' cash on hand	254.0	269.1	263.5	260.1	314.9
Unrestricted reserves/total long-term debt (%)	352.0	342.3	297.6	259.3	351.1
Unrestricted reserves/contingent liabilities (%)	826.1	813.8	705.9	614.2	1,178.3
Average age of plant (years)	11.6	11.4	11.4	11.4	10.5
Capital expenditures/depreciation and amortization (%)	189.1	171.9	122.3	105.9	146.8
Debt and liabilities					
Total long-term debt (\$000s)	6,891,253	7,007,883	7,238,031	7,498,272	2,096,105
Long-term debt/capitalization (%)	18.5	19.8	22.3	24.4	18.3
Contingent liabilities (\$000s)	2,935,820	2,947,565	3,061,615	3,165,423	684,404
Contingent liabilities/total long-term debt (%)	42.6	42.1	42.2	42.2	29.1
Debt burden (%)	1.16	1.27	1.44	1.60	1.60
Defined benefit plan funded status (%)	N.A.	81.08	77.26	78.16	97.80
Miscellaneous					
Medicare advance payments (\$000s)†	0	0	0	11,000	MNR
Short-term borrowings (\$000s)†	870,000	470,000	369,199	400,000	MNR
COVID-19 stimulus recognized (\$000s)	140,000	200,000	39,700	181,113	MNR
Total net special funding (\$000s)	814,767	991,815	908,507	333,790	MNR

*Based on S&P Global Ratings internal consolidation. †Excluded from unrestricted reserves, long-term debt, and contingent liabilities. N.A.--Not available. N/A--Not applicable. MNR--Median not reported.

Credit Snapshot

- Group rating methodology: We consider the obligated groups of Advocate Aurora Health, CMHA, and Wake Forest Baptist to all be core to the group credit profile of Advocate Health. The obligated groups remain separate and do not secure or guarantee any debt of each other. Atrium Health Navicent and Atrium Health Floyd are not members of the CMHA obligated group.
- Financial presentation: Our analysis utilizes the system's 2024 audit, which includes all legacy affiliates, combining FASB entities (AAH and WFB) with GASB entities (CMHA) under FASB standards. We consider this to be the most accurate approach for assessing the system's creditworthiness.
- Organization description: Advocate Health is the governing entity of the combined system that includes Advocate Aurora Health and Atrium Health. The latter also includes Wake Forest Baptist, Atrium Health Navicent, and Atrium Health Floyd. The system has 69 inpatient facilities across Illinois, Wisconsin, North Carolina, and Georgia, supplemented by hundreds of various outpatient access points. The system is headquartered in Charlotte, N.C.

Ratings List

Current Ratings

Healthcare

Advocate Health, North Carolina

Ratings List

Advocate Hlth Care, IL Health Care System General Obligation	AA/Stable
Advocate Hlth Care, IL Health Care System General Obligation	A-1+
Atrium Hlth, NC Health Care System Revenues	AA/Stable
Atrium Hlth, NC Health Care System Revenues	A-1+
Wake Forest Baptist Oblig Grp, NC Health Care System Revenues	AA/Stable

The ratings appearing below the new issues represent an aggregation of debt issues (ASID) associated with related maturities. The maturities similarly reflect our opinion about the creditworthiness of the U.S. Public Finance obligor's legal pledge for payment of the financial obligation. Nevertheless, these maturities may have different credit ratings than the rating presented next to the ASID depending on whether or not additional legal pledge(s) support the specific maturity's payment obligation, such as credit enhancement, as a result of defeasance, or other factors.

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MOODY'S RATINGS

Rating Action: Moody's Ratings upgrades ratings of Advocate Aurora Health and Atrium Health (legally known as Charlotte Mecklenburg Hospital Authority) to Aa2 and Wake Forest Baptist's to Aa3; outlooks stable

01 Oct 2025

New York, October 01, 2025 -- Moody's Ratings (Moody's) has upgraded the revenue bond ratings of Advocate Aurora Health and Atrium Health (legally known as Charlotte Mecklenburg Hospital Authority) to Aa2 from Aa3 and simultaneously upgraded the revenue bond rating of Wake Forest Baptist to Aa3 from A1. The outlooks have been revised to stable from positive at the higher rating levels. We have also affirmed the VMIG 1 and P-1 short term ratings assigned to various series of debt at Advocate Aurora Health and Atrium Health.

Advocate Health, Inc. was created as the governing entity of Advocate Aurora Health and Atrium Health, Inc. as member organizations. The debt of the various member organizations remains separately secured, however, we consider the linkages between them and the credit quality of the entire Advocate Health system in our analysis.

The upgrades reflect the strengthened financial profile of the Advocate Health system and its successful strategic expansion strategies which have augmented Advocate Aurora Health, Atrium Health, and Wake Forest Baptist. Governance is a key driver for the upgrades reflecting the view that management's execution of growth and integration strategies have undergirded Advocate Health's financial and operational success.

RATINGS RATIONALE

The Aa2 rating for Advocate Aurora Health and Atrium Health is supported by several key credit factors, including significant scale, strong market share in major metropolitan areas, and solid financial performance and liquidity. The system operates in demographically favorable markets, leveraging a strong position built on numerous convenient outpatient care access points, physician clinics, and high-acuity inpatient care at several academic hospitals. The second branch of Wake Forest University School of Medicine, in Charlotte, increases Advocate Health's prominence in that market and establishes a pipeline for physicians and medical staff over time. Disciplined financial and capital planning allows both organizations to fund capital spending and pursue growth opportunities while sustaining solid operating margins and favorable leverage and liquidity metrics. Though competition is high, population growth and a strong reputation are expected to help maintain or expand market share. The most significant challenges are the potential cuts in federal and state funding, although the legacy entities have a long history of effectively responding to operating pressures.

The Aa3 rating for Wake Forest Baptist is based on its solid market position in Winston-Salem, its status as an academic medical center, and its membership in the Advocate Health system. Membership in the Advocate Health system provides strategic and financial advantages, including access to capital and the resources of a larger system.

Affirmation of Atrium Health's P-1 and VMIG 1 ratings reflects the organization's strong treasury management and daily liquid assets that provide for adequate coverage of debt backed by Atrium Health's internal liquidity.

Affirmation of Advocate Aurora's P-1 reflects its long term rating and our approach to market access instruments.

Affirmation of Advocate Aurora's and Atrium Health's VMIG 1 reflects standby bond purchase agreements provided by the respective banks to support the tender features of the affected debt.

RATING OUTLOOK

The stable outlook reflects solid operating cash flow (OCF) margins above 7% and maintenance of very favorable cash and debt metrics

FACTORS THAT COULD LEAD TO AN UPGRADE OF THE RATINGS

- Further geographic diversification of cash flow
- Material and sustained improvement in operating margins that support exemplary leverage measures
- Significant increase in market share
- For short-term ratings: not applicable

FACTORS THAT COULD LEAD TO A DOWNGRADE OF THE RATINGS

- Sustained decline in OCF margin below 6%
- Additional debt that materially dilutes leverage metrics
- Short term ratings: material reduction in coverage level of assets backing the commercial paper program or downgrade of Advocate Aurora or Atrium's long term rating to A2 or lower; for bank enhanced ratings: downgrade of the short-term CR Assessment of the Bank

PROFILE

The Advocate Health system has significant patient care operations in four states spanning multiple major metro areas. It provides services across the care continuum with nearly 70 hospitals, numerous ambulatory and clinic locations, and 8,000 employed physicians. It is headquartered in Charlotte, NC.

METHODOLOGY

The principal methodology used in the long-term ratings was Not-for-profit Healthcare published in October 2024 and available at <https://ratings.moody.com/rmc-documents/430698>. The principal methodology used in the short-term ratings was US Municipal Short-term Debt published in October 2024 and available at <https://ratings.moody.com/rmc-documents/430699>. Alternatively, please see the Rating Methodologies page on <https://ratings.moody.com> for a copy of these methodologies.

REGULATORY DISCLOSURES

For further specification of Moody's key rating assumptions and sensitivity analysis, see the sections Methodology Assumptions and Sensitivity to Assumptions in the disclosure form. Moody's Rating Symbols and Definitions can be found on <https://ratings.moody.com/rating-definitions>.

For any affected securities or rated entities receiving direct credit support/credit substitution from another entity or entities subject to a credit rating action (the supporting entity), and whose ratings may change as a result of a credit rating action as to the supporting entity, the associated regulatory disclosures will relate to the supporting entity. Exceptions to this approach may be applicable in certain jurisdictions.

For ratings issued on a program, series, category/class of debt or security, certain regulatory disclosures applicable to each rating of a subsequently issued bond or note of the same series, category/class of debt, or security, or pursuant to a program for which the ratings are derived exclusively from existing ratings, in accordance with Moody's rating practices, can be found in the most recent Credit Rating Announcement related to the same class of Credit Rating.

For provisional ratings, the Credit Rating Announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating.

Moody's does not always publish a separate Credit Rating Announcement for each Credit Rating assigned in the Anticipated Ratings Process or Subsequent Ratings Process.

Regulatory disclosures contained in this press release apply to the credit rating and, if applicable, the related rating outlook or rating review.

At least one ESG consideration was material to the credit rating action(s) announced and described above. Moody's general principles for assessing environmental, social and governance (ESG) risks in our credit analysis can be found at <https://ratings.moody's.com/rmc-documents/435880>.

Please see <https://ratings.moody's.com> for any updates on changes to the lead rating analyst and to the Moody's legal entity that has issued the rating.

Please see the issuer/deal page on <https://ratings.moody's.com> for additional regulatory disclosures for each credit rating.

Beth Wexler
Lead Analyst

Daniel Steingart
Additional Contact

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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:

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 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.

The criterion is not applicable. Advocate Aurora Health, Inc has a AA long-term bond rating from Fitch and Standard & Poors. Advocate Aurora Health, Inc has an Aa2 long-term bond rating from Moody's.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

F. Total Effect of the Project on Capital Costs

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

See Attachment #37, Exhibit 1, 2 and 3.

The Chicago Index for Chicago Q3 2025 and the 2025 Third Quarter Construction Cost Report is provided in the Appendix.



ADVOCATE

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January 13, 2026

Mr. John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: **Advocate Health and Hospitals Corporation d/b/a Christ Medical Center – New
22 Bed Med Surg Project**

Dear Mr. Kniery:

This letter is to attest to the fact that the selected form of debt financing for the purpose of the Advocate Christ Medical Center project will be the lowest net cost available, or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgages, access to additional debt, term financing costs and other factors.

Respectfully,

Kevin Fitch
Group Vice President of Finance
Advocate Health and Hospitals Corporation

Subscribed and sworn to me

This 13 day of January, 2026

Notary Public

Reasonableness of Project and Related Costs

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
	A	B	C	D	E	F	G	H	Total Cost**
	Cost/Square Foot		Gross Sq. Ft		Gross Sq. Ft		Const. \$	Mod. \$	
Clinical Dept./Area	New	Mod.	New	Circ*	Mod.	Circ*	(A x C)	(B x E)	(G + H)
REVIEWABLE									
Medical/Surgical	\$ -	\$ 650	0		14,000		\$ -	\$ 9,100,000	\$ 9,100,000
Hemodialysis	\$ -	\$ 600			5,000		\$ -	\$ 3,000,000	\$ 3,000,000
Cardio diagnostics	\$ -	\$ 600			4,000		\$ -	\$ 2,400,000	\$ 2,400,000
Nuclear Medicine	\$ -	\$ 630			4,800		\$ -	\$ 3,024,000	\$ 3,024,000
Total Clinical	\$ -	\$ 630	0		27,800		\$ -	\$ 17,524,000	\$ 17,524,000
NON-REVIEWABLE									
General Circulation	\$ -	\$ 400	0		8,000		\$ -	\$ 3,200,000	\$ 3,200,000
Administration	\$ -	\$ 400			500		\$ -	\$ 200,000	\$ 200,000
Public Waiting	\$ -	\$ 400			150		\$ -	\$ 60,000	\$ 60,000
Staff Respite, Staff Lounge	\$ -	\$ 400			550		\$ -	\$ 220,000	\$ 220,000
EVS	\$ -	\$ 400			100		\$ -	\$ 40,000	\$ 40,000
Electrical	\$ -	\$ 400			160		\$ -	\$ 64,000	\$ 64,000
IS	\$ -	\$ 400			150		\$ -	\$ 60,000	\$ 60,000
Total Non-clinical	\$ -	\$ 400	0		9,610		\$ -	\$ 3,844,000	\$ 3,844,000
Total Excluding Contingency	\$ -	\$ 571			37,410		\$ -	\$21,368,000	\$ 21,368,000
Contingency	\$ -	\$ 80					\$ -	\$ 3,000,000	\$ 3,000,000
GRAND TOTAL	\$ 651	\$ 651	0		37,410		\$ -	\$ 24,368,000	\$ 24,368,000

* Percentage of space for circulation

** Construction Costs Only

Description of Premiums for the Advocate Christ Medical Center 4S Med/Surg Conversion Project
Ground level area of work is interior to the building.
Ground floor circulation spaces to be updated to be suitable for patient traffic.
Ground floor ceilings contain extensive infrastructure both supporting the previous use of the space (kitchen and dining) and the rest of the facility. Much of this infrastructure will require relocations and/or modifications. Additional demolition incurred to remove existing abandoned kitchen MEP utilities. This change in function also requires an increase in density of MEP scope to upgrade to patient care spaces compared to previous back of house uses.
Low ceiling heights on the ground level increase complexity of MEP design and eliminate many prefabrication opportunities
All existing infrastructure needs assessment to determine components for replacement. Age of most of the existing MEP infrastructure causes inability to reuse above ceiling MEP and power distribution equipment.
Shielding required in relocated Nuclear Medicine department.
Tying the new space to the existing building adds significant complexity to avoid disrupting ongoing operations.
Multiple construction phases required to relocate the existing departments from 4 th floor to ground level before construction can begin on 4 th floor. Additional sub-phases are also likely required to maintain operations adjacent to the work zones.
4 th floor space is located above and below active inpatient units.
Seismic bracing required for MEP infrastructure on the fourth floor.
Additional work will be required within the project areas to correct deficiencies identified in the Fire Safety Evaluation System (FSES) report.
Exterior windows at 4 th floor are from the 1960s.
Interior hospital work requires enhanced construction barriers, and consumables related to Infection Control (ICRA) and Life Safety (ILSM) mitigating work.
Many of the existing walls to be demoed as part of this construction are atypical (block walls, clay tile, etc.)
Project includes existing building improvements including (a) upgrade/replacement of existing mechanical shafts and (b) spray fireproofing of existing floor slabs.
Project includes enhancements of the existing IT Closets to bring them up to current Hospital standards.

D. Projected Operating Cost per Equivalent Pt Day in Year 1

E. Impact of Project on Capital Costs in Year of Completion (Year 1)

Advocate Health						
Advocate Christ Medical Center						
Cost per Equivalent Patient Day						
4 South Med/Surg Beds Certificate of Need						
	Projected 2029					
	Amount			Per EPD		
	Hospital	Project	Total	Hospital	Project	Total
Operating Costs	\$ 1,722,961,668	\$ 19,655,943	\$ 1,742,617,611	\$ 6,108	\$ 3,047	\$ 6,039
Capital Costs	\$ 66,887,141	\$ 1,637,000	\$ 68,524,141	\$ 237	\$ 254	\$ 237
Total	<u>\$ 1,789,848,809</u>	<u>\$ 21,292,943</u>	<u>\$ 1,811,141,752</u>	<u>\$ 6,345</u>	<u>\$ 3,301</u>	<u>\$ 6,277</u>
Note: The first full year of operation is 2029.						

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:

2. 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.

ADVOCATE CHRIST MEDICAL CENTER Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2022	2023	2024
Inpatient	867	1,144	660
Outpatient	4,875	5,484	4,208
Total	5,742	6,628	4,868
Charity (cost in dollars)			
Inpatient	\$3,809,882	\$5,384,932	\$6,512,630
Outpatient	\$3,138,046	\$4,098,413	\$3,892,212
Total	\$6,947,928	\$9,483,345	\$10,404,842
MEDICAID			
Medicaid (# of patients)	2022	2023	2024
Inpatient	10,893	10,990	10,622
Outpatient	85,433	89,356	88,202
Total	96,326	100,346	98,824
Medicaid (revenue)			
Inpatient	\$264,230,277	\$265,657,510	\$276,507,133
Outpatient	\$42,600,859	\$103,272,930	\$111,998,369
Total	\$306,831,136	\$368,930,440	\$388,505,502

Advocate Christ Medical Center (ACMC) takes great pride in providing high-quality, compassionate care, offering 95 subspecialties to residents living in Chicago's Far South suburbs. Advocate Christ is a level I trauma center, providing emergency care for more than 105,000 patient visits annually. A premier teaching institution and nationally ranked center for cardiology and heart surgery, Advocate Christ is also a major referral hospital in the Midwest for cancer care, heart and kidney transplantation, neurosciences, orthopedics, and women's health. The hospital has a strong relationship with the neighborhood, communities, organizations, and the agencies it serves.

US News and World Report recognizes Advocate Christ Medical Center as one of the top performing hospitals in Illinois, ranking fourth among all Illinois facilities. The hospital also received public recognition for health care excellence in the following areas:

Honors and Accreditations:

- **US News and World Report Rankings:**
 - Recognizes Advocate Christ Medical Center (ACMC) as one of the top performing hospitals in Illinois, ranking fourth among all Illinois facilities.
 - ACMC had six national rankings in 2025 (top 50 programs) that included the following:
 - #14 in Obstetrics & Gynecology
 - #23 in Cardiology, Heart & Vascular Surgery
 - #42 in Diabetes & Endocrinology
 - #43 in Pulmonology & Lung Surgery
 - #46 in Geriatrics
 - #49 in Gastroenterology & GI Surgery
 - ACMC had four specialties in 2025 that ranked as "high performing" (top 10%), which included Cancer Care, Neurology / Neurosurgery, Orthopedics, and Urology.
 - ACMC was ranked in 2025 as the top 10% of all US hospitals in 2025 for AAA Repair, Aortic Valve Surgery, Colon Cancer Surgery, COPD, Heart Bypass Surgery, Heart Failure, Lung Cancer Surgery, TAVR, Diabetes, Pneumonia, Heart Attack, Hip Fracture, Kidney Failure, Stroke, Gynecological Cancer Surgery, Leukemia, Lymphoma & Myeloma, Heart Arrhythmia, and Pacemaker Implantation.
- **Healthgrades Awards:**
 - America's 100 Best Hospitals Award (2026, 2025)
 - America's 250 Best Hospitals Award (2026, 2025, 2024)
 - America's 100 Best Hospitals for Cardiac Care Award (2026, 2025, 2024)
 - America's 100 Best Hospitals for Coronary Intervention Award (2026, 2025)
 - America's 100 Best Hospitals for Stroke Care Award (2026, 2025)
 - Neurosciences Excellence Award (2026, 2025)
 - Pulmonary Care Excellence Award (2026, 2025)
 - America's 100 Best Hospital for Gastrointestinal Care Award (2025)
 - Gastrointestinal Surgery Excellence Award (2025)
 - America's 100 Best Hospitals for Pulmonary Care Award (2024)
 - Coronary Intervention Excellence Award (2024)

- **Other Recognitions:**

- ACMC and ACH-OL received the Practice Green health's Environmental Excellence in Healthcare Award (Top 25) in 2025 and 2024. (Greening in the OR 2024).
- ACMC and ACH-OL received the Circles of Excellence Award (Top 10) in leadership (2024 and 2025), chemicals (2025) and waste mitigation (2024).
- Becker's 100 Hospitals and Health Systems with Great Heart Programs
- Society for Thoracic Surgeons 3 Stars
- DNV Certifications in Ventricular Assist Device
- SRTR Heart Transplant 5 bars
- Breast Care: Nationally recognized as a Breast Imaging Center of Excellence by the American College of Radiology.
- NAPBC Breast Accreditation
- Designated Magnet Recognition - the American Nurses Credentialing Center since 2005.
- AACN Beacon award status in STIC, NCCU, and CVTU
- Stroke Care: Fully accredited as a Comprehensive Stroke Center, the highest level awarded; meeting the rigorous standards needed to treat the most complex cases
- One of the top 5 VAD centers in the country.
- BCBS Center of Excellence for Heart Transplant
- LGBTQ+ Healthcare Equality Leader: ACMC received a perfect evaluation in the Human Rights Campaign Foundation's Healthcare Equality Index (HEI), the nation's foremost benchmarking survey of healthcare facilities on policies and practices dedicated to the equitable treatment and inclusion of their LGBTQ+ patients, visitors, and employees.
- CMS Certified Kidney Transplant Program
- Blue Distinction Centers for Adult Cardiac Care, Cardiovascular Surgery.
- Commission on Cancer (Integrative Network Cancer Program) accredited program.
- American Heart Association – Get with the Guidelines Stroke Gold Plus Quality Achievement Award, with Target: Stroke Honor Roll Elite and Target: Type 2 Diabetes Honor Roll and Mission Lifeline Receiving Center GOLD Recognition Award.

Health Equity:

Advocate Health Care advances health equity through intentional efforts in clinical operations, civil rights, language services. Together, these services enhance access to care, foster an inclusive workplace, and strengthen community partnerships.

Advocate Christ continues to assess the unique needs of the diverse populations in the hospital's service area and provide culturally competent care and programs to support these communities. In October 2025, Advocate Christ completed its Community Health Needs Assessment (CHNA) Report. Advocate Christ's Community Health team has since developed

evidence-based interventions to address the top three identified needs, which included (1) Diabetes (2) Social Drivers of Health – Food Insecurity, (3) Behavioral Health.

Advocate Christ places a high value on community education, and prevention, as well as addressing other key issues such as food insecurity, housing insecurity, and connecting people to vital social health resources in the community. The Community Health team at Advocate Christ works closely with local stakeholders and serves as a fundamental partner of the Alliance for Health Equity (AHE) group in Illinois. The AHE is a collaboration between the Illinois Public Health Institute and area hospitals, health departments, and community organizations across Chicago and Cook County. The Alliance for Health Equity envisions improved health equity, community wellness and quality of life across all neighborhoods and municipalities of the City of Chicago and Suburban Cook County.

- 1. Diabetes:** Diabetes remains a significant health concern. Diabetes was selected as the number one health priority by our AHE survey respondents. Christ PSA reports a diabetes diagnosis rate of 13.1%, which is notably higher compared to Cook County (10.8%) and Illinois (10.4%). Upon further investigation and when comparing the percentage of diabetes diagnosed across the PSA landscape, the percentage of adults diagnosed with diabetes across all 27 zip codes has increased since 2020. Hospitalization and emergency department (ED) visits are indicative of poorly controlled chronic diseases and a lack of access to routine preventive care. This elevated rate within the service area suggests a critical need for targeted diabetes management and intervention programs to mitigate the impact on local community health. As a result, the Advocate Christ's CHC decided that diabetes initiatives in this service area are still needed and continue to be a burden for residents. Some of the resources being utilized for this initiative include American Diabetes Association, PCC South Family Health Center, Advocate Diabetes Endocrinology, Illinois Alliance to Promote Opportunities for Health.
- 2. Social Drivers of Health – Food Insecurity:** Social drivers of health - such as housing, food access, transportation, education, economic stability - have a significant impact on overall health outcomes. Social drivers of health impact people's health and their wellbeing. While there are many SDOH that have need of addressing, the Advocate Christ team has decided to continue to focus efforts around food insecurity, as there are concerning trends, and it is an area that has dedicated resources. The hospital will strive to continue the momentum they currently have to impact outcomes. Some of the resources being utilized for this initiative include the Greater Chicago Food Depository, Find Help, and Find Food Illinois.
- 3. Behavioral Health:** Behavioral health, which includes mental health and substance abuse, was selected as another health priority. Mental health and substance use often co-occur. The Community Health Council identified mental health as a priority health need due to rising rates of emergency department visits, hospitalizations, and the growing demand for local mental health services. This need also reflects the strong connection between mental health and substance, as many individuals experience both conditions simultaneously and require combined support. The rising rates of both

substance use, and mental health data suggest that more work needs to be done to address the ever-growing need of additional services, access to programs and support services in our communities. The CHC has recommended strengthening our interventions that address both health issues. Mental health and substance use issues of individuals impacted by trauma will continue to be addressed through the Advocate Trauma Recovery Center. The high rates of Emergency Department (ED) visits and hospitalization due to mental health issues will continue to be addressed through employing coping mechanisms and resilience training. Examples include Mental Health First Aid trainings and trauma-informed workshops. Some of the resources being utilized for this initiative include Trauma Recovery, Sertoma Star Services, NAMI Chicago, Advocate Behavioral Health, Respond Now, BEDS Plus, NAMI of South Suburbs of Chicago, HRDI, and Southland RISE.

- **Southland Housing and Health Partnership:** Southland Housing and Health Partnership is a collaboration between Advocate Health Care and local social service agencies collaborating to provide medical care, emergency housing services, and short-term emergency assistance to families who are experiencing homelessness in Cook County. Advocate Christ coordinates services through its community health workers that identifies needs and connects unhoused patients to appropriate trusted local social service partners through Find Help. Medical respite care and street outreach specifically developed for the homeless and emergency assistance services are provided by collaborative partners named BEDS Plus and Respond Now. The community health workers team continues to support unhoused patients and serves as the point of contact for care teams and patients who need assistance or referrals if additional support is needed.

Other Hospital Programs for Key Populations

- Advocate Children's Hospital in Oak Lawn with the Ronald McDonald House Charities of Chicagoland and Northwest Indiana provides access to free school physicals and immunizations for at-risk children through the Ronald McDonald Care Mobile.
- Advocate Children's in Oak Lawn's Centering Pregnancy program offers prenatal care to at risk pregnant women.
- Support Group and Clinics are provided such as a Stroke Survivor Class, Heart Failure Clinic, Cancer Support Groups and Gilda's Club.
- The Community Health Worker (CHW) social health team provides community resource navigators to serve patients in the emergency department. They conduct an assessment to identify social determinants of health and link the patients to social services and community resources.

2024 Community Benefits Summary

Community services provided by Advocate Christ Medical Center in 2024 that are relevant to safety net service are included in the Community Benefits Summary. This report does not include other expenses accrued by Advocate Christ Medical Center, reportable for community

benefit, such as bad debt, cost of unreimbursed Medicaid and Medicare, charity care, and other reportable expenses document by Advocate Health Care's Tax and Finance team.

Advocate Christ - 2024 Community Benefits	
Language Services	\$916,249
In-Kind Donations	\$78,000
Volunteer Services	\$243,755
Health Professional Education	\$5,948,294
Subsidized Health Services (events, screenings, programs, subsidized health services and community health operations)	\$2,352,437
Total Site Costs for 2024	\$9,538,735

The impact of Advocate Christ is far reaching and is a critical organization supporting the communities of Chicago's South and Southwest suburbs. The communities have come to rely on many of these programs outlined to meet the special needs of the population in the service area. Advocate Christ's team members are aware of changes in health care and in the community and continue to develop new partnerships and services to support the health and wellbeing of everyone they serve.



Access & Opportunity for All

Our commitment to you: We affirm our unwavering commitment to lift everyone up by ensuring access and opportunity for all. We have a responsibility to our patients, teammates, learners and the communities we serve to embrace the differences among us and be welcoming, respectful and fair in all that we do.

From discovery to everyday moments, we're redefining care – for you, for us, for all.

Patients come first: We're committed to delivering compassionate, high-quality care that is safe, efficient and consistent – always honoring the unique needs and experiences of every patient we serve.

Respect for all cultures

We're committed to uplifting everyone by recognizing and respecting the individuality of our patients. Through self-reflection and lifelong learning, we work to recognize the various influences that, through understanding, allow us to provide better care. We emphasize building genuine, respectful relationships and learning from the unique and personal perspectives of those we serve. This enables us to deliver personalized, effective care that embodies our mission of care for all.

Language access & services

Effective communication is essential to delivering high-quality, compassionate health care. Our professional medical and sign language interpreters play a vital role in bridging communication between patients, families and providers to ensure language isn't a barrier to excellent care.

Disability & accessibility

We strive to cultivate a culture of accessibility and opportunity for all people with disabilities by promoting a deep awareness and understanding of the lived experience for people with disabilities. Our goal is to not only meet but exceed the minimum requirements of the Americans with Disabilities Act (ADA) by positively impacting the experiences of individuals with disabilities and prioritizing a sense of belonging for all.

Health care & wellness for all

We're committed to offering medical care to all people to ensure their personal, physical and mental health and well-being. As a partner with our patients and the communities we serve, we work to improve health through a welcoming environment and respectful care where each patient can be their best self.

Source: <https://www.advocatehealth.org/>

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.

ADVOCATE CHRIST MEDICAL CENTER CHARITY CARE			
	2022	2023	2024
Net Patient Revenue	\$1,372,696,815	\$1,499,785,406	\$1,634,888,321
Amount of Charity Care (charges)	\$26,758,820	\$34,682,219	\$42,715,503
Cost of Charity Care	\$6,947,928	\$9,483,345	\$10,404,842

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.

4. Applicant: Advocate Christ Medical Center 4400 W. 95th Street
(Name) (Address)

Oak Lawn IL 60453 (708) 684-8000

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

5. Project Location: 4400 W. 95th Street Oak Lawn, IL
(Address) (City) (State)

Cook Worth 03

(County) (Township) (Section)

6. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (<https://msc.fema.gov/portal/home>) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the **Go to NFHL**

Viewer tab above the map. You can print a copy of the floodplain map by selecting the



icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

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

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA:

Yes___ No X ?

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

Yes___ No X ?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ 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

APPENDIX

**2024 Financials
PDC Document**

Advocate Aurora Health, Inc.

Consolidated Financial Statements and Supplementary Information
As of and for the Years Ended December 31, 2025 and 2024



ADVOCATE AURORA HEALTH, INC.
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Report of Independent Auditors

The Board of Directors
Advocate Health, Inc.

Opinion

We have audited the consolidated financial statements of Advocate Aurora Health, Inc. (the System), which comprise the consolidated balance sheets as of December 31, 2025 and 2024, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the “financial statements”).

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the System at December 31, 2025 and 2024, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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 Auditor's Responsibilities for the Audit of the 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 Financial Statements

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

In preparing the 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 financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's 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 financial statements.



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with confidence**

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 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 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 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.

Other information

Management is responsible for the other information. The other information comprises the Annual Disclosure Statements but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Ernst & Young LLP

April 7, 2026

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED BALANCE SHEETS
(in thousands)

	December 31, 2025	December 31, 2024
Assets		
Current assets		
Cash and cash equivalents	\$ 304,990	\$ 733,229
Due from related party - centralized cash management arrangement	476,218	—
Assets limited as to use	183,210	179,057
Patient accounts receivable	2,187,133	2,009,794
Other current assets	2,049,483	1,086,141
Total current assets	5,201,034	4,008,221
Noncurrent assets		
Assets limited as to use	25,473,116	21,613,340
Property and equipment, net	6,395,432	6,079,747
Operating lease right-of-use assets	277,219	280,150
Other noncurrent assets	549,854	576,114
Total other assets	32,695,621	28,549,351
Total assets	\$ 37,896,655	\$ 32,557,572
Liabilities		
Current liabilities		
Long-term debt, current portion	\$ 462,253	\$ 343,589
Operating lease liabilities, current portion	61,712	67,961
Accrued salaries and employee benefits	1,270,602	1,400,664
Accounts payable and other accrued liabilities	2,432,691	1,536,878
Third-party payors payables	455,107	423,230
Total current liabilities	4,682,365	3,772,322
Noncurrent liabilities		
Long-term debt, less current portion	2,940,317	3,061,905
Operating lease liabilities, less current portion	263,532	249,594
Due to related party - investment pool	9,989,853	7,945,909
Other noncurrent liabilities	2,166,226	1,979,030
Total noncurrent liabilities	15,359,928	13,236,438
Total liabilities	20,042,293	17,008,760
Net assets		
Without donor restrictions		
Controlling interest	17,370,781	15,089,357
Noncontrolling interests in subsidiaries	217,324	203,353
Total net assets without donor restrictions	17,588,105	15,292,710
With donor restrictions	266,257	256,102
Total net assets	17,854,362	15,548,812
Total liabilities and net assets	\$ 37,896,655	\$ 32,557,572

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(in thousands)

	Year Ended December 31, 2025	Year Ended December 31, 2024
Revenue		
Patient service revenue	\$ 15,490,841	\$ 14,127,471
Other revenue	2,755,528	2,734,028
Total revenue	18,246,369	16,861,499
Expenses		
Salaries, wages and benefits	10,194,774	9,538,896
Supplies and drugs	3,936,287	3,419,075
Purchased services and other	2,837,061	2,845,762
Depreciation and amortization	576,782	558,606
Interest	121,772	121,293
Total expenses	17,666,676	16,483,632
Operating income	579,693	377,867
Nonoperating income		
Investment income, net	2,933,864	1,327,852
Other nonoperating loss, net	(1,246,802)	(432,698)
Total nonoperating income, net	1,687,062	895,154
Revenue in excess of expenses	2,266,755	1,273,021
Less income attributable to noncontrolling interests	(66,174)	(68,801)
Revenue in excess of expenses - attributable to controlling interest	\$ 2,200,581	\$ 1,204,220

(Continued)

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(in thousands)

	Year Ended December 31, 2025	Year Ended December 31, 2024
Net assets without donor restrictions, controlling interest		
Revenue in excess of expenses - attributable to controlling interest	\$ 2,200,581	\$ 1,204,220
Pension-related changes other than net periodic pension costs	80,333	56,068
Net assets released from restrictions for purchase of property and equipment	9,855	4,830
Other, net	(9,345)	(917)
Increase in net assets without donor restrictions, controlling interest	2,281,424	1,264,201
Net assets without donor restrictions, noncontrolling interests		
Revenues in excess of expenses	66,174	68,801
Distributions to noncontrolling interests	(52,203)	(57,030)
Increase in net assets without donor restrictions, noncontrolling interests	13,971	11,771
Net assets with donor restrictions		
Contributions	28,814	22,962
Investment income, net	15,733	8,032
Net assets released from restrictions for operations	(24,537)	(13,183)
Net assets released from restrictions for purchase of property and equipment	(9,855)	(4,830)
Other, net	—	(1,330)
Increase in net assets with donor restrictions	10,155	11,651
Increase in net assets	2,305,550	1,287,623
Net assets at beginning of period	15,548,812	14,261,189
Net assets at end of period	\$ 17,854,362	\$ 15,548,812

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Year Ended December 31, 2025	Year Ended December 31, 2024
Cash flows from operating activities		
Increase in net assets	\$ 2,305,550	\$ 1,287,623
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation, amortization and accretion	567,203	547,503
Noncash lease expense	66,048	65,417
Gain on sale of disposal group	—	(88,163)
Pension-related changes other than net periodic pension cost	(80,333)	(56,068)
Distribution to noncontrolling interests	62,074	54,483
Distribution from unconsolidated entities	8,224	8,727
Other	(21,482)	14,324
Changes in operating assets and liabilities		
Trading securities, net	(3,859,801)	(9,693,249)
Patient accounts receivable	(177,339)	(103,047)
Third-party payors receivables and payables, net	36,806	82,492
Due to related party	2,114,832	7,881,787
Other assets and liabilities, net	70,455	473,574
Net cash provided by operating activities	<u>1,092,237</u>	<u>475,403</u>
Cash flows from investing activities		
Capital expenditures	(905,472)	(681,508)
Net transfers to related party under centralized cash management arrangement	(476,218)	—
Cash received from sale of disposal group	—	184,298
Investments in unconsolidated entities, net	(1,758)	(11,009)
Purchases of investments designated as non-trading	(37,935)	(46,766)
Sales of investments designated as non-trading	37,961	46,896
Other	(1,606)	87
Net cash used in investing activities	<u>(1,385,028)</u>	<u>(508,002)</u>
Cash flows from financing activities		
Repayments of debt	(447,101)	(124,403)
Proceeds from issuance of debt	400,000	70,006
Distribution to noncontrolling interests	(62,074)	(54,483)
Other	(26,273)	360
Net cash used in financing activities	<u>(135,448)</u>	<u>(108,520)</u>
Net decrease in cash and cash equivalents	(428,239)	(141,119)
Cash and cash equivalents at beginning of period	733,229	874,348
Cash and cash equivalents at end of period	<u>\$ 304,990</u>	<u>\$ 733,229</u>
Supplemental disclosures of noncash information		
Operating lease right-of-use assets in exchange for new operating lease liabilities	\$ 132,538	\$ 44,510

See accompanying notes to consolidated financial statements.

ADVOCATE AURORA HEALTH, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
FOR THE YEAR ENDED DECEMBER 31, 2025
(dollars in thousands)

1. ORGANIZATION AND BASIS OF PRESENTATION

Description of Business

Advocate Aurora Health, Inc., a Delaware nonprofit nonstock corporation (the "Parent Corporation"), owns and operates primarily not-for-profit healthcare facilities in Illinois and Wisconsin. The Parent Corporation is the sole corporate member of Advocate Health Care Network, an Illinois not-for-profit corporation ("Advocate") and Aurora Health Care, Inc., a Wisconsin nonstock not-for-profit corporation ("Aurora"). The Parent Corporation, Advocate, Aurora and their controlled subsidiaries are collectively referred to herein as the "System." The System was formed in furtherance of the parties' common and unifying charitable health care mission to promote and improve the quality and expand the scope and accessibility of affordable health care and health care-related services for the communities they serve.

The System and Atrium Health, Inc., a North Carolina not-for-profit corporation, ("AHI") entered into a joint operating agreement pursuant to which they created Advocate Health, Inc. ("Advocate Health"), a Delaware nonprofit nonstock corporation, to manage and oversee an integrated health care delivery and academic system which focuses on meeting patients' needs by redefining how, when and where care is delivered. The System and AHI are the two corporate members of Advocate Health. The System maintains its separate legal existence and no sale, transfer or other conveyance of assets or assumption of debt and liabilities occurred in connection with the formation of Advocate Health.

The System provides a continuum of care through its 25 acute care hospitals, an integrated children's hospital, a psychiatric hospital, primary and specialty physician services, outpatient centers, physician office buildings, pharmacies, rehabilitation and home health and hospice care in northern Illinois and eastern Wisconsin.

Principles of Consolidation

Included in the System's consolidated financial statements are all of its wholly owned or controlled subsidiaries. All significant intercompany transactions have been eliminated in consolidation.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States ("GAAP") requires management to make estimates, assumptions and judgments that affect the reported amounts of assets, liabilities and amounts disclosed in the notes to the consolidated financial statements at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Cash Equivalents

The System considers all highly liquid investments with a maturity of three months or less when purchased, other than those included in the investment portfolio, to be cash equivalents.

Due From Related Party - Centralized Cash Management Arrangement

Beginning in 2025, the System transfers excess operating cash to Advocate Health to maximize cash management opportunities. The amount due from Advocate Health under the cash arrangement totaled \$476,218 at December 31, 2025.

Investments

The System has designated substantially all its investments as trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices or otherwise observable inputs. Investments in private equity limited partnerships and derivative products (hedge funds) are reported at fair value using net asset value as a practical expedient. Commingled funds are carried at fair value based on other observable inputs. Investment income or loss (including realized gains and losses, interest, dividends and unrealized gains and losses) is included in the nonoperating section of the accompanying consolidated statements of operations and changes in net assets, unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue in the accompanying consolidated statements of operations and changes in net assets. Investment income or loss that is restricted by donor or law is reported as a change in net assets with donor restrictions.

Assets Limited as to Use

Assets limited as to use consist of investments set aside by the System for future capital improvements and certain medical education and other health care programs. The System retains control of these investments and may, at its discretion, subsequently use them for other purposes. Additionally, assets limited as to use include investments held by trustees or in trust under debt agreements, self-insurance trusts, retirement plan assets, assets held in reinsurance trust accounts and donor-restricted funds.

Patient Service Revenue and Accounts Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including commercial payors and government programs and excludes revenues for services provided to patients under capitated arrangements) and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations.

Revenue is recognized as performance obligations are satisfied. Performance obligations are identified based on the nature of the services provided. Revenue associated with performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. Performance obligations satisfied over time relate to patients receiving inpatient acute care services. The System measures the performance obligation from admission into the hospital to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services, the performance obligation is satisfied as the patient simultaneously receives and consumes the benefits provided as the services are performed. Management believes this

method provides a faithful depiction of the transfer of services over the term of performance obligations based on the inputs needed to satisfy the obligations.

As the System's performance obligations relate to contracts with a duration of less than one year, the System has applied the optional exemption provided in the guidance and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which typically occurs within days or weeks of the end of the reporting period.

The System uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient revenue and major payor classes and types of services provided for outpatient revenue. Based on the historical collection trends and other analyses, the System believes revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

The System determines the transaction price, which involves significant estimates and judgment, based on standard charges for goods and services provided, reduced by explicit and implicit price concessions, including contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with policy and/or implicit price concessions based on the historical collection experience of patient accounts. The System determines the transaction price associated with services provided to patients who have third-party payor coverage based on reimbursement terms per contractual agreements, discount policies and historical experience. For uninsured patients who do not qualify for charity care, the System determines the transaction price associated with services based on charges reduced by implicit price concessions. Implicit price concessions included in the estimate of the transaction price are based on historical collection experience for applicable patient portfolios. Patients who meet the System's criteria for charity care are provided care without charge; such amounts are not reported as revenue. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change.

The System does not incur significant incremental costs in obtaining contracts with patients. Any costs incurred are expensed in the period of occurrence, as the amortization period of any asset that the System would have recognized is one year or less in duration.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreements with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as new information becomes available or as years are settled or are no longer subject to such audits, reviews and investigations. As a result, there is a possibility that recorded estimates will change by a material amount.

For the years ended December 31, 2025 and 2024, changes in the System's estimates of implicit price concessions, discounts and contractual adjustments or other changes to expected payments for performance obligations related to prior years were not material.

In the normal course of business, the System does receive payments in advance for certain services provided and would consider these amounts to represent contract liabilities. The contract liabilities received in the normal course of business at December 31, 2025 and 2024 were not material.

The System does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component, due to the expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less.

The System has entered into payment arrangements with patients that allow for payments over a term in excess of one year. The System has evaluated historical collections in excess of one year and current market interest rates to determine whether a significant financing component exists that would require an adjustment to the promised amount of consideration from patients and third-party payors. The System has determined that the impact of implicit financing arrangements for payment agreements in excess of one year is insignificant to the accompanying consolidated statements of operations and changes in net assets.

Reinsurance Receivables

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts. Reinsurance receivables are included in other current assets in the accompanying consolidated balance sheets.

Asset Impairment

The System considers whether indicators of impairment are present and, if indicators are present, performs the necessary tests to determine if the carrying value of an asset is recoverable. Impairment write-downs are recognized in the accompanying consolidated statements of operations and changes in net assets as a component of operating expense at the time the impairment is identified. There were no material impairment charges recorded for the years ended December 31, 2025 and 2024.

Property and Equipment, Net

Property and equipment are reported at cost or, if donated, at fair value at the date of the gift. Costs of computer software developed or obtained for internal use, including external and internal direct costs of materials and labor directly associated with internal-use software development projects, are capitalized during the application development stage and included in property and equipment. Internal labor and interest expense incurred during the period of construction of significant capital projects are capitalized as a component of the costs of the asset.

Property and equipment capitalized under direct financing leases are recorded at the present value of future lease payments, adding initial direct costs and prepaid lease payments, reduced by any lease incentives. Property and equipment capitalized under direct financing leases are amortized using the straight-line method over the related lease term. Amortization of property and equipment under financing leases is included in the accompanying consolidated statements of operations and changes in net assets in depreciation and amortization expense.

Property and equipment assets are depreciated on the straight-line method over the following estimated useful lives:

	Estimated Useful Life in Years
Land improvements	2-28
Buildings and other improvements	2-80
Fixed and movable equipment	2-25

Operating Lease Right-of-use Assets

The System records an operating lease right-of-use asset (an asset that represents the System's right to use the leased asset for the lease term) for leases that do not meet the criteria as a sales-type lease or a direct financing lease.

The System records operating lease right-of-use assets at the present value of future lease payments, adding initial direct costs and prepaid lease payments, reduced by any lease incentives. Operating lease right-of-use assets are amortized using the straight-line method over the related lease term. Amortization of operating lease right-of-use assets is included in purchased services and other expense in the accompanying consolidated statements of operations and changes in net assets.

Goodwill and Intangible Assets, Net

The System has elected to amortize goodwill using the straight-line method over a 10-year period. Intangible assets with expected useful lives are amortized over that period. Amortization is included in depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets.

Investments in Unconsolidated Entities

Investments in unconsolidated entities are included in other noncurrent assets in the accompanying consolidated balance sheets and are accounted for using the equity method or as an equity security without a readily determinable fair value. The System applies the equity method of accounting for investments in unconsolidated entities when its ownership or membership interest is 50% or less and the System has the ability to exercise significant influence over the operating and financial policies of the investee. The income (loss) on health-related unconsolidated entities is included in other revenue in the accompanying consolidated statements of operations and changes in net assets. The income (loss) on non-health-related unconsolidated entities is included in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets. All other unconsolidated entities are accounted for as an equity security without a readily determinable fair value. These unconsolidated entities are initially recorded at cost, tested for impairment at least annually and adjusted as market transactions occur that would indicate a fair value adjustment is needed. The income (loss) on these unconsolidated entities is included in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets.

Derivative Financial Instruments

The System enters into transactions to manage its interest rate, credit and market risks. Derivative financial instruments, including exchange-traded and over-the-counter derivative contracts and interest rate swaps, are recorded as either assets or liabilities at fair value. Subsequent changes in a

derivative's fair value are recognized in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets.

Bond Issuance Costs, Discounts and Premiums

Bond issuance costs, discounts and premiums are amortized over the term of the bonds using the effective interest method and are included in long-term debt, less current portion in the accompanying consolidated balance sheets.

General and Professional Liability Risks

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The System measures the cost of its unfunded obligations under such programs based upon actuarial calculations and records a liability on a discounted basis.

Net Assets with Donor Restrictions

Net assets with donor restrictions are those assets whose use has been limited by donors to a specific time period or purpose or consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity. Net assets with donor restrictions are used in accordance with the donor's wishes primarily to purchase property and equipment, to fund medical education or to fund health programs.

Assets released from restrictions to fund purchases of property and equipment are reported as increases to net assets without donor restrictions in the accompanying consolidated statements of operations and changes in net assets. Those assets released from restriction for operating purposes are reported in the accompanying consolidated statements of operations and changes in net assets as other revenue. When restricted, earnings are recorded as net assets with donor restrictions until amounts are expended in accordance with the donor's specifications.

Other Revenue

Other revenue is recognized at an amount that reflects the consideration to which the System expects to be entitled in exchange for providing goods and services. The amounts recognized reflect consideration due from customers, third-party payors and others. Primary categories of other revenue include capitation revenue, retail pharmacy revenue, clinical integration revenue, managed care risk/quality shared savings revenue and other miscellaneous revenue.

Capitation Revenue

The System has agreements with various commercial organizations under which the System provides or arranges for medical care to members of the organizations in return for a monthly payment per member. Revenue is earned each month as a result of the System agreeing to provide or arrange for their medical care. Capitation revenue is included in other revenue in the accompanying consolidated statements of operations and changes in net assets.

Other Nonoperating Loss, Net

Revenues and expenses related to the delivery of health care services are reported in operations. Income and losses that arise from transactions that are peripheral or incidental to the System's main purpose are included in other nonoperating loss, net. Other nonoperating loss, net includes an offset to

investment income representing AHI's share of the change in fair value of the investment pool (see Note 5. INVESTMENTS), fund-raising expenses, income taxes, unrealized changes in fair value of swaps and the net non-service components of the periodic benefit expense of the System's pension plans.

Revenue in Excess of Expenses and Changes in Net Assets

The accompanying consolidated statements of operations and changes in net assets includes the revenue in excess of expenses as the performance indicator. Changes in net assets without donor restrictions, which are excluded from revenue in excess of expenses, primarily include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), pension-related changes other than net periodic pension costs and distributions to noncontrolling interests.

Accounting Pronouncements Not Yet Adopted

In September 2025, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Updated ("ASU") 2025-06, *Intangibles- Goodwill and Other- Internal-Use Software (Subtopic 350-40)*. This guidance amends certain aspects of ASC 350-40 to better align with current software development methods. Under the new standard, entities will start capitalizing eligible costs when (1) management has authorized and committed to funding the software project and (2) it is probable that the project will be completed and the software will be used to perform the function it intended. In evaluating whether it is probable the project will be completed, the entity is required to consider whether there is significant uncertainty associated with the development activities of the software. The effective date is for fiscal years beginning after December 15, 2027, early adoption is permitted. The guidance can be applied on a prospective, modified or retrospective transition approach. The System is evaluating the impact of this guidance and does not expect it to have a material impact on the System's consolidated financial statements.

Change in Reporting Entity

In 2025, Advocate Health combined the operations of three of its captive insurance companies, including an AHI affiliate, in a subsidiary of the Parent Corporation. As the combining entities were under common control, the 2024 consolidated financial statements were retrospectively adjusted to include the previously unconsolidated AHI affiliate. The 2024 balance sheet impact was an increase in total assets and total liabilities and net assets of approximately \$90,000, which primarily consisted of increases in assets limited as to use and other noncurrent liabilities. The 2024 statements of operations and changes in net assets impact was a decrease of \$3,700 in revenue in excess of expenses.

3. COMMUNITY BENEFIT

The System provides health care services without charge or at discounted rates to patients who meet the criteria of its financial assistance policies. Charity care services are not reported as patient service revenue, because payment is not anticipated while the related costs to provide the health care are included in operating expenses. Qualifying patients can receive up to 100% discounts from charges. The System's cost of providing charity care was \$204,160 and \$161,402 for the years ended December 31, 2025 and 2024, respectively, as determined using total cost to charge ratios.

In addition to the provision of charity care, the System provides significant financial support to its communities to sustain and improve health care services.

These activities include:

- The unreimbursed cost of providing care to patients covered by the Medicare and Medicaid programs.
- The cost of providing services that are not self-sustaining, for which patient service revenues are less than the costs required to provide the services. Such services benefit uninsured and low-income patients, as well as the broader community, but are not expected to be financially self-supporting.
- Other community benefits, which include the unreimbursed costs of community benefits programs and services for the general community, not solely for those demonstrating financial need, including the unreimbursed cost of medical education, health education, immunizations for children, support groups, health screenings and fairs.

4. REVENUE AND RECEIVABLES

Patient service revenue

The composition of patient service revenue by payor is as follows:

	Year Ended December 31, 2025		Year Ended December 31, 2024	
Commercial	\$	8,089,954 52 %	\$	7,525,366 53 %
Medicare		4,934,113 32 %		4,513,293 32 %
Medicaid		2,067,132 13 %		1,720,313 12 %
Self-pay and other		399,642 3 %		368,499 3 %
	\$	15,490,841 100 %	\$	14,127,471 100 %

Deductibles, copayments and coinsurance under third-party payment programs which are the patient's responsibility are included within the primary payor category in the table above.

Revenue disaggregated by state and service line is as follows:

	Year Ended December 31, 2025		Year Ended December 31, 2024	
Illinois	\$	7,630,100	\$	6,459,073
Wisconsin		7,860,741		7,668,398
Total patient service revenue	\$	15,490,841	\$	14,127,471
Hospital	\$	11,749,679	\$	10,545,547
Clinic		3,369,367		3,240,291
Other		371,795		341,633
Total patient service revenue	\$	15,490,841	\$	14,127,471

Currently, the State of Illinois utilizes supplemental reimbursement programs to increase reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. These programs are designed with input from the Centers for Medicare & Medicaid Services and are funded with a combination of state and federal resources, including assessments levied on the providers. Under these supplemental programs, the System recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. In 2025, the State of Illinois updated its hospital assessment program which includes increases to the Managed Care Access Payments made to hospitals through the Health Choice Illinois Managed Care Organizations and increases in the monthly hospital assessments paid by the hospitals. Reimbursement and the

assessment under these programs are reflected in the accompanying consolidated statements of operations and changes in net assets as follows:

	Classification	Year Ended December 31, 2025	Year Ended December 31, 2024
Reimbursement	Patient service revenue	\$ 634,008	\$ 381,290
Assessment	Purchased services and other	352,163	217,317

The State of Wisconsin assesses a fee or tax on gross patient service revenue. The revenues from this assessment are used to increase payments made to hospitals for services provided to Medicaid and other medically indigent patients. The System's patient service revenue reflects this increase in payment for services to Medicaid and other medically indigent patients and hospital tax assessment expense reflects the fees assessed by the State. Reimbursement and the assessment under these programs are reflected in the accompanying consolidated statements of operations and changes in net assets as follows:

	Classification	Year Ended December 31, 2025	Year Ended December 31, 2024
Reimbursement	Patient service revenue	\$ 140,369	\$ 130,586
Assessment	Purchased services and other	102,964	101,736

There are no assurances regarding future reimbursement related to these Medicaid supplemental programs as they are subject to annual legislative and regulatory approvals that could be materially modified in the future.

Patient accounts receivable

The composition of patient accounts receivable is summarized as follows:

	December 31, 2025			December 31, 2024		
Commercial	\$	1,002,393	46 %	\$	907,753	45 %
Medicare		559,521	26 %		537,627	27 %
Medicaid		191,639	9 %		165,931	8 %
Self-pay and other		433,580	19 %		398,483	20 %
	\$	2,187,133	100 %	\$	2,009,794	100 %

The self-pay patient accounts receivable above includes amounts due from patients for co-insurance, deductibles, installment payment plans and amounts due from patients without insurance.

5. INVESTMENTS

The System has a pooled investment fund ("pool") where all of the pool investments are owned by a subsidiary of the System. Each participant in the pool is an affiliate of the subsidiary. Per the Investment Agreement, each participant in the pool has no ownership interest in the pool's investment assets. The participant receives a commensurate value in units of the pool, which is adjusted each month to the current market value. If redemption is sought under the terms of the agreement, the participant is only entitled to receive the fair market value of its units in cash. In April 2024, AHI became a participant in the pool. AHI's interest in the pool is \$9,989,853 and \$7,945,909 at December 31, 2025 and 2024, respectively, which is included in the consolidated balance sheets as due to related party investment pool. The change in fair value of the entire investment pool for the years ended December 31, 2025 and 2024, is included in investment income, net in the consolidated statement of operations and changes in net assets. The change in fair value attributable to AHI's

interest in the investment pool for the same period of \$1,132,718 and \$411,408, respectively, is recorded as an offset in other nonoperating loss, net.

The pool invests in a diversified portfolio of investments, including alternative investments, such as real asset funds, equity funds, hedge funds and private equity limited partnerships, whose fair value was \$13,711,364 and \$10,873,558 at December 31, 2025 and 2024, respectively. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods typically ranging from 1 to 90 days. Certain of these investments have redemption restrictions that may restrict redemption for up to 15 years. However, the potential for the System to sell its interest in these funds in a secondary market prior to the end of the fund term does exist for prices at or other than the carrying value.

At December 31, 2025, the System had additional commitments to fund alternative investments, including callable distributions of \$3,296,768 over the next seven years.

In the normal course of operations and within established investment policy guidelines, the System may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the System's strategic asset allocation and hedge security price movements. These instruments require the System to deposit cash or securities collateral with the broker or custodian. Collateral provided was \$19,315 and \$5,933 at December 31, 2025 and 2024, respectively. The gross notional value of the derivatives outstanding was \$126,255 and \$149,464 at December 31, 2025 and 2024, respectively.

By using derivative financial instruments, the System exposes itself to credit and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty and, therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in the underlying reference security. The market risk associated with market changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Receivables and payables for investment trades not settled are presented within other current assets and accounts payable and other accrued liabilities in the accompanying consolidated balance sheets. Unsettled sales resulted in receivables due from brokers of \$4,821 and \$6,119 at December 31, 2025 and 2024, respectively. Unsettled purchases resulted in payables due to brokers of \$22,333 and \$28,198 at December 31, 2025 and 2024, respectively.

Investment returns for assets limited as to use and cash and cash equivalents are composed of the following:

	Year Ended December 31, 2025	Year Ended December 31, 2024
Interest income and dividends	\$ 316,577	\$ 303,081
Income from alternative investments	612,564	458,052
Net realized gains	951,126	187,913
Net unrealized gains	1,101,927	430,239
Total	<u>\$ 2,982,194</u>	<u>\$ 1,379,285</u>

Investment returns are included in the accompanying consolidated statements of operations and changes in net assets as follows:

	Year Ended December 31, 2025	Year Ended December 31, 2024
Other revenue	\$ 32,597	\$ 43,401
Investment income, net	2,933,864	1,327,852
Net assets with donor restrictions	15,733	8,032
Total	<u>\$ 2,982,194</u>	<u>\$ 1,379,285</u>

The assets limited as to use presented within the accompanying consolidated balance sheets are comprised of the following:

	December 31, 2025	December 31, 2024
Internally designated for capital and other	\$ 23,501,866	\$ 20,545,013
Held for self-insurance	477,882	614,315
Donor restricted	124,951	111,146
Funds held under retirement plans	616,740	502,965
Investments under securities lending program	934,887	18,958
Total assets limited as to use	25,656,326	21,792,397
Assets limited as to use, current	183,210	179,057
Assets limited as to use, noncurrent	<u>\$ 25,473,116</u>	<u>\$ 21,613,340</u>

As part of the management of the investment portfolio, the System has entered into an arrangement whereby securities owned by the System are loaned primarily to brokers and investment banks. The loans are arranged through a bank. Borrowers are required to post collateral for securities borrowed equal to no less than 102% of the value of the security on a daily basis, at a minimum. The bank is responsible for reviewing the creditworthiness of the borrowers. The System has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At December 31, 2025 and 2024, the System loaned \$934,887 and \$18,958, respectively, in securities and accepted collateral for these loans in the amount \$988,296 and \$19,964, respectively, which represents cash and governmental securities, and are included in accounts payable and other accrued liabilities and other current assets in the accompanying consolidated balance sheets. In 2025, the System modified its lending policy to maintain higher outstanding loan balances throughout the year.

6. FAIR VALUE

The System accounts for certain assets and liabilities at fair value and categorizes assets and liabilities measured at fair value in the accompanying consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available under the circumstances.

The fair value of all assets and liabilities recognized or disclosed at fair value are classified based on the lowest level of significant inputs. Assets and liabilities that are measured at fair value are disclosed and classified in one of the three categories. Category inputs are defined as follows:

Level 1 — Quoted prices (unadjusted) in active markets for identical assets or liabilities on the reporting date.

Level 2 — Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 — Inputs that are unobservable for the asset or liability for which there is little or no market data.

The following section describes the valuation methodologies used by the System to measure financial assets and liabilities at fair value. In general, where applicable, the System uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments, such as domestic and international equities, exchange-traded funds and agency securities.

If quoted prices in active markets for identical assets and liabilities are not available to determine the fair value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, fixed-income securities, including fixed-income government obligations, commercial paper and certain agency, United States and international equities, which are not traded on an active exchange. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry-standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include adjustments related to the System's credit risk.

Investments owned by the System are exposed to various kinds and levels of risk. Equity securities and equity funds expose the System to market risk, performance risk and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is the risk associated with a company's operating performance. Fixed-income securities and fixed-income mutual funds expose the System to interest rate risk, credit risk and liquidity risk. As interest rates change, the value of many fixed-income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value, resulting in additional gains and losses in the near term.

The carrying values of cash and cash equivalents, accounts receivable and payable, other current assets and accrued liabilities are reasonable estimates of their fair values, due to the short-term nature of these financial instruments.

The fair values of financial assets and liabilities measured at fair value on a recurring basis are as follows:

	December 31, 2025	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	\$ 260,539	\$ 202,073	\$ 58,466	\$ —
Corporate bonds and other debt securities	1,626,084	—	1,626,084	—
United States government bonds	1,516,307	—	1,516,307	—
Bond and other debt security funds	229,355	228,678	677	—
Non-government fixed-income obligations	52,822	—	52,822	—
Equity securities	1,944,364	1,944,364	—	—
Equity funds	5,675,290	1,709,530	3,965,760	—
Funds held under retirement plans	616,740	142,920	473,820	—
	11,921,501	\$ 4,227,565	\$ 7,693,936	\$ —
Investments at net asset value				
Alternative investments	13,734,825			
Total investments	<u>\$ 25,656,326</u>			
Collateral proceeds received under securities lending program				
	<u>\$ 988,296</u>		<u>\$ 988,296</u>	
Liabilities				
Obligations under swap agreements	<u>\$ (22,729)</u>		<u>\$ (22,729)</u>	
Liabilities under retirement and benefit plans	<u>\$ (616,740)</u>		<u>\$ (616,740)</u>	
Obligations to return capital under securities lending program	<u>\$ (988,296)</u>		<u>\$ (988,296)</u>	

	December 31, 2024	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments				
Cash and short-term investments	\$ 257,884	\$ 234,216	\$ 23,668	\$ —
Corporate bonds and other debt securities	1,498,905	—	1,498,905	—
United States government bonds	1,266,608	—	1,266,608	—
Bond and other debt security funds	164,282	156,577	7,705	—
Non-government fixed-income obligations	63,140	—	63,140	—
Equity securities	1,846,361	1,831,700	14,661	—
Equity funds	5,295,135	2,382,630	2,912,505	—
Funds held under retirement plans	502,965	101,981	400,984	—
	10,895,280	\$ 4,707,104	\$ 6,188,176	\$ —
Investments at net asset value				
Alternative investments	10,897,117			
Total investments	<u>\$ 21,792,397</u>			
Collateral proceeds received under securities lending program				
	<u>\$ 19,964</u>		<u>\$ 19,964</u>	
Liabilities				
Obligations under swap agreements	<u>\$ (19,566)</u>		<u>\$ (19,566)</u>	
Liabilities under retirement and benefit plans	<u>\$ (502,965)</u>		<u>\$ (502,965)</u>	
Obligations to return capital under securities lending program	<u>\$ (19,964)</u>		<u>\$ (19,964)</u>	

7. PROPERTY AND EQUIPMENT, NET

The components of property and equipment, net are summarized as follows:

	December 31, 2025	December 31, 2024
Land and improvements	\$ 516,310	\$ 509,690
Buildings and other improvements	9,283,325	8,662,172
Fixed and movable equipment	3,444,252	3,101,227
Construction-in-progress	397,871	575,090
	13,641,758	12,848,179
Accumulated depreciation and amortization	(7,246,326)	(6,768,432)
Property and equipment, net	<u>\$ 6,395,432</u>	<u>\$ 6,079,747</u>

During 2025, the System wrote off fully depreciated property and equipment totaling \$76,285.

Property and equipment, net include assets recorded as finance leases and under other financing arrangements. See additional disclosure in Note 8. LEASES.

Depreciation expense was \$568,117 and \$549,970 for the years ended December 31, 2025 and 2024, respectively.

8. LEASES

The System leases office and clinical space, land and equipment. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheets. The System combines lease and non-lease components, except for medical equipment leases.

The depreciable lives of assets are limited by the expected lease terms. Most leases include options to renew. The majority of leases do not provide an implicit rate; therefore, the System has elected to use its incremental borrowing rate, which is the interest rate the System would borrow on a collateralized basis over a similar term, as the discount rate.

Operating and finance leases are classified as follows within the accompanying consolidated balance sheets:

Leases	Classification	December 31, 2025	December 31, 2024
Assets			
Operating	Operating lease right-of-use assets	\$ 277,219	\$ 280,150
Finance	Property and equipment, net	219,556	187,955
Total lease assets		<u>\$ 496,775</u>	<u>\$ 468,105</u>
Liabilities			
Current			
Operating	Operating lease liabilities, current portion	\$ 61,712	\$ 67,961
Finance	Long-term debt, current portion	24,733	21,188
Noncurrent			
Operating	Operating lease liabilities, less current portion	263,532	249,594
Finance	Long-term debt, less current portion	245,069	216,011
Total lease liabilities		<u>\$ 595,046</u>	<u>\$ 554,754</u>

Finance lease assets are recorded net of accumulated amortization of \$158,050 and \$138,538 as of December 31, 2025 and 2024, respectively.

Lease costs are classified as follows within the accompanying consolidated statements of operations and changes in net assets:

Lease cost	Classification	December 31, 2025	December 31, 2024
Operating lease cost	Purchased services and other	\$ 72,345	\$ 72,896
Short term and variable lease cost	Purchased services and other	54,912	54,747
Finance lease cost			
Amortization of lease assets	Depreciation and amortization	23,720	23,649
Interest on lease liabilities	Interest	18,085	17,911
Sublease income	Other revenue	(271)	(188)
Net lease cost		<u>\$ 168,791</u>	<u>\$ 169,015</u>

Lease terms, discount rates and other supplemental information are as follows:

	December 31, 2025	December 31, 2024
Weighted average remaining lease term (in years)		
Operating	6.7	5.8
Finance	8.0	7.9
Weighted average discount rate		
Operating	3.04 %	2.78 %
Finance	8.59 %	8.25 %
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows from operating leases	\$ 77,578	\$ 76,908
Operating cash flows from finance leases	18,085	17,911
Financing cash flows from finance leases	23,689	21,671

Future maturities of lease liabilities at December 31, 2025 are as follows:

	Operating Leases	Finance Leases	Total
2026	\$ 70,483	\$ 42,919	\$ 113,402
2027	61,801	45,201	107,002
2028	52,069	52,840	104,909
2029	42,017	53,090	95,107
2030	35,587	41,844	77,431
Thereafter	100,383	141,364	241,747
Future minimum lease payments	362,340	377,258	739,598
Less remaining imputed interest	37,096	107,456	144,552
Total	\$ 325,244	\$ 269,802	\$ 595,046

9. LONG-TERM DEBT

Long-term debt consisted of the following:

	December 31, 2025	December 31, 2024
Revenue bonds and revenue refunding bonds		
Series 2008A (weighted average rate of 4.35% during 2025 and 2024), principal payable in varying annual installments through November 2030; interest based on prevailing market conditions at time of remarketing	51,330	69,020
Series 2008C (weighted average rate of 2.66% and 3.40% during 2025 and 2024, respectively), principal payable in varying annual installments through November 2038; interest based on prevailing market conditions at time of remarketing	272,065	272,065
Series 2011B (weighted average rate of 2.98% and 3.67% during 2025 and 2024, respectively), principal payable in varying annual installments through April 2051, subject to a put provision that provides for a cumulative seven-month notice and remarketing period; interest tied to a market index plus a spread	69,660	69,660
Series 2011C (weighted average rate of 3.11% and 4.70% during 2025 and 2024, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 4, 2029; interest tied to a market index plus a spread	49,755	49,755
Series 2011D (weighted average rate of 3.11% and 4.70% during 2025 and 2024, respectively), principal payable in varying annual installments through April 2049, subject to a put provision on September 4, 2029; interest tied to a market index plus a spread	49,755	49,755
Series 2014, 4.00%, principal payable in varying annual installments through August 2038	60,050	67,330
Series 2015, 4.13%, principal payable in varying annual installments through May 2045	30,620	30,620
Series 2015B, 4.00% to 5.00%, principal payable in varying annual installments through May 2044	13,260	13,465
Series 2018A, 4.00% to 5.00%, principal payable in varying annual installments through August 2044	97,500	97,500

	<u>December 31, 2025</u>	<u>December 31, 2024</u>
Series 2018B (weighted average rate of 4.68% and 5.00% during 2025 and 2024, respectively), principal payable in varying annual installments through August 2054; interest based on prevailing market conditions at time of remarketing	176,730	176,730
Series 2018C (weighted average rate of 4.41% and 4.57% during 2025 and 2024, respectively), principal payable in varying annual installments through August 2054, interest tied to a market index plus a spread or prevailing market conditions at remarketing	182,255	182,255
	<u>1,052,980</u>	<u>1,078,155</u>
Taxable bonds		
Taxable Bond Series 2018, 3.83% to 4.27%, principal payable in varying annual installments through August 2048	799,510	799,510
Taxable Bond Series 2019, 3.39%, principal payable in October 2049	443,180	443,180
Taxable Bond Series 2020A, 2.21% to 3.01%, principal payable in varying annual installments through June 2050	700,000	700,000
	<u>1,942,690</u>	<u>1,942,690</u>
Finance lease obligations and financing arrangements	272,696	240,773
Commercial paper, weighted average interest rate of 4.34% and 5.13% during 2025 and 2024, respectively	120,000	120,000
	<u>3,388,366</u>	<u>3,381,618</u>
Net unamortized premiums and unamortized bond issuance costs	14,204	23,876
	<u>3,402,570</u>	<u>3,405,494</u>
Less amounts classified as current		
Long-term debt, current portion	(462,253)	(343,589)
	<u>(462,253)</u>	<u>(343,589)</u>
	<u>\$ 2,940,317</u>	<u>\$ 3,061,905</u>

Maturities of long-term debt, finance leases, and sinking fund requirements, assuming remarketing of the variable rate demand revenue refunding bonds, for the five years ending December 31, 2030, are as follows:

2026	\$	43,628
2027		47,095
2028		448,304
2029		68,437
2030		361,249

The System's outstanding bonds are secured by obligations issued under the Second Amended and Restated Master Trust Indenture dated as of August 1, 2018, as the same may be amended from time to time, between Advocate Aurora Health, Inc., the other affiliates identified therein as the Members of the Obligated Group and U.S. Bank Trust Company, National Association, as master trustee ("the System Master Indenture"). Under the terms of the bond indentures and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The System Master Indenture and other debt agreements, including bank agreements, also place restrictions on the System and require the System to maintain certain financial ratios.

The System's unsecured variable rate revenue bonds, Series 2011B of \$69,660, Series 2018B-2 of \$43,050, Series 2018B-4 of \$49,420, Series 2018C-1 of \$40,885, Series 2018C-2 of \$50,000 and Series 2018C-3 of \$45,610, while subject to a long-term amortization period, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after December 31, 2025, the principal amount of such bonds is included in long-term debt, current portion in the accompanying consolidated balance sheets. Management believes the likelihood of a material amount

of bonds being put to the System is remote. However, to address this possibility, the System has taken steps to provide various sources of liquidity, including assessing alternate sources of financing, including lines of credit and/or net assets without donor restrictions as a source of self-liquidity.

The System has standby bond purchase agreements with banks to provide liquidity support for the Series 2008C Bonds. In the event of a failed remarketing of a Series 2008C Bond upon its tender by an existing holder and subject to compliance with the terms of the standby bond purchase agreement, the standby bank would provide the funds for the purchase of such tendered bonds, and the System would be obligated to repay the bank for the funds it provided for such bond purchase (if such bond is not subsequently remarketed), with the first installment of such repayment commencing on the date one year and one day after the bank purchases the bond. As of December 31, 2025, there were no bank-purchased bonds outstanding. To the extent that the standby bond purchase agreement expiration date is within 12 months after December 31, 2025, the principal amount of such bonds would be classified as a current obligation in the accompanying consolidated balance sheets. The standby bond purchase agreements expire as follows: \$58,225 in September 2028, \$129,456 in January 2029 and \$87,694 in August 2029.

In January 2024, \$44,130 of the Series 2018B-3 Bonds were remarketed for a new long-term rate period and will next be subject to mandatory purchase on June 22, 2029. In connection with the remarketing, \$4,430 of the Series 2018B-3 Bonds were redeemed and a loss on refinancing was recorded in the amount of \$25.

In January 2024, \$45,760 of the Series 2018C-4 Bonds were remarketed for a new long-term rate period and will next be subject to mandatory purchase on June 22, 2029. In connection with the remarketing, \$4,590 of the Series 2018C-4 Bonds were redeemed and a loss on refinancing was recorded in the amount of \$26.

In January 2025, \$49,420 of the Series 2018B-4 Bonds were converted to a new long-term interest rate period and sold to a single institutional investor. The new long-term interest rate period will end on June 25, 2026.

As of December 31, 2025, the System has authorized the issuance of up to \$1,000,000 in commercial paper aggregate principal outstanding. As of December 31, 2025, \$120,000 of commercial paper notes were outstanding, with maturities ranging from 34 to 69 days. As of December 31, 2024, \$120,000 of commercial paper was outstanding, with maturities ranging from 21 to 62 days.

At December 31, 2025, the System had lines of credit with banks aggregating to \$1,000,000 in available commitments. These lines of credit provide for various interest rates and payment terms and as of December 31, 2025 expire as follows: \$300,000 in December 2026, \$325,000 in December 2027 and \$375,000 in December 2028. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures for general working capital purposes or to provide for certain letters of credit. At December 31, 2025, letters of credit totaling \$72,820 have been issued under one of these lines. At December 31, 2025 and 2024, no amounts were outstanding on these lines or letters of credit.

The System maintains an interest rate swap program on certain of its variable rate debt, as described in Note 10. INTEREST RATE SWAP PROGRAM.

The System's interest paid amount encompasses all debt agreements including revenue bonds and revenue refunding bonds, taxable bonds, finance lease obligations, financing arrangements and interest rate swaps. The System's interest paid, net of capitalized interest, amounted to \$119,543 and \$127,442

for the years ended December 31, 2025 and 2024, respectively. The System capitalized interest of \$9,597 and \$6,864 for the years ended December 31, 2025 and 2024, respectively.

10. INTEREST RATE SWAP PROGRAM

The System has interest rate-related derivative instruments to manage the exposure of its variable rate debt instruments. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk as described in Note 5. INVESTMENTS .

The System maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose the System to variability in interest payments due to changes in interest rates. To limit the variability of its interest payments and to take advantage of low interest rates, the System entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps convert the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in the principal outstanding under various bond series.

The System has two swaps that are being held as a swap portfolio as the related debt is no longer outstanding.

The following is a summary of the outstanding positions under interest rate swap agreements at December 31, 2025:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	\$ 129,900	November 1, 2038	61.7% of SOFR + 26bps	3.605 %
2008C-2B	58,425	November 1, 2038	61.7% of SOFR + 26bps	3.605 %
2008C-3A	88,000	November 1, 2038	61.7% of SOFR + 26bps	3.605 %
Swap portfolio	50,000	November 1, 2038	61.7% of SOFR + 26bps	3.605 %
Swap portfolio	20,860	February 1, 2038	70.0% of SOFR	3.314 %

The swaps are not designated as hedging instruments and, therefore, hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are classified as other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets. The net cash settlement payments, representing the realized changes in fair value of the swaps, are included as interest expense in the accompanying consolidated statements of operations and changes in net assets.

The fair value of the interest rate swap agreements was a liability of \$22,729 and \$19,566 as of December 31, 2025 and 2024, respectively, included in other noncurrent liabilities in the accompanying consolidated balance sheets. No collateral was posted under these swap agreements as of December 31, 2025 and 2024.

Amounts recorded in the accompanying consolidated statements of operations and changes in net assets are as follows:

	Year Ended December 31, 2025	Year Ended December 31, 2024
Net cash payments on interest rate swap agreements (interest expense)	\$ 1,910	\$ (115)
Change in fair value of interest rate swaps (other nonoperating loss, net)	\$ (3,163)	\$ 12,115

The interest rate swap instruments contain provisions that require the System to maintain an investment grade credit rating on its bonds from certain major credit rating agencies. If the System's

bonds were to fall below investment grade, it would be in violation of these provisions and the counterparties to the swap instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on interest rate swap instruments in net liability positions.

11. RETIREMENT PLANS

The System maintains various employee retirement benefit plans available to qualifying employees and retirees.

The Advocate Health Care Network Pension Plan (“Advocate Plan”) was frozen effective December 31, 2019 to new participants and participants ceased accruing additional pension benefits. The net pension benefit obligation of \$49,176 and \$100,078 at December 31, 2025 and 2024, respectively, for the Advocate Plan is included in other noncurrent liabilities in the accompanying consolidated balance sheets.

The Advocate Aurora Health Pension Plan (“AAH Plan”) was created through a merger of the Condell Health Network Retirement Plan (frozen effective December 31, 2007) and the Aurora Health Care, Inc. Pension Plan (frozen effective December 31, 2012). The net pension benefit obligation of \$99,331 and \$113,145 at December 31, 2025 and 2024, respectively, is included in other noncurrent liabilities in the accompanying consolidated balance sheets.

A summary of changes in the plan assets, projected benefit obligation and the resulting funded status for the year ended December 31, 2025 is as follows:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
Change in plan assets:			
Plan assets at fair value at beginning of period	\$ 906,341	\$ 951,888	\$ 1,858,229
Actual return on plan assets	81,942	92,072	174,014
Employer contributions	8,968	12,500	21,468
Benefits paid	(54,828)	(54,888)	(109,716)
Plan assets at fair value at end of period	<u>\$ 942,423</u>	<u>\$ 1,001,572</u>	<u>\$ 1,943,995</u>
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	\$ 1,006,419	\$ 1,065,033	\$ 2,071,452
Interest cost	52,553	59,662	112,215
Actuarial (gain) loss	(12,545)	31,096	18,551
Benefits paid	(54,828)	(54,888)	(109,716)
Projected benefit obligation at end of period	<u>\$ 991,599</u>	<u>\$ 1,100,903</u>	<u>\$ 2,092,502</u>
Plan assets less than projected benefit obligation	<u>\$ (49,176)</u>	<u>\$ (99,331)</u>	<u>\$ (148,507)</u>
Accumulated benefit obligation at end of period	<u>\$ 991,599</u>	<u>\$ 1,100,903</u>	<u>\$ 2,092,502</u>

A summary of changes in the plan assets, projected benefit obligation and the resulting funded status for the year ended December 31, 2024 is as follows:

	Advocate	AAH	Total
Change in plan assets:			
Plan assets at fair value at beginning of period	\$ 892,895	\$ 1,014,048	\$ 1,906,943
Actual return on plan assets	64,005	(21,330)	42,675
Employer contributions	5,381	12,500	17,881
Benefits paid	(55,940)	(53,330)	(109,270)
Plan assets at fair value at end of period	<u>\$ 906,341</u>	<u>\$ 951,888</u>	<u>\$ 1,858,229</u>
Change in projected benefit obligation:			
Projected benefit obligation at beginning of period	\$ 1,054,271	\$ 1,124,723	\$ 2,178,994
Interest cost	50,812	55,227	106,039
Actuarial gain	(42,724)	(61,587)	(104,311)
Benefits paid	(55,940)	(53,330)	(109,270)
Projected benefit obligation at end of period	<u>\$ 1,006,419</u>	<u>\$ 1,065,033</u>	<u>\$ 2,071,452</u>
Plan assets less than projected benefit obligation	<u>\$ (100,078)</u>	<u>\$ (113,145)</u>	<u>\$ (213,223)</u>
Accumulated benefit obligation at end of period	<u>\$ 1,006,419</u>	<u>\$ 1,065,033</u>	<u>\$ 2,071,452</u>

The Advocate Plan actuarial gain of \$12,545 for the year ended December 31, 2025 was primarily driven by a change in interest crediting rate which was partially offset by a change in discount rates.

The AAH Plan actuarial loss of \$31,096 for the year ended December 31, 2025 was primarily driven by a change in discount rates.

Pension plan expense included in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets is as follows for the year ended December 31, 2025:

	Advocate	AAH	Total
Interest cost	\$ 52,553	\$ 59,662	\$ 112,215
Expected return on plan assets	(46,550)	(49,527)	(96,077)
Amortization of:			
Actuarial loss	11,719	9,911	21,630
Prior service cost	—	3	3
Net pension expense	<u>\$ 17,722</u>	<u>\$ 20,049</u>	<u>\$ 37,771</u>

Pension plan expense included in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets is as follows for the year ended December 31, 2024:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
Interest cost	\$ 50,812	\$ 55,227	\$ 106,039
Expected return on plan assets	(53,839)	(60,124)	(113,963)
Amortization of:			
Actuarial loss	5,342	4,896	10,238
Prior service cost	—	3	3
Settlement loss	12,261	—	12,261
Net pension expense	<u>\$ 14,576</u>	<u>\$ 2</u>	<u>\$ 14,578</u>

The Advocate Plan paid lump sums totaling \$49,163 and \$51,236 in 2025 and 2024, respectively. The amount was greater than the sum of the Advocate Plan's service cost and interest cost, resulting in a settlement cost in the amount of \$12,261 in 2024.

The net change recognized in net assets without donor restrictions as a component of pension-related changes other than net periodic pension cost was as follows for the year ended December 31, 2025:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
Net change recognized	\$ (59,656)	\$ (21,364)	\$ (81,020)

The net change recognized in net assets without donor restrictions as a component of pension-related changes other than net periodic pension cost was as follows for the year ended December 31, 2024:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
Net change recognized	\$ (70,492)	\$ 14,969	\$ (55,523)

Included in net assets without donor restrictions at December 31, 2025 are the following amounts that have not yet been recognized in net pension expense:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
Unrecognized prior credit	\$ —	\$ 85	\$ 85
Unrecognized actuarial loss	181,191	390,540	571,731
	<u>\$ 181,191</u>	<u>\$ 390,625</u>	<u>\$ 571,816</u>

Expected employee benefit payments to be paid from the pension plans are as follows:

	<u>Advocate</u>	<u>AAH</u>	<u>Total</u>
2026	\$ 160,407	\$ 66,480	\$ 226,887
2027	82,771	69,619	152,390
2028	75,683	72,148	147,831
2029	76,155	74,422	150,577
2030	71,035	76,382	147,417
2031-2035	345,721	396,677	742,398
Total	<u>\$ 811,772</u>	<u>\$ 755,728</u>	<u>\$ 1,567,500</u>

Expected contributions to the pension plans are as follows:

	Advocate	AAH	Total
2026	\$ 8,234	\$ 12,500	\$ 20,734

Employer contributions are paid from employer assets. No plan assets are expected to be returned to the employer. All benefits paid under the Advocate Plan and AAH Plan (collectively referred to as the "Plans") were paid from the Plans' assets.

The System's asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors and manager style to minimize the risk of loss. The de-risking portfolio is comprised of cash and fixed-income instruments designed to hedge Plan liabilities. The System utilizes investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. The System regularly monitors manager performance and compliance with investment guidelines. The investment policy is broken out into de-risking and return seeking investments, with the asset allocation targets based on a floating basis dependent on the funded status of the Plan. The targets noted in the table below are based on the funded status of the Plan on December 31, 2025 and 2024:

	December 31, 2025		December 31, 2024	
Asset Category - Advocate Plan	Asset Allocation Target Range*	Actual	Asset Allocation Target Range*	Actual
De-risking portfolio	60%-85%	70 %	50%-85%	71 %
Return seeking portfolio	15%-40%	30 %	15%-50%	29 %

	December 31, 2025		December 31, 2024	
Asset Category - AAH Plan	Asset Allocation Target Range*	Actual	Asset Allocation Target Range*	Actual
De-risking portfolio	60%-85%	79 %	50%-85%	79 %
Return seeking portfolio	15%-40%	21 %	15%-50%	21 %

**Based on a PBO Funded Status Range of 80%-100%*

At December 31, 2025, the Advocate Plan and AAH Plan had commitments to fund alternative investments, including recallable distributions, of \$16,053 and \$7,500, respectively.

In the normal course of operations and within established investment policy guidelines, the Plans may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options and forward contracts. These instruments are used primarily to maintain the Plans' strategic asset allocation and hedge security price movements. These instruments require the Plans to deposit cash collateral with the broker or custodian.

Derivative contract information at December 31, 2025 are as follows:

	Advocate	AAH	Total
Cash and security collateral provided	\$ 16,130	\$ 4,787	\$ 20,917
Gross notional value	\$ (446,884)	\$ 276,981	\$ (169,903)

Derivative contract information at December 31, 2024 are as follows:

	Advocate	AAH	Total
Cash and security collateral provided	\$ 16,974	\$ 5,794	\$ 22,768
Gross notional value	\$ (447,743)	\$ 356,010	\$ (91,733)

By using derivative financial instruments, the System exposes itself to credit risk and market risk as described in Note 5. INVESTMENTS .

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 6. FAIR VALUE. Real estate commingled funds for which an active market exists are included in Level 2. The System opted to use the net asset value per share, or its equivalent, as a practical expedient for the fair value of the Plans' interest in hedge funds, private equity limited partnerships and real estate commingled funds. There is inherent uncertainty in such valuations and the estimated fair values may differ from the values that would have been used had a ready market for these investments existed. Private equity limited partnerships and real estate commingled funds typically have finite lives ranging from five to ten years, at the end of which all invested capital is returned. For hedge funds, the typical lockup period is one year, after which invested capital can be redeemed on a quarterly basis with at least 30 days' but no more than 90 days' notice. The Plans' investment assets are exposed to the same kinds and levels of risk as described in Note 6. FAIR VALUE.

The following are the Plans' financial instruments at December 31, 2025, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 6. FAIR VALUE:

Description	December 31, 2025	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and short-term investments	\$ 42,716	\$ 1,878	\$ 40,838	\$ —
Corporate bonds and other debt securities	839,131	—	839,131	—
United States government obligations	559,505	—	559,505	—
Equity funds	261,111	—	261,111	—
	1,702,463	\$ 1,878	\$ 1,700,585	\$ —

Investments at net asset value

Alternative investments	239,038
Total plan investments	1,941,501
Accruals carried at cost	2,494
Total plan assets	<u>\$ 1,943,995</u>

The following are the Plans' financial instruments at December 31, 2024, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 6. FAIR VALUE:

Description	December 31, 2024	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and short-term investments	\$ 51,913	\$ 1,764	\$ 50,149	\$ —
Corporate bonds and other debt securities	794,153	—	794,153	—
United States government obligations	566,026	—	566,026	—
Equity funds	177,146	5,831	171,315	—
	1,589,238	\$ 7,595	\$ 1,581,643	\$ —
Investments at net asset value				
Alternative investments	270,946			
Total plan investments	1,860,184			
Accruals carried at cost	(1,955)			
Total plan assets	<u>\$ 1,858,229</u>			

Assumptions used to determine benefit obligations are as follows:

	December 31, 2025	December 31, 2024
Discount rate - Advocate Plan	5.29 %	5.65 %
Discount rate - AAH Plan	5.49 %	5.77 %
Interest crediting rate - Advocate Plan	3.50 %	4.13 %

Assumptions used to determine benefit cost are as follows:

	December 31, 2025	December 31, 2024
Discount rate - Advocate Plan	5.65 %	4.99 %
Discount rate - AAH Plan	5.77 %	5.04 %
Assumed rate of return on assets - Advocate Plan	5.70 %	6.30 %
Assumed rate of return on assets - AAH Plan	5.10 %	5.40 %
Interest crediting rate - Advocate Plan	4.13 %	4.13 %

The assumed rate of return on each of the Plan's assets is based on historical and projected rates of return for asset classes in which the portfolio is invested.

The 2025 and 2024 mortality assumption for the Plans was the amounts-weighted aggregate rates from the Pri-2012 mortality study, with white-collar adjustments projected generationally from 2012 with Scale MP-2021.

In addition to these Plans, the System sponsors a defined contribution plan for its employees. Expense related to the plan, which is included in salaries, wages and benefits expense in the accompanying consolidated statements of operations and changes in net assets, was \$396,374 and \$357,985 for the years ended December 31, 2025 and 2024, respectively.

12. NET ASSETS WITH DONOR RESTRICTIONS

Net assets with donor restrictions are available for the following purposes:

	December 31, 2025	December 31, 2024
Purchases of property and equipment	\$ 13,206	\$ 16,641
Other health care related programs	253,051	239,461
	<u>\$ 266,257</u>	<u>\$ 256,102</u>

13. FUNCTIONAL OPERATING EXPENSES

Operating expenses directly attributable to a specific functional area of the System are reported as expenses of those functional areas. Expenses other than interest expense are directly allocated to functional departments at the time they are incurred. Interest expense that relates to debt financing is allocated based on the use of the related funds. General and administrative expenses primarily include legal, finance, marketing, supply chain and human resources. Fundraising costs are reported as other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets.

Functional operating expenses for the year ended December 31, 2025 are as follows:

	Health care services	General and administrative	Consolidated
Salaries, wages and benefits	\$ 9,332,889	\$ 861,885	\$ 10,194,774
Supplies and drugs	3,887,745	48,542	3,936,287
Purchased services and other	2,161,887	675,174	2,837,061
Depreciation and amortization	539,352	37,430	576,782
Interest	121,772	—	121,772
Total operating expenses	<u>\$ 16,043,645</u>	<u>\$ 1,623,031</u>	<u>\$ 17,666,676</u>

Functional operating expenses for the year ended December 31, 2024 are as follows:

	Health care services	General and administrative	Consolidated
Salaries, wages and benefits	\$ 8,773,179	\$ 765,717	\$ 9,538,896
Supplies and drugs	3,374,481	44,594	3,419,075
Purchased services and other	2,140,483	705,279	2,845,762
Depreciation and amortization	522,567	36,039	558,606
Interest	121,293	—	121,293
Total operating expenses	<u>\$ 14,932,003</u>	<u>\$ 1,551,629</u>	<u>\$ 16,483,632</u>

14. LIQUIDITY

The System's financial assets available within one year of the consolidated balance sheets date for general expenditures are as follows:

	December 31, 2025	December 31, 2024
Cash and cash equivalents	\$ 304,990	\$ 733,229
Due from related party - centralized cash management arrangement	476,218	—
Patient accounts receivable	2,187,133	2,009,794
Third-party payors receivables	32,269	37,199
Assets limited as to use		
Internally designated for capital and other	23,501,866	20,545,013
Held for self-insurance	477,882	614,315
Donor restricted	124,951	111,146
Funds held under retirement plans	616,740	502,965
Investments under securities lending program	934,887	18,958
Total assets limited as to use	25,656,326	21,792,397
Total financial assets	<u>\$ 28,656,936</u>	<u>\$ 24,572,619</u>
Less		
Amounts unavailable for general expenditures		
Alternative investments	(5,475,913)	(4,342,884)
Total amounts unavailable for general expenditure	(5,475,913)	(4,342,884)
Amounts unavailable to management without approval		
Due to related party - investment pool	(9,989,853)	(7,945,909)
Held for self-insurance	(477,882)	(614,315)
Held for employees under retirement plans	(616,740)	(502,965)
Donor restricted	(124,951)	(111,146)
Total amounts unavailable to management without approval	(11,209,426)	(9,174,335)
Total financial assets available to management for general expenditure within one year	<u>\$ 11,971,597</u>	<u>\$ 11,055,400</u>

15. COMMITMENTS AND CONTINGENCIES

Future Obligations

Aurora West Allis Medical Center has the right to operate the hospital under the terms of a lease agreement with the City of West Allis ("the City"). In accordance with the lease agreement, the City has title to all assets and any subsequent additions (with the exception of certain equipment used by Aurora for laboratory services). Aurora West Allis Medical Center has an exclusive right to the use of the assets and the obligation to maintain and replace them. The historical cost to the System of the leased facilities is included within the System's property and equipment, net. The agreement provides for annual payments of less than \$100 in lieu of annual lease payments and includes payment escalations each subsequent year. The lease expires in 2063.

The System is committed to constructing additions and renovations to its medical facilities that are expected to be completed in future years for which remaining commitments totaled approximately \$531,776 at December 31, 2025.

The System entered into agreements for information technology services provided by third parties. The maximum amount of future payments that the System could be required to make under these agreements is approximately \$252,059 over the next five years. The System has also entered into

various other agreements. The future commitments under these agreements are \$108,439 over the next eleven years.

Litigation

From time to time, the System receives and responds to investigations and requests concerning possible violations of reimbursement, false claims, anti-kickback and anti-referral statutes, environmental regulations and other regulations of health care providers from federal and state regulatory agencies. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims, or penalties would have on the System. To foster compliance with applicable laws and regulations, the System maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

The System also is involved in litigation such as medical malpractice and contractual disputes, as both plaintiff and defendant, and other routine labor matters, proposed class action complaints, tax examinations, security events resulting in potential privacy incidents, internal compliance activities and regulatory investigations and examinations arising in the ordinary course of business.

Based on the System's assessment of the above matters, the uncertainty of litigation, and the preliminary stages of many of the matters, the System cannot estimate the reasonable possible loss or range of loss that may result from these matters, except as stated in the consolidated financial statements, including this note. Management of the System is of the opinion, however, that the resolution of these legal actions will not have a material effect on the financial position of the System.

Two sets of plaintiffs have filed separate putative class action civil lawsuits against the System, in 2022 and 2023, alleging violations of Federal and State antitrust law arising out of, among other things, the System's arrangements with certain health plans. Both matters have completed the discovery stage and are in the expert-analysis stage. The System cannot estimate the reasonable possible loss or range of loss that may result from either of these matters and there can be no assurance that the resolution of either of these matters will not have a material adverse effect on System's consolidated financial position or results of operations.

16. GENERAL AND PROFESSIONAL LIABILITY RISKS

The System is self-insured for substantially all general and professional liability risks. The self-insurance programs combine various levels of self-insured retention with excess commercial insurance coverage. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Revocable trust funds, administered by a trustee and captive insurance companies, have been established for the self-insurance programs. Actuarial consultants have been retained to determine the estimated cost of claims, as well as to determine the amount to fund into the irrevocable trust and captive insurance companies.

The System's hospitals, clinics, surgery centers, physicians and certified registered nurse anesthetist providers that provide health care in Wisconsin are qualified health care providers that are fully covered for losses in excess of statutory limits through mandatory participation in the State of Wisconsin Injured Patients and Families Compensation Fund.

The estimated cost of claims is actuarially determined based on experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance liabilities and contributions to the trust were determined using a discount rate of 4.00% as of

December 31, 2025 and 2024. The System's accrued professional liability costs, including estimated claims incurred but not reported are classified as follows within the accompanying consolidated balance sheets:

	<u>December 31, 2025</u>	<u>December 31, 2024</u>
Accounts payable and other accrued liabilities	\$ 272,711	\$ 224,206
Other noncurrent liabilities	1,015,516	865,825

Total accrued insurance liabilities, excluding the reinsurance recoverable receivable, would have been \$202,452 and \$152,772 greater at December 31, 2025 and 2024, respectively, had these liabilities not been discounted.

As described in Note 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, the System consolidates a captive insurance company that operates on behalf of a related party. The captive insurance company recorded related party other operating revenue of \$16,676 and \$17,982 in the statements of operations and changes in net assets December 31, 2025 and 2024, respectively.

17. RELATED-PARTY TRANSACTIONS

As part of the Advocate Health joint operating agreement as described in Note 1. ORGANIZATION AND BASIS OF PRESENTATION, the System and AHI share certain expenses related to the management of Advocate Health. Advocate Health utilizes a management fee to allocate shared expenses between the System and AHI. The System recorded management fees of \$84,408 and \$96,234 included in purchased services and other expenses in the statements of operations and changes in net assets as of December 31, 2025 and 2024, respectively.

Before implementing a centralized cash management arrangement and described in Note 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, the System made or received payments on behalf of Advocate Health or AHI that required cash to be exchanged between the entities. The System had receivables of \$18,775 and \$52,114 from Advocate Health and AHI, respectively, included in other current assets in the accompanying consolidated balance sheets as of December 31, 2024.

18. INCOME TAXES AND TAX STATUS

The subsidiaries of the System are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) and their related income is exempt from federal income tax. Accordingly, no income taxes are recorded for the majority of the income in the accompanying consolidated financial statements for these entities. Unrelated business income is generated by certain of these entities through the provision of services or other activities not directly related to the provision of patient care.

At December 31, 2025, the System had \$256,551 of federal and \$128,145 of state net operating loss carryforwards with unutilized amounts of state net operating loss carryforwards expiring between 2025 and 2039. At December 31, 2024, the System had \$306,973 of federal and \$128,322 of state net operating loss carryforwards with unutilized amounts of state net operating loss carryforwards expiring between 2024 and 2044. As a result of the Tax Cuts and Jobs Act of 2017, net operating losses generated after 2017 do not expire for federal purposes. Of the \$256,551 of federal net operating loss carryforwards at December 31, 2025, \$105,046 was generated after 2017.

The System calculated income taxes for its taxable subsidiaries. Taxable income differs from pretax book income primarily due to certain income and deductions for tax purposes being recorded in the consolidated financial statements in different periods. Deferred income tax assets and liabilities are

recorded for the tax effect of these differences using enacted tax rates for the years in which the differences are expected to reverse.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent on the generation of future taxable income during the periods in which those temporary differences become deductible.

The System had deferred tax assets and liabilities as follows:

	Year Ended December 31, 2025	Year Ended December 31, 2024
Other deferred tax assets	\$ 6,252	\$ 8,497
Net operating loss carryforwards	63,664	72,078
Valuation allowances	(53,735)	(61,497)
Net deferred tax assets	16,181	19,078
Deferred tax liabilities	(2,492)	(1,785)
Net deferred tax assets	<u>\$ 13,689</u>	<u>\$ 17,293</u>

Provisions (credits) for federal, state and deferred income taxes are included in other nonoperating loss, net in the accompanying consolidated statements of operations and changes in net assets as follows:

	Year Ended December 31, 2025	Year Ended December 31, 2024
Federal	\$ 5,464	\$ 1,152
State	7,924	1,062
Deferred	3,604	(4,825)
	<u>\$ 16,992</u>	<u>\$ (2,611)</u>

19. SUBSEQUENT EVENTS

The System evaluated events and transactions subsequent to December 31, 2025 through April 7, 2026, the date of consolidated financial statement issuance.

In March 2026, the System Master Indenture was amended to add Advocate Health, Inc., Wake Forest University Baptist Medical Center, North Carolina Baptist Hospital and Wake Forest University Health Sciences, affiliates of AHI, as members of the Obligated Group. Advocate Health, Inc. was appointed as the Obligated Group Agent.

Supplementary Information



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**Shape the future
with confidence**

Report of Independent Auditors on Supplementary Information

The Board of Directors
Advocate Health, Inc.

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying consolidating balance sheet and consolidating statement of operations are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

A handwritten signature in black ink that reads 'Ernst & Young LLP' in a cursive script.

April 7, 2026

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATING BALANCE SHEET
December 31, 2025
(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Assets				
Current assets				
Cash and cash equivalents	\$ 293,278	\$ 11,712	\$ —	\$ 304,990
Due from related party - centralized cash management arrangement	883,584	(407,366)		476,218
Assets limited as to use	159,477	23,733	—	183,210
Patient accounts receivable	1,960,950	239,407	(13,224)	2,187,133
Receivable from subsidiaries	13,339	—	(13,339)	—
Other current assets	1,756,748	292,735	—	2,049,483
Total current assets	5,067,376	160,221	(26,563)	5,201,034
Noncurrent assets				
Assets limited as to use	24,883,384	843,832	(254,100)	25,473,116
Note receivable from subsidiaries	6,951	—	(6,951)	—
Property and equipment, net	6,000,406	395,026	—	6,395,432
Investments in subsidiaries	833,596	—	(833,596)	—
Operating lease right-of-use assets	204,291	72,928	—	277,219
Other noncurrent assets	417,175	132,679	—	549,854
Total other assets	32,345,803	1,444,465	(1,094,647)	32,695,621
Total assets	\$ 37,413,179	\$ 1,604,686	\$ (1,121,210)	\$ 37,896,655

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATING BALANCE SHEET
December 31, 2025
(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Current liabilities				
Long-term debt, current portion	\$ 461,506	\$ 747	\$ —	\$ 462,253
Operating lease liabilities, current portion	50,700	11,012	—	61,712
Accrued salaries and employee benefits	1,215,646	54,956	—	1,270,602
Accounts payable and accrued liabilities	2,006,885	439,030	(13,224)	2,432,691
Third-party payors payables	452,742	2,365	—	455,107
Accounts payable to subsidiaries	—	13,339	(13,339)	—
Total current liabilities	4,187,479	521,449	(26,563)	4,682,365
Noncurrent liabilities				
Long-term debt, less current portion	2,933,861	13,407	(6,951)	2,940,317
Operating lease liabilities, less current portion	197,412	66,120	—	263,532
Due to subsidiaries	254,100	—	(254,100)	—
Due to related party	9,989,853	—	—	9,989,853
Other noncurrent liabilities	1,898,013	268,213	—	2,166,226
Total noncurrent liabilities	15,273,239	347,740	(261,051)	15,359,928
Total liabilities	19,460,718	869,189	(287,614)	20,042,293
Net assets				
Without donor restrictions				
Controlling interest	17,765,371	98,028	(492,618)	17,370,781
Noncontrolling interests in subsidiaries	—	558,302	(340,978)	217,324
Total net assets without donor restrictions	17,765,371	656,330	(833,596)	17,588,105
With donor restrictions	187,090	79,167	—	266,257
Total net assets	17,952,461	735,497	(833,596)	17,854,362
Total liabilities and net assets	\$ 37,413,179	\$ 1,604,686	\$ (1,121,210)	\$ 37,896,655

ADVOCATE AURORA HEALTH, INC.
CONSOLIDATING STATEMENT OF OPERATIONS
Year Ended December 31, 2025
(in thousands)

	Credit Group	Noncredit Group	Eliminations	Consolidated
Revenue				
Patient service revenue	\$ 13,827,550	\$ 1,802,825	\$ (139,534)	\$ 15,490,841
Other revenue	1,691,910	1,444,312	(380,694)	2,755,528
Total revenue	15,519,460	3,247,137	(520,228)	18,246,369
Expenses				
Salaries, wages and benefits	9,216,139	984,649	(6,014)	10,194,774
Supplies and drugs	2,992,933	943,354	—	3,936,287
Purchased services and other	2,154,576	1,100,259	(417,774)	2,837,061
Depreciation and amortization	532,048	44,734	—	576,782
Interest	117,728	4,713	(669)	121,772
Total expenses	15,013,424	3,077,709	(424,457)	17,666,676
Operating income (loss)	506,036	169,428	(95,771)	579,693
Nonoperating income				
Investment income, net	2,822,366	111,498	—	2,933,864
Other nonoperating loss, net	(1,222,320)	(24,482)	—	(1,246,802)
Total nonoperating income, net	1,600,046	87,016	—	1,687,062
Revenue in excess of expenses	2,106,082	256,444	(95,771)	2,266,755
Less income attributable to noncontrolling interests	—	(161,945)	95,771	(66,174)
Revenue in excess of expenses- attributable to controlling interests	\$ 2,106,082	\$ 94,499	\$ —	\$ 2,200,581

Notes to Supplementary Information

1. Credit Group

The supplementary financial information for the Credit Group is in accordance with the Second Amended and Restated Master Trust Indenture dated as of August 1, 2018 between Advocate Aurora Health, Inc, the other affiliates identified therein as the Members of the Obligated Group, the Restricted Affiliates, and U.S. Bank Trust Company, National Association, as master trustee ("the System Master Indenture").

2. Credit Group Members

The Credit Group is comprised of the Obligated Group in combination with the Restricted Affiliates. The Obligated Group includes Advocate Aurora Health, Inc.; Advocate Health Care Network; Advocate Health and Hospitals Corporation; Advocate North Side Health Network; Advocate Condell Medical Center; Advocate Sherman Hospital; Aurora Health Care, Inc.; Aurora Health Care Metro, Inc.; Aurora Health Care Southern Lakes, Inc.; Aurora Health Care Central, Inc. d/b/a Aurora Medical Center Sheboygan County; Aurora Medical Center of Washington County, Inc.; Aurora Health Care North, Inc. d/b/a Aurora Medical Center Manitowoc County; Aurora Medical Center of Oshkosh, Inc.; Aurora Medical Group, Inc.; Aurora Medical Center Grafton LLC; and Aurora Medical Center Bay Area, Inc. The Restricted Affiliates include Advocate Charitable Foundation; Advocate Home Care Products, Inc.; EHS Home Health Care Service, Inc.; Evangelical Services Corporation, d/b/a Advocate Network Services, Inc.; Meridian Hospice; and West Allis Memorial Hospital Inc. d/b/a Aurora West Allis Medical Center. The Credit Group is with U.S. Bank Trust Company, National Association, as master trustee ("the System Master Indenture").

Despite Market Pressures, Non-Residential Construction Outlook Holds Steady with Modest Cost Increases

Nonresidential construction conditions remained steady through the third quarter, with market sentiment generally stable despite broader economic crosscurrents. Contractors continue to report consistent bidding activity, while owners are showing greater confidence in advancing projects that were previously delayed or under review. Supply chains continue to stabilize, and pricing volatility has eased across most major trades, helping keep overall cost escalation contained.

Broader market indicators reflect a cautious but tentatively more hopeful environment. The Dodge Momentum Index advanced sharply during the quarter, reflecting renewed planning activity across commercial and institutional sectors. Total construction starts also improved modestly in September, suggesting that underlying demand remains intact even as developers proceed cautiously amid policy and financing uncertainties.

Nationally, nonresidential construction costs tracked by the Mortenson Quarterly Cost Index for the third quarter of 2025 rose by +1.16% over the past quarter and +6.60% over the previous twelve months. All Mortenson regional offices reported modest cost increases this quarter. Portland and Chicago recorded the smallest quarterly changes, both at +0.78%. The remaining offices reported slightly elevated costs: Seattle (+0.88%), Milwaukee (+1.33%), Denver (+1.34%), Minneapolis (+1.38%), Phoenix (+1.42%), and Salt Lake City (+1.65%).

Material and labor costs increased nominally this quarter. **Tracked construction materials edged up slightly by +1.16%, nudging the year-over-year figure to +7.0%, while trade partner work increased +1.22% in Q3 and +6.3% annually.** Self-performed labor increased at a slower pace, two basis points lower compared to the previous quarter and 1.4% lower year over year.

Trucking and ocean freight markets are both expected to see relatively stable or declining prices in 2026 due to weak demand and ample capacity. In trucking, rates will likely remain low as warehouse prices fall amid strong inventory levels, though factors like driver shortages and rising container fees could create upward pressure.

Similarly, ocean freight rates are projected to decrease into early 2026 because of eased tariff front-loading, increased shipping capacity, and reduced congestion through the Panama Canal. While tariffs may briefly elevate prices in late 2025, freight costs are anticipated to stay low overall, with occasional temporary spikes caused by tariff pass-throughs and trade route changes.

Continued on next page

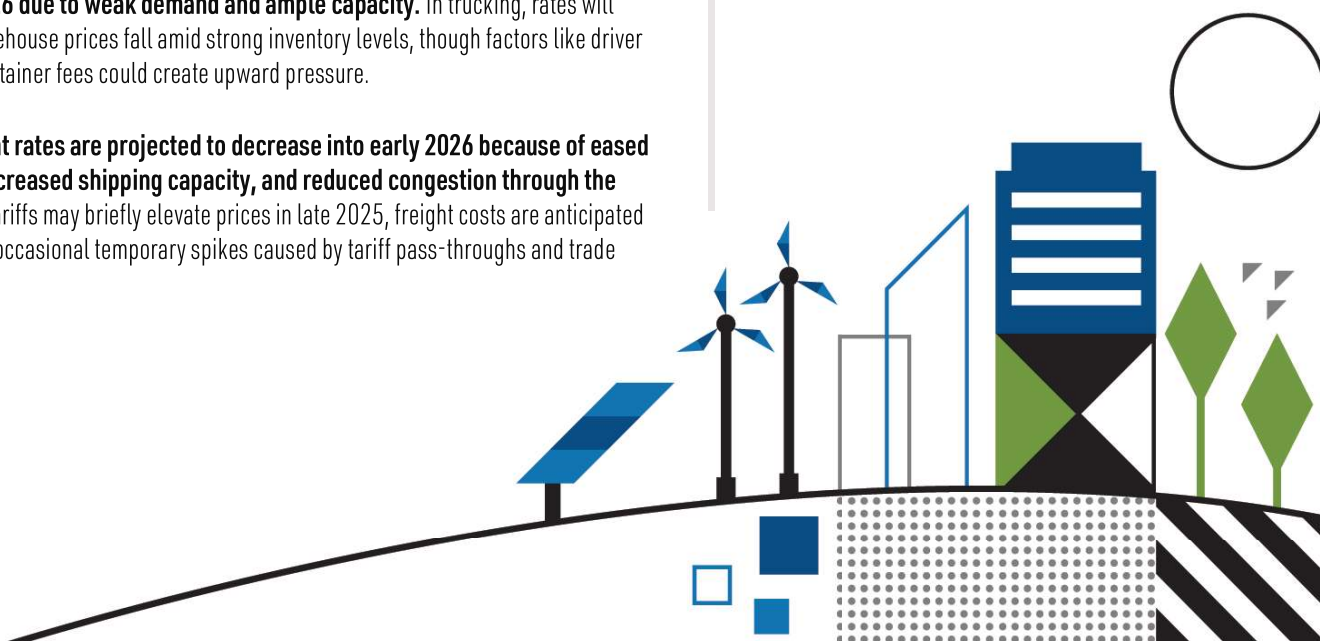
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COST INDEX

CHICAGO Q3 2025



Continued from previous page

Cost movement this quarter was primarily driven by select material and installation scopes, particularly those tied to steel and mechanical systems. Top scope packages showing quarterly cost increases include reinforcing steel material (+8.1%), installation of reinforcing material (+2.8%), steel framing erection (+4.0%), conveying systems (+2.0%), and plumbing systems (+2.5%).

Across regional markets, activity remained steady with increasing trade partner competition and continued aggressive pricing. Minneapolis and other upper Midwest markets reported a gradual improvement in project awards and a more optimistic outlook, while **labor availability remained stable nationwide.**

The Dodge Momentum Index, a leading indicator of nonresidential construction planning, continued its upward trajectory through the third quarter. The index surged 20.8% in July, followed by additional gains of 8% in August and 3% in September, signaling renewed confidence in both commercial and institutional sectors. **Total construction starts also improved, rising 3.1% in September with nonresidential building up 11.9% for the month.**

"After months of wait-and-see due to tariff uncertainty, owners and developers have begun to move forward with projects and assumed higher costs for them," said Sarah Martin, associate director of forecasting at Dodge Construction Network. "While the recent uptick points to strengthening planning activity, Dodge notes that overall momentum remains tempered by broader economic headwinds."

Despite cost stability, the design pipeline remains under pressure. The AIA/Deltek Architecture Billings Index fell to 43.3 in September, indicating billings at architecture firms continue to decline. **As a forward-looking indicator for nonresidential construction activity, this softness suggests future project starts may continue at a measured pace,** even as cost pressures stay contained.

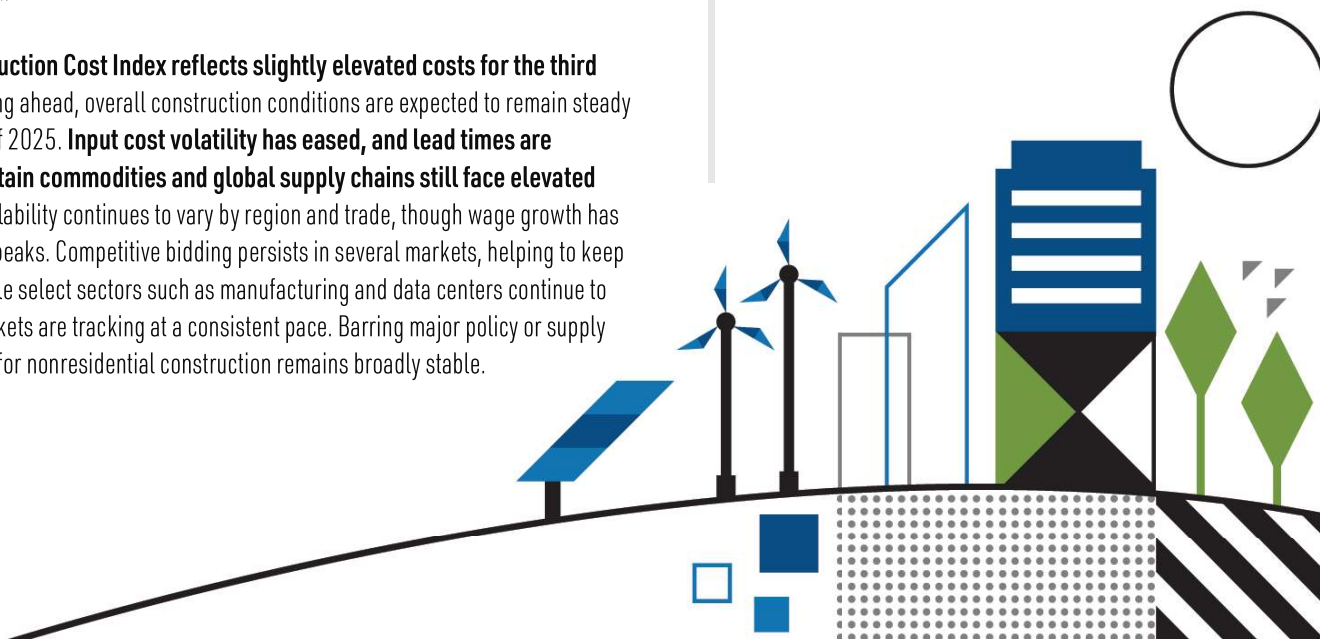
The Mortenson Construction Cost Index reflects slightly elevated costs for the third quarter of 2025. Looking ahead, overall construction conditions are expected to remain steady through the remainder of 2025. **Input cost volatility has eased, and lead times are improving, though certain commodities and global supply chains still face elevated uncertainty.** Labor availability continues to vary by region and trade, though wage growth has moderated from earlier peaks. Competitive bidding persists in several markets, helping to keep escalation in check. While select sectors such as manufacturing and data centers continue to drive demand, most markets are tracking at a consistent pace. Barring major policy or supply disruptions, the outlook for nonresidential construction remains broadly stable.

**VIEW THE FULL
CONSTRUCTION COST INDEX**



Mortenson tracks and reports on eight metropolitan areas in the U.S. including Chicago, Denver, Milwaukee, Minneapolis, Phoenix, Portland, Salt Lake City and Seattle. The Mortenson Construction Cost Index is calculated quarterly by pricing representative non-residential construction projects in various metropolitan areas. It is part of a portfolio of industry insights and market studies provided by Mortenson.

For nationwide construction cost index data visit:
Mortenson.com/Cost-Index.

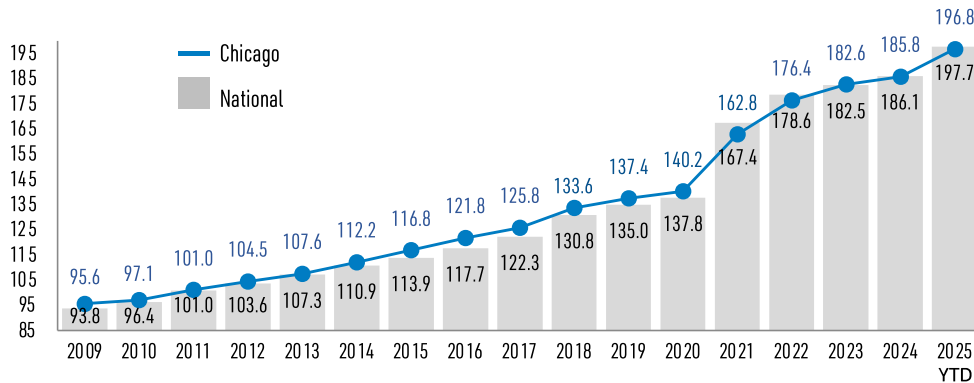


COST INDEX

CHICAGO Q3 2025



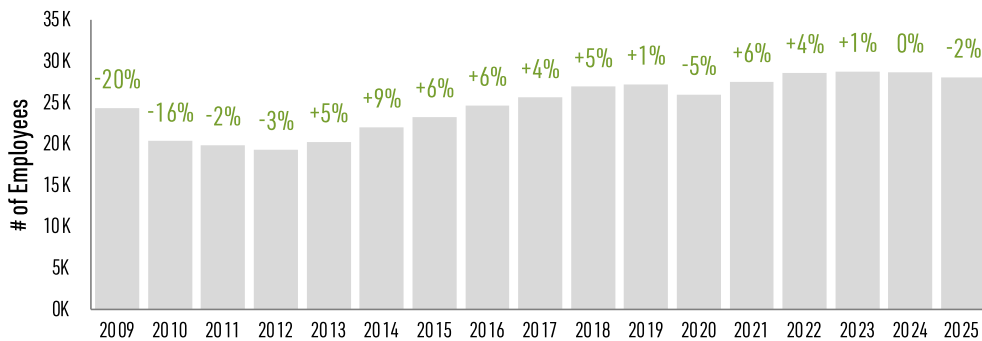
CONSTRUCTION COST INDEX (January 2009 = 100)



Nationally, the Mortenson Cost Index went up 1.2% in the third quarter of 2025 and is up 6.6% compared to a year ago.

In Chicago, costs rose 0.8% this quarter and 6.6% over the last twelve months.

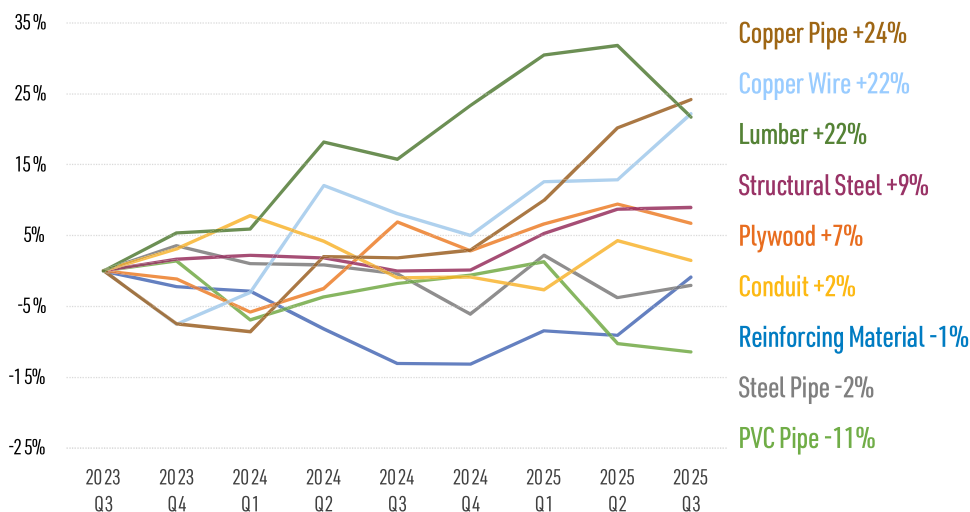
CHICAGO CONSTRUCTION EMPLOYMENT (Jan-Sept Average Monthly Employment and YoY % Change)



Building construction employment in the Chicago metro averaged 28,100 workers per month in the first nine months of 2025—a 2% decline compared to the same period in 2024. Labor availability remains stable, though the federal shutdown left September data unavailable, limiting late-Q3 visibility.

Source: Bureau of Labor Statistics
Chicago-Naperville-Schaumburg, IL - Construction of Buildings

MATERIAL PRICING CHANGES (National Average - Cumulative Q3 2023 to Q3 2025)



Construction material costs remain elevated amid a gradually stabilizing but volatile global supply chain, affected by economic uncertainty, tariffs, and fluctuating demand. Steel and copper continue to experience notable, upward price swings.



Photo courtesy of David Schacher Photography

2025 Third Quarter | QUARTERLY CONSTRUCTION COST REPORT

AT A GLANCE

NORTH AMERICA | Q3 2025



Paul Brussow
President
North America

A Market in Motion: Costs, Capital, and Capacity

Construction costs are sending a mixed message this quarter: stability on the surface, shifts underneath. While national averages point to moderation, local dynamics—from labor shortages to mega-project demand—are reshaping the landscape in ways owners can't afford to ignore. Deal-making across the AEC industry continues at a robust pace—private equity and strategic mergers are holding steady in 2025, even amid policy uncertainty. Additionally, if federal interest rates become more attractive, private investors will be willing to take on loans, creating new momentum for projects that have been on hold. Valuations remain strong, signaling that investors still have confidence in the sector's fundamentals. For owners, this is more than a headline; it's a call to examine whether strategic partnerships, recapitalization, or joint ventures might unlock new avenues of growth, innovation, or resilience.

Labor and the Scale of Projects

While employment levels and output are strong, labor shortages persist, especially as mega-projects in infrastructure and advanced manufacturing place new strains on the workforce. These large-scale efforts demand more than labor—they require effective collaboration platforms, shared data standards, and targeted training initiatives. Owners who invest in workforce development today will find themselves better positioned to deliver projects efficiently tomorrow.

Building Financial Resilience

If one theme defines the current market, it is change. Tariff uncertainty, global supply chain disruption, and shifting labor dynamics all contribute to cost swings that static budgets cannot absorb. Owners who continue to rely on fixed assumptions risk exposure. Instead, cost certainty comes from flexibility: rolling forecasts, scenario planning, and early procurement strategies. At RLB, desired outcome is to create living budgets that adapt with market conditions, ensuring resilience over the full lifecycle of a project.

Looking Ahead: Future-Proofing Investments

Owners today face an AEC landscape defined by rapid innovation and rising expectations. The rapid expansion of advanced technology sectors—such as data centers and semiconductor manufacturing—underscores how critical it is to build with speed, precision, and adaptability in today's global economy. The projects that thrive will be those designed not only for delivery but for endurance—built to remain resilient, efficient, and valuable for decades. My recommendation for our readers is to:

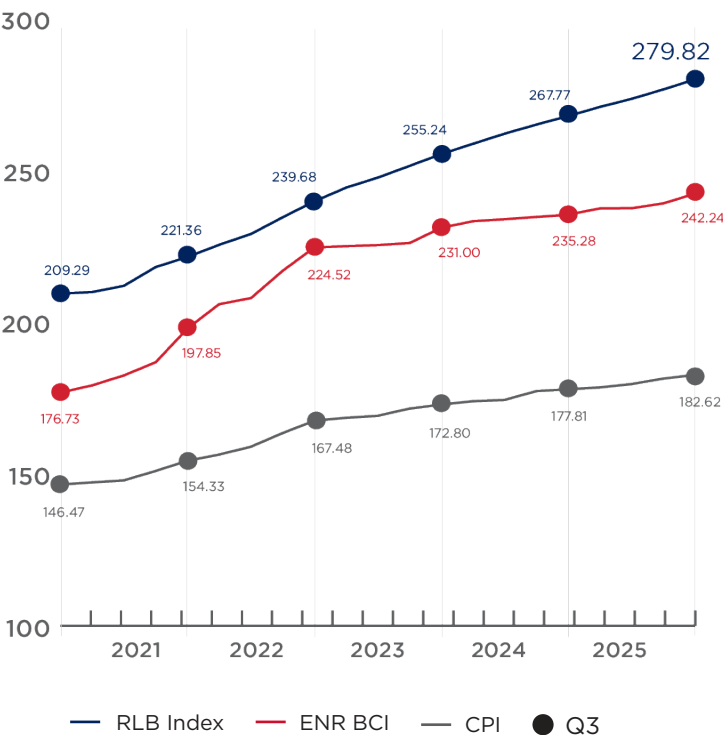
- Treat budgets as dynamic frameworks, not static documents.
- Apply consistent project delivery standards across entire portfolios.
- Link sustainability and technology decisions directly to long-term ROI.

By moving beyond reaction and into preparation, our industry can turn today's uncertainty into tomorrow's opportunity.



NATIONAL CONSTRUCTION COST INDEX

Welcome to the third quarter 2025 issue of the RLB Quarterly Cost Report! This issue contains data current to mid-Q3 2025.



Date	NCCI
Q3 2022	239.68
Q4 2022	244.19
Q1 2023	247.49
Q2 2023	251.34
Q3 2023	255.24
Q4 2023	258.62
Q1 2024	262.00
Q2 2024	264.94
Q3 2024	267.77
Q4 2024	270.75
Q1 2025	273.41
Q2 2025	276.51
Q3 2025	279.82

\$2,139.1
billion

According to the U.S. Department of Commerce, construction-put-in-place during July 2025 was estimated at a seasonally adjusted annual rate of \$2,139.1 billion, which is

0.1%
below

the revised June estimate of \$2,140.5 billion, and

2.8%
below

the July 2024 estimate of \$2,200.7 billion.

The National Construction Cost Index shows the changing cost of construction between July 2022 and July 2025, relative to a base of 100 in April 2001. Index recalibrated as of April 2011.

FEATURE PROJECT

PHOENIX,
ARIZONA



CITY OF PHOENIX POLICE HEADQUARTERS

The Phoenix Police Headquarters stands as a vital pillar of public safety and innovation in the heart of downtown. This 27-story facility has been thoughtfully renovated to support modern law enforcement needs. Designed to enhance operational efficiency and community engagement, the headquarters redefines the standard for urban police infrastructure.

RLB has been an invaluable partner to the City of Phoenix on the 100 W Washington project. Our team has provided expertise in Project Management and Cost Management throughout the project's lifecycle. From the initial programming phase, RLB has been actively involved in guiding the client through the complexities of transforming an older building to meet the needs of its end users. This has included updating outdated systems and ensuring compliance with Fire and Life Safety requirements. In addition, our team has served as the client's go-to resource for abatement coordination, construction management, furniture relocation, AV, security and access control coordination, and move-in logistics. RLB's close collaboration with Arrington Watkins Architects, Richard Kennedy Architects, Okland Construction, the City of Phoenix Public Works Department, and numerous other city entities has been key to ensuring the project's success.

Our team worked diligently to address the unique and complex needs of the Phoenix Police Department through continuous communication and coordination with the project team.

"One of the most significant highlights of this project was obtaining the Temporary Certificate of Occupancy for floors 23, 24, and 25, which allowed us to provide a new home for the Communications Bureau (911). The biggest challenge was moving the cutover date up by a month and securing all the necessary inspectors' signoffs, all while coordinating with their own vendors to get their technology up and running.

It was a tremendous effort from everyone involved. After countless long shifts and multiple tests of the Fire and Life Safety systems, we came together and successfully met the new cutover date. The transition went smoothly, and the client was extremely happy."

Melissa Araque, Project Manager

Rider Levett Bucknall

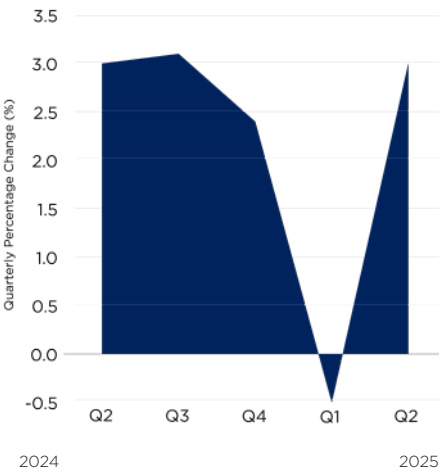


Photos courtesy of Larry Kantor Photography and David Schacher Photography

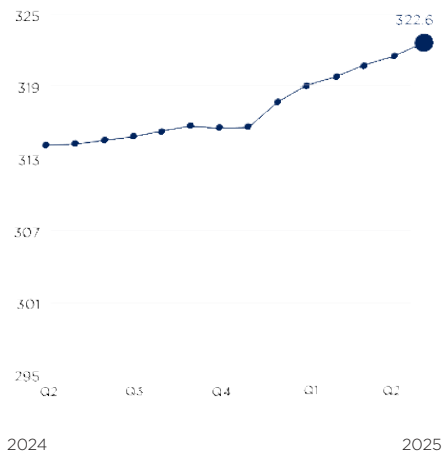


KEY STATISTICS

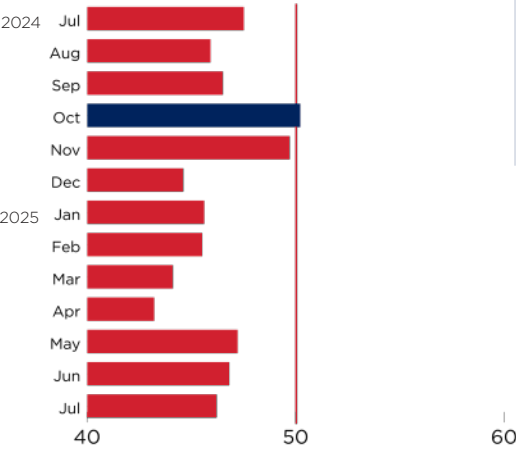
Gross Domestic Product* (GDP)



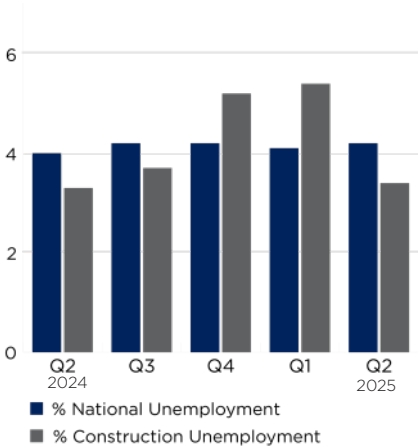
Consumer Price Index (CPI)



Architectural Billings



Unemployment Comparison



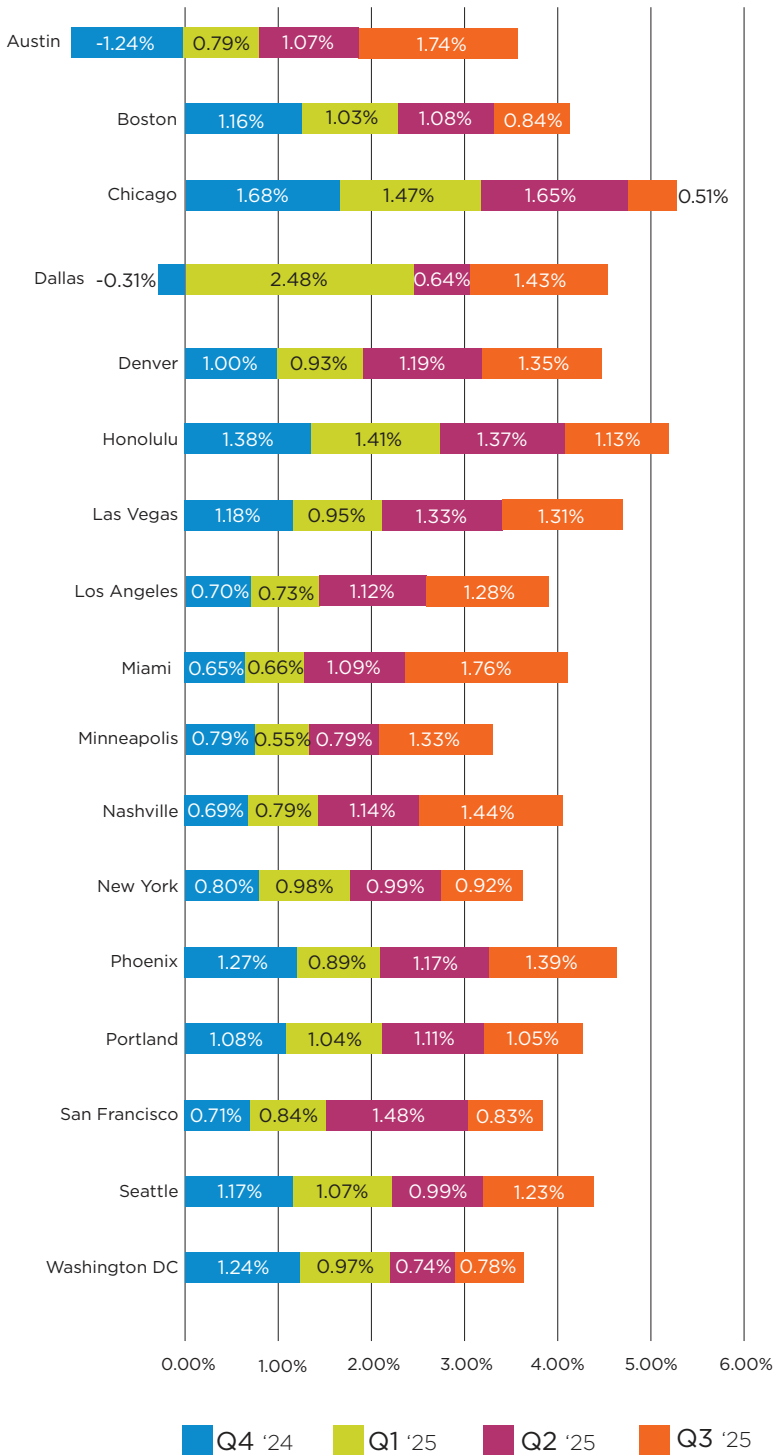
GDP represented in percent change from the preceding quarter, seasonally adjusted at annual rates. CPI figures represent the monthly value at the end of the quarter. ABI is derived from a monthly American Institute of Architects survey of architectural firms of their work on the boards, reported at the end of the period. Construction Put-in-Place figures represent total value of construction dollars in billions spent at a seasonally adjusted annual rate taken at the end of each quarter. General Unemployment rates are based on the total population 16 years and older. Construction Unemployment rates represent only the percent of experienced private wage and salary workers in the construction industry 16 years and older. National unemployment rates are seasonally adjusted, reflecting the average of a three-month period.

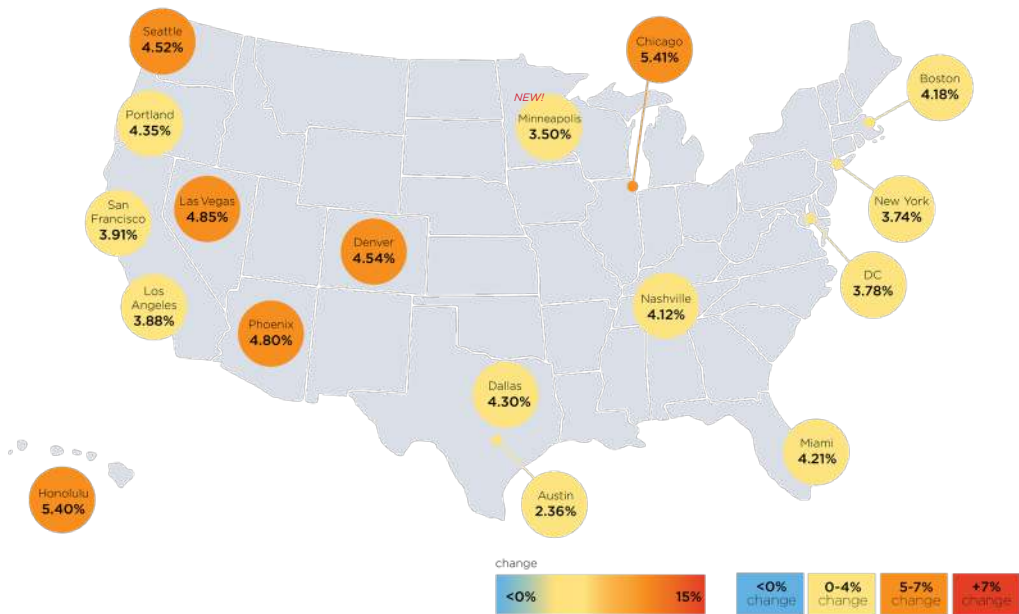
* Adjustments made to GDP based on amended changes from the Bureau of Economic Analysis.

Sources: U.S. Bureau of Labor Statistics, Bureau of Economic Analysis, American Institute of Architects.



COMPARATIVE COST INDEX



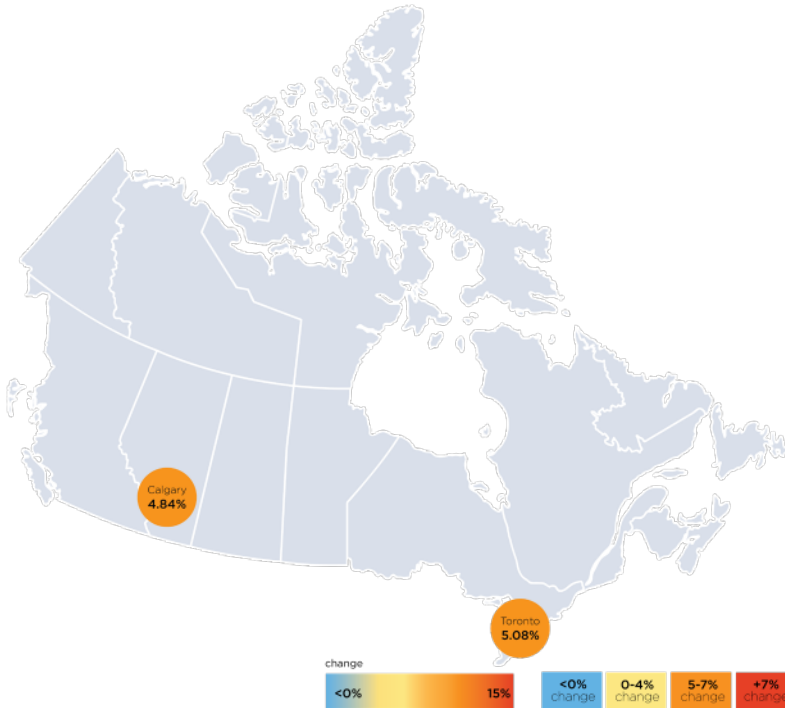


City	July 2024	October 2024	January 2025	April 2025	July 2025	Annual % Change
Austin	19,443	19,202	19,353	19,560	19,901	2.36%
Boston	31,309	31,672	32,000	32,346	32,619	4.18%
Chicago	32,130	32,670	33,151	33,697	33,870	5.41%
Dallas	19,375	19,315	19,794	19,922	20,207	4.30%
Denver	19,656	19,852	20,036	20,274	20,549	4.54%
Honolulu	31,471	31,906	32,356	32,798	33,170	5.40%
Las Vegas	19,391	19,619	19,806	20,069	20,331	4.85%
Los Angeles	28,532	28,731	28,942	29,265	29,640	3.88%
Miami	19,647	19,774	19,904	20,121	20,475	4.21%
Minneapolis <i>NEW!</i>	23,072	23,255	23,383	23,566	23,881	3.50%
Nashville	19,483	19,617	19,773	19,999	20,286	4.12%
New York	36,079	36,366	36,721	37,085	37,428	3.74%
Phoenix	20,260	20,518	20,700	20,942	21,232	4.80%
Portland	22,844	23,091	23,330	23,589	23,837	4.35%
San Francisco	35,822	36,076	36,378	36,916	37,223	3.91%
Seattle	25,861	26,162	26,442	26,703	27,030	4.52%
Washington, DC	28,934	29,293	29,576	29,796	30,029	3.78%

Comparative Cost Map Indicates percentage change between July 2024 to July 2025.



COMPARATIVE COST INDEX



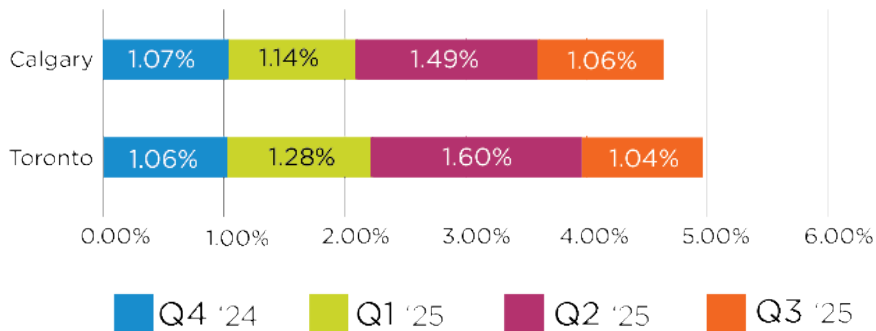
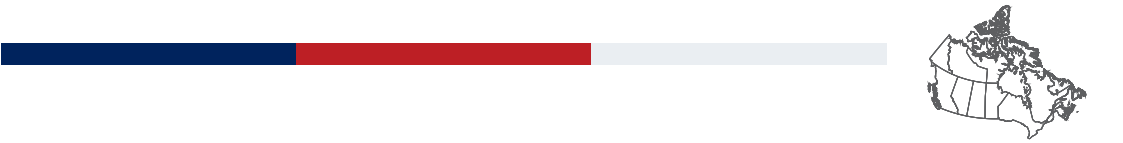
City	July 2024	October 2024	January 2025	April 2025	July 2025	Annual % Change
• Calgary	26,876	27,163	27,474	27,882	28,178	4.84%
• Toronto	35,573	35,952	36,413	36,995	37,379	5.08%

Alberta offers strong investment potential, driven by recent project approvals and rich natural resources. The province currently hosts 111 active and potential natural resource projects totaling \$148 billion, part of a broader \$633 billion federal pipeline. These projects primarily target the energy sector—oil and gas, carbon capture and storage, power generation and transmission, and downstream processing.

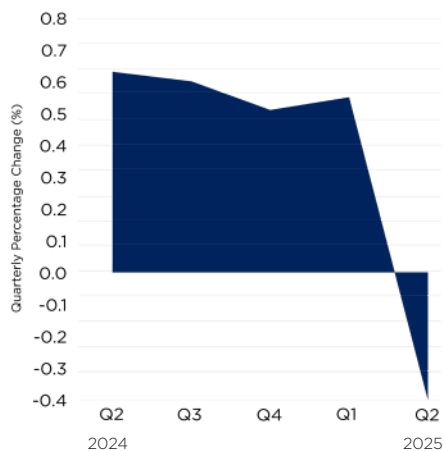
By the end of Q2 2025, Alberta municipalities issued \$2.1 billion in building permits, a 48.4% increase year-over-year. Non-residential construction remained stable despite a slight 0.2% monthly decline, with YTD investment up 9.7%. Institutional and governmental spending surged 54%, and industrial spending rose 36%. Non-residential construction intentions hit a record high, fueled by a 192% increase in institutional/governmental permits and a 38% rise in total permit value. Residential investment grew 4.6% in Q2 to \$2.0 billion, supported by strong renovation and conversion activity, though YTD investment declined 2.9%.

Ontario is advancing its largest infrastructure investment to date, with over \$200 billion earmarked for public assets like transit, highways, and hospitals. Infrastructure Ontario reports 28 projects in pre-procurement or active procurement stages, with a combined design and construction value exceeding \$30 billion. In the first half of 2025, ICI permit values rose 6% YTD, driven by a 29% increase in institutional sector activity—particularly in hospitals and medical facilities.

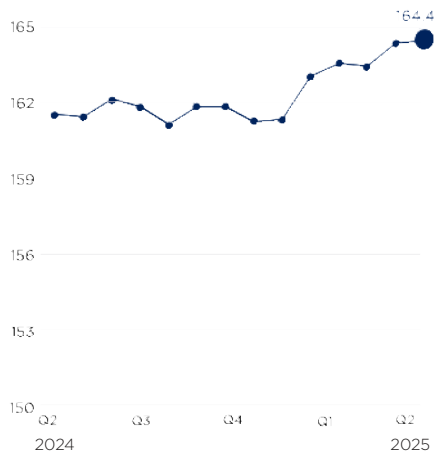
Toronto is prioritizing housing development, aiming to create 20,000 new rental units through a multi-million dollar incentive program. To revive stalled projects, the city is deferring property taxes, development charges, and other fees. The first phase targets over 8,000 units, contingent on additional funding from federal and provincial governments.



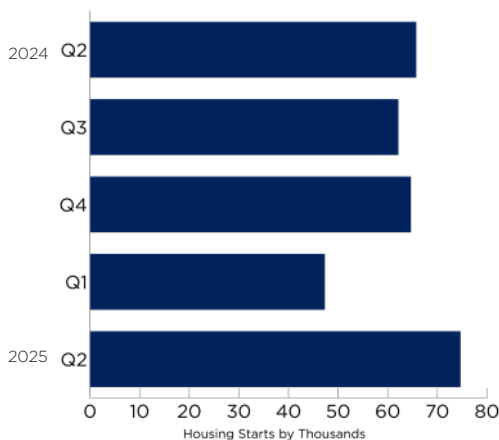
KEY STATISTICS



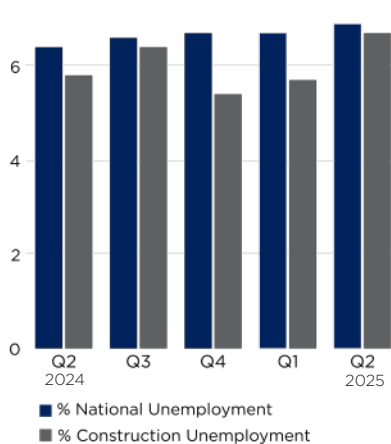
Gross Domestic Product* (GDP)



Consumer Price Index (CPI)



Housing Starts



Unemployment Comparison

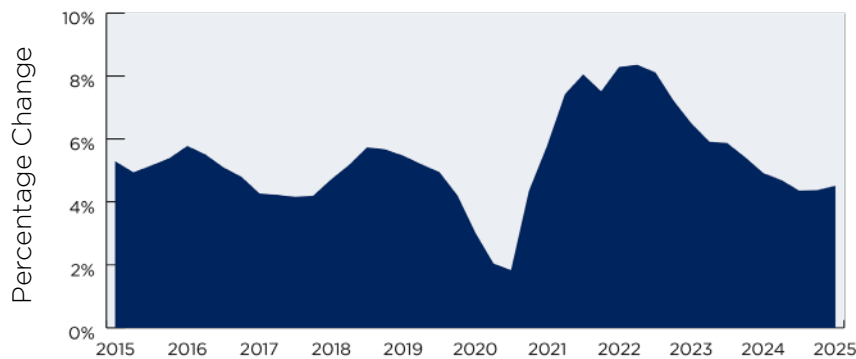


INDICATIVE CONSTRUCTION COSTS

	OFFICES				RETAIL SHOPPING				HOTELS				HOSPITAL	
	PRIME		SECONDARY		CENTER		STRIP		5 STAR		3 STAR		GENERAL	
LOCATION	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
USA														
Austin	250	420	165	225	200	330	190	255	425	580	300	445	475	670
Boston	455	705	270	405	250	405	175	280	475	805	330	555	605	1110
Chicago	345	570	215	350	215	460	170	280	520	800	380	510	450	920
Dallas	255	430	160	230	205	340	190	260	435	595	305	450	480	685
Denver	350	575	250	350	200	360	200	275	460	665	320	475	700	1000
Honolulu	385	645	245	375	305	615	285	465	735	880	420	665	565	950
Las Vegas	280	495	200	265	175	670	160	360	440	810	260	445	555	665
Los Angeles	270	410	210	300	190	400	160	230	435	675	310	415	695	1055
Miami	255	435	165	235	210	345	180	280	460	620	320	420	495	700
Minneapolis	420	685	295	420	240	420	240	325	545	745	385	565	830	1190
Nashville	360	595	260	360	210	360	195	285	470	645	330	435	710	980
New York	415	960	240	595	355	715	375	755	515	775	375	515	640	975
Phoenix	265	455	175	240	215	360	125	210	425	660	225	340	515	725
Portland	325	425	305	400	325	425	300	375	550	725	425	550	1000	1300
San Francisco	460	800	360	580	320	550	275	500	580	1020	430	660	750	1500
Seattle	370	660	245	340	275	445	210	335	485	735	340	485	650	920
Washington, D.C.	340	565	235	370	185	330	150	250	435	675	285	445	520	930
CANADA														
Calgary	295	440	250	300	245	335	145	215	320	495	240	275	715	970
Toronto	310	505	260	360	235	490	190	245	440	815	270	320	645	1005

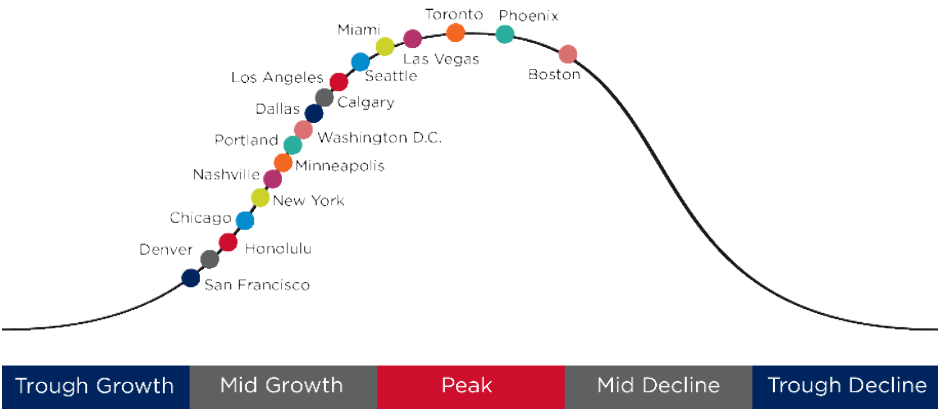
AT A GLANCE CONSTRUCTION COST CHANGE

As construction costs across the country continue to increase, RLB takes a historical view of the percentage change of year-on-year construction costs, dating back ten years.



The data in the chart below represents estimates of current building costs in each respective market. Costs may vary as a consequence of factors such as site conditions, climatic conditions, standards of specification, market conditions, etc. Values of U.S. locations represent hard construction costs based on U.S. dollars per square foot of gross floor area, while values of Canadian locations represent hard construction costs based on Canadian dollars per square foot.

INDUSTRIAL		PARKING				RESIDENTIAL				EDUCATION					
WAREHOUSE		GROUND		BASEMENT		MULTI-FAMILY		SINGLE-FAMILY		ELEMENTARY		HIGH SCHOOL		UNIVERSITY	
LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
75	150	115	190	165	260	180	270	190	515	275	390	310	475	420	645
130	220	110	165	140	190	285	390	305	430	595	675	625	800	650	900
150	240	100	150	165	285	210	480	285	570	320	480	370	510	450	910
75	150	115	190	165	265	185	275	195	520	280	400	315	480	430	660
130	205	125	200	175	280	210	375	240	475	375	500	400	610	650	900
145	290	180	235	205	315	300	505	335	625	565	930	585	790	725	1060
80	170	80	110	105	200	210	500	245	495	455	565	540	740	705	930
145	220	120	150	165	225	265	435	235	415	415	540	355	625	515	705
80	150	125	195	170	285	185	285	195	530	290	410	320	495	435	675
150	235	150	240	210	330	240	425	275	555	390	565	475	725	775	1070
130	205	130	210	185	290	210	365	240	475	335	485	410	630	645	725
145	240	115	210	170	250	250	490	355	715	550	695	595	765	585	840
85	160	60	115	95	170	195	290	205	555	295	425	335	515	455	695
275	350	275	325	300	375	325	415	305	450	600	750	750	1000	750	1000
150	255	130	205	250	350	400	640	330	580	650	950	700	1100	750	1200
185	255	140	205	215	310	285	485	265	410	450	675	385	675	595	810
130	215	75	100	90	155	215	360	270	395	390	595	405	610	490	740
115	175	95	130	100	155	215	300	325	470	270	370	275	380	355	535
140	200	130	175	170	235	265	335	330	650	285	350	285	375	325	580



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