

**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: Lurie Children's - Downers Grove Hospital & Outpatient Center		
Street Address: Woodcreek Road at Lacey Road		
City and Zip Code: Downers Grove	60515	
County: DuPage	Health Service Area: 7	Health Planning Area: 05

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

Exact Legal Name: Ann & Robert H. Lurie Children's Hospital of Chicago
Street Address: 225 E. Chicago Avenue
City and Zip Code: Chicago, IL 60611
Name of Registered Agent: Fatema Zanzi
Registered Agent Street Address: 225 E. Chicago Avenue, Box 261
Registered Agent City and Zip Code: Chicago, IL 60611
Name of Chief Executive Officer: Thomas P. Shanley, M.D.
CEO Street Address: 225 E. Chicago Avenue
CEO City and Zip Code: Chicago, IL 60611
CEO Telephone Number: 312-227-4327

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: Ann Sherline
Title: Senior Associate General Counsel
Company Name: Ann & Robert H. Lurie Children's Hospital of Chicago
Address: 225 E. Chicago Avenue, Box 261, Chicago, IL 60611
Telephone Number: 312-227-4312
E-mail Address: asherline@luriechildrens.org
Fax Number: 312-227-9532

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

Name: Ralph Weber
Title: Consultant
Company Name: Weber Alliance
Address: 920 Hoffman Lane, Riverwoods, IL 60015
Telephone Number: 847-791-0830
E-mail Address: rmweber90@gmail.com
Fax Number: None

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City and Zip Code: Downers Grove 60515		
County: DuPage	Health Service Area: 7	Health Planning Area: 05

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Exact Legal Name: Children's Hospital of Chicago Medical Center
Street Address: 225 E. Chicago Avenue
City and Zip Code: Chicago, IL 60611
Name of Registered Agent: Fatema Zanzi
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Telephone Number: 847-791-0830
E-mail Address: rmweber90@gmail.com
Fax Number: None

Post Permit Contact

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

Name: Ann Sherline
Title: Senior Associate General Counsel
Company Name: Ann & Robert H. Lurie Children's Hospital of Chicago
Address: 225 E. Chicago Avenue, Box 261, Chicago, IL 60611
Telephone Number: 312-227-4312
E-mail Address: asherline@luriechildrens.org
Fax Number: 312-227-9532

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: HP/AG Esplanade at Locust Point Land LP
Address of Site Owner: 1901 Butterfield Rd, Suite 270 Downers Grove, IL 60515
Street Address or Legal Description of the Site: property bordered by Lacey Road on the east, Woodcreek Road on the south, and Birchwood Place on the north; in Downers Grove
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Ann & Robert H. Lurie Children's Hospital of Chicago	
Address: 225 E. Chicago Avenue, Chicago, IL 60611	
☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other
○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. ○ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. ○ Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification :

☒ Substantive☐ Non-substantive

2. Narrative Description

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

Ann & Robert H. Lurie Children's Hospital of Chicago ("**Lurie Children's**") proposes to construct a new pediatric health care facility that will provide inpatient and outpatient ambulatory services, including 48 pediatric inpatient beds, a surgery department with 6 ORs, and an emergency department with 35 treatment stations. Diagnostic imaging includes MRI (2), CT (1), X-ray (3), EOS/ortho (1), fluoroscopy (1) and ultrasound (2). Other clinical services include physical and occupational therapy, laboratory and pharmacy. The project includes extensive pediatric outpatient care, including 50 multi-specialty pediatric outpatient exam and treatment rooms and 10 ambulatory infusion rooms.

This project will be located near the intersection of Interstate 355 and Butterfield Road in suburban Downers Grove. The 13.2-acre vacant site is bordered by Lacey Road on the east, Woodcreek Road on the south, and Birchwood Place on the north in the Esplanade at Locust Point. The project is the new construction of 298,669 sq ft of space, including 132,377 sq ft. of clinical space and 166,092 sq ft. of non-clinical space.

Total cost of the project is \$480,102,903. The project completion date is December 31, 2029.

The project is a Substantive Project because it is the establishment of an inpatient clinical service and a new facility.

The project is related to the discontinuation of the Lurie Children's Hospital Outpatient Center in Westchester. Outpatient services provided in Westchester, including surgical services with three operating rooms, will be relocated to the hospital and clinic project in Downers Grove. A separate Certificate of Need permit application addresses the discontinuation of the Westchester facility. Lurie Children's requests that the Illinois Health Facilities and Services Review Board review both the Downers Grove project and the Westchester Discontinuation at the same HFSRB meeting.

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: \$ <u>20,030,430</u> 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 \$ <u>\$203,400,000 operating expense year 1</u>

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): December 31, 2029

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: Ann & Robert H. Lurie Children’s Hospital of Chicago			CITY: Chicago		
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	0	0	0	0	0
Obstetrics	0	0	0	0	0
Pediatrics	126	6,845	40,388	0	126
Intensive Care	162	4,612	39,045	0	162
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	12	430	3,248	0	12
Neonatal Intensive Care	64	455	21,774	0	64
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)					
TOTALS:	364	12,342	104,455 *	0	364

Note: *Patient days includes 97,474 inpatient days and 6,981 observation days.

Note: In November, 2024, Lurie Children's requested and received a letter of consent from the State staff to add 4 Acute Mental Illness beds in a project that did not exceed the capital expenditure threshold. These beds will increase the AMI bed count from 12 to 16. They were opened in the second half of December, 2025 and will be shown in the capacity and utilization report in 2026.

FACILITY NAME: Lurie Children’s – Downers Grove Hospital & Outpatient Center			CITY: Downers Grove		
REPORTING PERIOD DATES: From: Jan 1, 2026 to: Dec 31, 2026					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	0	0	0	0	0
Obstetrics	0	0	0	0	0
Pediatrics	0	0	0	+48	48
Intensive Care	0	0	0	0	0
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other (identify)	0	0	0	0	0
TOTALS:	0	0	0	+48	48

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

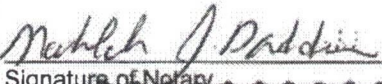

SIGNATURE

Thomas P. Shanley, M.D.
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:

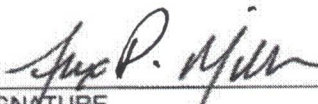
Subscribed and sworn to before me
this 19th day of May 2026


Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

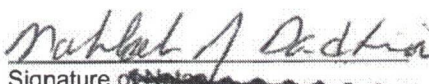

SIGNATURE

Alex P. Miller
PRINTED NAME

SVP, Chief Financial Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 19th day of May 2026


Signature of Notary

Seal

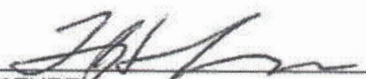


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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

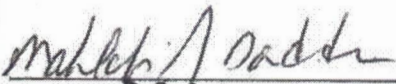

SIGNATURE

Thomas P. Shanley, M.D.
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:

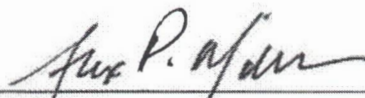
Subscribed and sworn to before me
this 19th day of May 2026


Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

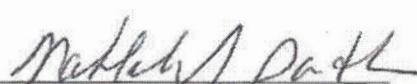

SIGNATURE

Alex P. Miller
PRINTED NAME

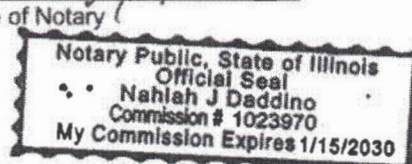
SVP, Chief Financial Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 19th day of May 2026


Signature of Notary

Seal



SECTION II. DISCONTINUATION NOT APPLICABLE TO THE DOWNERS GROVE APPL.

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project** **MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this Application for Discontinuation** <https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm>

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the **geographic service area**.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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:**THERE IS NO SHELL SPACE IN THE PROJECT.**

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		
☐ Obstetric		
☒ Pediatric	0	48
☐ 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
1110.200(d)(4) - Occupancy			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	
APPEND DOCUMENTATION AS <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
☐ See attachment 31		
☐		
☐		

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

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document 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]:

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

	terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

- 1) That the selected form of debt financing for the project will be at the lowest net cost available.
- 2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New 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)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			

	Outpatient			
	Total			

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

SECTION XI. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

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

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

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

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

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		31-33
2	Site Ownership		34-42
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		43-44
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		45-46
5	Flood Plain Requirements		47-48
6	Historic Preservation Act Requirements		49-50
7	Project and Sources of Funds Itemization		51-58
8	Financial Commitment Document if required		59
9	Cost Space Requirements		60-61
10	Discontinuation		N/A
11	Background of the Applicant		62-71
12	Purpose of the Project		72-131
13	Alternatives to the Project		132-135
14	Size of the Project		136
15	Project Service Utilization		137-139
16	Unfinished or Shell Space		N/A
17	Assurances for Unfinished/Shell Space		N/A
	Service Specific:		
19	Medical Surgical Pediatrics, Obstetrics, ICU		140-164
20	Comprehensive Physical Rehabilitation		N/A
21	Acute Mental Illness		N/A
22	Open Heart Surgery		N/A
23	Cardiac Catheterization		N/A
24	In-Center Hemodialysis		N/A
25	Non-Hospital Based Ambulatory Surgery		N/A
26	Selected Organ Transplantation		N/A
27	Kidney Transplantation		N/A
28	Subacute Care Hospital Model		N/A
29	Community-Based Residential Rehabilitation Center		N/A
30	Long Term Acute Care Hospital		N/A
31	Clinical Service Areas Other than Categories of Service		165-188
32	Freestanding Emergency Center Medical Services		N/A
33	Birth Center		N/A
	Financial and Economic Feasibility:		
34	Availability of Funds		189-240
35	Financial Waiver		241-250
36	Financial Viability		N/A
37	Economic Feasibility		251-262
38	Safety Net Impact Statement		263-268
39	Charity Care Information		269
40	Flood Plain Information		270-271
Appendix A	Letters of Support		272-283
Appendix B	Letters of Commitment to Refer Patients		284-310

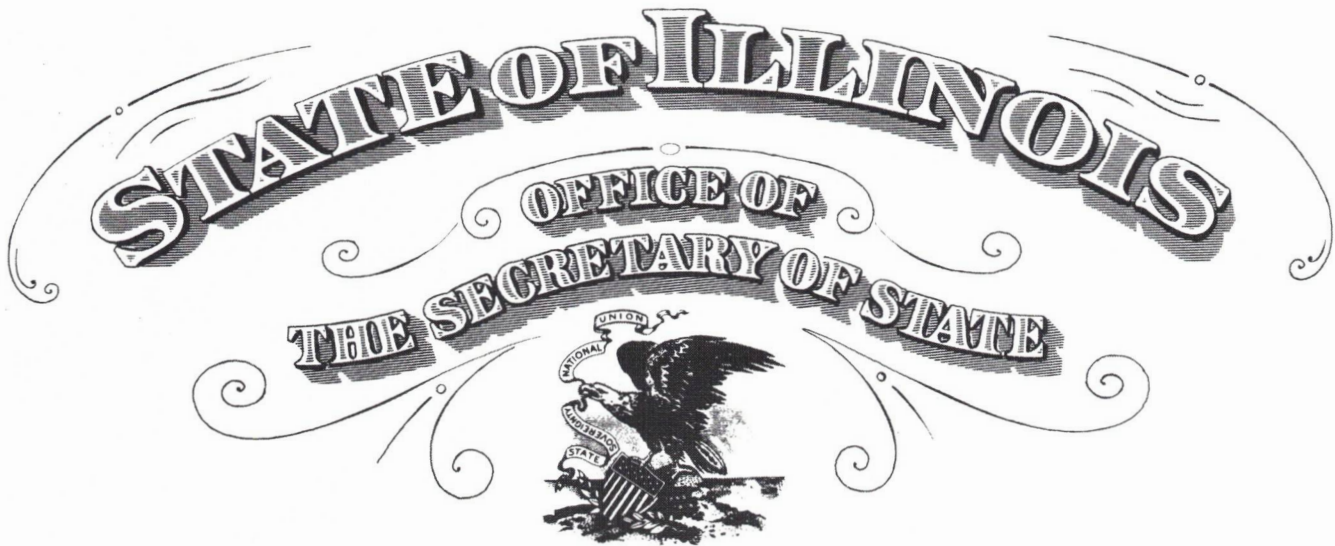
Certificates of Good Standing – Applicants

Ann & Robert H. Lurie Children's Hospital of Chicago
Children's Hospital of Chicago Medical Center

Attachment 1

File Number

0666-373-7



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

ANN & ROBERT H. LURIE CHILDREN'S HOSPITAL OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 27, 1894, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



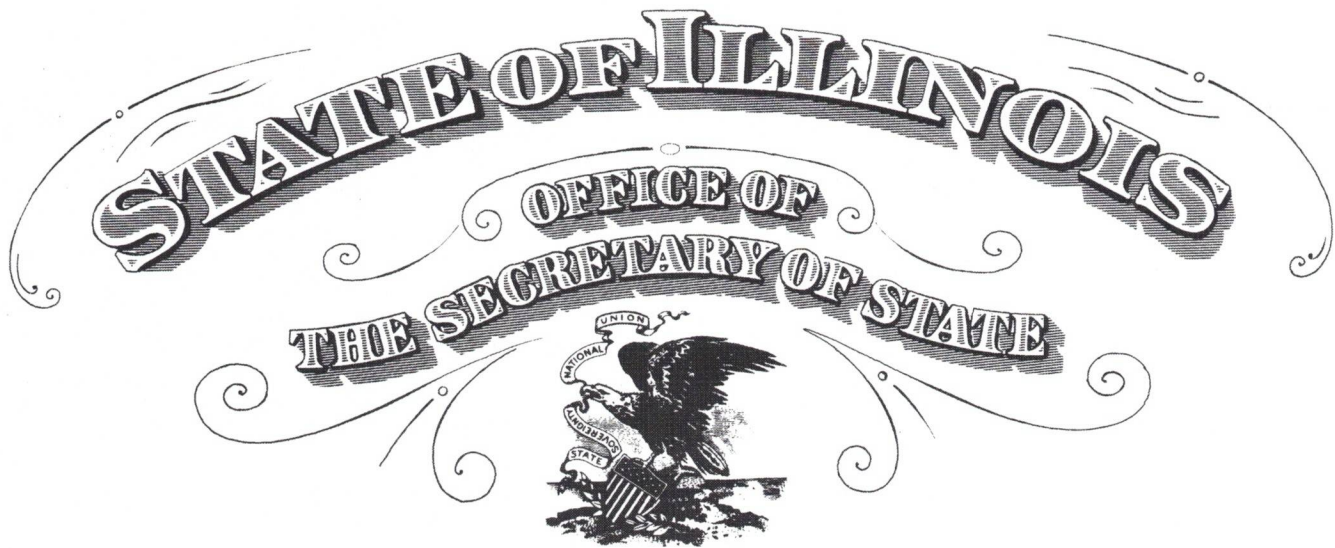
In Testimony Whereof, I hereto set
*my hand and cause to be affixed the Great Seal of
 the State of Illinois, this 11TH
 day of MAY A.D. 2026 .*

Authentication #: 2613102810 verifiable until 05/11/2027

Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulis

SECRETARY OF STATE



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

CHILDREN'S HOSPITAL OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 13, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 11TH day of MAY A.D. 2026 .

Alexi Giannoulis

SECRETARY OF STATE

Authentication #: 2613102822 verifiable until 05/11/2027

Authenticate at: <https://www.ilsos.gov>

SITE OWNERSHIP

Attached is the Letter of Intent dated October 1, 2025 for purchase of the land from owner HP/AG Esplanade at Locust Point Land LP.

Attachment 2

October 1, 2025

Buyer Revision: October 1, 2025 (Seller and Buyer engaged in email correspondence following Seller's receipt of Buyer's August 22, 2025 LOI revisions.)

VIA E-MAIL

Mr. Phillip Sheridan
Hamilton Partners
1901 Butterfield Road
Downes Grove, IL 60515
pjsheridan@hpre.com

**Re: Proposed Purchase and Sale ("Purchase Offer"):
574,913 SF of Land at Esplanade Locust Point**

Dear Phil,

This letter of intent ("**LOI**") outlines the general terms and conditions upon which our confidential client ("**Buyer**") desires to negotiate with Seller (as defined below) for the purchase and sale of that certain property described below (the "**Property**"). This LOI does not constitute a binding agreement or contract and neither Buyer nor Seller will be bound to purchase and sell the Property unless both Buyer and Seller execute a purchase and sale contract for the Property ("**Purchase Agreement**") and all other conditions are met. The purpose of this LOI is to express the desired terms and conditions to which Buyer is interested in purchasing the Property from Seller and to set forth a basis upon which the parties, together with their respective attorneys, may proceed to draft and negotiate toward the execution of a definitive and binding Purchase Agreement. It is understood that either party may terminate negotiation of the Purchase Agreement at any time and for any reason.

Based on the foregoing understanding, the parties desire to negotiate a Purchase Agreement with the following terms and conditions:

Property:	The Property consists of Seller's fee simple interest in the real estate, improvements, licenses, easements, and appurtenances for 574,913 SF of land at Esplanade Locust Point as shown on the attached site plan.
Seller:	HP/AG Esplanade at Locust Point Land LP
Purchase Price:	The Purchase Price shall be \$15,000,000.00 in cash at closing, subject to prorations provided for in the Purchase Agreement.
Earnest Money:	Buyer will place \$250,000 into an interest-bearing escrow account with Chicago Title Insurance Company (the " Title Company ") within three (3) business days following execution of the Purchase Agreement (" Earnest Money "). The Earnest Money, plus any interest earned thereon, will be refunded to Buyer if Buyer terminates the contract during the Due Diligence Period. If Buyer does not terminate the Purchase Agreement, the Earnest Money, plus any earned interest, will be applied to the Purchase Price (other than in the event of Seller's or Buyer's default or as may otherwise be provided in the Purchase Agreement).

Upon Buyer's waiver of its right to terminate the Purchase Agreement upon the expiration of the Due Diligence Period, Buyer shall place an additional \$250,000 Earnest Money in escrow. The combined \$500,000 deposit shall be a non-refundable deposit to Seller to be applied to the Purchase Price (other than in the event of Seller's or Buyer's default or as may otherwise be provided in the Purchase Agreement).

In the event Buyer exercises the Approval Extension Period (as defined below), Buyer shall place an additional \$500,000 Earnest Money in escrow as an additional non-refundable deposit. If Buyer does not terminate the Purchase Agreement at the expiration of the Approval Extension Period, such additional Earnest Money plus any earned interest will be applied to the Purchase Price (other than in the event of Seller's or Buyer's default or as may otherwise be provided in the Purchase Agreement).

Title and Survey:

Within one (1) business days following execution of the Purchase Agreement, Seller shall order an updated ALTA survey of the Property (the "**Survey**") and use best efforts to deliver the Survey to Buyer within twenty-one (21) days following execution of the Purchase Agreement. Should the Survey be delayed beyond twenty-one (21) days, the Due Diligence Period shall be extended by one day for every day beyond twenty-one (21) days until the Survey is delivered. Within ten (10) business days following the execution of the Purchase Agreement, Seller will provide Buyer with a current title commitment issued by the Title Company (the "**Title Commitment**"), together with legible copies of all recorded documents evidencing the exceptions to the title that are described in Schedule B of the Title Commitment. At Closing, Seller will furnish to Buyer, at Seller's expense and as a condition to Buyer's obligation to close, an ALTA Owner's Title Insurance Policy issued by the Title Company (a) in the amount of the Purchase Price; (b) including extended coverage; (c) showing Buyer (or its assignee) as sole owner of Property; and (d) subject only to (i) liens for taxes not yet due and payable and (ii) encumbrances and such other title-related matters that are acceptable to Buyer (the "**Title Policy**"). Buyer will pay for the additional cost of any desired endorsements.

Due Diligence Period:

Buyer will have a one hundred thirty-five (135) day period (the "**Due Diligence Period**"), commencing on the date the Purchase Agreement is fully executed, to inspect the physical and environmental condition, status of permits, zoning and other governmental approvals, condition of title and survey relating to the Property and to perform such other due diligence with respect to the Property as Buyer desires. During the Due Diligence Period, Buyer and Buyer's agents, employees and consultants shall have access to the Property at reasonable times to make a physical inspection of the Property. Seller will cooperate with Buyer in a timely manner and will provide Buyer with all documents and other materials reasonably requested by Buyer. This Due Diligence Period will be utilized by Buyer to satisfy the conditions stated in the Conditions Precedent paragraph herein. During the Due Diligence Period Buyer shall have the right to terminate the transaction for any reason or no reason, and the Earnest Money shall be promptly refunded to Buyer.

Following Seller's execution of this Letter of Intent, Seller and Buyer shall enter into an access agreement so that Buyer may, at its own cost and expense, enter the Property to conduct any and all due diligence, studies and tests of the Property.

Approvals Period:

Buyer shall have a period of one (1) year after the execution of the Purchase and Sale Agreement (the "**Approval Period**") to obtain all zoning, entitlements, special uses and all other approvals from the Village of Downers Grove (the "**Village**") and any other federal, state, or local governmental authorities having jurisdiction thereof, as Buyer shall reasonably deem necessary in order to allow and permit use of the Property by Buyer for Buyer's intended use (collectively, the "**Approvals**"). Seller agrees to cooperate with Buyer and to facilitate Buyer's submission of all applications for Approvals from the Village. If the Approvals are not obtained during the Approval Period, then the Approval Period may be, at Buyer's sole discretion, extended for such time as may be necessary for Buyer to obtain the Approvals (by providing Seller the additional \$500,000 non-refundable Earnest Money extension deposit noted above); provided, however, that Seller shall not be obligated to allow the Approval Period to be extended by Buyer for more than an additional one hundred twenty (120) days (the "**Approval Extension Period**"). After the expiration of the Due Diligence Period, in the event that Buyer terminates the Purchase and Sale Agreement during the Approval Period, as it may be extended, then all Earnest Money shall be delivered to Seller. All costs and expenses to obtain the Approvals shall be Buyer's sole responsibility.

Seller shall cooperate with Buyer in Buyer's efforts to obtain the Approvals, at Buyer's sole cost and expense, including, but not limited to, signing approval applications and/or other reasonable documents as owner of the Property and any other actions as deemed reasonably necessary by Buyer.

If Buyer fails to obtain all Approvals prior to the expiration of the Approval Period or, if applicable, the Approval Extension Period, then Buyer shall have the option, in its sole discretion, to elect to either (i) terminate the Purchase Agreement or (ii) waive the receipt of its Approvals and continue to closing pursuant to the terms and conditions of the Purchase Agreement.

If Buyer does not terminate the Purchase Agreement prior to the end of the Approval Period or, if applicable, the Approval Extension Period, the Approval Period contingency shall be deemed waived and Buyer's Earnest Money will become non-refundable (other than in the event of Seller's default or as may otherwise be provided in the Purchase Agreement).

Document Delivery:

Upon the execution of the Purchase Agreement, Seller will provide Buyer with such due diligence information relating to the Property as is within Seller's reasonable possession or control (Seller will not be required to engage vendors or provide anything not currently in its possession), including: (a) any encumbrances on the Property and associated documentation including but not limited to ground leases (if any), (b) existing engineering reports and plans, (c) environmental assessments/reports (i.e., Phase I and Phase II) and soil reports (i.e. Geotech), (d) service contracts and Property maintenance records, (f) copies of past three (3) years property/real estate tax bills and assessment, and all related notices including but not limited to the status of any assessed valuation protest work/appeals, including appraisals, (g) site

plans for the Property, (h) permits/licenses/zoning reports and reviews, (i) insurance claims history, if any, (j) the Survey, (k) easement and/or use agreements; (l) flood plain certificate(s), flood plain reports/maps, topographical maps and other similar materials; (m) geological studies; (n) utility maps and plans; (o) Title Commitment and any prior title policies; (p) covenants and restrictions; (q) approval of signage requirements; (r) most recent soil and land testing reports and/or environmental studies and such other information as the Buyer may deem necessary. Such due diligence items (collectively, the **"Diligence Deliverables"**) shall be listed on an exhibit to the Purchase Agreement.

The Property and all such Diligence Deliverables shall remain available to Buyer for inspection during the Due Diligence Period at any time with reasonable notice from Buyer to Seller. During the Due Diligence Period, Seller agrees to give Buyer and its agents, representatives and engineers access to the Property during normal business hours and shall arrange meetings with Seller's representatives as requested by Buyer upon adequate notice to Seller.

Closing

The purchase of the Property will close (**"Closing"**) within thirty (30) days after the expiration of the Approval Period or the Extended Approval Period (if applicable) and satisfaction of the Conditions Precedent, or earlier or later subject to mutual consent of the Seller and Buyer. Seller and Buyer shall be responsible for their respective customary closing costs.

Closing Costs:

Seller shall pay the following customary costs in connection with the conveyance of the Property pursuant to the terms of the Purchase Agreement:

1. State and county transfer taxes;
2. Seller's share of closing adjustments as discussed below;
3. Seller's attorney fees;
4. Brokerage commissions related to the sale, as stated herein.
5. Costs of obtaining the Survey; and
6. The cost of the Title Commitment and Title Policy

Buyer shall pay the following customary costs in connection with the conveyance of the Property pursuant to the terms of the Purchase Agreement:

1. The cost of any title endorsements requested by Buyer;
2. Buyer's share of closing adjustments as discussed below; and
3. Buyer's attorney's fees

Other costs in connection with the conveyance of the Property will be split per county or municipality custom.

Closing Adjustments:

At Closing, Buyer and Seller shall cooperate to provide cash adjustments and prorations for certain expenses (including real estate taxes and any POA fees, which shall be prorated accordingly on an accrual basis using the last ascertainable real estate tax bill) that would customarily be provided in a similar transaction.

The amount of the current general taxes not then ascertainable shall be adjusted on the basis of 103% of the most recent ascertainable taxes. All prorations shall be final.

Conditions Precedent:	Buyer's obligation to purchase the Property will be contingent upon: 1. Buyer determining (in its sole discretion) during the Due Diligence Period that it wishes to move forward with the transaction; 2. Buyer receiving formal approval from its Board of Directors to proceed with the transaction during the Due Diligence Period; 3. Buyer's receipt of the Title Policy; and 4. Buyer's receipt of the Approvals or Buyer's waiver thereof.
Representations & Warranties:	The Purchase Agreement will contain warranties, representations and covenants of Seller that would customarily be provided in a similar transaction.
Purchase & Sale Agreement:	A draft of the Purchase Agreement will be delivered by Seller to Buyer within ten (10) business days from the execution of this LOI.
Default:	If Buyer defaults prior to Closing, Seller's sole and exclusive remedy shall be to retain the Earnest Money (including any additional deposits, as described herein), as liquidated damages; other than Buyer's indemnity for damages caused by its entry onto the Property. If Seller defaults prior to Closing, Buyer may either (a) pursue specific performance, or (b) terminate the Purchase Agreement in which event (i) Seller shall cause the Title Company to return the Earnest Money (including any additional deposits, as described herein) to Buyer, without delay, deduction or offset, and (ii) Seller shall also reimburse Buyer for its reasonable out of pocket costs incurred in connection with the transaction, up to a maximum of \$100,000.
Building Design and Site Plan Requirements:	The Seller and Buyer have agreed upon certain building design and site plan requirements as set forth on Exhibit A.
Exclusivity Period:	Buyer agrees that until execution the Purchase Agreement or negotiations are otherwise terminated, Seller will not (a) promote the sale of the Property to, or solicit offers to purchase the Property from, other parties, or (b) negotiate with other parties regarding any solicited or unsolicited offers received from such other parties.
Confidentiality:	This LOI is being delivered to you with the understanding that you will keep this LOI and its contents strictly confidential, except that you may engage in discussions with your agents, representatives, lenders, accountants, attorneys and other third parties that you absolutely require to require to be involved in this process. Neither Buyer nor Seller may issue any public statement or press release without the prior written consent of the other party.
Broker:	It is acknowledged that CBRE, Inc. is exclusively representing the Buyer in the purchase of the Property, and that Hamilton Partners is representing the Seller. Seller shall pay CBRE, Inc. a commission equal to four percent (4%) of the purchase price per the terms of a separate agreement. Seller represents that it has not dealt with any broker other than CBRE, Inc. and Hamilton Partners, and shall hold Buyer harmless from any claim made in

connection with the transaction from any broker alleging to represent Seller. CBRE, Inc. and Hamilton Partners shall be paid at closing.

Non-Binding:

This LOI is not intended to articulate every detail of the proposed transaction and is non-binding and not enforceable against either party except under the Exclusivity Period provisions. The parties hereto and all other persons are expressly estopped from a claim in any actionable reliance hereon or upon any negotiations occurring prior to execution of the Purchase Agreement.

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26-026

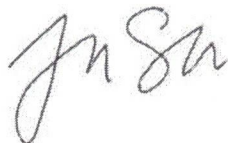
If you have any questions regarding any aspect of this LOI, please reach out to us at your earliest convenience. If you desire to proceed to negotiate a Purchase Agreement based upon the foregoing understandings, please indicate acceptance of this LOI by signing the acknowledgement below and returning to our attention.

AGENCY DISCLOSURE

As required by Real Estate License Act of 2000, 225 ILCS 454/15-35, please acknowledge that Seller has been informed, both orally and by this written disclosure that (1) CBRE, Inc. is acting on behalf of the prospective Buyer of the real estate and (2) information given to the Agent by Seller may be disclosed to the Buyer.

Sincerely,

CBRE, INC.



Jonathan S. Springer
Vice Chairman

AGREED AND ACCEPTED ("Buyer"): Signed by: <u>Donk S. Wheeler</u> By: <u>CADF99D3896D431...</u> Title: <u>Executive Vice President and</u> Date: <u>10/8/2025</u>	AGREED AND ACCEPTED ("Seller"): By: <u>[Signature]</u> Title: <u>Chief Operating Officer</u> Date: <u>10/8/25</u>
--	--

EXHIBIT A**Building Design and Site Plan Requirements**

1. Maximum Floor Area Ratio (FAR) is .89 in accordance with site zoning; Buyer has the right to utilize the full FAR.
2. Maximum Building Height is 140' in accordance with the Planned Development requirements.
3. Minimum of 30% glass curtainwall on all buildings excluding the parking garage.
4. Minimum Setback 35' along north & west perimeters of the Property.
5. Loading dock(s) will not face the 3250 Lacey Road Building.
6. The buildings, excluding the parking garage, will be constructed substantially similar to the Lurie Children's hospital outpatient center in Schaumburg with elements of Lurie Children's Hospital in Chicago.

The following items will be reviewed by Seller and Buyer once buyer completes its preliminary site plan, anticipated to be completed by December 1, 2025. Buyer acknowledges that these items are reflective of Seller's preferences and Buyer will work with Buyer's architect to comply, if possible, dependent upon the results of Buyer's due diligence findings and design process. In the event that Buyer can not comply with the requirements, Buyer and Seller will collaborate to identify a mutually agreeable position that is compliant with all federal, state and local regulatory requirements applicable to Buyer's intended use of the Property.

1. Orient buildings to west property line
2. Place parking garage on south side of site

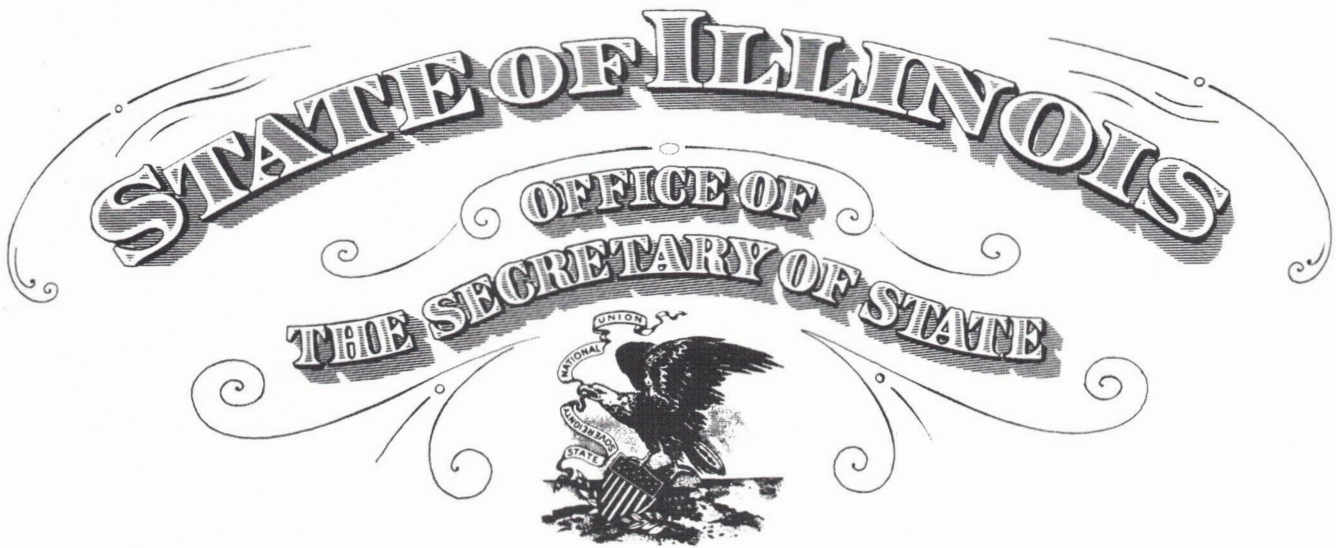
Certificate of Good Standing – Operating Identity / Licensee

Ann & Robert H. Lurie Children's Hospital of Chicago

Attachment 3

File Number

0666-373-7



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

ANN & ROBERT H. LURIE CHILDREN'S HOSPITAL OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 27, 1894, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 11TH day of MAY A.D. 2026 .

Authentication #: 2613102810 verifiable until 05/11/2027

Authenticate at: <https://www.ilsos.gov>

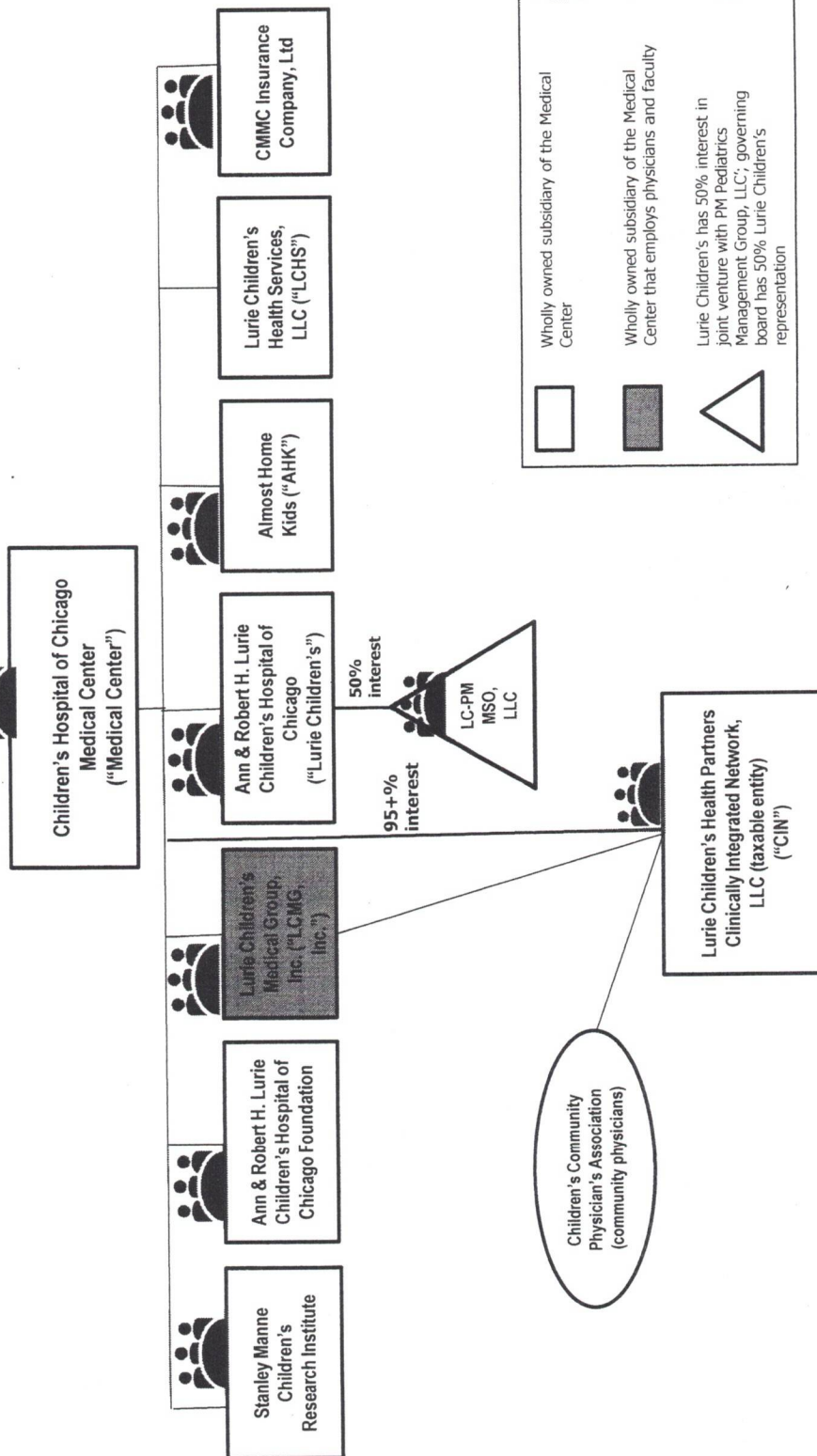
Alexi Giannoulas

SECRETARY OF STATE

ORGANIZATION CHART

Attachment 4

Corporate Overview – Effective 1/1/2025



Flood Plain Requirements

The following page includes the most recent National Flood Hazard Layer FIRMette for the location of the property in Downers Grove bordered by Lacey Road on the east, Woodcreek Road on the south, and Birchwood Place on the north.

The site is located in Zone X, panels 17043C0158J and 17043C0159J, effective 8/1/2019. According to FEMA, Zone X consists of “areas determined to be outside 500-year floodplain determined to be outside the 1% and 0.2% annual chance floodplains.” (www.floodmaps.com/zones.htm). This classification designates areas least susceptible to flooding in the FEMA system.

Illinois Executive Order #2006-5, “Construction Activities in Special Flood Hazard Areas” defines “Special Flood Hazard Areas” or “Floodplains” as areas subject to “100 year frequency flood and shown as such on the most current Flood Insurance Rate Map published by the Federal Emergency Management Agency.”

The FIRMette designates the site as located in an “Area of Minimal Flood Hazard.”

National Flood Hazard Layer FIRMMette

88°2'10"W 41°49'52"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, AO, AH, VE, AR
- Regulatory Floodway

- 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
- Area with Flood Risk due to Levee
Zone D

OTHER AREAS OF FLOOD HAZARD

- NO SCREEN
- Area of Minimal Flood Hazard
Zone X
- Effective LOMRs
- Area of Undetermined Flood Hazard
Zone D

OTHER AREAS

- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

GENERAL STRUCTURES

- Cross Sections with 1% Annual Chance Water Surface Elevation
- Coastal Transect
- Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

OTHER FEATURES

- Digital Data Available
- No Digital Data Available
- Unmapped

MAP PANELS



The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

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 **1/11/2026 at 11:36 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.

26-026



88°1'33"W 41°49'25"N

1:6,000

Feet

2,000

1,500

1,000

500

250

0

Basemap Imagery Source: USGS National Map 2023

HISTORIC RESOURCES PRESERVATION ACT REQUIREMENTS



DuPage County
Downers Grove
Lacey Rd. and Woodcreek Dr.
IHFSRB
CON - Ann and Robert H. Lurie
Children's Hospital Outpatient Center

PLEASE REFER TO: SHPO LOG #016021926

March 18, 2026

Ralph Weber
Weber Alliance
920 Hoffman Lane
Riverwoods, IL 60015

The Illinois State Historic Preservation Office is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted, or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural, or archaeological resources will be affected within the proposed project area.

According to the information you have provided there is no federal involvement in your project. Be aware that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits (including non-reporting), use federal property, or involve assistance from a federal agency then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This approval remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

If further assistance is needed, please contact Jeff Kruchten, Principal Archaeologist, at 217/785-1279 or jeff.kruchten@illinois.gov.

Sincerely,

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer

Project Costs and Sources of Funds

- Table
- Narrative Descriptions of Line Items

Project Costs and Sources of Funds
Lurie Children's – Downers Grove Hospital & Outpatient Center

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	\$ 2,031,487	\$ 1,512,284	\$ 3,543,771
Site Survey and Soil Investigation	\$ 30,000	\$ 45,000	\$ 75,000
Site Preparation	\$ 6,184,689	\$ 16,474,668	\$ 22,659,357
Off Site Work	-	-	-
New Construction Contracts	\$ 119,094,084	\$ 158,917,322	\$ 278,011,406
Modernization Contracts	-	-	-
Contingencies	\$ 11,700,000	\$ 49,487,845	\$ 61,187,845
Architect/Engineering Fees	\$ 6,371,000	\$ 13,972,929	\$ 20,343,929
Consulting and Other Fees	\$ 13,816,540	\$ 9,211,027	\$ 23,027,567
Moveable or Other Equipment			
- Furnishings	\$ 3,084,500	\$ 1,890,500	\$ 4,975,000
- Equipment	\$ 29,259,672	\$ 17,933,348	\$ 47,193,020
Bond Issuance Expense	\$ 66,667	\$ 66,666	\$ 133,333
Net Interest Expense During Construction	-	-	-
FMV of Leased Space or Equipment	-	-	-
Other Costs to be Capitalized	-	-	-
- Artwork	\$ 243,000	\$ 725,175	\$ 968,175
- Dietary Equipment	-	\$ 1,600,000	\$ 1,600,000
- Technology/AV	\$ 9,250,500	\$ 7,134,000	\$ 16,384,500
Acquisition of Building or Other Property (excl land)	-	-	-
TOTAL USES OF FUNDS	\$ 201,132,139	\$ 278,970,764	\$ 480,102,903

SOURCE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Cash and Securities	\$ 51,132,139	\$ 128,970,764	\$ 180,102,903
Pledges	-	-	-
Gifts and Bequests - philanthropy	\$ 50,000,000	\$ 50,000,000	\$ 100,000,000
Bond Issues (project related)	\$ 100,000,000	\$ 100,000,000	\$ 200,000,000
Mortgages	-	-	-
Leases (fair market value)	-	-	-
Government Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$ 201,132,139	\$ 278,970,764	\$ 480,102,903

Project Costs and Sources of Funds
Lurie Children's – Downers Grove Hospital & Outpatient Center

Narrative Descriptions of Line Items

Item 1. Preplanning Costs - \$3,543,771

Market studies, feasibility studies and background work, real estate analysis and site selection; Phase 1 cultural and environmental assessments; initial traffic and parking studies; legal and zoning investigation.

Preplanning costs assigned to clinical uses total \$2,031,487. This amount is 1.2% of \$163,138,256 the total of \$119,094,084 for clinical construction plus \$11,700,000 clinical contingency plus \$32,344,172 for clinical equipment and furnishings. 1.2% meets the State standard, under 1.8%.

Item 2. Site survey and soil investigation - \$75,000

Soil testing and geotechnical work; property survey. \$30,000 of this amount is assigned to clinical cost.

Item 3. Site Preparation - \$22,659,357

Site work includes earthwork and grade leveling, utility infrastructure installation, irrigation and drainage systems, retention pond configuration, asphalt paving, and landscaping; access road construction; improvement to adjacent streets and right-of-way including turn lanes; signage and signalization. Site work includes helipad construction. Site work assigned to clinical costs is \$6,184,689.

Item 4. Off-site work - \$0

There is no off-site work for this project.

The total site related work items 2, 3 and 4 is \$22,734,357, of which \$6,214,689 is assigned to clinical. \$6,214,689 is 4.8% of \$130,794,084, the sum of clinical construction (\$119,094,084) plus clinical contingency (\$11,700,000). 4.8% meets the State standard, under 5.0%.

Item 5. New Construction Contracts - \$278,011,406

The project is the construction of a four story plus lower level and penthouse (hospital) and connected two story clinic building, totaling 298,669 sq ft. Of this total, 132,577 sq ft is clinical. Construction costs include foundation and slab, core and shell, roofing, doors and windows, thermal and moisture protection, fixed equipment (other than medical equipment referenced below), interior buildout and finishings, and contractor's overhead. Electrical, plumbing and heating and air conditioning systems are included.

Of the total construction cost, \$119,094,084 is allocated to clinical uses. Cost per sq ft for clinical construction is \$898.28.

There are several characteristics of this project that contribute to construction costs above the RSMeans standard. The following items result in higher costs for pediatric inpatient care, several of which differentiate pediatrics from adult care, that are not factored into RSMeans calculations. Based on recent experience of the project's healthcare facility consultants with comparable pediatric projects, the associated premiums are estimated for the following factors:

- Larger patient rooms, mostly to accommodate family member visiting and overnight stays, 3 – 6%
 - Pediatric rooms are typically designed to support family-centered care, including sleeper sofas and in-room storage for overnight accommodations. Benchmark comparisons from recent children’s hospital projects show room sizes increasing from 15 to 30% over adult equivalents, directly impacting overall building area and cost per bed. The upper part of the range includes dedicated caregiver space for charting and supplies.
- Increased design complexity (theming, custom finishes), 2 – 4%
 - Pediatric environments often incorporate themed interiors, interactive elements and custom millwork to create a more supportive, homelike and less clinical atmosphere. Examples include wall graphics, specialty lighting and play features in waiting and treatment areas. These elements are typically excluded from RSMeans-type baselines, which assume more standardized healthcare finishes, and are increasingly common in children’s fit-out packages.
- Specialized/flexible equipment accommodations, 2 – 5%
 - This factor relates to additional space provided on the pediatric units, diagnostic imaging, and surgery for a range of equipment and supplies sized to fit ranges of infants and children, rather than adult sizes that are more standard. Examples include headwalls designed for multiple acuity levels, adjustable exam tables, and imaging equipment with pediatric protocols. Recent pediatric imaging and OR projects have provided space and allowances for specialized accommodations.
- Enhanced safety and security requirements, 1 – 3%
 - Pediatric facilities require additional layers of security and safety, including infant protection systems, controlled access zones, anti-ligature hardware, tamper resistant devices, and lockdown capability. Certain units require infant monitoring and tracking. Increasing regulations and security standards contribute to unit cost increases.
- Reduced standardization – greater room type variability, 2 – 4%
 - While the pediatric rooms are sized the same for stacking on the two-unit floors, and uniformity is conducive to efficient patient care staffing operations, there is individual variability within the rooms. Unlike adult facilities where room types are often highly repeatable, pediatric facilities require a broader mix of room configurations to support different age groups and care models. This factor reduces construction efficiency and limits some prefabrication opportunities.
- More durable/high performance materials, 1 – 3%
 - Materials in pediatric environments are typically selected for higher durability due to increased wear from patients, families and staff. Examples include impact-resistant wall protection, higher-grade flooring systems, and cleanable infection-control-driven finishes. These selections exceed standards RSMeans assumptions for commercial and basic healthcare construction.

- Higher infrastructure demands, 5 – 10%
 - Operating rooms, imaging and procedure-based spaces have higher MEP requirements than other outpatient and lower acuity clinical areas. This includes medical gases, redundancy in electrical power systems, specialized ventilation, air handling and cooling to support operational requirements. Certain of the rooms require multiple gas outlets and higher air change rates compared to adult med/surg.

While each of these factors independently contributes modest cost increases, collectively they can reasonably result in an overall premium that is 15 – 35% higher than the RSMeans standard of \$572.74 selected for this project. Collectively, the costs associated with these factors could add about \$200.00 per sq ft above the standard (at the 35% high end).

In addition to the above, the inpatient units with 48 pediatric beds are sized as ICUs. 12 of the 48 rooms are built out for ICU use, although they are pediatric rooms, and if conversion to ICU in the future is needed, it will require separate CON review and approval. These 12 rooms have sliding glass doors, medical gases and electric support for functioning as ICU rooms with a minimum of extra future cost. They are not equipped as ICU rooms. The sizing of all 48 as ICU is driven by efficiencies in construction, such as stacking requirements. This decision was made to provide flexibility for the future. The capital cost of this flexibility now is much less than reconstructing (and disrupting) the area in the future.

Having all rooms built at ICU size adds 32 clinical sq ft per room, and \$39.42 to the cost per sq ft of the pediatric units, as shown in the following calculations:

- 1,671 additional sq ft on level 3 + 1,841 on level 4 = 3,512 sq ft larger pediatric units.
- 3,512 / 48 pediatric rooms = additional 73 sq ft per pediatric room (per bed)
- 73 sq ft x (132,577 sq ft clinical / 298,669 sq ft total) = 73 x 0.44 = 32 clinical sq ft per room
- 32 sq ft x 48 x \$800 per sq ft for pediatric clinical construction = extra cost of \$1,228,800.
- \$1,228,800 / 31,171 sq ft for pediatrics = **\$39.42**, the cost per sq ft added to the pediatric units.
- (\$1,228,800 / 132,577 total sq ft clinical = \$9.27, the cost per sq ft added to the entire project)

An additional construction cost is associated with building out 12 of the 48 pediatric rooms as ICU-capable. These rooms will have ICU sliding glass doors, headwalls with medical gases and meeting ICU power requirements, etc. They will not be used as ICUs, but as pediatric rooms. They are capable of being converted to ICUs if the need evolves in the future, and subject to specific review and approval for future conversion to ICU. The cost of these features is estimated to be \$30,000 per room, or \$360,000 for the 12 rooms. This additional cost, spread over the pediatric units, is **\$46.20** per sq ft.

- \$360,000 / 7,793 sq ft for 12 pediatric rooms = \$46.20 per sq ft.
- (\$360,000 / 132,577 total sq ft clinical = \$2.72, the cost per sq ft added to the entire project)

Considering these factors including the sizing of pediatric rooms as ICU rooms and building out 12 rooms for potential possible future conversion to ICU, the clinical construction cost of \$898.30 per sq ft includes \$212.00 in cost premiums (\$200.00 + \$9.27 + \$2.72) above the RSMeans standard of \$572.74. These factors explain \$212.00 of the \$325.56 difference between the project construction cost of \$898.30 per sq ft and the RSMeans standard of \$572.74.

Item 7. Contingencies - \$61,187,845

Contingencies are allowances for unforeseen circumstances, such as delays in shipping and receipt of materials and supplies that affect the construction schedule, escalation above anticipated pricing of materials and labor, or site conditions resulting in plan modification.

\$11,700,000 is the contingency allocated to clinical uses. \$11,700,000 is 9.8% of clinical construction costs of \$119,094,084, thereby meeting the State standard of below 10%.

Item 8. Architectural and Engineering Fees - \$20,343,929

A/E fees include the functional program and space plan, preliminary design, schematic design, design development, construction document services, bidding and negotiation, and construction administration services. The costs of A/E services for construction are \$20,343,929, of which \$6,371,000 is allocated to clinical uses.

A/E contingency of \$6,371,000 is 4.87% of the clinical construction cost \$119,094,084 plus clinical contingency of \$11,700,000. This amount is consistent with the State standard range of 3.59% - 5.39% for construction and contingency for amounts over \$100 million.

Item 9. Consulting and Other Fees - \$23,027,567

This work includes legal fees, environmental evaluation, utilities during construction, builder's risk insurance policy premiums, and equipment planning. It also includes regulatory and permit fees, including Certificate of Need consulting and IDPH fees, as well as commissioning fees.

Of the \$23,027,567, \$13,816,539 is allocated to clinical costs.

Item 10. Moveable Equipment and furnishings not in construction contracts - \$52,168,020

The equipment list for the new hospital and clinic building is extensive, spanning over 2,800 rows and listing items from MRI and CT scanners to waste receptacles and glove boxes. The total amount for equipment is \$47,193,020, of which \$29,259,672 is clinical and \$17,933,348 is non-clinical. In addition, the furnishings budget is \$4,975,000, of which \$3,084,500 is clinical and \$1,890,500 is non-clinical.

Major equipment that individually or collectively exceeds \$200,000 is listed by functional area in the following table.

**Preliminary Estimated
Major Equipment Costs by Functional Area
Lurie Children's – Downers Grove Hospital & Outpatient Center**

FUNCTIONAL AREA		COST
Surgery, Prep, Recovery, Central Sterilization		\$ 13,119,336
- Washer/cart	\$	220,500
- Sterilizers (2)	\$	238,140
- Washer/disinfector (3)	\$	198,450
- Portable C-Arm	\$	330,750
- Integration Controller (6)	\$	992,250
- Anesthesia Atlan 350XL (6)	\$	496,125
- Equipment Boom S-Series (6)	\$	429,975
- Anesthesia Boom (6)	\$	396,900
- PYXIS drug dispensing system (6)	\$	396,900
- Surgical tables (6)	\$	369,944
- Supply dispensing unit (6)	\$	330,750
- Surgical light w flat panel arm (18)	\$	754,110
- Camera Head (12)	\$	317,520
- Prep/Recovery Physiological Monitor (22)	\$	521,483
- Stretchers (22)	\$	242,550
Imaging		\$ 11,528,855
- CT Scanner	\$	2,976,750
- MRI 3.0T	\$	2,866,500
- MRI 1.5T	\$	2,535,750
- Digital Fluoroscopy	\$	628,425
- X-Ray	\$	385,875
- EOS-Ortho	\$	400,000
- Ultrasound Scanner	\$	220,500
Emergency Department		\$ 5,445,113
- X-Ray	\$	220,500
- Ultrasound Scanner	\$	220,500
- Physiological Monitor (23)	\$	456,435
- Stretchers (23)	\$	253,575
Inpatient Pediatric Units		\$ 5,151,831
- Physiological Monitor (44)	\$	1,018,710
- Electric beds (44)	\$	873,180
- Patient Headwall (22)	\$	242,550
Laboratory		\$ 1,431,139
- Automated analyzer - hematology	\$	496,125
- Automated analyzer - chemistry (2)	\$	352,800
Outpatient Clinics		\$ 6,422,588
- Ophthalmology	\$	264,600
- ENT Cart, video 9805T (4)	\$	926,100
- PYXIS Drug Dispensing Units (7)	\$	501,618
- Supply Dispensing Unit (4)	\$	220,500
Rehabilitation		\$ 741,773
- Audiology booth (2)	\$	277,830
Engineering, MEP Systems, Maintenance		\$ 631,269
Sleep / EEG		\$ 687,560
Pharmacy		\$ 571,608
All other spaces		\$ 1,461,948
EQUIPMENT COST TOTAL		\$ 47,193,020

**Note: Only includes equipment that individually or collectively exceeds \$200,000.*

Additional clinical equipment with relatively smaller aggregate costs constitute the remainder of the clinical equipment budget. The balance of the equipment budget includes a large volume of equipment located in exam rooms and other non-clinical areas. Examples of these items are: procedure carts, mobile workstations, exam tables, exam stools, medical gas carts, defibrillators and AEDs, video procedure carts, microscopes, wheelchairs and wheelchair scales, sharps containers, and nebulizers.

Furnishings include tables and chairs for waiting areas, conference rooms, and administrative and staff areas, desks and workstations.

Item 11. Bond Issuance Expense - \$133,333

Lurie Children's will be issuing bonds for several capital projects, including the Downers Grove hospital and clinic building. Arrangements have not been finalized at this time. The project-related bond issuance expense is estimated to be \$133,333 for this project, split equally between clinical and non-clinical use.

Item 12. Net Interest Expense During Construction - \$0

Interest on the bonds will be treated as a cost of operations and is not being capitalized.

Item 13. FMV of Leased Space or Equipment -\$0

There is no leased space or equipment in the project.

Item 14. Other Costs to be Capitalized - \$18,952,675

Information technology, incl computers, switches, cabling, low voltage, audio/visual	\$ 16,384,500
Artwork for lobby and public areas, waiting, exam rooms	\$ 968,175
Dietary equipment	\$ 1,600,000

Project Status and Completion Schedules
Lurie Children's – Downers Grove Hospital & Outpatient Center

Financial Commitment for this project is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies.

The following language is taken from the agreement with the Design/Build contractor:

Below is CON language for the DB contract:

§ 15.24 CON and Zoning Contingency. The Design-Builder acknowledges that the Project requires a Certificate of Need ("CON") from the Illinois Health Facilities and Services Review Board and zoning approvals from authorities having jurisdiction. The obligations of the Owner to proceed forward with construction of the Project are expressly contingent upon receipt of such CON and zoning approvals. Owner will pursue obtaining any required CON and zoning approvals in good faith and on a reasonable time frame. The Design-Builder will cooperate with Owner and assist it as necessary in obtaining any CON and zoning approvals. If Owner is unsuccessful in obtaining any required CON or zoning approvals, Owner may terminate the Agreement for convenience. If, however, Owner is successful in obtaining the requisite CON permits and zoning approvals, the Design-Builder shall cooperate with Owner in good faith and assist it as necessary in maintaining compliance with all CON and zoning requirements including, but not limited to, parameters relating to construction costs and gross square feet. Contractor represents and warrants that total Contract Sum shall not exceed any CON approved Project budget.

Cost/Space Requirements Table

Cost Space Requirements
Lurie Children's - Downers Grove Hospital & Outpatient Center

CONSTRUCTION COSTS							
Department/Area	Cost	Gross Square Feet		Amount of Proposed Total Sq Ft That Is:			
		Existing	Proposed	New Const	Modernized	As Is	Vacated
Clinical/Reviewable							
Pediatric Beds (48)	\$ 24,936,800		31,171	31,171			
Emergency Stations (35)	\$ 22,612,850		23,803	23,803			
Surgery (6 ORs)	\$ 29,711,659		28,280	28,280			
Diagnostic Imaging							
X-Ray (3)	\$ 1,797,000		2,396	2,396			
Ortho EOS (1)	\$ 509,150		599	599			
Fluoroscopy (1)	\$ 762,850		803	803			
Ultrasound (2)	\$ 382,800		638	638			
MRI (2)	\$ 3,762,200		2,894	2,894			
CT (1)	\$ 950,000		950	950			
Exam/Treatment Rooms (50)	\$ 14,941,300		17,578	17,578			
Ancillary Testing	\$ 4,448,500		5,740	5,740			
Sleep Lab	\$ 2,307,950		2,978	2,978			
Infusion (10)	\$ 2,568,350		3,314	3,314			
Rehabilitation (PT/OT, Gym)	\$ 3,258,875		2,768	2,768			
Lab	\$ 3,643,100		1,437	1,437			
Pharmacy	\$ 2,500,700		4,286	4,286			
Clinical Subtotal	\$ 119,094,084		132,577 sf	132,577 sf			
Non-Clinical/Non-Reviewable							
Support/Workstations	\$ 6,216,210		9,009	9,009			
Food Service (Kitchen, Dining)	\$ 7,667,580		8,157	8,157			
Reception, Registration, Waiting Areas	\$ 15,562,930		25,513	25,513			
Supplies/Storage	\$ 9,483,760		18,238	18,238			
Mechanical, Building Systems, Housekeeping	\$ 101,928,822		78,737	78,737			
Administration	\$ 4,469,120		6,983	6,983			
Lockers/Lounges	\$ 7,759,300		12,515	12,515			
Restrooms	\$ 5,829,600		9,940	9,940			
Non-Clinical Subtotal	\$ 158,917,322		166,092 sf	166,092 sf			
Total Construction	\$ 278,011,406		298,669 sf	298,669 sf			

OTHER PROJECT COSTS	
Department/Area	Cost
Preplanning Cost	\$ 3,543,771
Site Survey & Soil Investigation	\$ 75,000
Site Preparation	\$ 22,669,357
Off Site Work	-
Contingencies	\$ 61,187,845
Architecture / Engineering Fees	\$ 20,343,929
Consulting & Other Fees	\$ 23,027,567
Moveable or Other Equipment	\$ 52,168,020
Furniture	\$ 4,975,000
Medical Equipment	\$ 47,193,020
Bond Issuance Expense	\$ 133,333
Net Interest Exp During Construction	-
Fair Market Value of Leased Space or Equipment	-
Other Capital Costs	\$ 18,952,675
Other Project Costs Subtotal	\$ 202,091,497
Grand Total of Project Costs	\$ 480,102,903

CRITERION 1110.230 – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES**BACKGROUND OF APPLICANT**

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

Ann & Robert H. Lurie Children's Hospital of Chicago
 225 East Chicago Avenue
 Chicago, Illinois 60611
 Licensure: Pediatric Hospital

Lurie Children's Outpatient Services at Westchester
 2301 Enterprise Drive
 Westchester, Illinois 60154
 Licensure: Ambulatory Surgical Treatment Center

Lurie Children's Outpatient Services at Northbrook
 1121 Techny Road
 Northbrook, Illinois 60062
 Licensure: Ambulatory Surgical Treatment Center

Almost Home Kids
 211 East Grand Avenue
 Chicago, Illinois 60611
 Licensure: Children's Community Based Health Care Center

Almost Home Kids
 7S. 721 Route 53
 Naperville, Illinois 60540
 Licensure: Children's Community Based Health Care Center



ILLINOIS DEPARTMENT OF
PUBLIC HEALTH

HF136093

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	DIRECTOR	CATEGORY	I.D. NUMBER
6/8/2027			0005843
Pediatric Hospital			
Effective: 06/09/2026			

Ann & Robert H Lurie Children's Hospital of Chicago
dba Lurie Children's
225 East Chicago Avenue Box 140

Chicago, IL 60611

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26-026

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CONSPICUOUS PLACE

Exp. Date 6/8/2027

Lic Number 0005843

Date Printed 3/25/2026

Validation Num

Ann & Robert H Lurie Children's Hospit
dba Lurie Children's
225 East Chicago Avenue Box 140
Chicago, IL 60611

ATTACHMENT 11

FEE RECEIPT NO.



June 3, 2026

Thomas Shanley, MD
President & CEO
Ann & Robert H. Lurie Children's Hospital of Chicago
225 E. Chicago Ave.
Chicago, IL 60611

Re: # 7269
CCN: # 143300
Deemed Program: Hospital
Accreditation Expiration Date: March 21, 2029

Dear Dr. Shanley:

This letter confirms that your March 17, 2026 - March 20, 2026 unannounced full resurvey event was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 2, 2026, Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of March 21, 2026.

Joint Commission is also recommending your organization for continued Medicare certification effective March 21, 2026. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

This recommendation applies to the following locations:

Ann & Robert H. Lurie Children's Hospital of Chicago
225 E. Chicago Ave., Chicago, IL, 60611

Lurie Children's Outpatient Services in New Lenox
1870 Silver Cross Blvd. Ste 100 & 210, New Lenox, IL, 60451

Lurie Children's Outpatient Center in Lincoln Park- Clark
2515 North Clark, Chicago, IL, 60614-7362

Lurie Children's Outpatient Services in Westchester
2301 Enterprise Drive, Westchester, IL, 60154

Lurie Children's Outpatient Center in Lincoln Park - Deming
467 West Deming Place, Chicago, IL, 60614-7362

Lurie Children's Outpatient Center in Lake Forest
900 Westmoreland, Suite 110, Lake Forest, IL, 60045

Rehabilitative Services at Westbrook
11301 W. Cermack Rd., Suite 100, Westchester, IL, 60154



Lurie Childrens Outpatient Clinic in Northbrook
1131 Techny Road, Northbrook, IL, 60062

Lurie Childrens Outpatient Clinic Uptown
4867 N. Broadway, Chicago, IL, 60640

Lurie Children's Hospital - Outpatient Center Dayton
1440 North Dayton Street, Chicago, IL, 60642

Northbrook ASTC and MD Clinic
1121 Techny Road, Northbrook, IL, 60062

Outpatient Center at Skokie
3722 W Touhy Ave, Skokie, IL, 60076

Lurie Children's Hospital Outpatient Center in Schaumburg
1895 Arbor Glen Blvd., Schaumburg, IL, 60195

Please be assured that Joint Commission will keep the report confidential, except as required by law or court order. To ensure that Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ken Grubbs".

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

cc: CMS/Baltimore Office/Quality, Safety & Oversight Group/Division of Continuing and Acute Care Providers
CMS/SOG Location 5 /Survey and Certification Staff



June 3, 2026

Thomas Shanley, MD
 President & CEO
 Ann & Robert H. Lurie Children's Hospital of Chicago
 225 E. Chicago Ave.,
 Chicago, IL 60611

Joint Commission ID #: 7269
 Program: Hospital Accreditation
 Accreditation Activity: 60-day Evidence of Standards
 Compliance
 Accreditation Activity Completed : 6/2/2026

Dear Dr. Shanley:

I am pleased to share Joint Commission's accreditation decision of Accredited for all services surveyed following your recent survey. For all services surveyed under the applicable manual 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 March 21, 2026 and is customarily valid for up to 36 months, although, 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, Joint Commission Connect.

To recognize your commitment and achievement to quality, 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

HF134290

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	DIRECTOR	CATEGORY	I.D. NUMBER
9/24/2026			7003221
Ambulatory Surgery Treatment Center			
Effective: 09/25/2025			

Lurie Children's Surgery Center In Northbrook
1121 Techny Road
Northbrook, IL 60062

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26-026
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Exp. Date 9/24/2026

Lic Number 7003221

Date Printed 7/31/2025

Validation Num 2325

Lurie Children's Surgery Center In Nort

1121 Techny Road

Northbrook, IL 60062-5503

ATTACHMENT 11
FEE RECEIPT NO.



ILLINOIS DEPARTMENT OF
PUBLIC HEALTH

HF136412

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	DIRECTOR	CATEGORY	I.D. NUMBER
6/25/2027			7001555
Ambulatory Surgery Treatment Center			
Effective: 06/26/2026			

Children's Outpatient Services at Westchester
2301 Enterprise Dr
Westchester, IL 60154

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26-026
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Exp. Date 6/25/2027

Lic Number 7001555

Date Printed 5/19/2026

Validation Num 31621

Children's Outpatient Services at West

2301 Enterprise Dr

Westchester, IL 60154-5802

ATTACHMENT 11
FEE RECEIPT NO.

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF134344

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.

Issued under the authority of
the Illinois Department of
Public Health

Sameer Vohra, MD, JD, MA

EXPIRATION DATE	CATEGORY	ID NUMBER
9/7/2026	Director	4000024
Children's Community Based Health Care Center		
Licensed Beds: 12		

Almost Home Kids
211 East Grand Avenue
Chicago, IL 60611

Exp. Date 9/7/2026

Lic Number 4000024

Date Printed 8/5/2025

Validation Num 1803

Almost Home Kids

211 East Grand Avenue
Chicago, IL 60611

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FEE RECEIPT NO.

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		ILLINOIS DEPARTMENT OF PUBLIC HEALTH		HF134034	
LICENSE, PERMIT, CERTIFICATION, REGISTRATION					
The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.					
Sameer Vohra, MD,JD,MA Director			Issued under the authority of the Illinois Department of Public Health		
EXPIRATION DATE 8/1/2026	CATEGORY	I.D. NUMBER 4000020			
Children's Community Based Health Care Center					
Licensed Beds: 12					
Almost Home Kids 7 S. 721 Route 53 Naperville, IL 60540					

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Exp. Date 8/1/2026

Lic Number

4000020

Date Printed 6/26/2025

Almost Home Kids

FEE RECEIPT NO.

May 19, 2026

Ms. Debra Savage
Chairperson
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: No Adverse Actions / Authorized Access to Information

Dear Ms. Savage:

I hereby certify that no adverse action has been taken against Children's Hospital of Chicago Medical Center (the "Medical Center") or Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's") or any facility owned or operated by the Medical Center or Lurie Children's, directly or indirectly, within three (3) years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.

I hereby authorize the Health Facilities and Services Review Board ("Board") and the Illinois Department of Public Health ("IDPH") to access any documentation they find necessary to verify any documentation or information submitted, including but not limited to official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations. I further authorize the Board and IDPH to obtain any additional documentation or information that Board or IDPH deems necessary to process the application.

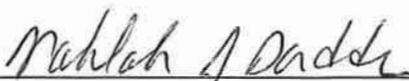
If you have any questions, please contact Ann Sherline, Senior Associate General Counsel, Ann & Robert H. Lurie Children's Hospital of Chicago at asherline@luriechildrens.org.

Sincerely,



Thomas P. Shanley, MD
President and Chief Executive Officer
Ann & Robert H. Lurie Children's Hospital of Chicago
225 E. Chicago Avenue
Chicago, IL 60611

Subscribed and sworn to before me
this 19th day of May, 2026.



Signature of Notary Public



Seal

Purpose of the Project

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

Ann & Robert H. Lurie Children's Hospital of Chicago ("**Lurie Children's**") proposes to construct a new pediatric health care facility that will provide inpatient and outpatient ambulatory services, including 48 pediatric inpatient beds, a surgery department with 6 operating rooms ("**ORs**"), and an emergency department with 35 treatment stations. Diagnostic imaging includes MRI (2), CT (1), X-Ray (3), EOS/ortho (1), fluoroscopy (1), and ultrasound (2). Other clinical services include physical and occupational therapy, laboratory and pharmacy. The project includes extensive pediatric outpatient care, including 50 multi-specialty pediatric outpatient exam and treatment rooms as well as 10 ambulatory infusion rooms.

This project will be located near the intersection of Interstate 355 and Butterfield Road in suburban Downers Grove. The 13.2-acre site is bordered by Lacey Road on the east, Woodcreek Road on the south, and Birchwood Place on the north. The location will enable the potential for future phases and long-term flexibility as patient care advances and community needs evolve. Adjacent property is available for potential future expansion.

There are several purposes for the project:

1. Enhance pediatric health care in western communities of the Chicago metropolitan area by introducing pediatric health care facilities and services that will enable pediatric patients who reside in the West Region (defined below) to receive care closer to their homes and reduce the significant outmigration of care that has been occurring over past decades.
2. Facilitate the establishment of the Lurie Children's health care delivery system, allowing Lurie Children's main hospital in the Streeterville neighborhood of Chicago ("**Lurie Children's - Streeterville**") to function as a regional referral center for tertiary and quaternary pediatric care. In part, the construction of a hospital facility in the western suburbs will allow patients from western communities to receive care from Lurie Children's without traveling downtown to Chicago. This factor will relieve increasing capacity pressures at Lurie Children's - Streeterville.
3. Replace aging hospital outpatient facilities operated by Lurie Children's in Westchester.

A. Enhance pediatric health care in western communities of the Chicago metropolitan area.

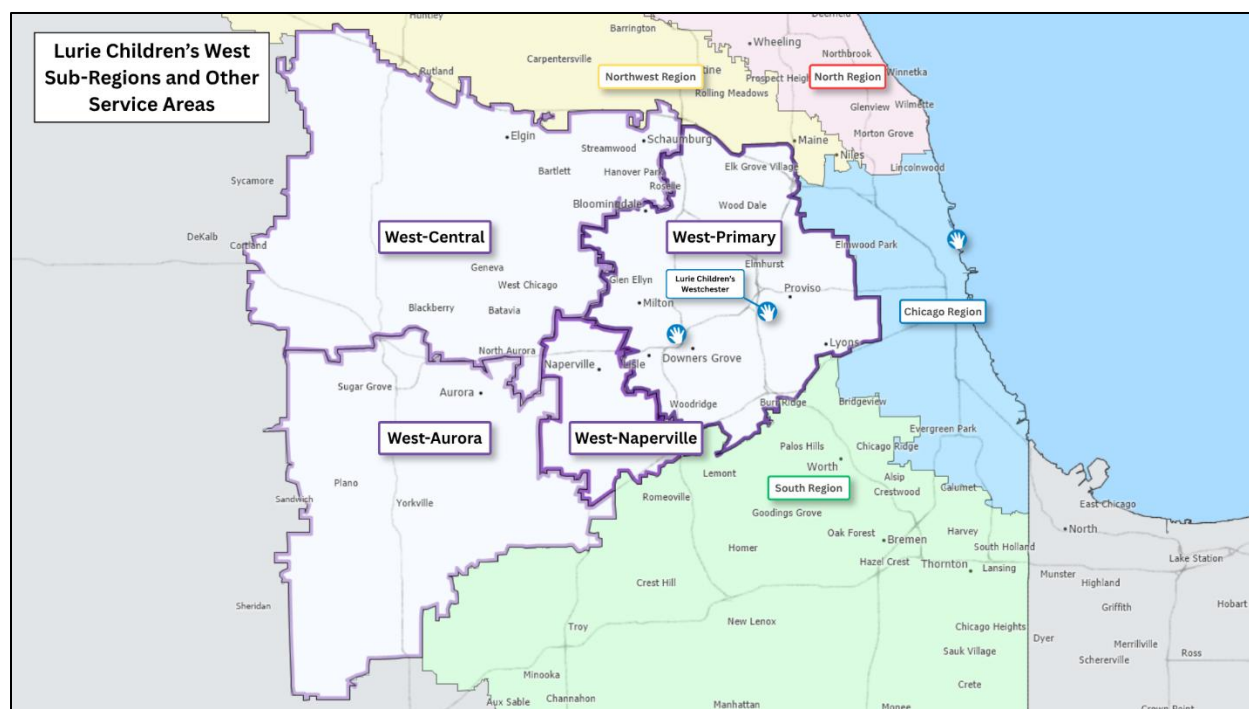
The site is located in the "West Region" of metropolitan Chicago, one of five metropolitan regions served by Lurie Children's. (See the map on the following page.) Together, these five regions accounted for 5,771 inpatient admissions at Lurie Children's in 2024. 1,179 of these admissions came from the West Region. In addition to these five regions in the metropolitan area, 832 admissions at Lurie Children's were from other areas of Illinois and outside of Illinois. In total, there were 6,603 admissions at Lurie Children's in 2024, an increase from 6,033 in 2023 and 5,471 in 2022.

The 1,179 admissions were 17.9% of the total 6,603 admissions at Lurie Children's 2024. The other regions and their counts of admissions at Lurie Children's in 2024 are:

- Chicago Region (2,721 admissions, 41.2%)
- North Region (671 admissions, 10.2%)
- Northwest Region (471 admissions, 7.1%)
- South Region (729 admissions, 11.0%)

The balance of 832 admissions from outside the area is the remaining 12.6% of all admissions at Lurie Children's in 2024.

The data shows that the West Region is the second largest source of Lurie Children's inpatient admissions, after the Chicago Region.



There are 19 acute care community hospitals located in the West Region with a total of 135 pediatric beds. Of these 19, 8 have pediatric units. Four of the pediatric units have a total of 86 authorized pediatric beds, with active pediatric services. (Central DuPage Hospital, Loyola University Medical Center, Saint Alexius Medical Center, and Edward Hospital). The other four units, with 49 total authorized pediatric beds, each have an average daily census less than one patient: UChicago Medicine AdventHealth Hinsdale, MacNeal Hospital, Mercy Medical Center – Aurora, and West Suburban Medical Center). These four hospitals hold authorized pediatric beds in the State inventory, without having programs of significant volume.

For a pediatric population of approximately 539,000 in the West Region, 86 beds is minimal capacity. The majority of patients requiring pediatric hospitalization receive that inpatient care outside the area. According to IHA COMPdata, there were 8,248 children ages 0 – 18 residing in the West Region who were hospitalized for inpatient pediatric care in 2024. 3,962 (48%) were admitted at hospitals located in the West Region. The remaining 4,286 children (52%) received care at hospitals outside of the area. Of the 4,286 patients who migrated out of the area, 1,808 (42.2%) were admitted at Lurie Children's - Streeterville. Based on traffic conditions, a significant number of these patients travel more than 60-90 minutes for care at Lurie Children's - Streeterville, a trip that family members make several times during their child's inpatient stay, not to mention their travel for pre-admission visits and follow up care post discharge. The planned facility that is centrally located in the West Region will provide care much closer to their homes and significantly reduce their travel times. A purpose of

the project is to offer a large, dedicated pediatric inpatient service to give local residents the option of receiving Lurie Children's care closer to their homes.

The planned facility in Downers Grove will also address the reduction of inpatient pediatric bed capacity in the West Region. As is the case in Illinois and throughout the US, the West Region has seen a significant number of pediatric unit closures and reductions of unit sizes over the past decade. 27 hospitals in metropolitan Chicago with a total of 319 authorized pediatric beds closed their units since 2013. Of these, six closed hospital pediatric units with a total of 54 beds are located in the West Region: Elmhurst Hospital (6 beds, 2019), Good Samaritan - Advocate (7 beds, 2019), Advocate Sherman Hospital (8 beds, 2021), Alexian Brothers Medical Center (16 beds, 2018), Gottlieb Memorial Hospital (4 beds, 2023), and Saint Joseph Hospital – Elgin (13 beds, 2025) as part of a plan to shift pediatrics to Edward Hospital in Naperville. A 5-bed pediatric unit was discontinued as part of the total closure of Westlake Hospital. An additional net reduction of 46 pediatric beds is attributed to units that were downsized but not closed in metropolitan Chicago during the same timeframe. (Information on the unit closures and reductions in size is contained in part 3 of this Section.)

Small pediatric programs are facing increasing operational and financial pressure, a factor contributing to the trend of pediatric bed closures in the West Region. The small and declining number of pediatric units and beds in the West Region is one of the factors leading Lurie Children's to plan an inpatient and ambulatory care facility in the western suburbs. Lurie Children's receives the largest number of West Region residents who leave the area for inpatient care (1,179 patients). A Consumers Choice survey indicates that families and community physicians in the western suburbs expect more from Lurie Children's. Lurie Children's ranks as the first or second choice for care 94% of the time. Locating a hospital in the West Region will be much more convenient for families who would like to seek care at Lurie Children's.

In addition to providing pediatric inpatient care closer to patients, a new Downers Grove hospital will provide inpatient and outpatient surgical services, emergency and urgent care, diagnostic imaging, and a full range of outpatient services at the new site. All of these services will be more conveniently available at the Downers Grove hospital.

B. Facilitate the establishment of the Lurie Children's health care delivery system, allowing Lurie Children's - Streeterville to function as regional referral center for tertiary and quaternary pediatric care.

The construction of a hospital and ambulatory care facility in the western suburbs will not only benefit patients living in that area who want Lurie Children's services closer to home but will relieve increasing capacity pressures at Lurie Children's - Streeterville. The new hospital in Downers Grove will focus on basic pediatric inpatient needs and pediatric specialty outpatient services. Keeping patients in the western suburbs who do not require tertiary level care is expected to accommodate up to 75% of the patients now going downtown for inpatient and outpatient services.

Lurie Children's relocated from its aging and undersized facility in the Lincoln Park community area to the Northwestern campus in Streeterville in June, 2012. It opened with 144 pediatric beds and 92 ICU beds. Since then, it has experienced increasing occupancy of inpatient units and ambulatory services downtown. In order to serve the region by accommodating increasingly complex clinical cases, Lurie Children's has increased its ICU capacity through several projects. It has converted

administrative and other support space to 66 additional ICU beds: CON projects 16-050 approved by HFSRB in May, 2017 (44 ICU beds and 4 NICU beds) and 17-054 approved in February, 2018 (22 hem/onc beds). The hospital currently operates 162 ICU beds. As part of this shift, pediatric beds were reduced from the initial 144 beds to 126. Annual utilization downtown continues to increase. Lurie Children's is expected to be at full capacity by the end of this decade. The proposed project in Downers Grove is intended to relieve some of this capacity pressure by serving patients residing in the West Region with a dedicated pediatric facility closer to their homes.

Related to this shift, Lurie Children's will no longer concentrate all of its inpatient activity at Lurie Children's - Streeterville. It will transition to a regional health care delivery system, with inpatient beds in selected suburban areas, and significant outpatient centers, such as the new Lurie Children's Outpatient Center in Schaumburg that opened in 2025 (Project 22-032) and the Ambulatory Surgical Treatment Center in Northbrook (Project 16-044). The new facility in Downers Grove will not duplicate the tertiary and quaternary services centered in Lurie Children's - Streeterville, but will provide pediatric specialty community hospital care.

C. Replace aging facilities operated by Lurie Children's in Westchester.

This new facility in Downers Grove will replace Lurie Children's aging and operationally inefficient facility currently located at 2301 Enterprise Drive in Westchester, IL. Lurie Children's has been delivering pediatric hospital outpatient services including ambulatory surgery at the location since 1989. The facility is limited in its ability to align with patient and family experience expectations and accommodate significant community demand for care. The surgical services and outpatient services in Westchester will be relocated to the Downers Grove facility. A separate CON permit application addresses the discontinuation of the facility in Westchester.

Lurie Children's goal is to ensure that children and families receive the right care, at the right time, in the right setting. By establishing these services at a second modern campus, this proposed project will expand access to high-quality, family-centered pediatric care while enhancing operational efficiency, enabling systematic care coordination, and improving patient outcomes. Additionally, the new location will be more geographically convenient for the majority of families in the defined planning area and surrounding communities, reducing travel time and barriers to care.

Planning Process for Lurie Children's – Downers Grove Hospital & Outpatient Center

Grounded in a broader strategic shift toward becoming a regional health system, Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's") has undertaken a comprehensive and methodical planning process over the last 18-24 months to guide the development of the new pediatric hospital in Downers Grove.

This effort was initiated in Fall 2024 with the identification of a strategic need to expand beyond a single hospital model. Lurie Children's Board of Directors approved an initial business case to advance additional detailed planning in Spring 2025. Lurie Children's subsequently engaged The Chartis Group, a leading healthcare consulting firm, to evaluate national trends in pediatric care, test key assumptions, conduct demand forecasting, build a preliminary pro forma, and validate the opportunity to more efficiently and better serve the western suburban Chicago region. That area is the second largest source of Lurie Children's patients following the City of Chicago. It has seen the closure of seven pediatric inpatient units in the past 13 years and outmigration of more pediatric patients than receive care at hospitals located in the region. The Chartis Group's deliverables confirmed the project's scale, program, and long-term strategic positioning. Lurie Children's Board of Directors approved moving forward with the project in December 2025.

To execute the project, Lurie Children's assembled a multidisciplinary Design-Build team comprised of nationally recognized experts alongside local Chicago-based partners. This integrated team is led by Clayco, a Chicago-based construction firm, and includes healthcare planners, architects, engineers, and equipment and technology specialists, ensuring alignment with current best practices and evolving standards in pediatric care delivery.

As part of the process of evaluating comparable pediatric health systems, Lurie Children's leadership and the project team conducted targeted site visits at two other nationally recognized independent children's hospitals that recently completed similar community hospital expansion projects. Lurie Children's incorporated lessons learned and best practices from these and other leading institutions into the plans and design for the new Lurie Children's hospital in Downers Grove. These insights informed key decisions regarding room sizing, operational flexibility, care model integration, and support space allocation.

Extensive engagement with clinical and operational users has been central to the planning process, including physicians, nursing leadership, operational stakeholders, support services, patients, and families. These groups have informed detailed program requirements, workflow optimization, and equipment planning across core clinical areas including inpatient units, surgical services, imaging, emergency care, and outpatient clinics, while also emphasizing patient, family, and staff experience. Collectively, this structured, iterative, and milestone-driven approach has advanced Lurie Children's strategic, clinical, and operational objectives, incorporated national benchmarks for program planning, design, and construction, and reinforced the overall appropriateness and reasonableness of the proposed project scope, scale, and associated costs.

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

Lurie Children's has identified five regions in northeastern Illinois that are used to guide planning for the delivery of pediatric health care services: Chicago, North, Northwest, South and West. Lurie Children's has facilities and/or established affiliations with providers in each of these five regions.

The "West Region" is selected as the planning area for the project.

The planning area has an estimated population of 538,943 pediatric residents, ages 0 – 18. It is made up of a Primary Service Area and a Secondary Service Area. The Primary Service Area (West-Primary") has a pediatric population of 258,684. The Secondary Service Area has three sub-areas: West-Naperville (population of 55,894), West-Central (138,649), and West-Aurora (85,716)

The table following this page shows the patient origin for 1,179 admissions at Lurie Children's from zip codes of the West Region in 2024. 681 of these admissions were from the Primary Service Area; 498 were from the three sub-areas of the Secondary Service Area.

With an expected admissions volume of approximately 2,700 admissions (not including observation cases), it is anticipated that 80% will be from the Planning Area.

Service Area Population & Lurie Children's Admissions by West Region ZIP Code

Primary Service Area	ZIP	City	CY25 Pediatric Population	CY22	CY23	CY24	CY31
West-Primary	60804	Cicero	20,894	66	96	99	
	60402	Berwyn	13,673	45	33	41	
	60707	Elmwood Park	7,897	40	28	38	
	60302	Oak Park	6,520	20	33	32	
	60137	Glen Ellyn	9,273	20	23	31	
	60126	Elmhurst	10,983	34	17	29	
	60139	Glendale Heights	6,874	15	11	26	
	60517	Woodridge	6,765	10	4	23	
	60153	Maywood	5,247	18	13	20	
	60187	Wheaton	6,236	8	7	20	
	60148	Lombard	10,516	9	18	19	
	60525	La Grange	6,629	29	18	17	
	60164	Melrose Park	4,537	15	18	17	
	60513	Brookfield	4,189	5	15	17	
	60558	Western Springs	3,429	11	3	17	
	Other West-Primary		135,022	276	294	235	
West-Primary Subtotal			258,684	621	631	681	
Secondary Service Area	ZIP	City	CY25 Pediatric Population	CY22	CY23	CY24	CY31
West-Naperville	60440	Bolingbrook	11,159	25	42	50	
	60565	Naperville	8,730	8	12	16	
	60490	Bolingbrook	4,992	22	9	16	
	60564	Naperville	10,566	18	27	15	
	60555	Warrenville	3,049	5	11	8	
	60540	Naperville	9,177	22	21	8	
	60563	Naperville	8,221	8	8	5	
West-Naperville Subtotal			55,894	108	130	118	
West-Central	60193	Schaumburg	8,291	15	14	23	
	60169	Hoffman Estates	6,692	15	21	20	
	60185	West Chicago	7,690	10	6	19	
	60177	South Elgin	5,680	1	12	17	
	60140	Hampshire	5,861	10	14	15	
	60107	Streamwood	7,781	11	17	15	
	60134	Geneva	6,676	16	24	14	
	60103	Bartlett	8,387	6	6	13	
	60124	Elgin	6,066	7	5	13	
	60173	Schaumburg	2,918	4	1	10	
	Other West-Central		72,607	88	109	76	
West-Central Subtotal			138,649	183	229	235	
West-Aurora	60505	Aurora	14,105	21	20	42	
	60560	Yorkville	7,160	7	10	17	
	60506	Aurora	11,318	13	11	15	
	60504	Aurora	9,368	17	15	14	
	60585	Plainfield	6,941	10	14	12	
	60543	Oswego	10,238	14	14	9	
	60538	Montgomery	8,067	5	13	8	
	60545	Plano	3,561	2	5	8	
	60503	Aurora	4,577	11	5	8	
	Other West-Aurora		10,381	10	22	12	
West-Aurora Subtotal			85,716	110	129	145	
West Region Total			538,943	1,022	1,119	1,179	2,150
Outside West Region							550
Grand Total Admissions (Observation cases not included)							2,700

Sources/Filters:

- Pediatric Population: Claritas Pop-Facts 2025, Sg2 Analytics; Population Age: 0-18 by ZIP code
- Lurie Children's Admissions: Lurie Children's Enterprise Decision Support Database; Aggregate encounter data used for IDPH AHQ Surveys; Inpatient; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry

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

There are several existing problems that the proposed project is planned to address:

- A. National and local trends reveal reduced access to high quality pediatric care. The majority of patients living in western suburbs migrate out of the area for inpatient pediatric care. There is significant travel burden for existing patient families.
- B. Capacity constraints at Lurie Children's - Streeterville are significant and increasing.
- C. Lurie Children's facilities in Westchester are undersized and aging.

A. National and local trends reveal reduced access to high quality pediatric care.

Articles and research studies document significant reduction in inpatient pediatric bed capacity in recent decades:

- Research Article: "National Trends in Pediatric Inpatient Capacity", JAMA Pediatrics, Vol. 179, No. 2.
From 2008 to 2022, the US lost 29.9% of pediatric inpatient units, but only 4.4% of adult units, revealing continued declines in inpatient capacity. The number of pediatric units declined from 1,749 to 1,226; beds decreased from 31,133 to 25,064. "Most pediatric admissions occur in general hospitals which increasingly transfer rather than hospitalize children, resulting in care concentrations in larger pediatric centers." (Emphasis added, Attachment 12A)
- Research Article: "Four Trends in Pediatric Hospital Utilization," Children's Hospital Association, October 19, 2022.
There are fewer inpatient cases, but higher severity. Even with discharges down, total patient days, inclusive of observation cases, are higher. The severity of cases is higher, driving a higher average length of stay in 2021 compared to 2019. (Attachment 12B)
- Research Article: "Closure of Licensed Pediatric Beds in Health Care Markets within Illinois," Academy of Pediatrics, June 30, 2022.
The article states: From 2012 through 2017, the number of licensed pediatric beds declined from 1,706 to 1,254 (-26.5%). Over the same period, annual pediatric inpatient days minimally changed (+1.1%), while annual pediatric inpatient days at hospitals affiliated with the Children's Hospital Association increased (+30.5%). After accounting for re-openings, the 33 hospitals that closed all licensed pediatric beds fit four distinct typologies:
 - 1) Hospitals with minimal pediatric volume throughout the study (n = 19);
 - 2) Hospitals that sustained at least 50% of their pediatric volume after closure of licensed pediatric beds (n = 8);
 - 3) Hospitals with low market shares in metropolitan areas (n = 5); and
 - 4) Hospital with a decline in pediatric market share, while a nearby hospital saw a corresponding rise in pediatric market share (n = 1). (Attachment 12C)

- Research Article: “Pediatric Hospitalization Trends at Children’s and General Hospitals, 2000–2019.” JAMA Vol. 330, No. 19, published October 30, 2023
The article reports the significant shift of pediatric inpatients from pediatric units in general community hospitals to freestanding and non-freestanding children’s hospitals. The percentage of discharges from non-children’s hospitals decreased from 41.1% to 18.2% over the two decades. The percentage of total national discharges from children’s hospitals increased significantly, from 58.9% to 81.8%. An increase in inter-facility transports accompanied the changes in the distribution of patients. In 2000, 6.1% of pediatric patients were transferred from one facility to another; in 2019, 18.8% of patients were transported. (*Attachment 12D*)
- Research Article: “A National Analysis of General Pediatric Inpatient Unit Closures and Openings, 2011 – 2018”
From 2011 to 2018, 638 (15.7%) general inpatient pediatric units in 4,069 hospitals closed. 558 units opened (13.7%) during the same time period, for a net closure rate of 2.0%. Of the units that closed, 89% were in a hospital that otherwise remained open. In Illinois, a net 6.5% of units closed. (*Attachment 12E*)
- Research Article: “What’s behind an increase in closures of pediatric units,” October 15, 2022
An interview with Dr. Scott Krugman, Vice Chair of the Department of Pediatrics at Herman and Walter Samuelson Children’s Hospital at Sinai Hospital in Baltimore, and Professor of Pediatrics at Georgetown University School of Medicine, commenting on the nationwide wave of hospitals closing their pediatric units. The New York Times that week reported on the problem, decades in the making, citing a 20% decline in the number of hospitals with pediatric units from 2008 to 2018. (*Attachment 12F*)
- Research Article: “As Hospitals Close Pediatric Units, Where Does That Leave Lachlan?” The New York Times, October 11, 2022
“The decline of local access to children’s inpatient care began over a decade ago and accelerated during the pandemic. Between 2008 and 2018 ... pediatric inpatient units in the United States decreased almost 20%, and nearly a quarter of children found themselves farther from their nearest pediatric unit.” Lachlan Rutledge is a 6-year-old with a connective tissue disorder, severe allergies and asthma receiving care at the Children’s Hospital at Saint Francis, the only remaining inpatient pediatric option in Tulsa. (*Attachment 12G*)

The articles are included in their entirety as attachments to this Purpose of the Project Section.

The Metropolitan Chicago area, and Illinois in general, has been experiencing the condition of pediatric unit closures covered in these articles. The following table lists 27 hospitals in the metropolitan Chicago area (Hospital Planning Areas A-01 through A-14) that closed their inpatient pediatric units from 2013 through 2025. The closures resulted in a reduction of 319 authorized pediatric beds. One of the 27 hospitals, Westlake Hospital with five pediatric beds, closed entirely; the other 26 hospitals remain in service.

Discontinuations of Pediatric Inpatient Services, Chicago Metropolitan Area

(Highlighted rows indicate hospitals located in the West Region)

Hospital Name	State Planning Area	Number of beds	Month / Year Discontinued or Approved for Discontinuation
Saint Joseph Hospital - Elgin	A-13	13	April, 2025
Palos Community Hospital	A-04	8	July, 2024
Gottlieb Memorial Hospital	A-06	4	March, 2023
Prime Saints Mary & Elizabeth Hospital	A-02	14	July, 2021
Advocate Condell Medical Center	A-09	16	January, 2021
Advocate Sherman Hospital	A-11	8	January, 2021
St. Bernard Hospital	A-03	6	October, 2019
Elmhurst Hospital	A-05	6	October, 2019
Ingalls Memorial Hospital – UChicago	A-04	17	September, 2019
Illinois Masonic Medical Center - Advocate	A-01	14	April, 2019
Highland Park Hospital	A-09	6	March, 2019
Good Samaritan Hospital - Advocate	A-05	7	2019
Good Shepherd Hospital - Advocate	A-09	8	2019
Westlake Hospital	A-06	5	hospital closed 2019
OSF Little Company of Mary Hospital	A-04	20	November, 2018
Humboldt Park Health	A-02	5	February, 2018
Alexian Brothers Medical Center	A-07	16	January, 2018
Advocate South Suburban Hospital	A-04	10	November, 2017
Mount Sinai Hospital	A-02	31	2017
Franciscan St. James Health - Chicago Heights	A-04	10	March, 2016
Insight Hospital (Mercy-Chicago)	A-03	37	2016
Loretto Hospital	A-02	10	2015
South Shore Hospital	A-03	6	2015
Skokie Hospital	A-08	2	2015
Riverside Medical Center	A-14	18	2014
Prime St. Francis	A-08	12	2013
NM Lake Forest Hospital	A-09	10	2013
Total Beds		319	

Sources:

- *Inventory of Health Facilities and Services and Need Determinations, December 2023; Addendum Inventory of Health Care Facilities, March 31, 2026.*
- Lurie Children's internal dataset

As previously stated in the first part of this section, of the 27 closed pediatric units, six hospital pediatric units with a total of 54 beds are located in the West Region: Elmhurst Hospital (6 beds, 2019), Good Samaritan Hospital – Advocate (7 beds, 2019), Advocate Sherman Hospital (8 beds, 2021), Ascension Alexian Brothers Medical Center (16 beds, 2018), Gottlieb Memorial Hospital (4 beds, 2023), and Saint Joseph Hospital – Elgin (13 beds, 2025) as part of a plan to shift pediatrics to Edward Hospital in Naperville. In addition, a five-bed pediatric unit was discontinued as part of the total closure of Westlake Hospital.

The next table below shows an additional 9 hospitals in the metropolitan area that added to or reduced their pediatric units. For these hospitals, there was a net reduction of an additional 46 authorized pediatric inpatient beds above and beyond the 319 beds in unit closures.

Changes in Pediatric Beds (not discontinuations of pediatric units) Chicago Metropolitan Area

Hospital Name	State Planning Area	Beds Added	Date Added	Beds Reduced	Date Reduced	2025 Total
Lurie Children's	A-01	4	9/20/2019	2	1/1/2024	126
John H Stroger, Jr. Hospital	A-02			14	2016	26
Rush University Medical Center	A-02			2	12/15/2015	20
St. Anthony Hospital	A-02	6	2018			18
University of Illinois Hospital and Clinics	A-02			12	2/28/2018	20
University of Illinois Hospital and Clinics	A-02			12	6/11/2021	20
Palos Community Hospital	A-04			7	4/1/2022	8
UChicago Medicine AdventHealth Hinsdale	A-05			1	2014	18
Central DuPage Hospital	A-05	12	2014			28
Central DuPage Hospital	A-05	6	10/29/2020			28
Vista Medical Center East	A-09			10	2013	11
Vista Medical Center East	A-09			14	8/25/2015	11
Total Beds		28		74		

Sources:

- *Inventory of Health Facilities and Services and Need Determinations, December 2025; Addendum Inventory of Health Care Facilities, December 31, 2025.*
- Lurie Children's internal dataset

These unit closures and reductions have contributed to a shift of care from hospitals located within the West Region to hospitals outside the area. The following table shows that 3,962 patients (48% of the total 8,248 pediatric residents who were hospitalized for pediatric care) residing in communities in the West Region stayed local for inpatient pediatric care. The remaining 4,286 left the area for their hospitalizations.

Inpatient Admissions by Patient Residence and Hospital Location

Primary Service Area	Patients Admitted to West Region Hospitals	Patients Admitted to Non-West Region Hospitals	Total West Region Admissions
Primary Service Area Subtotal	1,788	2,196	3,984
Secondary Service Area			
West-Central Subtotal	1,118	990	2,108
West-Aurora Subtotal	635	731	1,366
West-Naperville Subtotal	421	369	790
Secondary Service Area Subtotal	2,174	2,090	4,264
West Region Grand Total	3,962	4,286	8,248

Source/Filters:

- IHA COMPdata, CY2024; Inpatient only; Age: 0-18; Medical/Surgical Specialties based on Diagnosis; Patient and Hospital Planning Regions based on ZIP code

3,491 (88%) of the 3,962 patients residing in the West Region and admitted for pediatric care at hospitals in the West Region in 2024 were at four hospitals:

- Central DuPage Hospital: 1,298 admissions
- Edward Hospital: 890
- Loyola University Medical Center: 679
- Saint Alexius Medical Center: 624

The remaining 471 pediatric admissions were split among 21 general acute care hospitals in the West Region, all of which had an Average Daily Census of 1.0 or less in 2024. 11 of these 21 hospitals have no authorized pediatric beds (no inpatient pediatric unit), although they admit pediatric patients. 4 of these 21 hospitals reported only one pediatric admission for the entire year 2024.

In conclusion, the closures of 7 pediatric units in the West Region (including the unit at the closed Westlake Hospital) and the migration of the majority of pediatric patient residents of the area who receive care outside the area are two facts that indicate that access to care is a health care problem needing solutions.

B. Capacity constraints at Lurie Children's are significant and increasing.

Lurie Children's opened Lurie Children's - Streeterville in June 2012, replacing the aging Children's Memorial Hospital in Lincoln Park. For most of the years since relocating, the hospital witnessed growth in inpatient services, emergency visits, surgical cases, and outpatient visits. The table on the next page consolidates utilization information reported in the hospital's Annual Hospital Questionnaires from 2017 through 2025.

The following facts are selected highlights from the table:

- Pediatric bed patient days at Lurie Children's increased from 30,282 in 2017 to 35,230 in 2025, with ADC averaging 97.5 for the past three years, 126 pediatric beds;
- Neonatal occupancies averaged 88.1% for the last 9 years, 64 beds;
- ICU occupancies averaged 67.2% for the past 9 years; during this time, 70 ICU beds were added, increasing authorized beds from 92 to 162;
- AMI occupancy averaged 80.2% for the past 9 years; the 12-bed unit was recently increased to 16 beds;
- Emergency visit volumes fluctuated around an average of 55,482 for the 7 non-COVID years; from 2020 to 2021, Lurie Children's ED visits dropped 35% consistent with the national trend from 48 visits per 1,000 children in 2019 to 31 in 2020. ED volumes rebounded to normal in 2022.
- Surgical cases averaged over 15,900 per year, including 2020 and 2021, two reduced volume years due to COVID;
- All major diagnostic imaging modalities showed increases over the past 9 years;
- Outpatient visits – on and off campus – showed increases, from a total 614,320 in 2017 to 834,274 in 2025.

Lurie Children's Hospital – Historical Utilization by Service Category

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Pediatrics									
Authorized beds (as of Oct 1)	76	124	128	128	128	114	128	126	126
Admissions	5,696	5,198	5,300	5,178	5,437	5,586	6,121	6,603	6,845
Patient Days	30,282	32,382	31,216	29,700	32,494	33,444	36,130	35,485	35,230
ALOS	5.32	6.23	5.89	5.74	5.98	5.99	5.9	5.37	5.15
ADC	82.96	88.72	85.52	81.15	89.02	91.63	98.99	96.95	96.52
Occupancy	1.09	0.72	0.67	0.63	0.70	0.80	0.77	0.77	0.77
Emergency Department									
Number of treatment stations	43	39	39	39	39	39	39	40	40
ED Visits	57,242	56,143	57,029	37,337	47,877	56,022	56,147	53,029	52,776
Surgery									
Number of ORs	21	21	21	21	21	21	21	21	20
IP Cases	3,892	3,858	4,011	3,666	3,784	3,806	3,278	4,238	4,001
OP Cases	12,395	13,040	12,470	10,158	11,679	12,484	13,422	12,704	10,548
Total Surgical Cases	16,287	16,898	16,481	13,824	15,463	16,290	16,700	16,942	14,549
Total Hours, incl clean up	35,936	38,270	37,315	34,299	34,829	34,739	37,387	36,790	32,804
Neonatal									
Authorized beds (as of Oct 1)	60	64	64	64	64	64	64	64	64
Admissions	817	655	567	487	427	472	436	458	455
Patient Days	20,016	18,918	20,629	19,161	20,643	20,880	22,216	20,044	21,774
ALOS	24.5	28.88	36.38	39.34	48.34	44.24	50.95	43.76	47.85
ADC	54.84	51.83	56.52	52.35	56.56	57.21	60.87	54.77	59.65
Occupancy	0.91	0.81	0.88	0.82	0.88	0.89	0.95	0.86	0.93
ICU									
Authorized beds (as of Oct 1)	92	116	160	140	160	140	150	162	162
Admissions	3,719	3,878	4,739	3,247	3,593	3,487	3,436	4,273	4,612
Patient Days	27,836	30,943	37,338	30,442	35,229	36,846	37,922	37,046	37,222
ALOS	7.48	7.98	7.88	9.38	9.8	10.57	11.04	8.67	8.07
ADC	76.26	84.78	102.3	83.17	96.52	100.95	103.9	101.22	101.98
Occupancy	0.83	0.73	0.64	0.59	0.60	0.72	0.69	0.62	0.63
AMI									
Authorized beds (as of Oct 1)	12	12	12	12	12	12	12	12	12
Admissions	562	584	535	523	438	439	375	362	430
Patient Days	3,539	3,367	3,090	3,636	4,104	3,626	3,623	3,320	3,248
ALOS	6.3	5.77	5.78	6.95	9.37	8.26	9.66	9.17	7.55
ADC	9.7	9.22	8.47	9.93	11.24	9.93	9.93	9.07	8.90
Occupancy	0.81	0.77	0.71	0.83	0.94	0.83	0.83	0.76	0.74
Diagnostic Imaging (incl IP/OP)									
Gen Rad/Fluor	65,784	70,651	72,738	79,840	70,205	82,728	86,529	81,386	88,719
Nuclear Medicine	537	514	548	596	1155	1136	1274	984	522
Ultrasound	23227	25281	26747	26616	28209	30334	32224	32269	34272
MRI	15117	17597	16604	14932	16416	17851	18797	18976	20046
MRI (Contractual)	1491	1450	1599	1488	1481	1623	1980	1715	2071
CT	5650	5791	5595	5450	6179	6715	6997	6797	7427
PET	239	270	217	220	294	245	299	250	315
Interventional	6352	7406	6861	6400	6397	6479	6052	5861	6298
Laboratory									
Total Lab Studies	945,190	1,020,271	1,074,941	1,020,318	1,175,461	1,207,171	1,255,310	298,485	344,684
Outpatient Visits									
Total OP Visits	614,320	640,609	661,424	636,332	752,164	775,129	786,368	764,482	834,274

Source: IDPH Annual Hospital Questionnaire, 2017 – 2025

As noted in the first part of this Purpose of the Project section, Lurie Children's has increased capacity by converting available non-clinical space to support clinical program growth. By the end of this decade, it is expected that there will not be further options to convert space on the downtown campus. As evidenced by the expansion of ICU beds at the hospital, Lurie Children's has taken on higher acuity cases in the past decade, in its appropriate function as a regional referral center for complex patients. In recent planning efforts, hospital leadership is identifying strategic actions to prepare the downtown facility to maximize its capacity to accommodate increasing tertiary and quaternary needs of pediatric patients.

Part of Lurie Children's strategy is to identify opportunities in its different planning regions in metropolitan Chicago to keep some of the lower and medium acuity patients closer to their homes. These strategies include working with established partner hospitals in the region, as well as establishing new facilities in selected locations. The plan is to assure that patients and families have continued access to Lurie Children's care, and to allow Lurie Children's to utilize more of its downtown capacity for tertiary and quaternary care needs.

C. Lurie Children's facilities in Westchester are undersized and aging.

Since 1989, Lurie Children's has operated an outpatient center in Westchester, IL. The center provides pediatric specialty outpatient services, diagnostic imaging, and ambulatory surgery. The facility has multiple mechanical, electrical and plumbing issues, characteristic of a building approaching 40 years of service. For example, the steam boilers are original to the building, as are the medical gas manifolds and control air compressor providing pneumatic air for the building's heating and cooling control systems. The emergency generator is also original to the building. The central chiller plant has had multiple service calls in recent years to address compressor failures and refrigerant leaks. Refrigerant is no longer manufactured; replacement refrigerant is expensive. The domestic water heaters are 15 years old and beyond their useful life. Equipment and other building systems maintenance and repair costs have exceeded \$300,000 in the past 6 years, with replacement parts for original equipment being increasingly unavailable or difficult to obtain. Significant costs are looming to replace some of the major equipment in the next 5 years.

A \$1.1 million project to replace the roof to address leaks was completed in September, 2025, and a \$380,000 project to replace ceiling tiles and diffusers throughout the building is planned for July, 2026. The exterior façade of the building needs replacement of brick and repair of deteriorating mortar joints. The parking lot has numerous patches requiring annual repair. Sidewalks are uneven and require regular attention.

Moreover, there are many operational efficiency improvements needed with clinical services delivery at this site. For example, the three operating rooms do not allow for the efficient scheduling of surgeons, which is usually optimized when there are even numbers of surgery rooms to enable scheduling continual procedures. In addition, cases are not scheduled after 2:00 PM, since later cases that have the potential for requiring extended observation and recovery times are not able to be accommodated due to limited evening and nighttime coverage.

Finally, the 37,134 square foot facility has limited size, and cannot accommodate more physicians who would like to practice at the Westchester location.

4. Cite the sources of the documentation.

- Annual Hospital Questionnaires: Ann & Robert H. Lurie Children's Hospital of Chicago
- Annual Questionnaires: Westchester ASTC, Northbrook ASTC
- Hospital records
- HFSRB Hospital Profiles
- HFSRB: Inventory of Health Facilities and Services and Need Determinations, December 2023 and updates to the Inventory, December 31, 2025
- COMPdata, Illinois Hospital Association
- Chartis – compendium of market analyses
- 2025 Mapbox@OpenStreetMap
- Claritas Pop-Facts2025 via SG2 Analytics
- Axiom Decision Support, Strata Decision Technology
- "National Trends in Pediatric Inpatient Capacity," JAMA Pediatrics, Vol 179, No. 2, December 2, 2024, Kenneth A Michelson, MD, MPH; Anna M. Cushing, MD; Emily Bucholz, MD, PhD, MPH
- "4 Trends in Pediatric Hospital Utilization," Children's Hospital Association, October 19, 2022
- "Closure of Licensed Pediatric Beds in Health Care Markets within Illinois," Acad Peadtr. 2021, June 25; 22(3):431-439; Paige VonAchen, Matthew M Davis, Jennifer Cartland, Amy D'Arco, Kristin Kan
- "A National Analysis of General Pediatric Inpatient Unit Closures and Openings, 2011-2018, October 2, 2024. Carolyn M. San Soucie, BA, BSA; Nancy Beaulieu, PhD; Jason X. Buxbaum, PhD, MHSA; David M. Cutler, PhD; JoAnna K. Leyenaar, Md, PhD, MPH; Sarah C. McBride, MD; Olivia Zhao, MPhil; Alyna T. Chen, MD, MS
- "What's behind an increase in closures of pediatric units, October 12, 2022, Dr. Scott Krugman, vice chair of the Department of Pediatrics at Herman and Walter Samuelson Children's Hospital
- "Pediatric Hospitalization Trends at Children's and General Hospitals, 2000-2019," Michael J. Steiner, MD, MPH, Matt Hall, PhD, Ashley G. Gordon, MD, et al, JAMA, Vol. 330, No. 19, published online October 30, 2023
- "As Hospitals Close Children's Units, Where Does That Leave Lachlan?" New York Times, October 11, 2022

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

Lurie Children's is already one of the largest providers of inpatient pediatric care to residents of the West Region, in spite of the fact that it is located in downtown Chicago. 1,808 pediatric cases (pediatric admissions, observations and ICU cases) at Lurie Children's - Streeterville in 2024 were residents of the West Region. This volume was 22% of patients from the West Region who were hospitalized for pediatric care in 2024. The location in Downers Grove will be more geographically convenient for the majority of families in the defined planning area and surrounding communities, reducing travel time and barriers to care.

Lurie Children's project will stabilize regional pediatric capacity, in response to the closure of six pediatric units with 54 beds in the West Region since 2013. An additional 5 bed pediatric unit closed as part of a discontinuation of the Westlake Hospital. The majority of inpatient pediatric admissions of West Region residents have been hospitalizations outside the West Region.

While much of the focus of the analysis has been on regional capacity for inpatient pediatric services, the project is broader than beds, including emergency and urgent care, inpatient and outpatient surgery, diagnostic imaging, ambulatory outpatient care, and other clinical services. Establishing these services at a single modern campus will expand access to high-quality, family-centered pediatric care while improving care coordination, and patient outcomes. The project enables the delivery of care to the region's children that is safe, high quality and geographically convenient. The new, right-sized facility will meet modern standards of care and create a consistent patient experience. Operational efficiency will be enhanced by transferring Lurie Children's services in Westchester to the new hospital and outpatient center in Downers Grove.

By providing pediatric inpatient services in a community hospital setting, the project will relieve capacity constraints at the downtown campus and create backfill opportunities for high-acuity services downtown.

Lurie Children's has relationships with several hospitals throughout metropolitan Chicago. For over 2 decades, Northwestern Medicine and Lurie Children's have worked together to provide pediatric care in the western suburbs. Together, both institutions established a pediatric emergency care department, inpatient units, and multispecialty outpatient clinics at Central DuPage Hospital, as well as an outpatient clinic and neonatal and pediatric imaging at Delnor Hospital. These facilities have provided exceptional care to thousands of pediatric patients and their families since 2006. The collaboration is shifting to better serve families in the communities they support and to respond to a changing healthcare landscape. Throughout this transition and after the new facility opens, they will continue to collaborate to address the needs of the patients they serve.

Leadership of Lurie Children's has discussed the proposed project with local and State of Illinois officials, to inform them about the plans for the new hospital and how the project will improve access to inpatient and ambulatory pediatric specialty services in the western suburbs. These meetings include reviews and presentations during the zoning process in Downers Grove. There is broad-based support for the proposed hospital. Several letters of support are included in Appendix A at the end of this permit application:

Ken Hedley, President, NM Central DuPage Hospital

Sean Casten, U.S. House of Representatives, 6th District Illinois

Deborah A. Conroy, DuPage County Board Chair

Anne Stava, State Representative, 81st District

Margaret A. DeLaRosa, State Representative, 42nd District

Marti Deuter, State Representative, 45th District

Laura Ellman, State Senator, 21st District

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

1. Improve patient access by enabling about 1,000 low/medium acuity patients (admitted at Lurie Children's from the West Region, 2031 projected) to remain in the region for medical/surgical hospitalization.
2. Increase the percent of community residents served locally, from 48% to 60%.
Calculation:
 - 1,000 patients now admitted at Lurie Children's - Streeterville + 3,962 patients admitted at other hospitals in the West Region in 2024 = 4,962
 - $4,962 / 8,248$ total West Region residents admitted = 0.60
3. Accommodate approximately 2,700 admissions and over 1,200 observation days at the new hospital (ADC of 40.6, occupancy of 84.6% of 48 beds).
4. Accommodate over 42,000 annual ED visits in the new Downers Grove facility by 2031. It is anticipated that ED visit growth will not plateau but continue to increase thereafter.
5. Support 101 physicians and 16 nurse practitioners currently affiliated with Lurie Children's Clinically Integrated Network (CIN), with the ability to accommodate more providers who wish to affiliate in the network.

Index of Research Papers and Articles

- Attachment 12A
“National Trends in Pediatric Inpatient Capacity,” JAMA Pediatrics, Vol 179, No. 2, December 2, 2024, Kenneth A Michelson, MD, MPH; Anna M. Cushing, MD; Emily Bucholz, MD, PhD, MPH
- Attachment 12B
“4 Trends in Pediatric Hospital Utilization,” Children’s Hospital Association, October 19, 2022
- Attachment 12C
“Closure of Licensed Pediatric Beds in Health Care Markets within Illinois,” Academy of Pediatrics, 2021, June 25; 22(3):431-439; Paige VonAchen, Matthew M Davis, Jennifer Cartland, Amy D’Arco, Kristin Kan
- Attachment 12D
“Pediatric Hospitalization Trends at Children’s and General Hospitals, 2000-2019,” Michael J. Steiner, MD, MPH, Matt Hall, PhD, Ashley G. Gordon, MD, et al, JAMA, Vol. 330, No. 19, published online October 30, 2023
- Attachment 12E
“A National Analysis of General Pediatric Inpatient Unit Closures and Openings,” 2011-2018, October 2, 2024. Carolyn M. San Soucie, BA, BSA; Nancy Beaulieu, PhD; Jason X. Buxbaum, PhD, MHSA; David M. Cutler, PhD; JoAnna K. Leyenaar, Md, PhD, MPH; Sarah C. McBride, MD; Olivia Zhao, MPhil; Alynna T. Chen, MD, MS
- Attachment 12F
“What’s behind an increase in closures of pediatric units,” October 12, 2022, Dr. Scott Krugman, vice chair of the Department of Pediatrics at Herman and Walter Samuelson Children’s Hospital
- Attachment 12G
“As Hospitals Close Children’s Units, Where Does That Leave Lachlan?” New York Times, October 11, 2022

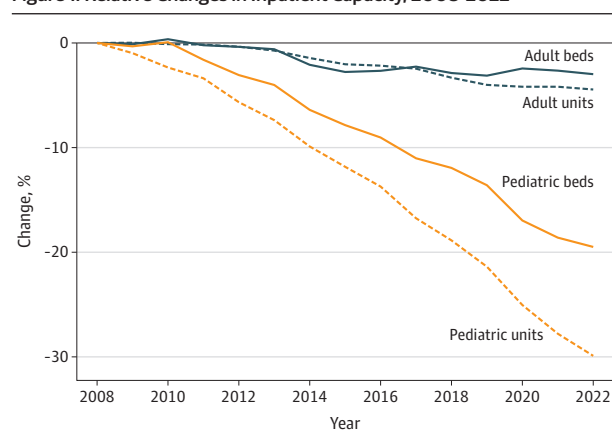
National Trends in Pediatric Inpatient Capacity

Most pediatric hospitalizations occur in general hospitals, which increasingly transfer rather than hospitalize children, resulting in care concentration at large pediatric centers.¹ This shift in pediatric care delivery is partly due to inpatient unit closures, with 19.1% of 1753 closing between 2008 and 2018.²

Whether trends have leveled, persisted, or steepened since the COVID-19 pandemic is unclear. Recent surges in pediatric respiratory illnesses have tested system resilience.³ Continued pediatric capacity losses suggest lower national flexibility to weather future volume surges. We evaluated recent trends and the association of the COVID-19 pandemic with inpatient capacity, comparing child and adult access.

Methods | This cross-sectional study used US medical-surgical hospital data for January 1, 2008, to December 31, 2022, from the American Hospital Association Annual Survey, excluding never-responders and specialty and long-term hospitals. As data are deidentified and publicly available, local ethics review and informed consent were not required in accordance with the Common Rule. We followed the [STROBE](#) reporting guideline.

Figure 1. Relative Changes in Inpatient Capacity, 2008-2022



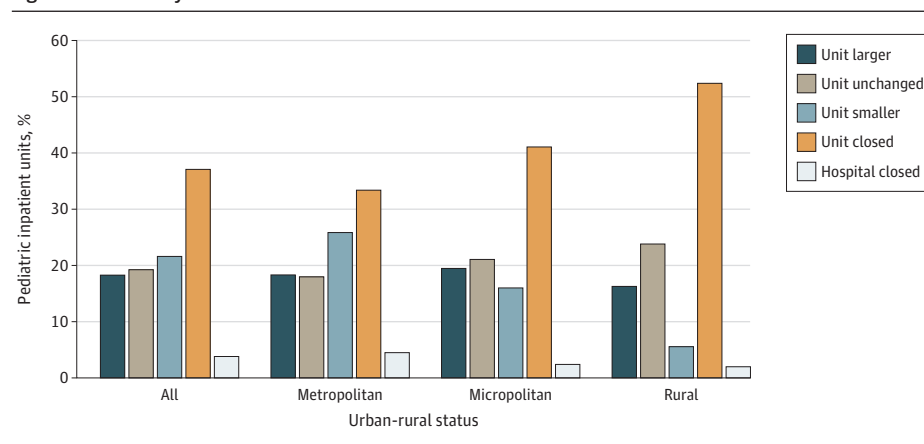
The primary outcome was number of pediatric inpatient units, defined as hospitals with any inpatient beds set up and staffed for pediatric care. Secondary outcomes included counts of pediatric beds, adult units and beds, and closures. Units were considered closed if the latest number of beds was 0. Hospitals were considered closed the first year they were absent from the dataset. We imputed missing bed counts by carrying forward or backward the last reported value. Urban-rural status was determined from census designations.

We used Poisson regression to compare 2022 with 2008 counts. Pediatric and adult trends were compared using a Poisson model with 3 covariates: 2008 or 2022, adult or pediatric, and their interaction (estimated difference between adult and pediatric changes). To assess the pandemic's influence, we used interrupted time series models to evaluate immediate changes (ie, beyond the preexisting slope) at the 2020 pandemic onset and change in slope postpandemic in units and beds.⁴ We report closures as proportions. Data were analyzed using R, version 4.4.0 (R Foundation).

Results | Of 4808 hospitals analyzed, 2074 ever reported a pediatric inpatient unit. From 2008 to 2022, pediatric inpatient units decreased from 1749 to 1226, declining 29.9% (95% CI, 24.6%-34.8%), and beds decreased from 31 133 to 25 064 (19.5%; 95% CI, 18.1%-20.8%) (Figure 1). Adult inpatient units decreased from 4519 to 4318, declining 4.4% (95% CI, 0.4%-8.4%), and beds decreased from 405 908 to 393 802 (3.0%; 95% CI, 2.6%-3.4%). Pediatric inpatient units and beds decreased 26.6% (95% CI, 20.2%-32.6%) and 17.0% (95% CI, 15.6%-18.4%) more, respectively, than adult counterparts. Of pediatric inpatient units ever open, 848 (40.9%) closed by 2022 (Figure 2).

With the onset of the pandemic, we observed no significant immediate change in pediatric units but observed an immediate decrease of 3.4% (95% CI, 2.1%-4.6%) for pediatric beds. Among adult units, there was no significant immediate change, but adult beds had an immediate 1.2% increase (95% CI, 0.9%-1.6%). Before the pandemic, pediatric units declined by 2.2% (95% CI, 1.8%-2.6%) per year and beds by 1.4% (95% CI, 1.3%-1.5%) per year, while adult units and beds declined 0.4% (95% CI, 0.1%-0.6%) and 0.3% (95% CI, 0.3%-0.4%) per year, respec-

Figure 2. Closures by Urban-Rural Status



Closures and bed shifts at all pediatric units open at any time from 2008 to 2022 are stratified by urban-rural status in 2022. Bed shifts were determined based on the earliest reported bed count and the status of the unit in 2022.

tively. There were no significant changes in slopes after pandemic onset in adult or pediatric units and beds.

Discussion | From 2008 to 2022, the US lost 29.9% of pediatric inpatient units but only 4.4% of adult units, revealing continued declines in pediatric inpatient capacity, modestly exacerbated by the pandemic. Possible explanations may be that adult beds generate more revenue than pediatric beds,⁵ pediatric staffing shortages make units difficult to operate, and pediatric hospitalizations are increasingly complex and require specialty resources. Furthermore, pandemic bed conversions may not have been rolled back.⁶ Study limitations include increased uncertainty through bed count imputation and use of a single dataset. Innovative approaches should be considered to stem future declines in pediatric capacity, which may further decrease access and resilience to surge.

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Author Contributions: Dr Michelson had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: Michelson, Cushing.

Drafting of the manuscript: Michelson.

Critical review of the manuscript for important intellectual content: Cushing, Bucholz.

Statistical analysis: Michelson.

Obtained funding: Michelson.

Administrative, technical, or material support: Michelson.

Supervision: Cushing.

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Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Data Sharing Statement: See the [Supplement](#).

1. Michelson KA, Hudgins JD, Lyons TW, Monuteaux MC, Bachur RG, Finkelstein JA. Trends in capability of hospitals to provide definitive acute care for children: 2008 to 2016. *Pediatrics*. 2020;145(1):e20192203. doi:10.1542/peds.2019-2203

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6. Yager PH, Whalen KA, Cummings BM. Repurposing a pediatric ICU for adults. *N Engl J Med*. 2020;382(22):e80. doi:10.1056/NEJMc2014819

State Parental Consent Law and Treatment Use Among Adolescents With Depression

Depression is a major public health problem among US adolescents.¹ Despite progress in the development of effective interventions, most adolescents experiencing depression do not receive treatment.^{1,2} There are many reasons for this discrepancy, with youths' inconsistent ability to receive care independently being a potential factor. Some states require parental or guardian (hereafter, caregiver) permission for mental health treatment until adolescents are aged 18 years, with variable exceptions for factors such as marital status and treatment type. In other states, youths older than 12 years can consent but must still identify a caregiver to access certain kinds of care.

Youths with caregivers who are unavailable or unwilling to consent risk losing access to potentially life-saving treatment. Adolescents experiencing depression cite parents as a major barrier to accessing mental health support.³ Yet, there has been no systematic effort to characterize the nature and role of state laws in adolescents' rights to consent to mental health treatment. Thus, we conducted a legal mapping study to characterize current state-level policies regarding adolescent consent to mental health treatment. We then tested the exploratory hypothesis that adolescents experiencing depression are less likely to receive treatment in states with stringent consent laws.

Methods | In accordance with the Common Rule, this cross-sectional ecologic study was exempt from ethics review and informed consent requirement because it was not human participant research. We followed recommended legal mapping research practices⁴ and the [STROBE](#) reporting guideline.

Using 2 legal databases (LexisNexis and Justia), we extracted and coded all US (50 states and District of Columbia [DC]) statutes regarding adolescents' ability to independently consent to inpatient and outpatient mental health treatment (eMethods in [Supplement 1](#)). We then classified state laws as follows: allows adolescents to independently consent with no or limited stipulations, and prohibits adolescents to independently consent and mandates caregiver consent.

Additionally, we extracted from the National Survey on Drug Use and Health (NSDUH) the 2021 to 2022 state-level estimates on past-year treatment rates among adolescents with past-year major depressive episodes (MDEs) (eMethods in [Supplement 1](#)).⁵ We used analysis of covariance to test whether adolescents with past-year MDEs were less likely to access mental health treatment in states that allowed vs prohibited adolescents to independently consent to services, adjusting for the

 **Supplemental content**

SUMMARY —

4 Trends in Pediatric Hospital Utilization

A comparison of hospital utilization trends in acute care, surgery and emergency departments pre- and mid-pandemic.

 BOOKMARK

Published Oct. 19, 2022 1 min. read



Over two years out from the onset of the pandemic, data comparing 2019 (pre-pandemic) to 2021 (first calendar year after the pandemic) shows how the children's hospital industry, and populations, are changing. According to an analysis of data from CHA's [Pediatric Health Information System®](#) (PHIS), here are four trends hospitals are seeing.

Less inpatient cases, but higher severity

In 2021, patient discharges rebounded compared to 2020 but were still almost 6% lower than 2019. Meanwhile, there is a greater mix of cases, remaining 5%-6% higher than 2019 numbers. Inpatient discharges are down but the severity of the cases is higher, driving a higher average length of stay in 2021 compared to 2019.

More patient days require different resource needs

Even with discharges down, total patient days, inclusive of observation cases, are higher. Observation cases were 8% higher in 2021 and represent 35% of total admission. Additionally, the behavioral health crisis persists as admissions with a primary mental health diagnosis increased 14% in 2021 and represent 21% of total admissions. These patients require different staffing resources and tend to stay longer, either awaiting discharge or transfer to a program or facility able to meet their needs.

Higher severity of surgical cases, but less overall volume in cases

In 2021, surgical cases rebounded by 17% but remain 7% lower than 2019. Similar to the inpatient population, the severity of surgical cases increased in 2020 and 2021, remaining 5% higher than 2019.

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Attachment 12B

These trends indicate a patient population characterized by higher severity illness and longer stays compared to prior years, which comes with increased costs and lower reimbursement. Patients with more severe illness tend to be on Medicaid, which reimburses at lower rates than private payers, and these patients require specialized resources that may be more costly due to supply chain shortages. Historically, observation and behavioral health cases also receive lower reimbursement and in nearly all cases don't cover the cost of providing care, according to studies in [Pediatrics](#) and the [Journal of Hospital Medicine](#).

26-026

DATA AND TRENDS

PEDIATRIC HEALTH CARE CAPACITY

COVID-19

BEHAVIORAL AND MENTAL HEALTH

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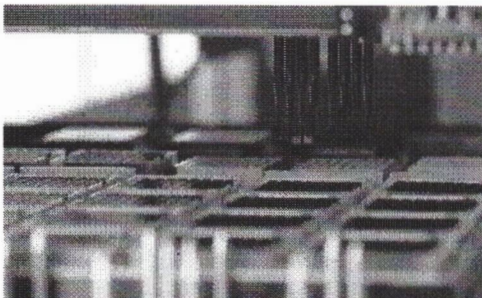
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Closure of Licensed Pediatric Beds in Health Care Markets Within Illinois



Paige VonAchen, MD[#]; Matthew M. Davis, MD, MAPP; Jenifer Cartland, PhD; Amy D'Arco, MBA; Kristin Kan, MD, MPH, MSc

From the Mary Ann & J. Milburn Smith Child Health Outreach, Research and Evaluation Center, Stanley Manne Children's Research Institute, Ann & Robert H. Lurie Children's Hospital of Chicago (P VonAchen, MM Davis, J Cartland, A D'Arco, and K Kan), Chicago, Ill; University of Michigan Medical School (P VonAchen), Ann Arbor, Mich; and Division of Advanced General Pediatrics and Primary Care, Department of Pediatrics, Northwestern University Feinberg School of Medicine (MM Davis and K Kan), Chicago, Ill

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ABSTRACT

OBJECTIVE: Our objective was to understand the market characteristics related to closures of licensed pediatric hospital beds that may be related to increasing regionalization of pediatric hospital care.

METHODS: We performed a retrospective descriptive analysis of 110 hospitals with licensed pediatric hospital beds from a statewide survey of health care facilities (2012–2017) and administrative data of hospital admissions (2013–2018) in Illinois. We quantified closures of licensed pediatric hospital beds and categorized hospital bed closures by hospital and market characteristics.

RESULTS: From 2012 through 2017, the number of licensed pediatric beds declined from 1706 to 1254 (–26.5%). Over the same time period, annual pediatric inpatient days minimally changed (+1.1%), while annual pediatric inpatient days at hospitals affiliated with the Children's Hospital Association increased (+30.5%). After accounting for re-openings, the 33 hospitals that closed all licensed pediatric beds fit 4 distinct

typologies: 1) Hospitals with minimal pediatric volume throughout the study (n = 19); 2) Hospitals that sustained at least 50% of their pediatric volume after closure of licensed pediatric beds (n = 8); 3) Hospitals with low market share in metropolitan areas (n = 5); and 4) Hospital with a decline in pediatric market share, while a nearby hospital saw a corresponding rise in pediatric market share (n = 1).

CONCLUSIONS: In Illinois, licensed pediatric hospital beds declined while pediatric inpatient days stayed the same over a recent 6-year period. Typologies of closures describe the nuanced dynamics leading to decline of pediatric hospital beds. Understanding these patterns is critical to ensure that children receive quality pediatric-tailored care.

KEYWORDS: access to care; health care markets; hospital closures; pediatric regionalization

ACADEMIC PEDIATRICS 2022;22:431–439

WHAT'S NEW

We examined licensed pediatric hospital bed closures, and related market factors, in Illinois from 2012 to 2017. Licensed pediatric hospital beds declined while pediatric inpatient days remained the same. We identified four patterns of market dynamics related to closures.

PEDIATRIC LICENSED BEDS are designated by many states through a certificate of need (CON) process. While CON programs were tied to federal funding in the 1970s to address the rapid growth in the number of medical facilities around the country, only 36 states now have a CON program.^{1,2} Designating a licensed pediatric bed indicates that hospitals commit to having a qualified physician for pediatric care, appropriate regulation for qualified staff for pediatric care, and a separate pediatric unit from adult care. States

can use this information for planning, such as emergency preparedness³, to ensure the state has enough available beds to meet the demands of its residents. Given that licensed beds are used by states to monitor appropriate access to care, they can also serve as a measure of the potential geographic accessibility of care.

Recently, a few states have reported substantial losses in pediatric beds.^{3,4} Closure of pediatric inpatient beds may be associated with insufficiently trained local health professionals to meet the hospital-level needs of pediatric populations and limit the locations that pediatric patients can obtain inpatient care. Regionalization of pediatric care has been described and linked to both decreased access to definitive hospital care for children and increased transfers for common pediatric conditions.^{5–7} Thus, licensed pediatric hospital bed closures may impact patients' access to care and adversely affect pediatric health outcomes.

The reasons for closures of pediatric beds are likely varied. However, existing studies about facilities and beds for adult acute care services and specialties may provide some insights. In the past decade, certain types of inpatient care have progressively shifted to the outpatient setting.⁸ As a result, hospital closures and mergers have accelerated.^{9–13} Although previous investigators have examined the causes and outcomes of hospital closures, those studies are focused on adult care, emergency departments, and obstetric practices or predominantly rural areas.^{10,11,14–24}

In contrast, few pediatric-focused studies have described the change in available inpatient care for children^{5,6,25,26} or closures of licensed pediatric hospital beds and factors related to this phenomenon.²⁷ The pediatric population and inpatient admissions have been declining over recent years nationwide⁸; however, little is known about how this change in demand may be influencing the supply of licensed pediatric hospital beds in the context of local market and hospital characteristics. In Illinois, a large state with a CON policy and declining pediatric population, we examined recent closures of licensed pediatric beds over a recent 6-year period. We sought to quantify changes in licensed pediatric hospital beds and characterize hospitals that closed all of their pediatric licensed hospital beds.

METHODS

DATA SOURCES

Licensed pediatric beds: We used the Annual Health Questionnaire that contains the number and type of licensed beds at each health care facility, published by the Illinois Department of Public Health's Health Facilities and Services Review Board (Board). We used Annual Health Questionnaire data from 2012 through 2017 to identify changes in the number of licensed pediatric beds from 2013 through 2017. In Illinois, licensed pediatric beds are defined as nonintensive, non-neonatal, and non-psychiatric care beds for patients 0 to 14 years old.

Pediatric admissions and inpatient days: To assess the number of pediatric admissions and inpatient days at individual hospitals (ie, pediatric volume) and in hospital markets, we used comprehensive statewide administrative data from the Illinois Hospital Association Comparative Health Care and Hospital Data Reporting Services. This database contains administrative billing data for all admissions at Illinois Hospital Association member hospitals. We analyzed all inpatient admissions of patients aged 0 to 14 years from January 2013 through December 2018, excluding newborn, psychiatric, and intensive care admissions, in order to align with the state's pediatric hospital bed licensure definition. Admission volume was stratified based on hospital affiliation with the Children's Hospital Association (CHA)²⁸ in order to further characterize admission patterns. We included data from 2018 in order to characterize trends in pediatric admissions for at least 12 months after closure of licensed pediatric beds. We excluded admissions by patients whose zip codes were not in Illinois because we did not have access to admissions data from other states,

and therefore could not appropriately assess market characteristics for those admissions.

IDENTIFICATION OF CLOSURES IN LICENSED PEDIATRIC HOSPITAL BEDS

Hospitals with a decrease in the number of licensed pediatric beds between 2 consecutive years were identified as having pediatric bed closures during the second year. If the number of licensed pediatric beds decreased to zero, the hospital was identified as having a *full pediatric bed closure*. Because the specific closure date within the second year could not be discerned from the annual survey, the closure was assumed to have occurred at the end of the second year.

HOSPITAL AND MARKET CHARACTERISTICS

For hospitals with full pediatric bed closures, we described hospital and market characteristics. We first categorized the hospital's geography into metropolitan, micropolitan, or rural based on the hospital address based on the US Office of Management and Budget standards.²⁹ A metropolitan area is an urbanized area of 50,000 or more population, a micropolitan area is based on urban clusters of at least 10,000 population, while all other counties are considered rural.

Next, we assessed the pediatric inpatient admissions volume at each hospital. Volume trends were categorized into 3 categories based on comparing average quarterly admissions (number of admissions per standard calendar quarter) preclosure versus posthospital closure using all data available in the study period. 1) Hospitals with a decrease of more than 85% of their volume from preclosure to postclosure were considered to have had "lost almost all pediatric volume." 2) Hospitals with a decrease of less than 50% of their volume from preclosure to postclosure were considered to have "maintained pediatric volume." The change in average quarterly volume from pre- to postclosure for these hospitals that "maintained pediatric volume" ranged from a decrease in volume by 50% to an increase in volume by 50%. 3) Hospitals that had a median of 0 admissions per quarter (interquartile range [IQR] 0–1) were considered to have "negligible volume." These three mutually exclusive and comprehensive categories were defined based on observed trends of individual hospital volumes (Fig. 1). Pre- and postclosure quarterly admissions were averaged in order to account for seasonal variation in volume.

Last, we empirically derived each hospital's *catchment area*. A catchment area was defined using the zip codes of patients from pediatric hospital admissions. For a given hospital, the zip codes that cumulatively comprised the top 80% of the hospital's preclosure pediatric admissions were defined as that hospital's catchment area (Fig. 2). The *market share* was then calculated as the percentage of pediatric admissions from a catchment area that was admitted to a specific hospital. Mathematically, the numerator of *market share* was the number of admissions

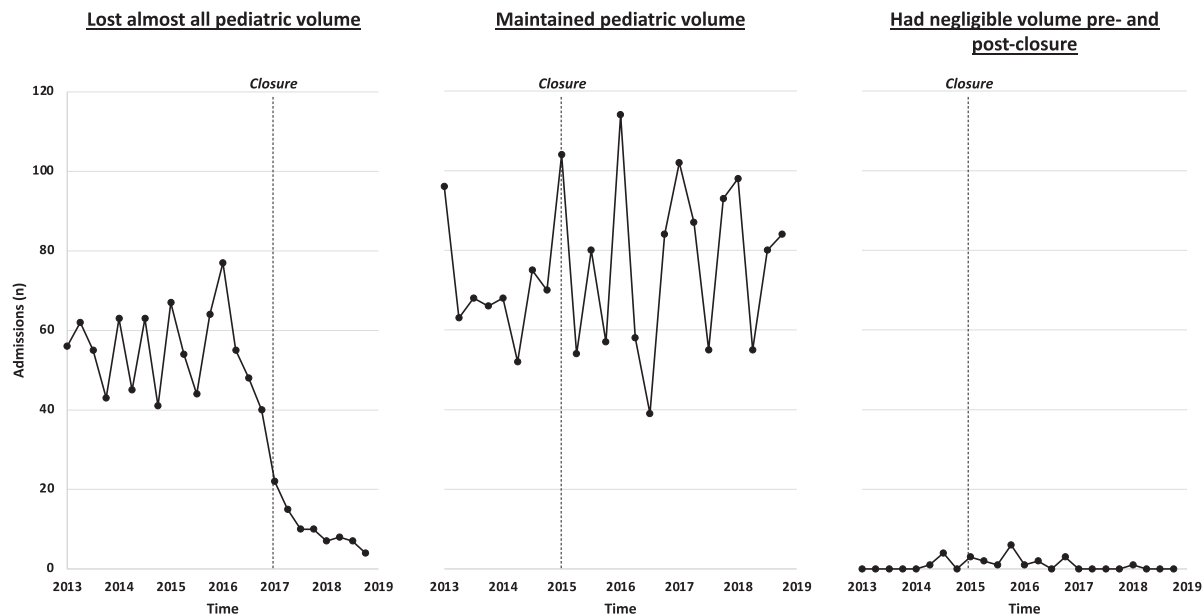


Figure 1. Examples of 3 mutually exclusive volume trends for hospitals that closed licensed pediatric beds. Graphs include quarterly admissions data for 1 hospital from each volume trend: 1) lost almost all pediatric volume, 2) maintained pediatric volume, and 3) had negligible volume pre- and postclosure. Hospitals have been anonymized.

to the hospital that closed licensed pediatric beds from the catchment area. The denominator was the total number of pediatric admissions in the catchment area, including all hospitals with admissions for children in the same catchment area as the hospital that closed licensed pediatric beds. We calculated the market share for each hospital with a full bed closure prior to and after full bed closure.

One hospital's catchment area can overlap with other nearby hospitals' catchment area (eg, patients from a given zip code may split to multiple nearby hospitals). Thus, we determined the number of nearby hospitals with overlapping catchment areas to each hospital that closed, as an indicator of market competition.

DEFINING HOSPITAL BED CLOSURE TYPOLOGIES

Our final analysis categorized the hospitals with full pediatric bed closures into typologies, based on patterns of hospital and market characteristics described above. We used these characteristics to identify patterns of nuanced local characteristics that might have been associated with pediatric hospital bed closures. All hospitals were de-identified for publication. All quantitative analyses were performed using STATA Version 16 (StataCorp LLC, College Station, Tex) software. This study of de-identified patient data was declared exempt from review by the Ann and Robert H. Lurie Children's Institutional Review Board.

RESULTS

CHANGES IN LICENSED PEDIATRIC HOSPITAL BEDS, VOLUME, AND LENGTH OF STAY

From 2012 through 2017, the number of hospitals with licensed pediatric beds in the state of Illinois declined 98

from 110 to 78 (-29.1%; Table 1). Thirty-three hospitals closed all of their licensed pediatric beds, only 2 of which were for-profit. Notably, one hospital closed all licensed pediatric hospital beds, re-opened the hospital beds, and then re-closed them again during the study period. Simultaneously, 18 hospitals closed some, but not all, of their licensed pediatric beds and 3 hospitals increased their numbers of licensed pediatric beds. Consequently, from 2012 through 2017, the total number of licensed pediatric beds in the state of Illinois declined from 1706 to 1254 (-26.5%), with 476 licensed pediatric bed closings and 24 bed openings. The majority of licensed pediatric bed closings ($n = 300$; 63%) were located in hospitals that closed all of their licensed beds.

Simultaneously, the pediatric population (<14 years old) in the state of Illinois decreased by 6.5%. The number of pediatric admissions decreased from 43,587 in 2013 to 38,034 in 2018 (-12.7%); however, the number of pediatric admissions at CHA affiliated hospitals increased from 18,423 in 2013 to 20,569 in 2018 (+11.6%). While the overall number of inpatient days was effectively unchanged from 94,076 in 2013 to 95,114 in 2018 (+1.1%), the number of inpatient days at CHA affiliated hospitals increased from 47,938 in 2013 to 62,546 in 2018 (+30.5%).

CHARACTERISTICS OF HOSPITALS THAT CLOSED ALL LICENSED PEDIATRIC HOSPITAL BEDS

Among the 33 hospitals with full bed closures, there was a median of 8 beds closed per hospital (IQR 2–14, Table 2). Nineteen of the hospitals with full bed closures had negligible pediatric volume with a median number of admissions of 0 (IQR 0–1). Other volume trend categories in hospitals with full pediatric bed closures included: 6 hospitals that “lost almost all pediatric volume,” which had a decline of

Empiric Catchment Area Derivation:

Zipcode1 40 Admissions	Zipcode4 40 Admissions	Zipcode7 40 Admissions	Zipcode10 20 Admissions	Zipcode13 15 Admissions
Zipcode2 40 Admissions	Zipcode5 80 Admissions ★	Zipcode8 40 Admissions	Zipcode11 20 Admissions	Zipcode14 15 Admissions
Zipcode3 40 Admissions	Zipcode6 40 Admissions	Zipcode9 40 Admissions	Zipcode12 15 Admissions	Zipcode15 15 Admissions

 Hospital Location
 Hospital Catchment Area

Market Share Calculation:

Total admissions
to hospital from
catchment area
(ZIP codes 1-9)

Total admissions to
all hospitals from
catchment area
(ZIP codes 1-9)

Hospital market
share in catchment
area

$$400 \div 1,000 = 40\%$$

Figure 2. Illustrative example of hospital catchment area and market share. The zip codes that cumulatively comprised the top 80% of the hospital's pediatric admissions were defined as that hospital's catchment area. The market share was calculated as the number of admissions to the hospital from the catchment area divided by the total number of admissions to all hospitals from the catchment area. Note: Illustrative example, total admissions to all hospitals (1000) from catchment area (zip codes 1–9) not visualized.

85% from average quarterly admissions preclosure to post-closures; and 8 hospitals that “maintained pediatric volume,” which sustained at least 50% (but up to a 50% increase) of their preclosure volume.

Prior to full bed closures, 14 hospitals with sufficient pediatric volume to estimate market share had a median pediatric market share of 31.6% (IQR 12.0%–54.7%). This market share was stable on a year-over-year basis. After closure, these hospitals had a median pediatric market share of 24.3% (IQR 0.5%–47.2%). Nineteen hospitals with full bed closures had a median of 0 admissions per quarter (IQR 0–1). An empiric hospital catchment area and corresponding market share for these hospitals were not

calculated because the number of admissions was too low to identify the hospital's pediatric catchment area.

TYPOLOGIES OF CLOSURE

We identified 4 typologies of hospitals that had full pediatric bed closures (Table 3).

Typology 1: The majority of hospitals that closed all of their licensed pediatric beds had little or no pediatric volume throughout the study period. Notably, 14 of these 19 closures were in metropolitan areas of the state. One hospital in this group closed all pediatric licensed beds, reopened them, and then closed them again during the study

Table 1. Hospital and Licensed Pediatric Hospital Bed Summary Statistics

	2012	2013	2014	2015	2016	2017	2018	Percent Change
Hospitals								
No. Hospitals with licensed pediatric beds	110	102	100	91	85	78	-	-29.1%
No. Licensed pediatric beds	1706	1575	1536	1443	1342	1254	-	-26.5%
Population								
No. IL children (<14 years old)	2,523,550	2,499,134	2,460,191	2,456,259	2,406,689	2,388,946	2,359,833	-6.5%
No. Licensed pediatric beds per 100,000 IL children	67.6	63.0	62.4	58.7	55.8	52.5	-	-22.4%
Volume								
Total admissions total	-	43,587	41,225	40,283	39,055	39,039	38,034	-12.7%
Admissions at CHA affiliated hospitals	-	18,423	18,373	18,692	18,894	19,999	20,569	+11.6%
Admissions at non-CHA affiliated hospitals	-	25,164	22,852	21,591	20,161	19,040	17,465	-30.6%
Length of stay								
Total inpatient days	-	94,076	89,929	89,699	89,672	93,418	95,114	1.1%
Inpatient days at CHA affiliated hospitals	-	47,938	48,505	50,257	53,176	57,748	62,546	+30.5%
Inpatient days at non-CHA affiliated hospitals	-	46,138	41,424	39,442	36,496	35,670	32,568	-29.4%

CHA indicates Children's Hospital Association.

2012 hospital data were used to determine hospital bed closures in 2013 only.

2018 volume data were used to assess postclosure volume and market trends only.

Table 2. Characteristics of Illinois Hospitals That Closed Licensed Pediatric Beds, 2013 to 2017

Hospital Characteristics	
No. beds closed per hospital closure (n = 33), median (IQR)	8 (2–14)
Hospital geography*, n (%)	
Metropolitan	24 (72.7%)
Micropolitan	4 (12.1%)
Rural	5 (15.2%)
Volume trend†, n (%)	
Lost almost all pediatric volume	6 (18.2%)
Maintained pediatric volume	8 (24.3%)
Had negligible volume pre- and postclosure	19 (59.6%)
Market characteristics for individual hospitals (n = 14)‡	
Market share prior to closure, median (IQR)	31.6% (12.0%–54.7%)
Market share after closure, median (IQR)	24.3% (0.5%–47.2%)
Percent change in market share, median (IQR)	-23.7% (-94.1% to +2.5%)

IQR indicates interquartile range.

*Metropolitan area is an urbanized area of 50,000 or more population, a micropolitan area is based on urban clusters of at least 10,000 population, while all other counties are considered rural.²⁹

†Lost almost all pediatric volume" included hospitals with a decrease of more than 85% of their volume from preclosure to postclosure; "Maintained pediatric volume" included hospitals with a decrease of less than 50% of their volume from preclosure to postclosure; "Had negligible volume pre- and postclosure" included hospitals that had a median of 0 admissions per quarter (IQR 0–1).

‡Market share characteristics were calculated for the 14 hospitals that had sufficient pediatric volume to determine the hospital catchment area.

period, and had zero pediatric admissions throughout the period under study. While we refer to eighteen hospitals that closed throughout the study, it should be noted that there were 19 episodes of full pediatric bed closures.

Typology 2: Eight hospitals with full bed closures sustained at least half of their mean quarterly, preclosure pediatric volume even after closure. These hospitals were not specific to metropolitan, micropolitan, or rural areas. Of these hospitals, 6 were the primary hospital for pediatric admissions in their catchment area and the other 2 held the second-largest market share after pediatric bed closures.

Typology 3: Five hospitals with full bed closures were located in a metropolitan area with more than 8 other

hospitals sharing the catchment area. Each of these hospitals had <15% market share prior to closure and had multiple hospitals within close geographic proximity. All of these hospitals saw almost a complete decline to zero in the number of admissions postclosure. One or more of the nearby hospitals experienced a modest increase in market share postclosure.

Typology 4: One hospital with a full pediatric bed closure had one nearby hospital with an overlapping catchment area that appeared to subsequently acquire the pediatric volume from the hospital that closed. The hospital that closed its licensed pediatric beds was located in a metropolitan region and had a decline in pediatric volume over the course of several years prior to closure. After

Table 3. Typologies of Illinois Hospitals That Closed All Licensed Pediatric Beds, 2013 to 2017

	No. Hospitals in Typology	Geographic Characteristics*	Volume Trends	Market Environment Prior to Bed Closure	Market Environment After Bed Closure
Typology 1: Hospital with little to no pediatric volume	19	Any location: Metropolitan (n = 14, 73.7%), Micropolitan (n = 1, 5.3%), Rural (n = 4, 21.1%)	Had negligible pediatric volume pre- and postclosure. Median quarterly volume of pediatric admissions: 0 (IQR 0–1)	-	-
Typology 2: Hospital that sustained pediatric volume	8	Any location: Metropolitan (n = 4, 50%), Micropolitan (n = 3, 37.5%), Rural (n = 1, 12.5%)	Maintained pediatric volume. Median volume decline from preclosure volume: 3.3% (IQR -12.5% to +11.1%)	Hospital with largest or 2nd largest market share in catchment area: Largest market share (n = 5, 62.5%), 2 nd largest market share (n = 3, 37.5%) Median market share: 45.7% (IQR 26.1%–63.0%)	Maintained largest or 2nd largest market share in catchment area: Largest market share (n = 5, 62.5%), 2 nd largest market share (n = 3, 37.5%) Minimal changes in market share. Median change in market share: +1.3% (IQR -2.8% to 3.8%).
Typology 3: Urban hospital with low market share	5	Metropolitan (n = 5, 100%)	Lost almost all pediatric volume. Median volume decline from preclosure volume: -99.0% (IQR -97.6% to -100.0%)	Low market share. Median market share: 8.1% (IQR 3.9%–11.1%)	Decline in market share to near zero. Median postclosure market share: 0.2% (IQR 0.0% - 0.4%)
Typology 4: Bed closure with main alternative hospital	1	Metropolitan (n = 1, 100%)	Lost almost all pediatric volume. Volume decline of from preclosure volume: 86.1%	Predominant hospital in catchment area, majority of market share: 56.8%	Major decline from preclosure market share: -38.1%. One nearby hospital with corresponding increase in market share from preclosure market share: +29.4%

IQR indicates interquartile range.

*Metropolitan area is an urbanized area of 50,000 or more population, a micropolitan area is based on urban clusters of at least 10,000 population, while all other counties are considered rural.²⁹

closure of all licensed pediatric beds, the nearby hospital approximately doubled their market share compared to preclosure.

DISCUSSION

Using a comprehensive inpatient administrative dataset in a large state with a CON policy, we found that Illinois experienced a 29% decline in the number of hospitals with licensed pediatric beds and an overall 27% decrease in licensed pediatric beds from 2013 to 2017. Based on a set of available hospital and market characteristics, we used Illinois as a case study to identify 4 distinct hospital typologies that reflect a mixture of low or declining pediatric inpatient volume and local market dynamics that may have influenced decisions by hospital administrators to close pediatric licensed beds.

The results of our study suggest that some pediatric hospital beds that closed were no longer needed given the declining demand for inpatient pediatric care in the surrounding geographic area. The lack of volume in a large

majority of hospitals was not necessarily due to the hospitals being in sparsely populated areas, as approximately 75% of these hospitals were located in metropolitan regions. Rather, the findings are consistent with overall national trends of declining pediatric hospital admissions, including metropolitan areas with competitive hospital catchment areas.^{8,30,31} The cause of this national decline in inpatient admissions is likely multifactorial. For example, improved ambulatory care-based prevention services have lowered the need for inpatient care, and common pediatric conditions are now safely managed in outpatient settings.^{32–34} These closures may not have impacted individual patient access to care, as patients were not seeking care at these hospitals prior to their closure.

In other situations, pediatric hospital bed closures may have closed as a result of local market characteristics, including competition between hospitals. Five hospitals located in metropolitan areas had 8 to 12 other nearby hospitals with overlapping catchment areas, including at least one nearby CHA-affiliated hospital, that saw a corresponding increase in market share postclosure. In such

competitive areas, changes in patient preference, physician referral networks and shifts in insurance networks might have driven a shift to other hospitals that appeared to attract patients who previously might have been admitted to the hospital that closed its pediatric beds. On the other hand, one hospital had a nearby hospital that appeared to subsequently acquire the majority pediatric volume from the hospital that closed. In this case, the rise in market share of pediatric admissions in the nearby hospital preceded the hospital of interest's closure of its licensed pediatric beds. In both of these situations, the directionality of the cause of pediatric volumes shifts (eg, the hospital closure led to patients going to another nearby hospital vs patients preferring a nearby hospital led to the hospital closing) remains unclear. While nearby hospitals were available to capture the volume of each of the hospitals that closed, it remains unknown whether patients' preference aligns with the remaining hospital supply in that geographic area. Future research should assess patient perspective of the availability of nearby hospitals and whether these patients are experiencing differences in quality of care, outcomes, and/or cost of care, as variation in health care, even within small geographies, is well established.^{35–38}

Separately, the observed persistent pediatric volumes at hospitals that closed their licensed pediatric hospital beds raises the question of the meaning of the licensed bed designation. Eight hospitals maintained at least half of the volume of pediatric inpatient admissions even after closing their licensed pediatric hospital beds. In these cases, the patients were presumably admitted to medical-surgical adult beds, as the admitting hospitals had withdrawn their commitment to having qualified pediatric staff by closing all licensed pediatric hospital beds. A potential concern is that these hospitals may not be able to provide pediatric tailored medical resources for pediatric patients. Flexible beds can be useful when planning for the statewide response to health emergencies,³⁹ such as a surge in demand for pediatric inpatient admission during the H1N1 outbreak of 2009³ or a decline from the typical pediatric admission rates during the COVID-19 pandemic. However, routinely admitting pediatric patients to adult beds can complicate the state's ability to use licensed pediatric hospital beds for planning purposes. These findings highlight the importance of aligning policies with clinical application, particularly given that CON policies were developed across the United States several decades ago. As such, Illinois state policy administrators are currently evaluating how to modernize the CON policy to reflect current practices in pediatric care.

Overall, our results are consistent with studies describing a recent pattern of regionalization, where pediatric patients are increasingly obtaining care at high-volume, high-expertise hospitals.^{5,6} While the total pediatric admissions for the state declined over the study period, the number of pediatric inpatient days remained the same. In other words, pediatric admissions are declining while children who are admitted experience longer

hospitalizations. Simultaneously, CHA hospitals saw a rise in admissions and inpatient days during the study period. This rise in admissions at CHA hospitals may reflect an increase in the number of admissions for children with complex chronic conditions or a rise in the number of patients obtaining care at CHA hospitals for routine care, both of which have been described at the national level.^{5–8} It remains unclear how directly community hospital closures are related to these phenomena, including the extent to which patient preference, market dynamics, or other forces are driving pediatric patients to receive care at CHA hospitals. While our case study appears in line with national patterns, the application of our individual market analysis approach to additional geographies may provide further insight into the generalizability of these results.

Previous adult literature has suggested that market driven hospital closures can lead to decreased access to care,¹⁵ increased costs,²³ and worse health outcomes including increased mortality.¹⁷ Future research should assess how closures of licensed pediatric beds, including those due to decreased demand, are affecting child health outcomes and health care costs. It is important that children who do require care can obtain access in a timely fashion and that hospitals accepting pediatric patients maintain capacity for patients' with potentially longer and more complex admissions.

There are limitations to our study. First, the study focused only on one large state and may not be generalizable nationally. The advantage of the dataset, however, was that it provided information on all pediatric inpatient admissions across the state, including those from non-teaching hospitals that might be missed in other national administrative databases.^{40,41} Second, as observation stays became a designation after the development of the CON programs, it is unclear whether these encounters should require a licensed pediatric inpatient bed. Observation stays that were not admitted were excluded from the analysis; however, this should be a consideration as CON policies are updated. The exclusion of observation stays and other admissions that do not require a licensed pediatric hospital bed in Illinois (eg, patients >14 years old) may also have affected the aggregate pediatric volume reported.⁴² Third, the definitions of catchment area and market share were derived for the purposes of this study and have not been formally validated. Prior work, predominantly the Dartmouth Atlas Project,⁴³ has attempted to define health care markets, however, were developed using Medicare data and were defined based on the location of major cardiovascular procedures. Thus, these previous definitions are less relevant for defining pediatric health care markets than an empirically derived definition. Last, we do not have access to proprietary information that may shape local supply and demand, such as hospital pricing arrangements with insurance companies, hospital finances, or information regarding consolidations. Additional patient-level factors including demographics and Medicaid-status may also drive utilization or affect a hospital's financial position.

CONCLUSION

Our findings can provide policymakers with more detailed context regarding the characteristics that might contribute to the closure of pediatric inpatient units and their relationship to pediatric hospital bed licensing. These results provide clinical providers with an understanding of patterns in the location of pediatric clinical resources and insight into where children are receiving their care. The majority of hospitals that closed pediatric inpatient units in Illinois were likely due to insufficient pediatric volume or nearby market competition, with patients moving to other nearby hospitals, including those affiliated with CHA. Additionally, some hospitals closed their pediatric inpatient unit yet continued to admit pediatric patients, raising concerns about the availability of pediatric-tailored care at these hospitals, and the need to align CON policies with current clinical practices. Future analysis of changes in licensed pediatric beds should focus on the impact on children, including patient costs and health outcomes.

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State ERBs do not publicly publish their union election results. Therefore, to examine unionization activities, we used NLRB's election reports, limited to private institutions, from January 2011 through June 2023; reports before 2011 did not allow identification of physicians in training. Using keyword search and manual evaluation, we selected union elections pertaining to *physicians in training*, *nurses*, and other *health care workers* (Supplement 1). We calculated the proportion of eligible individuals who voted (voter turnout), proportion of voters who voted to unionize, outcome, margin of victory or defeat in each election, and overall union win percentage. Characteristics examined included representing labor organization, location, bargaining unit size, and presence of right-to-work laws. Analyses were conducted using RStudio version 2023.03.0. This study was approved by the Harvard Pilgrim Health Care institutional review board.

Results | We evaluated 1909 programs from 1188 public and private institutions, identifying 67 unique physicians-in-training unions against their employer. Most unions were in non-right-to-work states ($n = 65$; 97.0%), were against private employers ($n = 40$; 59.7%), and were represented by CIR/SEIU ($n = 61$; 91.0%). California ($n = 22$) and New York ($n = 19$) had the most unions.

Of 15 366 union elections through the NLRB since 2011, 18 were among physicians in training (Table), occurring in 6 of 13 years, with most in 2023 ($n = 7$). A mean (SD) of 17 (6) elections occurred yearly among nurses, and 64 (27) among other health care workers; 2017 had the most elections for nurses ($n = 26$) and other health care workers ($n = 119$). CIR/SEIU represented physicians in training in 16 elections (88.9%). All physicians-in-training elections occurred in non-right-to-work states.

Mean voter turnout for physicians in training was 73.8% (range, 43.2%-97.5%) vs 84.7% (range, 49.1%-100%) for nurses and 78.8% (range, 12.5%-100%) for other health care workers. Physicians in training elected to unionize in 16 of 18 elections (88.9%) vs 83.6% among nurses and 77.0% among other health care workers. Margin of victory for physicians in training ranged from 0.9% to 50.0%; margin of defeat ranged from 15.0% to 17.4%.

Discussion | Most ACGME-sponsoring institutions in internal medicine, family medicine, pediatrics, and psychiatry did not have physicians-in-training unions as of July 2023. Among private union elections since 2011, participation was variable, but most voted to unionize. Relative to other groups in health care, physicians in training had a higher percentage of union election wins but lower voter turnout, notable because NLRB determines election results based on votes cast. Most unions were located in non-right-to-work states, consistent with literature documenting low union density in such states.⁵

Study limitations include potential underestimation of unionization efforts if unionized physicians in training were missed during review or employers voluntarily recognized a labor union, bypassing the need for elections. Unionization activities reflected only 2011 through mid-2023 and physicians in training with private employers.

Research is needed to understand why physicians in training decide to unionize and the effect of unionization on physicians in training, training programs, and patients.

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Supervision: Li.

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Data Sharing Statement: See Supplement 2.

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Pediatric Hospitalization Trends at Children's and General Hospitals, 2000-2019

Historically, most children hospitalized in the US were treated at general hospitals that cared for both pediatric and adult patients.¹ However, the number of hospitals providing inpatient care to children has decreased during the past decade,² and the viral infection surge in the fall of 2022 highlighted capacity shortages. Because pediatric hospitalizations have concentrated into fewer locations, we explored whether pediatric inpatient care has been redistributed from general hospitals into children's hospitals (CHs).

Methods | We used the Kids' Inpatient Database (KID) to identify inpatient nonbirth discharges for children younger than 18 years from 2000 to 2019. The KID, aggregated by the Agency for Healthcare Research and Quality, generates national



Supplemental content

highlighted capacity shortages.

Table. Pediatric Inpatient Discharges From Different Types of Hospitals That Care for Children (Excludes Birth Hospitalization Discharges)^a

Year	Median age, (IQR)	Total, No.	Nonchildren's hospital ^b		Children's hospitals total					
			No.	% (95% CI) ^e	Combined	% (95% CI) ^e	Freestanding ^c	% (95% CI) ^e	Nonfreestanding ^d	% (95% CI) ^e
2000	1.9 (0.9-3.8)	2 273 225	934 847	41.1 (38.2-44.0)	1 338 378	58.9 (56.0-61.8)	438 643	19.3 (16.0-22.6)	899 734	39.6 (36.2-43.0)
2003	1.9 (0.9-3.7)	2 415 918	923 447	38.2 (35.6-40.8)	1 492 471	61.8 (59.2-64.4)	499 064	20.7 (17.5-23.8)	993 407	41.1 (37.9-44.3)
2006	1.9 (0.9-3.8)	2 332 593	788 547	33.8 (31.3-36.3)	1 544 046	66.2 (63.7-68.7)	516 234	22.1 (18.8-25.5)	1 027 812	44.1 (40.7-47.4)
2009	1.9 (0.9-3.7)	2 277 859	703 083	30.9 (28.4-33.3)	1 574 776	69.1 (66.7-71.6)	550 220	24.2 (20.5-27.8)	1 024 555	45.0 (41.4-48.6)
2012	1.9 (0.9-3.9)	2 017 501	540 634	26.8 (24.4-29.2)	1 476 867	73.2 (70.8-75.6)	565 018	28.0 (23.6-32.5)	911 849	45.2 (41.2-49.2)
2016	2.0 (0.9-4.4)	1 769 780	369 648	20.9 (18.7-23)	1 400 132	79.1 (77.0-81.3)	572 925	32.4 (27.5-37.2)	827 207	46.7 (42.4-51.1)
2019	2.1 (1.0-4.5)	1 671 515	303 962	18.2 (16.2-20.2)	1 367 553	81.8 (79.8-83.8)	572 053	34.2 (29.4-39.1)	795 501	47.6 (43.1-52.1)

^a Hospital classification was determined independently at each year examined.^b Nonchildren's hospitals had fewer than 1500 pediatric acute care discharges during the year.^c Freestanding as identified in the Healthcare Cost and Utilization Project database.^d Nonfreestanding is a children's hospital not identified as freestanding but had more than 1500 pediatric discharges during the year.^e $P < .001$ for trend test across years.

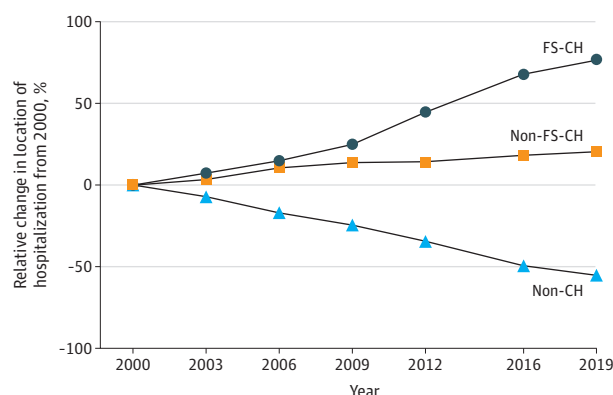
estimates for inpatient pediatric discharges; the 2019 version includes an 80% inpatient sample from 3991 hospitals in 48 states.³ The study was deemed exempt by the University of North Carolina institutional review board because it did not represent human subjects research.

We created 3 categories of hospitals that care for children and reassigned the appropriate category at each analysis year. Freestanding CHs were identified with a specific label available within KID. Nonfreestanding CHs were defined as hospitals that had more than 1500 annual pediatric discharges (excluding healthy newborns) but were not identified as freestanding CHs. This volume cutoff has been used to identify CHs and includes 95% of hospitals in the Children's Hospital Association Annual Benchmark Survey.⁴ Freestanding CHs and non-freestanding CHs are collectively referred to as CHs. Hospitals that discharge fewer than 1500 children annually were categorized as non-CHs.

We estimated the total number of national pediatric non-birth discharges per year by hospital type. To further explore redistribution, we also analyzed the percentage of children experiencing interfacility transfer (IFT) during hospitalization, which includes those initially cared for in the emergency department or inpatient unit of one hospital who are then transferred to another hospital for subsequent care; these were counted as 1 hospitalization. We calculated descriptive statistics and used the Cochran-Armitage test for trend to compare hospitalization characteristics by hospital type across years. Analyses, performed with SAS version 9.4, were weighted to produce national estimates; statistical testing was 2-sided, with $P < .05$ considered statistically significant.

Results | We included 14 758 391 discharges. Annual inpatient discharges decreased by 26.5% from 2000 to 2019 (2 273 225 to 1 671 515, respectively; Table). Simultaneously, the percentage of total national discharges from CHs increased significantly, from 58.9% (95% CI, 56.0%-61.8%) in 2000 to 81.8% (95% CI, 79.8%-83.8%) in 2019: discharges from freestanding

Figure. Relative Percentage Change of Inpatient Pediatric Hospitalization Within Different Hospital Types



A freestanding children's hospital (FS-CH) is identified as an FS CH in the Healthcare Cost and Utilization Project database. A Non-FS-CH is a CH not identified as FS but had more than 1500 pediatric acute care discharges during the year. Non-CH is a hospital that had fewer than 1500 pediatric discharges during the year. Hospital classification was determined independently at each year examined.

CHs increased from 19.3% (95% CI, 16.0%-22.6%) to 34.2% (95% CI, 29.4%-39.1%), those at nonfreestanding CHs increased from 39.6% (95% CI, 36.2%-43.0%) to 47.6% (95% CI, 43.1%-52.1%), and percentage of discharges from non-CHs decreased from 41.1% (95% CI, 38.2%-44.0%) to 18.2% (95% CI, 16.2%-20.2%; P trend $< .001$ for all; Table and Figure).

An increase in IFT accompanied the changes in the distribution of pediatric discharges. In 2000, 138 939 pediatric patients (6.1% [95% CI, 5.3%-6.8%] of total discharges) were transferred from one facility to another before discharge; in 2019, 314 646 patients (18.8%; 95% CI, 17.3%-20.2%) experienced an IFT (P trend $< .001$). Of children experiencing an IFT in 2019, 88.0% (95% CI, 85.5%-89.8%) were transferred to a CH.

Discussion | Between 2000 and 2019, total inpatient pediatric hospitalizations decreased significantly, but with a greater proportion at freestanding CHs and other high-volume hospitals. In 2019, 4 of every 5 pediatric inpatients were discharged from such hospitals, and an increasing percentage of hospitalized children required IFT to receive care. This redistribution is likely related to the trend of national pediatric inpatient unit closures, primarily at smaller non-CHs.²

The effect of concentration of care on access and quality is unknown. In some areas of medicine, regionalization has improved care quality.⁵ However, decreased local inpatient pediatric hospitalization capacity, particularly in rural areas, may create barriers to care and decrease emergency capacity.

Study limitations include that there is no universal definition of a nonfreestanding CH. The definition used was empirically derived. Also, KID captures inpatient but not observation status hospitalizations, so potential shifts of admissions to observation status cannot be determined, and a change in care complexity may have occurred to potentially justify centralization at CHs.

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COMMENT & RESPONSE

Prophylaxis Against *Pneumocystis* Pneumonia

To the Editor A recent JAMA Insights article reviewed indications for *Pneumocystis jirovecii* pneumonia prophylaxis in immunocompromised adults.¹ The authors commented that patients receiving corticosteroids at doses equivalent to at least 20 mg/d of prednisone for at least 4 weeks who have an additional cause of immunosuppression should receive *Pneumocystis* pneumonia (PCP) prophylaxis.¹ They also noted there is no consensus for when to initiate PCP prophylaxis among patients with autoimmune disease.¹ Unfortunately, without consensus and with no clear definition of "additional cause of immunosuppression," confusion may arise regarding the appropriateness of PCP prophylaxis in individual cases. To help decide whether PCP prophylaxis for patients with autoimmune disease is indicated, clinicians can consider the number needed to treat (NNT) to prevent 1 episode of PCP balanced against the number needed to harm (NNH) (ie, occurrence of serious adverse drug reactions resulting from prophylaxis with trimethoprim-sulfamethoxazole). In a systematic review of patients with malignancies, a PCP risk greater than or equal to 6.2% determined the threshold for prophylaxis,² likely exceeding the PCP risk among patients with certain autoimmune disorders (eg, the incidence of PCP was calculated to be 0.1% among patients with autoimmune blistering disorders).³ Among patients with cancer, the NNT was 19 to prevent 1 case of PCP.² In a study of patients with rheumatic disease receiving greater than 30 mg/d of prednisone for more than 4 weeks, PCP risk was higher for certain diseases, including microscopic polyangiitis and dermatomyositis, and for initial prednisone doses of greater than 60 mg/d.⁴ The NNT for patients receiving a prednisone dose greater than 60 mg/d was 32, whereas the NNT was 215 among patients receiving more than 30 mg/d of prednisone, which is higher than the NNH of 131.⁴ In another study of patients with rheumatologic illnesses receiving lower doses of corticosteroids, the NNT for patients receiving greater than or equal to 15 mg/d and less than 30 mg/d of prednisone or the equivalent was 204, exceeding the NNH of 45.⁵ However, the NNT fell to 31 for a

RESEARCH ARTICLE

A National Analysis of General Pediatric Inpatient Unit Closures and Openings, 2011–2018

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OBJECTIVES: This paper provides an examination of: (1) the frequency and net rates of change for general pediatric inpatient (GPI) unit closures and openings nationally and by state; (2) how often closures or openings are caused by GPI unit changes only or caused by hospital-level changes; and (3) the relationship between hospital financial status and system ownership and GPI unit closures or openings.

METHODS: This study used the Health Systems and Providers Database (2011–2018) plus 3 data sources on hospital closures. We enumerated GPI unit closures and openings to calculate net rates of change. Multinomial logistic regressions analyzed associations between financial distress, system ownership, and the likelihood of closing or opening a GPI unit, adjusting for hospital characteristics.

RESULTS: Across the study period, more GPI units closed than opened for a net closure rate of 2.0% (15.7% [638 of 4069] closures minus 13.7% [558 of 4069] openings). When GPI units closed, 89.0% (568 of 638) did so in a hospital that remained operating. Hospitals with the most financial distress were not more likely to close a GPI unit than those not (odds ratio: 1.01 [95% confidence interval: 0.68–1.50]), but hospitals owned by systems were significantly less likely to close a GPI unit than those not (odds ratio: 0.66 [95% confidence interval: 0.47–0.91]).

CONCLUSIONS: Overall, more GPI units closed than opened, and closures mostly involved hospitals that otherwise remained operational. A hospital's overall financial distress was not associated with GPI unit closures, whereas being owned by a system was associated with fewer closures.

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Ms San Soucie conceptualized and designed the study, conducted all analyses, and drafted the initial manuscript; Drs Beaulieu and Cutler obtained funding and conceptualized and designed the primary dataset; Mr Buxbaum contributed to the validation of hospital closure information and to initial analyses of the dataset; Ms Zhao contributed to the initial analyses of the dataset; Dr Chien obtained funding, contributed to the design and content of the primary dataset, conceptualized and designed the study, and helped draft the initial manuscript; and all authors critically reviewed and revised the manuscript, approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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In the United States, general pediatric inpatient (GPI) units must be prepared to treat any 1 of our nation's 73.1 million children and adolescents for unexpected illnesses and injuries.¹ About 1.5 million pediatric hospitalizations occur annually,² but the medical complexity of the pediatric-aged population has been increasing.³ Hospitalization rates are highest among the growing percentage of children and adolescents with chronic, complex, or disabling health conditions, who have survived historically lethal conditions at birth (eg, extreme prematurity) or been diagnosed at earlier ages (eg, autism, congenital heart lesions).^{4–8} Going forward, pediatric hospitalizations may continue to decline as national birth rates decrease,⁹ but GPI units will likely need to be prepared for greater complexity among pediatric patients. Understanding the dynamics of GPI unit closures and openings and the hospitals they are located in is a key step in assessing the degree to which the pediatric population can be adequately and appropriately cared for.

The hospital industry has been robustly studied,^{10–16} but less is known about the availability of GPI services for children. Government agencies¹⁰ and research institutions¹¹ track the number of hospitals annually for certification, participation in public insurance programs, financial assistance (eg, disproportionate share hospital payments and critical access status), and monitoring of closures and openings. Certain hospital service lines, like GPI units, are not monitored as closely. Individual hospitals may report that they have a GPI unit voluntarily (eg, through the American Hospital Association [AHA]'s Annual Hospital Survey) or in response to regulatory mandates (eg, the Centers of Medicaid and Medicare Services [CMS] Provider of Service file), but, to our knowledge, there is no single gold standard source of information on GPI units. A recent study using the AHA survey found a net closure rate of approximately 20% for GPI units between 2008 and 2018,¹⁷ prompting alarm because the rate was at least 4 to 5 times higher than that for hospitals in the United States more generally.^{10,12} However, the number of hospitals identified in this study was less than half of that published by other sources,⁷ and likely reflects the limitations of relying on a single hospital source for closure studies. A priori, we hypothesized that the GPI unit closure rate would be much lower than previous estimates when combining multiple sources of data.

Drivers of GPI unit closures are also poorly understood. Hospitals have cited¹⁸ lower margins for pediatric services compared with adult services as a reason for closing pediatric units. The way that hospitals are owned have also been identified as a reason for cessation of pediatric services¹⁹ (eg, hospitals that belong to larger healthcare systems may be able to shift resources across multiple member hospitals). Both of these factors may also fuel the concentration of pediatric inpatient services in specific US regions.^{20–23}

This study, therefore, seeks to examine: (1) the frequency and net rates of change for GPI unit closures and openings nationally and by state; (2) how often closures or openings are caused by GPI unit changes only or caused by hospital-level changes; and

(3) the relationship between hospital financial status and system ownership and GPI unit closures or openings.

METHODS

Study Design and Data Sources

We combined 5 data sources to conduct this descriptive study spanning the period between 2011 and 2018: a novel database, the Health Systems and Provider Database (HSPD); 3 independent sources of data on hospital closures; and CMS' Healthcare Cost Report Information System (HCRIS). The HSPD was developed by the National Bureau of Economic Research Center of Excellence on Comparative Health Systems from 25 governmental and proprietary sources.²⁴ It provides a near census of physicians, practices, hospitals, and health systems in the United States and ownership relationships between each entity.²⁴ The primary sources for the HSPD hospital file were: mandatory reports from all US hospitals in CMS' Provider of Service files, voluntary responses to AHA's Annual Hospital Survey (annual response rate about 75%),²⁵ and proprietarily-gathered information from SK&A.²⁴ The HSPD is unique in how it applies a series of triangulations and cross-validations to resolve conflicting or missing data across the 3 hospital data sources and in how it connects hospitals to their larger health systems,²⁴ which were defined as organizations that own at least 1 hospital and deliver services across the outpatient and inpatient care continuum.²⁴

Hospital closures were verified using: the Dartmouth Atlas tracking files, the American Hospital Directory, and the University of North Carolina Sheps Center.^{11,26,27} These 3 sources had high agreement levels (eg, Dartmouth and American Hospital Directory agreed on urban hospitals closures 75% of the time; the Sheps list agreed with at least 1 of the 2 other sources on rural hospital closures 83% of the time).

Hospital financial information in HCRIS comes from all CMS-certified institutional providers and contains data for virtually all general, acute care hospitals in the United States but not on the finances for individual GPI units; approximately 89% of the 142 independent children's hospitals in 2011 did not report financial information to HCRIS.

Study Population

The study population includes all child-serving hospitals, defined as any hospital that had at least 1 of 4 child-serving units (general newborn, neonatal intensive care, general pediatric inpatient unit, or PICU) in at least 1 year during the 2011 to 2018 study period ($N = 4518$). This population was used for analyses pertaining to entire hospital closure or opening. The subset of hospitals with a GPI unit for at least 1 year during the study period ($N = 4069$) was used for subsequent analyses.

Hospitals were determined to have a GPI unit in a given year using a stepped approach: (1) if hospitals reported that general pediatric services were provided by staff per the POS file; or (2) if POS data were missing, they reported that the hospital provided

TABLE 1 Characteristics of Child-Serving Hospitals in 2011		
	N	Percent
All child-serving hospitals, 2011–2018 ^a	4518	
Hospitals with a GPI unit, 2011–2018	4360	
All child-serving hospitals in 2011 base year	4069	100 ^b
Hospitals with a GPI unit in 2011 base year	3559	81.6
Hospital belongs to a system ^c		
Yes	2547	58.4
No	1755	40.3
Missing ^d	58	1.3
Hospital type		
General acute care	4105	94.2
Children's ^e	111	2.6
Other ^f	94	2.2
Psychiatric	50	1.2
Profit status		
Not-for-profit	2538	58.2
Public	1117	25.6
For-profit	613	14.1
Missing	92	2.1
Size		
≤50 beds	1362	31.2
51–100 beds	593	13.6
101–500 beds	2072	47.5
>500 beds	333	7.6
Service lines		
Has newborn unit	3381	77.6
Has NICU	1260	28.9
Has PICU	538	12.3
Has pediatric emergency unit	537	12.3
Has pediatric psychiatric unit	416	9.5
Teaching status		
Nonteaching hospital	3353	76.9
Teaching hospital	1007	23.1
Rurality of hospital location		
Metropolitan	2803	64.3
Micropolitan	1236	28.4
Rural	321	7.4
Region of hospital location		
South	1610	36.9
Midwest	1300	29.8
West	851	19.5
Northeast	599	13.7

TABLE 1 Continued		
	N	Percent
		Mean
County population ages 0–19 (mean)		298 797
^a Any hospital with at least 1 of 4 units for at least 1 year of the study period: newborn, neonatal intensive care, general pediatric inpatient, or pediatric intensive care. ^b Percentages may not add to 100 because of rounding. ^c A health system is defined as containing a minimum of 1 general acute care hospital, 10 primary care physicians whose primary billing TIN is owned or managed by the system, and 50 total physicians primarily billing under a system TIN. The minimum set of providers must be located within a single healthcare referral region (Beaulieu, et al 2023). ^d Missing rates were 0 for all categories unless otherwise represented. ^e Defined if self-identified as such on any of our survey sources (Beaulieu, et al 2023). ^f Includes Specialty and Women's hospitals.		

general pediatric services on the AHA survey; or (3) if hospitals were missing data for both (1) and (2), they reported that they had a non-zero number of general pediatric beds on the AHA survey. Hospital and GPI unit closures were determined by a hospital or unit being present in the HSPD in 1 year but not in subsequent years. Hospital closures were verified by at least 1 of the 3 external sources on hospital activity. Hospital and GPI unit openings were defined by whether the hospital or unit went from being absent to newly present in the HSPD. Four percent of hospitals both opened and closed GPI units over the study period; these hospitals were classified according to the final event within the study period for our χ^2 tests.

Outcomes

The net change in the number of GPI units was calculated by subtracting the total number of closures from the total number of openings and then dividing by the total number of unique hospitals with a GPI unit across the study period, such that positive rates reflect openings, whereas negative rates reflect closures. GPI unit changes were considered to be caused by an entire hospital closing or opening if the hospital was determined to have closed or opened. A hospital was considered to belong to a larger health system using established definitions and methods: their Taxpayer Identification Number (TIN) was owned or managed by another TIN that owned at least 1 general acute care hospital and was the primary billing TIN for 50 total physicians, of which 10 were primary care physicians and if hospitals and physicians were located within a single healthcare referral region.²⁴ Hospital financial distress was determined by HCRIS variables and by calculating each hospital's likelihood of bankruptcy using a modified Altman z score (ie, the weighted average z score of 4 different financial ratios: liquidity ([current assets – current liabilities]/total assets), profitability (fund balance/total assets), efficiency ([net patient revenue – total operating costs]/total assets), and net worth ([total assets – total liabilities]/total liabilities)).²⁸ For the

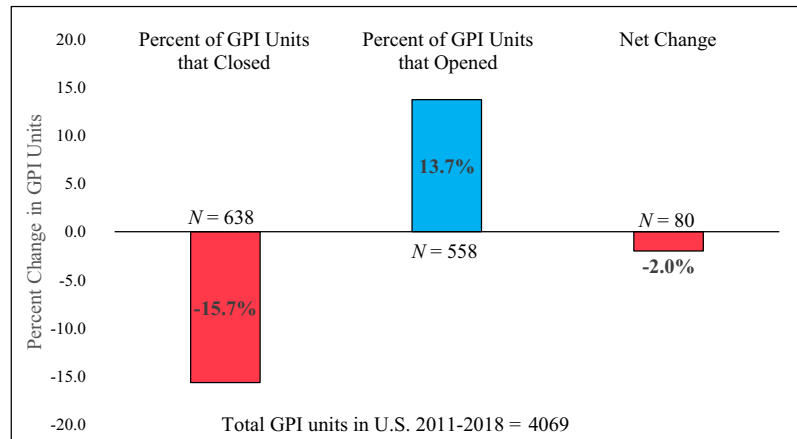


FIGURE 1 Percent change of GPI units closing or opening among all GPI units: United States, 2011–2018.

regression analysis, z scores were then converted into quartiles of hospital financial health for each year of the study period and with dummy variables representing a hospital's presence in a quartile.

Covariates

Secondary hospital characteristics were hospital type (eg, general acute care or children's), hospital profit status (for-profit,

not-for-profit, or public), overall hospital size based on bed count, types of child-serving service lines available, teaching status, rurality, whether the state had expanded Medicaid,²⁹ and county-level population ages 0 to 19.³⁰

Statistical Methods

Simple descriptive statistics to compute net changes in the absolute number of and percent change in GPI units across the 8-year

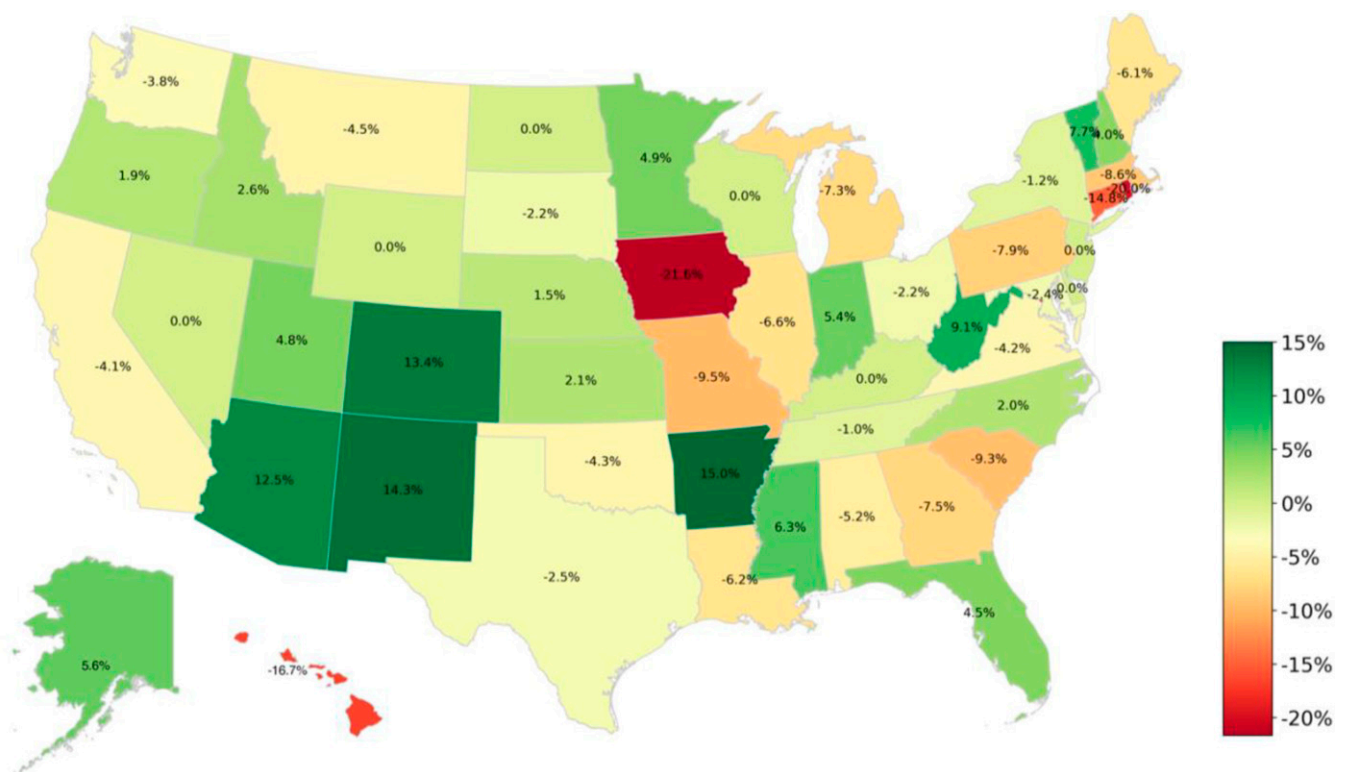


FIGURE 2 State variation in net rates of GPI unit changes, U.S. 2011 to 2018. There were a total of 4069 GPI units in the United States from 2011 to 2018.

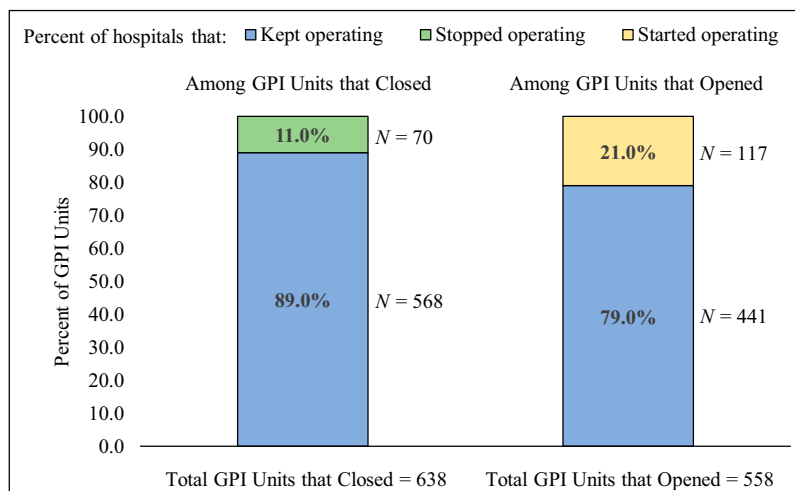


FIGURE 3 Percent of GPI openings or closures that occur in hospitals that keep operating, United States 2011 to 2018.

period. Since the data represented a near-census and not a sample, we provide point estimates only. χ^2 tests compared the distribution of characteristics of hospitals that closed a GPI unit and of hospitals that opened a GPI unit. Multinomial logistic regressions estimated the likelihood of either a GPI unit closure or opening (relative to hospitals that continued to operate an existing unit) given system ownership or hospital financial status, adjusting for hospital characteristics. All analyses were performed using Stata 17.0.³¹

RESULTS

Study Population

Across the study period, there were 4518 hospitals that served children through 1 of 4 service lines: newborn, neonatal intensive care, general pediatric, and pediatric intensive care (Table 1). In the base year 2011, there were 4360 child-serving hospitals. Most of these hospitals were general acute care hospitals (4105 or 94.2%), not-for-profit (2538 or 58.2%), urban in location (2803 or 64.3%), nonteaching in mission (3353 or 76.9%), and belonged to a health system (2547 or 58.4%). Of these hospitals, 3559 (81.6%) had a GPI unit.

Rates of GPI Unit Net Closures

From 2011 to 2018, 4069 hospitals had a GPI unit for at least 1 year (Fig 1). Across the study period, 15.7% (638 of 4069) of these hospitals experienced a GPI unit closure, and 13.7% (558 of 4069) experienced a GPI unit opening (see Supplemental Figs 6 and 7 for yearly number and percent of unit changes, respectively). Thus, there was a net closure rate of 2.0% (13.7% [558 of 4069] openings minus 15.7% [638 of 4069] closures) for GPI units during the study period. About 4% (145 of 4069) of hospitals experienced both a GPI unit closure and a GPI unit opening. The net rates of change in GPI units across states during the study differed quite noticeably (Fig 2). The median net rate of change across states was -1%

(data not shown), whereas the minimum and maximum were -22% (Iowa) and 15% (Arkansas), respectively.

Unit-Level Versus Hospital-Level Changes

In all, across the full study period, 78 of the child-serving hospitals closed, whereas 152 new child-serving hospitals opened. Not all hospitals operated GPI units, and the number of GPI unit closures and openings vastly exceeds the number of hospital closures and openings. So, it follows that the majority of GPI unit closures and openings occurred in hospitals that remained operating. When GPI units closed, 89.0% (568 of 638) did so in a hospital that otherwise remained operating, whereas 11% (70 of 638) did so when an entire hospital closed (Fig 3). When GPI units opened, 79.0% (441 of 558) did so in a hospital that was already operating, whereas 21% (117 of 558) occurred as part of a new hospital.

Associations Between Hospital Characteristics and GPI Unit Changes

In the bivariate analysis utilizing Pearson's χ^2 Tests (Table 2), there were a few characteristics that had significantly different distributions between hospitals that closed and opened GPI units. More GPI unit closures occurred in hospitals that were in the most financial distress, whereas the hospitals with GPI unit openings were more evenly spread out across quartiles of financial distress (34.6% versus 25.8% [$P = .046$]). More GPI unit closures occurred in general acute care hospitals as compared with GPI unit openings (94.7% versus 86.4% [$P < .001$]). A larger share of GPI unit openings was in smaller hospitals than closures (62.3% versus 52.5% [$P = .001$]). When contrasting other pediatric services these hospitals offered, we found that more GPI unit openings occurred in hospitals with a pediatric psychiatric unit as compared with GPI unit closures (10.4% versus 6.1% [$P = .01$]). Regarding teaching status, more GPI unit openings occurred in teaching hospitals as compared with GPI unit closures (92.6% versus 87.3% [$P = .005$]).

TABLE 2 Characteristics of Hospitals That Opened or Closed Their GPI Units Between 2011 and 2018

	Hospitals With a Net GPI Unit Closure		Hospitals With a Net GPI Unit Opening		Pearson χ^2 Value	P
	N	Percent	N	Percent		
Hospitals with a GPI unit						
Net GPI unit closure ^a	589	100 ^b	—	—	—	
Net GPI unit opening	—	—	462	100	—	
Hospital financial distress year of activity (quartiles of Altman score) ^c	—	—	—	—	8.01	.046
Top quartile (least distress)	120	20.4	92	19.9		
Second quartile	118	20.0	104	22.5		
Third quartile	111	18.9	100	21.7		
Bottom quartile (most distress)	204	34.6	119	25.8		
Missing ^d	36	6.11	47	10.2		
Hospital belongs to a system ^e					0.50	.48
Yes	257	43.6	190	41.1		
No	324	55.0	262	56.7		
Missing	8	1.4	10	2.2		
Hospital type					23.29	<.001
General acute care	558	94.7	399	86.4		
Other ^f	31	5.3	63	13.6		
Profit status					0.49	.78
For-profit	111	18.9	87	18.8		
Not-for-profit	257	43.6	206	44.6		
Public	213	36.2	155	33.6		
Missing	8	1.4	14	3.0		
Size					10.29	.001
≤50 beds	309	52.5	288	62.3		
>50 beds	280	47.5	174	37.7		
Service lines ^g						
Has newborn unit	289	49.1	217	47.0%	0.46	.50
Has NICU	74	12.6	58	12.6	0.00	.99
Has PICU	34	5.8	31	6.7	0.39	.53
Has pediatric emergency unit	51	8.7	45	9.7	1.43	.23
Has pediatric psychiatric unit	36	6.1	48	10.4	6.44	.01
Teaching status					8.04	.005
Teaching hospital	75	12.7	34	7.4		
Nonteaching hospital	514	87.3	428	92.6		
Rurality					0.63	.73
Urban	291	49.4	218	47.2		
Micropolitan	214	36.3	172	37.2		
Rural	84	14.3	72	15.6		
Region					5.23	.16
Midwest	172	29.2	130	28.1		
Northeast	61	10.4	34	7.4		

TABLE 2 Continued

	Hospitals With a Net GPI Unit Closure		Hospitals With a Net GPI Unit Opening		Pearson χ^2 Value	P
	N	Percent	N	Percent		
South	253	43.0	197	42.6		
West	103	17.5	101	21.9		
Medicaid expansion					0.007	.93
State did expand Medicaid	307	52.1	242	52.4		
State did not expand Medicaid	282	47.9	220	47.6		
	Mean		Mean			
County population ages 0–19 (mean)	355 285		265 838			

Categorical variables were combined when sample sizes were less than 30. Nongeneral acute care hospitals were combined into 1 category, and hospitals with more than 50 beds were combined into 1 category. —, not applicable.

^a Many hospitals (146) had both a unit opening and closure during the study period. These numbers include the last unit activity for each hospital.

^b Percentages may not add to 100 because of rounding.

^c Altman's Z-score is the output of 4 different financial ratios: liquidity ([current assets - current liabilities]/total assets), profitability (fund balance/total assets), efficiency ([net patient revenue - total operating costs]/total assets), and net worth ([total assets - total liabilities]/total liabilities) (Lord, et al 2020). The Z-scores were then converted into quartiles of hospital financial health for each year of the study period.

^d Missing rates were 0 for all categories unless otherwise represented.

^e A health system is defined as containing a minimum of 1 general acute care hospital, 10 primary care physicians whose primary billing TIN is owned or managed by the system, and 50 total physicians primarily billing under a system TIN. The minimum set of providers must be located within a single healthcare referral region (Beaulieu, et al 2023).

^f Includes Children's, Psychiatric, Specialty, and Women's hospitals.

^g Services lines indicate whether the hospital had the listed unit in the year of the GPI unit opening or closure.

Adjusting for covariates in the multinomial analysis, a hospital being in the financial distress (ie, the lowest quartile of Altman z score) compared with those in other quartiles of Altman z score was not associated with closing a GPI unit compared with hospitals that maintained their GPI unit: odds ratio of 1.01 (95% confidence interval [CI]: 0.68–1.50; $P = .96$) (Table 3). However, hospitals belonging to a health system were 0.66 (95% CI: 0.47–0.91; $P = .013$) times less likely to experience a closure and 0.67 (95% CI: 0.47–0.96; $P = .03$) times less likely to experience opening of their GPI unit than hospitals that were not in a system. Large hospitals, those with greater bed counts as well as those with many pediatric service lines, experienced fewer changes in their GPI units – either closures or openings – which may be related to both financial status and system ownership.

DISCUSSION

In summary, using multiple data sources describing GPI units and child-serving hospitals, as well as validating hospital closures via 3 external data sources, we find the net change in GPI units to be that of –2.0% between 2011 and 2018. Second, we find that most GPI unit closures occurred in hospitals that otherwise remained operating, and the minority of closures were caused by entire hospitals closing. Lastly, a hospital's overall financial health was not significantly associated with GPI unit closures or opening, although if hospitals were members of health systems, both GPI unit closures and openings were less likely to occur.

Taken together, the findings of this study highlight the fluidity in GPI units across years. In all, roughly a quarter of hospitals with a GPI unit experienced a closure or opening of that unit during the 8-year

study period. The large number of changes in units may create a general feeling of instability regarding the market for pediatric inpatient services even though the net GPI unit closure rate is not as large as previously estimated.¹⁷ Such feelings of instability can be especially acute during times of stress on the supply of GPI units (eg, during the “triple-demic” of influenza, coronavirus disease 2019 [COVID-19], and respiratory syncytial virus³²). Future changes in the availability of GPI units should be monitored to ensure that children can be adequately cared for. Government agencies can regularly update counts of GPI units in the country based on POS data, or researchers could regularly triangulate the data from POS and AHA to report counts of units nationally.

The findings in this study regarding the overall closure rate of GPI units contrasts starkly with a recent estimate that put the closure rate at nearly 20% from 2008 to 2018.¹⁷ The most likely reason for this sizeable discrepancy is the incorporation and triangulation of additional sources of data. The results showing that most closures and openings of GPI units occur in hospitals that remain operating, as well as a lack of relationship between hospital financial status and GPI unit closures, indicates that there may be other factors that influence hospitals' decisions to change the service lines they offer. Additionally, the lack of a significance around hospital financial status may be because the Altman z score is constructed as a measure of the hospital's overall financial health, which can mask financial impacts of unit-level changes within the hospital. Current policies that aim to bolster entire hospital operations may not be targeted enough to address patient needs when a GPI unit is facing closure.

TABLE 3 Relative Risk Ratio of Hospital Closing or Opening a GPI Unit Compared With Hospitals That Kept GPI Unit Operating, 2011 to 2018

	GPI Unit Closures			GPI Unit Openings		
	<i>N</i>	Relative Risk Ratio (95% Confidence Interval)	<i>P</i>	<i>N</i>	Relative Risk Ratio (95% Confidence Interval)	<i>P</i>
Hospital financial health (quartiles of Altman score) ^a						
First (least distress)	131	Reference		117	Reference	
Second	132	0.94 (0.60–1.46)	.78	118	1.07 (0.64–1.78)	.81
Third	120	0.84 (0.54–1.30)	.43	112	0.99 (0.60–1.63)	.96
Fourth (most distress)	219	1.01 (0.68–1.50)	.96	157	1.21 (0.77–1.91)	.41
Hospital is in health system ^b	275	0.66 (0.47–0.91)	.013	239	0.67 (0.47–0.96)	.03
Hospital type						
General acute care	604	Reference		484	Reference	
Children's ^c	<5 Children's hospitals closed a GPI unit			17	0.67 (0.18–2.42)	0.54
Psychiatric	12	1.10 (0.33–3.69)	.87	17	4.52 (1.45–14.02)	.009
Other ^d	19	0.59 (0.27–1.28)	.18	36	1.79 (0.92–3.46)	.09
Profit status						
Not-for-profit	278	Reference		238	Reference	
For-profit	120	1.31 (0.86–1.99)	.21	88	1.35 (0.84–2.17)	.21
Public	215	1.03 (0.71–1.49)	.90	201	0.18 (0.76–1.82)	.47
Size						
≤50 bed	348	Reference		359	Reference	
51 – 100 beds	89	0.68 (0.39–1.17)	.016	75	0.48 (0.26–0.90)	.02
101 – 500 beds	191	0.45 (0.29–0.71)	.001	111	0.29 (0.17–0.51)	<.001
>500 beds	10	0.13 (0.04–0.40)	<.001	9	0.16 (0.05–0.53)	.003
Teaching hospital	76	1.16 (0.77–1.75)	.48	42	0.91 (0.55–1.52)	.72
Rurality						
Metropolitan	307	Reference		254	Reference	
Micropolitan or rural	239	0.90 (0.56–1.46)	.67	211	1.03 (0.63–1.69)	.91
Region						
Midwest	185	Reference		145	Reference	
Northeast	66	1.13 (0.63–2.04)	.68	38	0.79 (0.38–1.65)	.54
South	276	1.46 (0.95–2.24)	.08	254	1.41 (0.86–2.29)	.17
West	111	1.14 (0.70–1.86)	.61	117	0.92 (0.53–1.58)	.76
Service lines ^e						
Has newborn unit	315	0.31 (0.21–0.46)	<.001	246	0.31 (0.19–0.50)	<.001
Has NICU	81	0.92 (0.62–1.38)	.70	65	1.40 (0.86–2.29)	.18
Has PICU	36	0.51 (0.26–1.01)	.05	37	0.78 (0.39–1.56)	.48
Has pediatric emergency unit	54	0.62 (0.39–0.98)	.04	54	0.93 (0.57–1.50)	.76
Has pediatric psychiatric unit	40	1.00 (0.54–1.84)	.99	53	1.17 (0.61–2.27)	.63
State expanded Medicaid	189	0.94 (0.66–1.34)	.75	176	1.13 (0.74–1.72)	.57

TABLE 3 Continued

	GPI Unit Closures			GPI Unit Openings		
	<i>N</i>	Relative Risk Ratio (95% Confidence Interval)	<i>P</i>	<i>N</i>	Relative Risk Ratio (95% Confidence Interval)	<i>P</i>
County population ages 0–19 (mean)	348 660		<.001	277 809		.66
Constant		0.08 (0.04–0.13)	<.001		0.05 (0.03–0.10)	<.001

Multinomial logistic regressions analyzed associations between hospital financial status, system ownership, and the likelihood of closing or opening a GPI unit adjusting for hospital and area characteristics. Standard errors are clustered at the hospital level.

^a Altman's Z-score is the output of 4 different financial ratios: liquidity ([current assets - current liabilities]/total assets), profitability (fund balance/total assets), efficiency ([net patient revenue - total operating costs]/total assets), and net worth ([total assets - total liabilities]/total liabilities) (Lord, et al 2020). The Z-scores were then converted into quartiles of hospital financial health for each year of the study period.

^b A health system is defined as containing a minimum of 1 general acute care hospital, 10 primary care physicians whose primary billing Taxpayer Identification Number (TIN) is owned or managed by the system, and 50 total physicians primarily billing under a system TIN. The minimum set of providers must be located within a single healthcare referral region (Beaulieu, et al 2023).

^c Defined if self-identified as such on any of our survey sources (Beaulieu, et al 2023).

^d Includes specialty and women's hospitals.

^e Services lines indicate whether the hospital had the listed unit in the year of the GPI unit opening or closure.

This study focuses on the state of GPI units before the COVID-19 pandemic, a period that is important to understand before examining shifts in pediatric care that occurred because of the pandemic. The COVID-19 pandemic changed the landscape of how hospitals provided and were reimbursed for patient care. Research has shown that hospital operating margins declined notably during the pandemic as hospitals experienced low volumes of care. At the same time, overall hospital profit margins remained at previous years' levels because of the extensive relief from the federal government. It is unclear currently how these findings translate into the provision of general pediatric inpatient services and whether GPI units were more likely to close, open, or remain operating during the pandemic. With this study and others that examine the pandemic period, we are beginning to have a better understanding of how hospitals' financial status may fluctuate under steady-state and pandemic circumstances and how that may impact the provision of GPI services. Further work should involve linking hospital discharge data to structural datasets like the HSPD to analyze the clinical demand being placed on hospitals and their GPI units before and during the COVID-19 pandemic.

This study has several limitations. First, from our study alone, it is unclear how changes in the number of GPI units affects both bed counts and pediatric inpatient volume. Although there was a net closure rate across our study period, this could have resulted in more efficiently organized units or an increased regionalization of care. This is especially pertinent as systems become the dominant owners of GPI units. Second, we do not have information on specific unit-level financials. Overall hospital financial health was not indicative of whether a hospital would close or open a GPI unit, and more granular data on the unit-level may provide a more complete picture on how hospital financials influence changes in service lines. Third, we do not have robust information on unit-level bed counts or how general pediatric services are structured at the hospital level. Because of this, we are unable to show the relative changes in pediatric inpatient beds during the study time.

CONCLUSIONS

The number of GPI units is important to understand as the pediatric population needing hospitalization is becoming increasingly complex and as concerns over caring for children in future pandemics are growing. There has been more substantial research^{33,34} into the number and location of neonatal intensive care units over time, but similar depth and breadth of research does not exist for GPI units. Further studies on the effects of changes in GPI units are needed, as well as continued data to compare this study's trend with that during and following the COVID-19 pandemic.

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What's behind an increase in closures of pediatric units

Oct 15, 2022 5:30 PM EST

This week, the New York Times reported a nationwide wave of hospitals shutting down their pediatric units. Though the pandemic, loss of staff and more profitable adult patients are a few key factors, the problem has been decades in the making. Dr. Scott Krugman, vice chair of the Department of Pediatrics at Herman and Walter Samuelson Children's Hospital, joins Geoff Bennett to discuss.

Read the Full Transcript

Notice: Transcripts are machine and human generated and lightly edited for accuracy. They may contain errors.

Geoff Bennett:

We're going to shift our focus now to another crisis of care, this one involving children brought to our attention by reporting this past week by the New York Times, a nationwide wave of hospitals closing the doors of their pediatric units. The COVID-19 pandemic loss of staff and more profitable adult patients are just a few of the key factors. But this problem is decades in the making, from 2008 to 2018, there was a 20% decline in the number of hospitals with inpatient pediatric care units, leaving many families to travel far to find care for their children.

Joining us now to talk about this is Dr. Scott Krugman. He's Vice Chair of the Department of Pediatrics at Herman and Walter Samuelson Children's Hospital at Sinai Hospital in Baltimore. And he's also Professor of Pediatrics at Georgetown University School of Medicine. Thanks for being with us.

Scott Krugman, Herman & Walter Samuelson Children's Hospital: Thank you for having me.

Geoff Bennett:

So, what exactly is driving the pediatric unit closures at hospitals across the country, and just how widespread of an issue is this?

Scott Krugman:

So, you mentioned a lot of the key drivers and really the biggest one really is money, our healthcare system, unfortunately, is set up for profit. And most hospitals try to make enough money to keep investing and survive. So, hospitals are prioritizing things that make money which is adult services, like surgeries, and oncology, and orthopedics. And that shuts out the low yield specialties like pediatrics. And when you have something that costs a lot, and there's low volume, there's very little incentive to keep it going.

Attachment 12F

Geoff Bennett:

Why is it so critical to have doctors trained in pediatric care, and not just have experienced generalists who can also provide care for children?

Scott Krugman:

So, a lot of us who go into pediatrics job because we really like taking care of kids and not adults, and people who go into adult medicine like to go take care of adults and not kids, and they really are very different physiologies, different disease conditions. And we've demonstrated over the years that when kids are taken care of by nurses and doctors and staff trained to be pediatric friendly, and pediatric skilled, they do a much better job. And while the General Hospital with adult providers and emergency room or family physicians can do a good job to stabilize kids, those with really significant illnesses and chronic conditions, often need pediatric specialists. And we train three to six years sometimes more to be able to do these things.

Geoff Bennett:

What have you seen in your own experience? I mean, how does the loss of pediatric beds and hospitals affect children and their families directly?

Scott Krugman:

So, the biggest thing we're seeing across the country is kids having to wait or travel long distances to get definitive care. And by definitive care means you show up to a place and you have a condition that gets treated and the child gets discharged and is better. And what's happening now is, in rural areas, they have to travel very long distances to children's hospitals. And even in urban areas, and states like Massachusetts and Maryland, many community in hospitals in the suburbs have shut down. So even if a child shows up, not that far from the Children's Hospital, they still might have significant wait times and have to sit in, in general ER, for hours and hours waiting for transport to that Children's Hospital. And that delay and care has risk, it has a potential of the child getting worse, or maybe a potential outcome like they didn't make it when they should have.

Geoff Bennett:

So why doesn't that factor into the decision making of these hospitals when they decide to close these pediatric units?

Scott Krugman:

Well, it does for some, and you got to give a lot of hospitals credit that they keep their pediatric units open, despite losing money. And despite the challenges of finding staff and keeping staff trained, and many hospitals still do that across this country. But more and more hospitals are looking around the area and saying, you know what, it's only 10 miles to the Children's Hospital. Why are we bothering do this? It's too hard. It's costing too much money. So, every hospital makes their own decision.

Scott Krugman:

So, I think there's a couple things that we need to look at as a country. One is how are we paying for medical care for kids in general. So, we have Medicare, which is a safety net program for adults over 65. And that sort of sets the floor for payment. So, if you're a hospital taking care of adults, you at least know you're getting Medicare rates. And usually when you have adults with other types of insurance, they're actually getting more than Medicare rates.

The floor for kids is actually Medicaid. And Medicaid pays much less than Medicare. Sometimes it's like 70% on the dollar, so 70 cents for each dollar. And that's just not covering the costs. And that doesn't cover the cost of kids who don't even have insurance and it doesn't cover the cost of what it takes to have a fully trained staff and 24/7 pediatricians and child life and all the other ancillary services you need to take for kids. So, we really need to have a system that prioritizes care for kids. And sets up what is done in rural hospitals like a guaranteed payment. If you take care of kids, you will be paid as a hospital and be kept total so that we can keep these places open and have the people needed to do what needs to be done.

Geoff Bennett:

Dr Scott Krugman, thanks so much for your insights and for your time, I appreciate it.

Scott Krugman:

Thank you for having me.

As Hospitals Close Children's Units, Where Does That Leave Lachlan?

Adult beds are more lucrative than children's beds. So as institutions look to boost profit margins, pediatrics is often among the first services to be cut.



By Emily Baumgaertner

Oct. 11, 2022

BROKEN ARROW, Okla. — It was Lachlan Rutledge's sixth birthday, but as he mustered a laborious breath and blew out one candle, it was his mother who made a wish: for a pediatric hospital bed in northeast Oklahoma.

The kindergartner has a connective tissue disorder, severe allergies and asthma. Those conditions repeatedly landed him in the pediatric intensive care unit at Ascension St. John Medical Center in Tulsa, with collapsed veins and oxygen levels so low, he was unresponsive to his mother's voice.

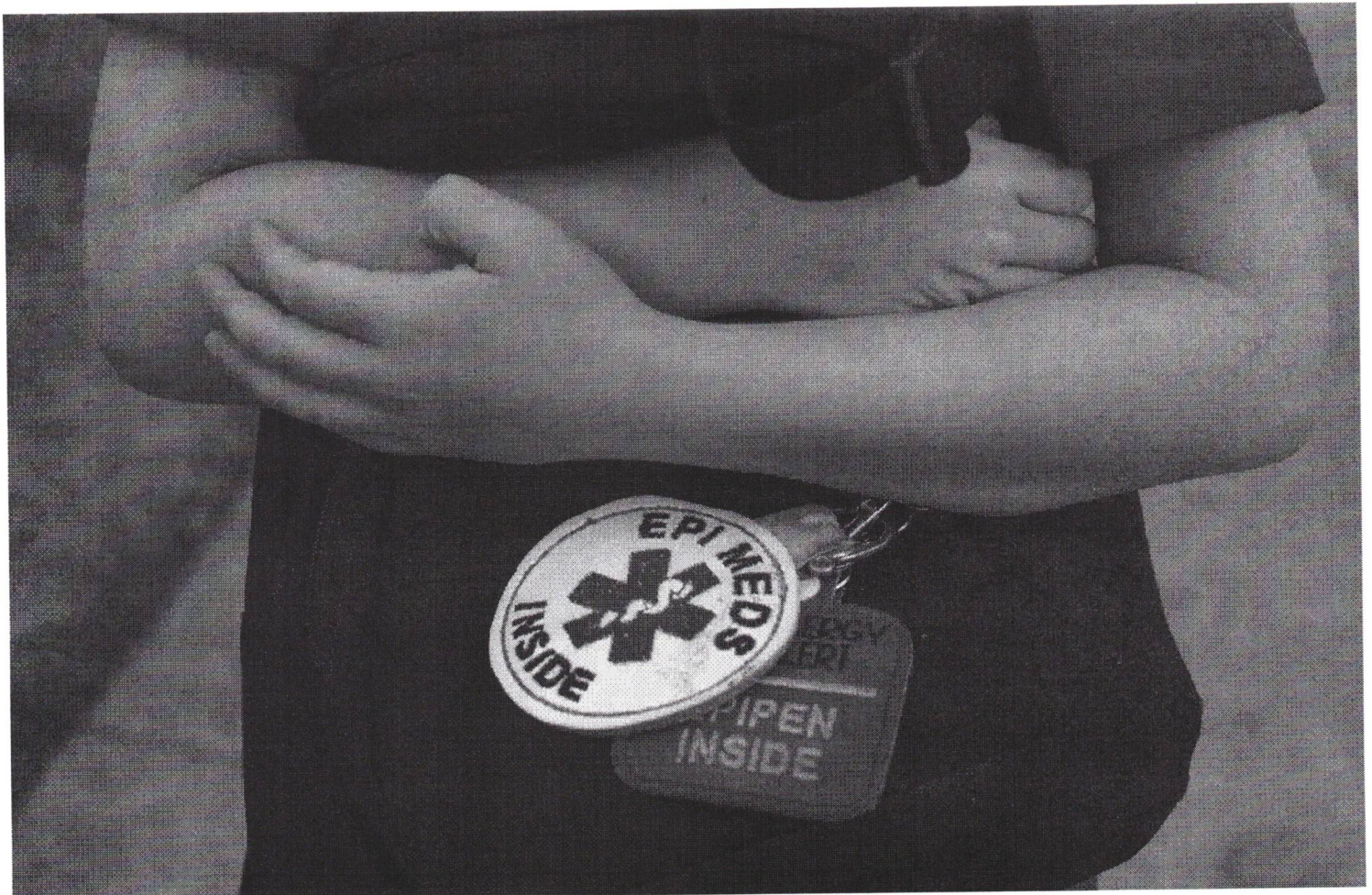
But in April the hospital closed its children's floor to make room for more adult beds. So on a September morning, after coming down with Covid for the fourth time and with what looked like bilateral pneumonia, Lachlan was struggling to breathe in an overcrowded emergency room at the Children's Hospital at Saint Francis — the only remaining inpatient pediatric option in Tulsa.

"We're always preparing for battle. It's just a question of where we're going to fight," said his mother, Aurora Rutledge, looking frightened as she twisted the blond ringlets that poked out from under Lachlan's Spider-Man headphones.

Hospitals around the country, from regional medical centers to smaller local facilities are closing down pediatric units. The reason is stark economics: Institutions make more money from adult patients.

In April, Henrico Doctors' Hospital in Richmond, Va., ended its pediatric inpatient services. In July, Tufts Children's Hospital in Boston followed suit. Shriners Children's New England said it will close its inpatient unit by the end of the year. Pediatric units in Colorado Springs, Raleigh, N.C., and Doylestown, Pa., have closed as well.

"They're asking: Should we take care of kids we don't make any money off of, or use the bed for an adult who needs a bunch of expensive tests?" said Dr. Daniel Rauch, chief of pediatric hospital medicine for Tufts Medicine, who headed its general pediatric unit until it closed over the summer. "If you're a hospital, that's a no-brainer."



Lachlan's backpack is full of EpiPens and medications — and clear labeling — to manage his allergies when he's at school. Melissa Lukenbaugh for The New York Times

26-026

Many hospitals have converted children's beds to adult I.C.U. beds during the pandemic and are reluctant to change them back. Now, staff shortages, inflation — drug costs have increased 37 percent per patient compared to prepandemic levels — low Medicaid reimbursement and dwindling federal subsidies granted during the pandemic have left some health centers operating on negative margins and eager to prioritize the most profitable patients.

Young patients like Lachlan, who has private insurance, occupy beds to recover from infections or asthma attacks but don't undergo lucrative, billable procedures — like joint or heart surgeries — that are more common among aging patients.

Physician reimbursement through Medicaid, the insurance program for low-income people, is often only about 70 percent of the amount reimbursed through Medicare, the insurance program for elderly people of all incomes. More than a third of children in the United States are enrolled in Medicaid.

There have been no aggressive legislative efforts to keep hospitals from closing or shrinking their pediatric units. Democratic senators introduced a bill last year to grant funding to specialized children's hospitals to improve their infrastructure, but it has not moved past the assigned committee.

Health policy experts say an important solution would be to encourage hospitals to care for children by increasing Medicaid reimbursement rates. But even higher Medicaid and private rates wouldn't come close to what hospitals can charge for remunerative adult procedures, and with many state budgets already strained, experts say the regulatory move is unrealistic.

Hospitals that no longer admit children rely on transferring them to pediatric units at other hospitals. But when even the largest pediatric floors in the country are at capacity, the pileup of critically ill children in E.R.s can cause patients' conditions to worsen.

An E.R. crush



Lachlan during a recent visit to the overcrowded emergency room at The Children's Hospital at Saint Francis — the only remaining inpatient pediatric option in Tulsa. Emily Baumgaertner/The New York Times

26-026

“Picu kids don’t belong here,” an overwhelmed E.R. doctor in a small Boston area hospital wrote two weeks ago to his hospital’s chief medical officer in an expletive-ridden text message reviewed by The Times. (P.I.C.U. is the acronym for pediatric I.C.U. The text message was shared on the condition that the hospital not be identified.)

Every I.C.U. for children in Boston was full at the time, and the nearest open beds were in New Haven, Conn., and Vermont. The doctor who sent the text message considered intubating the child in the E.R. while he waited for a closer bed to become available.

As children return to school, waves of illnesses are overrunning many of the units that remain.

“Forget the two-week January crush. We couldn’t find beds in May or August or September,” said Dr. Melissa Mauro-Small, the chief of pediatrics at Signature Healthcare Brockton Hospital, near Boston. “There is no more respiratory season. It’s respiratory season year-round.”

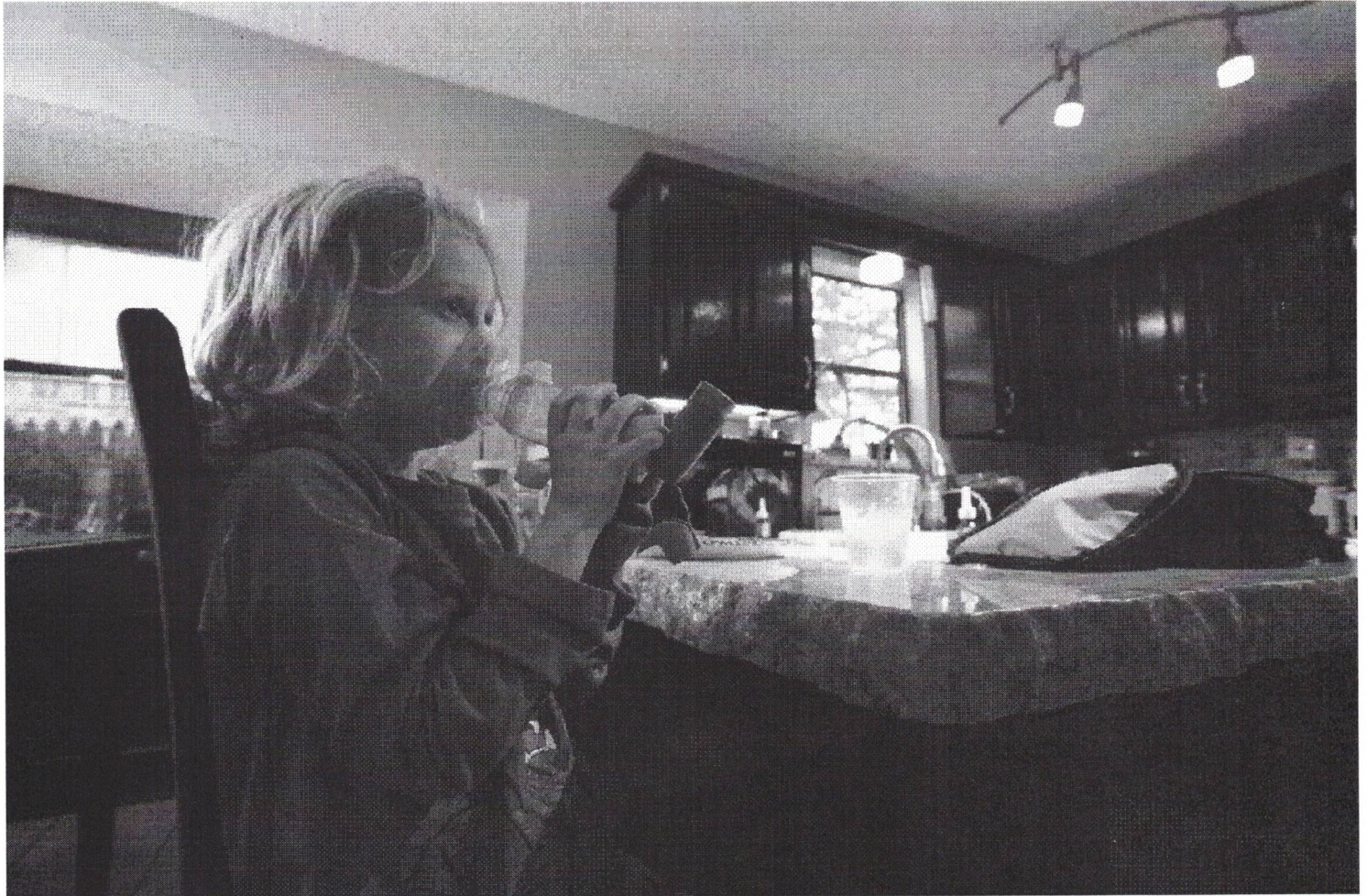
A hospital in Plymouth, Mass., that had not transferred a patient to Dr. Mauro-Small’s hospital in a decade did so six times in 10 days recently, she said. The E.R. staff at Lowell General Hospital outside Boston had to ask eight hospitals across New England whether they had room for an intubated 2-year-old, according to patient charts reviewed by The Times. It transferred another patient to the closest I.C.U. bed available — in Maine.

“At some point, this was going to become a crisis,” Dr. Mauro-Small said. “And here we are.”

St. John Medical Center in Tulsa had been a community treasure for almost a century when Ascension acquired it in 2013. The closure of the pediatric unit triggered opposition from both families and referring pediatricians.

26-026

Dr. Michael Stratton, a pediatrician in Muskogee, Okla., said Ascension St. John had been “the number one place to send a child,” and its pediatric unit closure had been “such a huge disservice to all of eastern Oklahoma.”



Lachlan's morning routine involves time with the inhaler after breakfast while preparing for school. Melissa Lukenbaugh for The New York Times

A spokeswoman for Ascension St. John, where Lachlan had been admitted to the I.C.U. three times before the closure, declined to be interviewed but said in an email that the closure was driven by a demand for more adult beds. She also pointed to past statements that said the Children's Hospital at Saint Francis was “more than capable of picking up the slack.”

A spokeswoman for the Children's Hospital at Saint Francis said that it had occasionally reached full capacity and that the staff transferred about 23 patients to other facilities, including in Arkansas, so far this year.

Attachment 12G

26-026

The E.R. “was busy even prior to the closure of the St. John’s pediatric unit,” she said. Still, she said the hospital had not become overburdened. “Volume is fairly consistent with what we usually see on a seasonal basis,” she said.

Some Oklahoman families with chronically ill children say they routinely drive to Memphis, St. Louis and Rochester, Minn., for care. The distances cause financial strain and, in the worst cases, cause them to forgo care, said Katy Kozhimannil, director of the University of Minnesota Rural Health Research Center.

For those in rural communities, pediatric closures have made travel to what Dr. Rauch calls “bread-and-butter pediatrics” untenable. Sixteen-year-old Johnny in Childress, Texas, had to be home-schooled so he could travel eight hours to Dallas for dialysis treatment three times a week, according to his doctor.

Jamaal Bets His Medicine, a 2-year-old with an autoimmune disease in Fort Kipp, Mont., routinely takes an 11-hour trip to Billings, Mont., to receive infusions, his mother, Patricia, said.

'Children are not small adults'

26-026



Lachlan and his mother, Aurora Rutledge, outside the Saint Francis Emergency Center. Melissa Lukenbaugh for The New York Times

26-026

The decline of local access to children's inpatient care began over a decade ago and accelerated during the pandemic. Between 2008 and 2018 — the most recent national data available — pediatric inpatient units in the United States decreased almost 20 percent, and nearly a quarter of children found themselves farther from their nearest pediatric unit.

The steepest decline in pediatric inpatient beds was in rural regions, where large health systems acquired community hospitals and consolidated pediatrics to one campus.

Centering pediatric care in specialized centers can erode a local hospital's ability to care for a critically ill child, doctors say.

"Children are not small adults," said Dr. Meredith Volle, a pediatrician at Southern Illinois University School of Medicine in Springfield, Ill., who routinely sees patients who travel from two to three hours away. The number of pediatric beds in Illinois has declined, and 48 of its counties now have no pediatrician at all.

"When nurses and respiratory therapists become less comfortable with children's cases, when the units don't have child-sized equipment," Dr. Volle said, "at a certain point, you really shouldn't treat kids anymore because you don't treat them often enough to be good at it."

Critically ill children are four times as likely to die in hospitals and twice as likely to die in trauma centers that scored low on a "pediatric readiness" test, according to research. Only one-third of children in a national research survey had access to an emergency department deemed highly "pediatric-ready," and of those, nine out of 10 lived closer to a less-prepared one.

A parent who is unaware of the wide variability, said Dr. Katherine Remick, the executive director of the National Pediatric Readiness Quality Initiative, "could make a split-second decision that changes their child's fate."

Lachlan's life

26-026



“We’re always preparing for battle. It’s just a question of where we’re going to fight,” said Ms. Rutledge. Melissa Lukenbaugh for The New York Times

The Rutledge family lives in Broken Arrow, a sunny Tulsa suburb with a frozen custard shop and a dentistry called Super Smiles. Their front porch is home to potted succulents, an abandoned scooter and a 140-pound Great Dane named Thor.

But their lives are far from ordinary. The last time Lachlan needed to see an allergy specialist, his mother packed the car with his nebulizer and medications for a 14-hour drive to Denver, leaving her husband, their two other sons and her mother, who was undergoing chemotherapy, for two weeks. Later, when doctors told her that Lachlan’s disorder appeared to be causing stomach ulcers — but that the sole pediatric gastroenterologist at Saint Francis wasn’t available for months — she began planning a journey to Dallas.

Attachment 12G

26-026

On the September morning that Lachlan was in St. Francis struggling to breathe, the E.R. was so busy that Ms. Rutledge hooked him up to a pulse oximeter herself, quieting the monitor's settings so it wouldn't frighten him every time his heart rate spiked.

Lachlan tugged at his collar bone, his chest looking retracted. Five hours later, he still hadn't been admitted. Ms. Rutledge's hands trembled and tears streamed down her face.

"I know you guys are exhausted at this hospital, and I get it," she shouted, leaning over Lachlan's bed to level her eyes with the attending physician on the other side. "But you will not send this child home so he can watch his own vitals drop."

Lachlan was discharged from the E.R. after 10 hours with a course of steroids to fight the inflammation in his lungs. He sleeps in his parents' bedroom so they can check his oxygen levels and administer nebulizer treatments every few hours throughout the night.

Emily Baumgaertner is a national health reporter for The Times, focusing on public health issues that primarily affect vulnerable communities.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: As Hospitals Chase Profitable Patients, Beds for Children Vanish

1110.120 – Project Scope, Utilization, and Unfinished/Shell SpaceALTERNATIVES

The project proposes the construction of a health care facility of approximately 299,000 sq ft, composed of a new pediatric hospital and outpatient care clinic building. The project will be located on property being acquired by Ann & Robert H. Lurie Children’s Hospital of Chicago (“**Lurie Children’s**”) in Downers Grove, Illinois, immediately south of Butterfield Road and immediately west of Highway 355. The project is designed to primarily serve patients residing in the West Region, including a significant number of pediatric patients living in western suburban communities who come to Lurie Children’s downtown for their inpatient care. The project will also allow for Lurie Children’s to vacate their aging outpatient center in Westchester and shift services provided in Westchester to the Downers Grove facility.

There were several alternatives considered in the planning process:

1. Add capacity at Lurie Children’s in Streeterville (“**Lurie Children’s - Streeterville**”).
2. Expand the existing Westchester facility.
3. Select a different location or existing facility in the West Region.
4. Build a larger facility at the selected site.
5. Selected Project: Construct a 48-bed pediatric hospital with outpatient services in an adjacent clinic building.

1. Add capacity at Lurie Children’s - Streeterville

Since it relocated from Lincoln Park in 2012, Lurie Children’s has been serving pediatric patients and their families from its main location on the Streeterville campus of Northwestern University. It opened with 144 medical/surgical pediatric beds, 92 ICU beds and 12 acute mental illness (“AMI”) beds. Since then, it has experienced significant growth.

The increasing occupancy of inpatient units and ambulatory services downtown over the past decade resulted in many projects to adjust the facility, including adding beds. In order to serve the region by accommodating increasingly complex clinical cases, Lurie Children’s has increased its ICU capacity from 92 to the current 162 ICU beds. Two projects added 66 ICU beds by converting administrative and other support space into bed units (CON projects 16-050 approved by HFSRB in May, 2017 and 17-054 approved in February, 2018). In addition, Lurie Children’s has completed several projects in the last ten years to expand its outpatient services, opening outpatient centers in Northbrook (Project 16-044), Skokie (Project 19-012), and Schaumburg (Project 22-032), while maintaining the high-volume outpatient center at Clark and Deming in Chicago. In 2025, Lurie Children’s added 4 new AMI beds for 16 total.

Lurie Children’s is expected to be at full capacity by the end of this decade.

The Alternative of adding capacity on the downtown Chicago campus was considered and rejected. Dealing with space constraints would require significant capital investment to accommodate additional capacity, if it were to be feasible at all. The density of the downtown location also presents access and parking challenges for patients and families. The service area spans the entire Chicago metropolitan area; about 60% of med/surg pediatric bed inpatients at Lurie Children’s reside outside

Chicago and a significant number have advocated for Lurie Children's to deliver inpatient care closer to their homes. The current location of Lurie Children's - Streeterville does not have available options for expansion, nor is it geographically or conveniently accessible to serve broad sections of the regional population.

Additionally, the downtown campus is envisioned to become more focused on high-acuity, tertiary-level care with a cost model that might be too challenging for accommodating expanded lower-acuity pediatric services. Serving more low and moderate acuity pediatric patients downtown is not an appropriate strategy.

There is no ability to accommodate 299,000 sq ft of clinical and support space at or near the downtown campus. Even if it were possible, dislocations of existing services and extended implementation time sequences would be necessary to accommodate such a project downtown. An estimated cost of such a project would be at least \$500 - \$600 million, or 20% higher than the proposed project.

2. Expand the existing Westchester facility

Lurie Children's Hospital Outpatient Center in Westchester at 2301 Enterprise Drive has been in service since 1989. The facility includes an Ambulatory Surgical Treatment Center with three operating rooms. Multi-specialty outpatient services provided by Lurie Children's pediatricians and medical and surgical specialists include: Adolescent & Young Adult Medicine, Audiology, Cardiology & Cardiac Surgery; Dermatology; Endocrinology, Gastroenterology & GI Surgery, Medical Imaging, Nephrology, Neurosurgery, Ophthalmology, Orthopedics, Orthotics & Prosthetics, Otolaryngology, Pathology & Laboratory Medicine, Plastic & Reconstructive Surgery, Psychiatry & Behavioral Health, Rehabilitative Services, Sports Medicine, General Surgery and Urology.

Medical equipment at the center includes Echocardiogram, Electrocardiogram, Fetal Echocardiogram, Holter & Event Monitoring, MRI, Neuroimaging, Ultrasound, Video EEG, x-ray and a Clinical Neurophysiology Lab. There are no inpatient beds at the facility. The building is 37,134 square feet.

Continuing current operations at the existing Westchester facility does not support long-term sustainability or regional access goals. Expansion of the facility was not pursued because the site has limited physical capacity for expansion to accommodate the program planned at the new facility. In addition, the existing building has surpassed its useful life and requires increasingly costly maintenance. The current site provides no inpatient services and lacks the commercial visibility and accessibility required to effectively serve the planning region.

Site size limitations prevent consideration as an option for the location of the future inpatient and outpatient center. As a result, there is no capital cost estimate for this alternative.

3. Select a different location or existing facility in the West Region

Lurie Children's evaluated six other sites within the region, including properties with existing buildings and properties with open land. Each presented significant conversion and development challenges, including site constraints, infrastructure limitations, and the inability to accommodate project goals and pediatric-specific programming. These options did not offer sufficient flexibility to support phased development or potential future expansion and were therefore not considered viable long-term solutions.

The other sites varied in purchase price, but none were functionally or programmatically acceptable compared to the Downers Grove site. Other sites considered require higher site development costs and off-site improvement costs compared to the Downers Grove site.

4. Build a larger facility at the selected site

Project planning included significant market analysis and assumptions about the continued future operations of existing pediatric services in the West Region. As mentioned in other sections of this permit application, seven hospital pediatric units with 59 authorized pediatric beds in the West Region closed during the last 12 years. These closures were a subset of the 27 pediatric unit closures in the Chicago metropolitan area, reducing authorized pediatric beds by more than 300. In 2024, four existing pediatric units at hospitals located in the West Region had low average daily census (each less than or equal to one patient). Other hospitals in the area with no authorized pediatric beds have limited back up for their pediatric care compared to hospitals with inpatient pediatric units. Lurie Children's does not make predictions about the potential for closures of pediatric units with low census units. Nor does Lurie Children's speculate whether hospitals without pediatric units will continue to serve pediatric patients. While it is likely that there will be fewer pediatric units in the future, institution-specific shifts of patient volumes were not part of the projected future volumes at the proposed facility.

A larger facility (more than 48 pediatric beds, a larger emergency department, a larger surgery department and 60 exam/treatment rooms in the outpatient clinic) was considered as a "full build-out option." This option was considered but rejected. The volume forecasts behind the proposed project are conservative. Moreover, the magnitude of the capital investment required for a larger facility and the associated operational risks of that alternative were noted. Proceeding with a larger facility would reduce flexibility to incrementally adjust scope based on community demand and service utilization. A phased approach based on the monitoring of future market events and area provider commitments to their existing pediatrics programs in the future allows for prudent investment, operational scalability, and the ability to align facility development with demonstrated need over time.

Various larger facility options that were considered had associated capital costs ranging from \$550 million to \$600 million.

5. *Selected Project: Construct a 48-bed pediatric hospital with outpatient services in an adjacent clinic building*

Each alternative was assessed against operational feasibility, capital requirements, regional accessibility, patient care quality, and long-term flexibility.

The proposed project was viewed as appropriately scaled to address community needs. The project contains 48 pediatric beds, a 35-room emergency department, a surgical department with 6 ORs, diagnostic imaging, pharmacy and laboratory. Other clinical and non-clinical support services are included. An adjacent connected clinic building is designed with 50 exam/treatment rooms. The project is sized as 298,669 sq ft with a total construction capital cost of \$278 million.

Located at the intersection of Highway 355 and Butterfield Road, the currently vacant site has high accessibility in the west suburbs.

The proposed project in Downers Grove is intended to relieve some of this capacity pressure on the downtown campus by serving patients residing in the West Region with a facility closer to their homes.

Related to this shift, Lurie Children's will no longer concentrate all of its inpatient activity on the downtown campus. It will transition to a regional health care delivery system, with inpatient beds in selected suburban areas, and significant outpatient centers, such as the new Lurie Children's Outpatient Center in Schaumburg that opened in the fall of 2025. The new facility in Downers Grove will not duplicate the tertiary and quaternary services centered on the downtown campus, but will provide pediatric specialty community hospital care.

After careful evaluation of all feasible options, Lurie Children's determined that the proposed pediatric facility in Downers Grove represents the most effective, cost-efficient, and strategically aligned approach to meeting current and projected community needs.

1110.120 – Project Scope, Utilization, and Unfinished/Shell Space**SIZE OF THE PROJECT**

The project is the construction of a new hospital and clinics building on vacant property in Downers Grove. The total size of the project is 298,669 sq ft, of which 132,577 sq ft is clinical, and 166,092 sq ft is non-clinical space. The table below shows that all clinical spaces in the project meet State standards.

The project includes two stacked floors with 48 pediatric beds in private rooms. To enhance future flexibility, all 48 rooms are sized as ICUs; 12 of the rooms will be built for conversion to ICUs with a minimum of capital cost. The 48 rooms are all classified and authorized as pediatric rooms. If there is a conversion of some of these rooms to ICU in the future, Lurie Children's will submit a permit application for the establishment of an ICU service.

Space Allocations and Comparisons to State Standards
Lurie Children's – Downers Grove Hospital & Outpatient Clinic

Clinical Area	Proposed DGSF	State Standard	Allowed by Standard	Difference	Meet State standard?
Pediatric Beds (48)	31,171	560-660 DGSF / Bed x 48 beds	< 31,680	509	Yes
Emergency Stations (35)	23,803	900 DGSF / Station x 35	< 31,500	7,697	Yes
Surgery (6 ORs)	28,280		< 28,420	140	Yes
		2,750 per OR x 6	< 16,500		
		180 DGSF per Recovery Station I x 4	< 720		
		400 DGSF per Recovery Station II x 28	< 11,200		
Imaging					
X-Ray (3)	2,396	1,300 DGSF per unit x 3	< 3,900	1,504	Yes
Ortho EOS (1)	599	1,300 DGSF per unit	< 1,300	701	Yes
Fluoroscopy (1)	803	1,300 DGSF per unit	< 1,300	497	Yes
Ultrasound (2)	638	1,800 DGSF per unit x 2	< 3,600	2,962	Yes
MRI (2)	2,894	1,800 DGSF per unit x 2	< 3,600	706	Yes
CT (1)	950	1,800 DGSF per unit	< 1,800	850	Yes
Exam/Treatment (50)	17,578	800 DGSF per room x 50	< 40,000	22,422	Yes
Testing	5,740	NA	---		NA
Sleep Lab	2,978	NA	---		NA
Infusion	3,314	NA	---		NA
Rehabilitation	2,768	NA	---		NA
PT/OT/gym	1,437	NA	---		NA
Lab	4,286	NA	---		NA
Pharmacy	2,942	NA	---		NA
Total Clinical Space	132,577				

1110.120 – Project Scope, Utilization, and Unfinished/Shell SpacePROJECT SERVICES UTILIZATION

Ann & Robert H. Lurie Children’s Hospital of Chicago (“Lurie Children’s”) has prepared forecasts of utilization for each of the clinical service areas. The forecasts are shown on individual tables in Sections 1110.200 and 1110.270 that present factors used to make the projections, historical utilization for the factors, and projected volumes for 2031, two years after project completion.

The factors used to make projections incorporate Lurie Children’s past and current experience in the West Region. For example, inpatient admissions, observation cases and ED visits at Lurie Children’s main hospital in the Streeterville neighborhood of Chicago (“Lurie Children’s - Streeterville”) associated with pediatric residents of the West Region are expected to shift to the new hospital in Downers Grove. These patient counts are considered Referrals from an Inpatient Base, and their historical volumes are documented in the tables. Similarly, outpatient clinic visits and ambulatory surgery volumes at Lurie Children’s Hospital Outpatient Center in Westchester will shift to Downers Grove, upon the planned closure of the Westchester facility following the approval and opening of the Downers Grove project. Forecasts of diagnostic imaging and ancillary testing utilize ratios of procedures and tests associated with current utilization by Lurie Children’s inpatients, observation cases, ED visits and clinic visits. Various other factors behind the projected volumes include service to patients who leave the West Region for hospitalization, and documented requests for transfer that cannot be accommodated due to lack of capacity at the time of request.

Lurie Children’s developed a standard format to present the data. The left column of each table lists the factors driving projected utilization. For most factors, there are four years of historical utilization, 2022 through 2025, recognizing that the COVID years 2020 and 2021 were unusual years, often characterized by lower pediatric patient volumes. For most of the tables, the historical volumes are summarized in a column displaying 4-year averages. In many cases, the average introduces conservative projections, compared to historical years of increasing patient volumes. The tables show for most of the factors the percentages of patients that are expected to shift to Downers Grove. Finally, the columns on the right side of the table show projected year volumes. Each table has footnotes documenting the sources of information. Lurie Children’s has strived for consistency in the use of data across the tables. For example, the four-year average for inpatient admissions (used to justify pediatric beds in 1110.200) is the same volume to which use rates are applied for projecting diagnostic tests on inpatients.

These individual tables are not repeated in this Project Services Utilization section. A summary table on the next page shows the volume information and comparison to state standards for all planned clinical services at the Downers Grove facility.

It is important to note that most of the individual tables show historical volumes for *each component factor* used in projecting future utilization. For example, the x-ray utilization and projection (Table C(1) in Section 1110.270) measures volume from three factors (sources): ambulatory clinic visits, inpatient admissions and observation cases, and ED visits. There are different x-ray use rates for each of these patient types. Consequently, the columns in the table feature historical volumes associated with each patient source, and there are no historical volumes shown in the total row. The application of the use rates does, however, yield totals for future year projections.

**Clinical Services, Historical Volumes, and Utilization Projections
Lurie Children's - Downers Grove Hospital & Outpatient Center**

Clinical Service	Historical Utilization					Projected Utilization			State Standards	
	2022	2023	2024	2025	Avg	Units	2030	2031	Standard	Meets Standard?
Pediatric Beds	11,142	11,392	9,889	9,496	10,480	48 Beds	84.6%	84.6%	80%	Yes
Surgery	18,779	21,341	20,443	21,356	20,480	6 ORs	7,974 hrs	7,974 hrs	1,500 hrs/OR	Yes
Emergency Visits	110,998	106,009	101,515	98,600	104,303	35 Stations	36,248	36,248	2,000/Station	No
							43,679	43,679		
Outpatient Clinic Visits	256,091	272,633	279,049	296,477	276,063	50 Rooms	67,884	71,371	2,000/Room	No
Diagnostic Imaging										
X-Ray	See Section 1110.270, Table C(1)					3 Units	18,617	19,178	8,000/Unit	Yes
Fluoroscopy	See Section 1110.270, Table C(2)					1 Unit	1,709	1,875	6,500/Unit	Yes
Ortho/EOS	See Section 1110.270 (b) (2), Subsection C(6)					1 Unit	2,449	2,735	6,500/Unit	Yes
Ultrasound	See Section 1110.270, Table C(3)					2 Units	6,373	6,544	3,100/Unit	Yes
MRI	See Section 1110.270, Table C(4)					2 Units	3,538	3,770	2,500/Unit	Yes
CT	See Section 1110.270, Table C(5)					1 Unit	6,879	7,088	7,000/Unit	Yes
Ancillary Testing										
Electrocardiogram (ECG)	676	679	743	788	722	1 Unit	795	810	-	-
Echocardiogram (ECHO)	350	350	388	431	380	1 Unit	417	425	-	-
Pulmonary Function Tests (PFT)	286	290	285	268	282	1 Unit	309	315	-	-
Electroencephalogram (EEG)	See Section 1110.270, Table E					1 Unit	2,080	2,080	-	-
Video EEG	See Section 1110.270, Table E					1 Unit	468	468	-	-
Sleep Studies	See Section 1110.270, Table E					4 Units	1,040	1,040	-	-
Infusion	8,461	9,274	9,092	13,803	13,269	10 Rooms	3,569	3,701	-	-
Rehabilitation (incl PT/OT, Gym, Speech, Audiology)	12,018	12,778	12,292	13,026	12,529	1 Room	14,915	15,506	-	-
Laboratory Services	See Section 1110.270, Table H					2 Labs	168,703	169,610	-	-
Pharmacy Services	See Section 1110.270, Table I					1 Pharmacy	293,826	294,001	-	-

Sources: Section 1110.200 (Pediatric Utilization); Section 1110.270, Tables A through I

There are two services that do not meet the State standards: The emergency department and the clinic exam/treatment rooms.

The documentation submitted in support of the emergency department provides data on 68 hospitals that are members of the Children's Hospital Association. The data show that average utilization for the 68 hospital EDs is 1,344 visits/station/year. Of the 68 facilities, 19 are satellite hospitals, similar to Downers Grove, that average 1,115 visits/station/year. With the planned 35 ED rooms that results in a volume of 36,248 visits per year, the ED at Downers Grove is projected to accommodate 1,036 visits per room. Lurie Children's consistently experiences peak volumes in October, November, and December that are 20.5% higher than the annual average of all other months. This volume is the equivalent of an extra 7,400 patients, resulting in an equivalent of 43,679 visits, adjusted for peak months. This average of 1,250 visits per station per year would exceed the national average for satellite children's hospitals.

Further, Lurie Children's practice is to have an emergency room ready as soon as possible after a patient arrives, rather than have patients and family members experience lengthy waits in the ED waiting area. The goal is to have care start and proceed as quickly as possible, but when waiting is necessary, waiting in a room provides more privacy and comfort than the public waiting area affords. The room count is sized, in part, for this purpose.

The clinic volume projection of 71,371 visits is an average of 1,428 visits per room per year. This level of utilization compares to the visit volumes at other Lurie Children's outpatient facilities in metropolitan Chicago.

Section 1110.200 – Medical/Surgical, Obstetric, Pediatric, and Intensive Care

Service	# of Existing Beds	# of Proposed Beds
Pediatrics	0	48

1110.200(b)(1) Planning Area Need – Formula Calculation

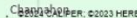
There are two factors relevant to the presentation of Planning Area Need. First, the State’s Need Determination methodology does not separate adult need from pediatric need. As a result, there is not a specific determination of pediatric bed need in the planning area. Second, Ann & Robert H. Lurie Children’s Hospital of Chicago (“**Lurie Children’s**”) has selected its West Region (defined below) as the planning area for this project. The West Region is one of Lurie Children’s five planning regions that cover metropolitan Chicago. The West Region contains communities in several of the State’s designated “Hospital Planning Areas”, but there is not an exact relationship between the West Region and Hospital Planning Area boundaries. Both topics are addressed as follows.

The geography of the West Region contains all of State Hospital Planning Areas A-05 and A-06, most of A-11 and A-12, and smaller fringe parts of A-04, A-07 and A-13. See the map on the following page. The West Region is the large triangular area shaded light purple. The Hospital Planning Areas are overlayed. According to the State’s *Inventory of Health Care Facilities and Services and Need Determinations* (December, 2023, updated through March 2026), there is a combined excess of 633 medical/surgical and pediatric beds in A-05 (excess of 234 beds) and A-06 (excess of 399 beds). A-11 shows a deficit of 52 beds and A-12 an excess of 115 beds. Small parts of Hospital Planning Areas A-07 to the north and A-04 and A-13 to the south are in the edges of the West Region; most of the areas of these three HPAs are outside the West Region. Their need data are as follows: A-04 has an excess of 135 medical/surgical and pediatric beds; A-07 has an excess of 467 beds; A-13 has a deficit of one pediatric bed.

It is important to note that the need calculations do not differentiate between adult medical/surgical and pediatric. In reporting the bed need information above, the major findings of bed need, deficits and excesses relate to adult medical/surgical care.

Because the focus of this project is exclusively pediatric care, the following information is relevant when considering the need for pediatric beds. There are 19 general acute care community hospitals located in the West Region with a total of 135 pediatric beds. Of these 19, only 8 have designated authorized pediatric units. Four of these pediatric units have a total of 86 authorized pediatric beds, with active pediatric service volumes. (Central DuPage Hospital, Loyola University Medical Center, Saint Alexius Medical Center, and Edward Hospital). The other four units, with 49 total authorized pediatric beds, each have an average daily census (ADC) of less than one patient: UChicago Medicine AdventHealth Hinsdale, MacNeal Hospital, Mercy Medical Center – Aurora, and West Suburban Medical Center. Collectively, the combined ADC of these four hospitals in 2024 was 1.0 patient. These hospitals hold authorized pediatric beds in the State inventory, without having programs of substantial volume. Utilization data on these 19 hospitals is shown on a table later in this section.

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For a pediatric population of approximately 539,000 in the West Region, 86 beds at the four general acute care hospitals with active pediatric programs is minimal capacity. The majority of West Region pediatric patients requiring pediatric hospitalization receive that inpatient care outside the area. According to IHA COMPdata, there were 8,248 children ages 0 – 18 residing in the West Region who were hospitalized for inpatient pediatric care in 2024. 3,962 (48%) were admitted at hospitals located in the West Region. The remaining 4,286 children (52%) received care at hospitals outside of the area. Of the 4,286 patients who migrated out of the area, 1,808 (42.2%) were admitted at Lurie Children's. Based on traffic conditions, a significant number of these patients travel more than 60-90 minutes for care at Lurie Children's location in the Streeterville neighborhood of Chicago ("Lurie Children's - Streeterville"), a trip that family members make several times during their child's inpatient stay, not to mention their travel for pre-admission visits and follow up care post discharge. The planned facility that is centrally located in the West Region will provide care much closer to their homes and significantly reduce their travel times. A purpose of the project is to offer a large dedicated pediatric inpatient service to give local residents the option of receiving Lurie Children's care closer to their homes.

The planned facility in Downers Grove will also address the ongoing reduction of inpatient pediatric bed capacity in the West Region. As is the case in Illinois and throughout the US, metropolitan Chicago including the West Region has seen a significant number of pediatric unit closures and reductions of unit sizes over the past decade. 27 hospitals in metropolitan Chicago with a total of 319 authorized pediatric beds closed their units since 2013. Of these, six closed hospital pediatric units with a total of 54 beds are located in the West Region: Elmhurst Hospital (6 beds, 2019), Good Samaritan Hospital – Advocate (7 beds, 2019), Advocate Sherman Hospital (8 beds, 2021), Alexian Brothers Medical Center (16 beds, 2018), Gottlieb Memorial Hospital (4 beds, 2023), and Saint Joseph Hospital – Elgin (13 beds, 2025). A 5-bed pediatric unit was discontinued as part of the total closure of Westlake Hospital. An additional net reduction of 46 pediatric beds is attributed to units that were downsized but not closed in metropolitan Chicago during the same timeframe.

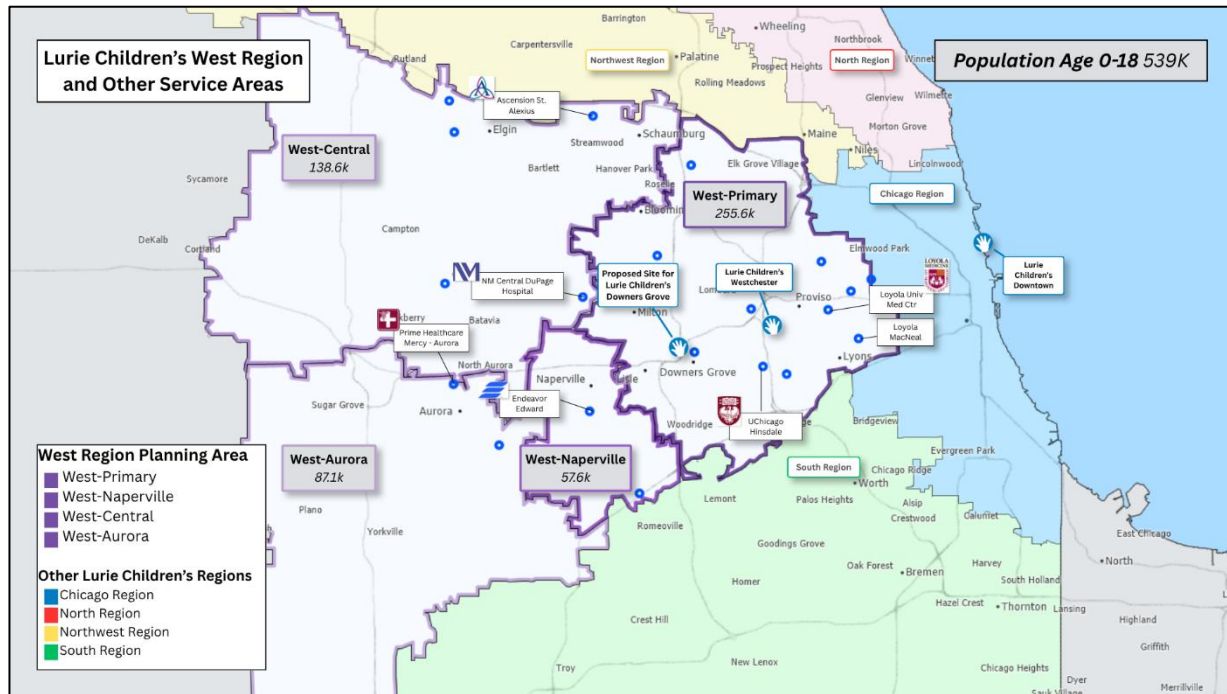
1110.210(b)(2) Planning Area Need – Service to Planning Area Residents

Lurie Children's has identified five regions in northeastern Illinois that are used to guide planning for the delivery of pediatric health care services: Chicago, North, Northwest, South and West. Lurie Children's has facilities and/or established affiliations with providers in each of these five regions.

The "West Region" is selected as the Planning Area for the project. The planning area has an estimated population of 539,000 pediatric residents, ages 0 – 18. It is made up of a Primary Service Area and a Secondary Service Area. The Primary Service Area ("West-Primary") has a pediatric population of 255,600. The Secondary Service Area has three sub-areas: West-Naperville (population of 57,600), West-Central (138,600), and West-Aurora (87,100). The following map shows the West Region and its sub-areas, and the locations of hospitals in the West Region with designated pediatric units.

The table following the map shows the patient origin for 1,179 admissions at Lurie Children's Hospital from ZIP codes of the West Region, 2024. 681 of these admissions were from the Primary Service Area; 498 were from the three sub-areas of the Secondary Service Area.

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Service Area Population & Lurie Children's Admissions by West Region ZIP Code

Primary Service Area	ZIP	City	CY25 Pediatric Population	CY22	CY23	CY24	CY31
West-Primary	60804	Cicero	20,894	66	96	99	
	60402	Berwyn	13,673	45	33	41	
	60707	Elmwood Park	7,897	40	28	38	
	60302	Oak Park	6,520	20	33	32	
	60137	Glen Ellyn	9,273	20	23	31	
	60126	Elmhurst	10,983	34	17	29	
	60139	Glendale Heights	6,874	15	11	26	
	60517	Woodridge	6,765	10	4	23	
	60153	Maywood	5,247	18	13	20	
	60187	Wheaton	6,236	8	7	20	
	60148	Lombard	10,516	9	18	19	
	60525	La Grange	6,629	29	18	17	
	60164	Melrose Park	4,537	15	18	17	
	60513	Brookfield	4,189	5	15	17	
	60558	Western Springs	3,429	11	3	17	
	Other West-Primary		135,022	276	294	235	
West-Primary Subtotal			258,684	621	631	681	
Secondary Service Area	ZIP	City	CY25 Pediatric Population	CY22	CY23	CY24	CY31
West-Naperville	60440	Bolingbrook	11,159	25	42	50	
	60565	Naperville	8,730	8	12	16	
	60490	Bolingbrook	4,992	22	9	16	
	60564	Naperville	10,566	18	27	15	
	60555	Warrenville	3,049	5	11	8	
	60540	Naperville	9,177	22	21	8	
	60563	Naperville	8,221	8	8	5	
West-Naperville Subtotal			55,894	108	130	118	
West-Central	60193	Schaumburg	8,291	15	14	23	
	60169	Hoffman Estates	6,692	15	21	20	
	60185	West Chicago	7,690	10	6	19	
	60177	South Elgin	5,680	1	12	17	
	60140	Hampshire	5,861	10	14	15	
	60107	Streamwood	7,781	11	17	15	
	60134	Geneva	6,676	16	24	14	
	60103	Bartlett	8,387	6	6	13	
	60124	Elgin	6,066	7	5	13	
	60173	Schaumburg	2,918	4	1	10	
	Other West-Central		72,607	88	109	76	
West-Central Subtotal			138,649	183	229	235	
West-Aurora	60505	Aurora	14,105	21	20	42	
	60560	Yorkville	7,160	7	10	17	
	60506	Aurora	11,318	13	11	15	
	60504	Aurora	9,368	17	15	14	
	60585	Plainfield	6,941	10	14	12	
	60543	Oswego	10,238	14	14	9	
	60538	Montgomery	8,067	5	13	8	
	60545	Plano	3,561	2	5	8	
	60503	Aurora	4,577	11	5	8	
	Other West-Aurora		10,381	10	22	12	
West-Aurora Subtotal			85,716	110	129	145	
West Region Total			538,943	1,022	1,119	1,179	2,150
Outside West Region							550
Grand Total Admissions (Observation cases not included)							2,700

Sources/Filters:

- Pediatric Population: Claritas Pop-Facts 2025, Sg2 Analytics; Population Age: 0-18 by ZIP code
- Lurie Children's Admissions: Lurie Children's Enterprise Decision Support Database; Aggregate encounter data used for IDPH AHQ Surveys; Inpatient; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry

1110.200(b)(3) Planning Area Need – Service Demand – Establishment of a Category of Service

Justification of beds needed - Overview

The following table presents the six factors that contribute to utilization forecasts for the proposed 48-bed pediatric unit and justifications for those forecasts. Each of the forecasts is based on historical utilization associated with these six factors. The factors are:

- 1) *Inpatient admissions of pediatric patients residing in the West Region, who have been admitted at Lurie Children's - Streeterville.*

This count of patients includes only those residents with less than tertiary or quaternary conditions. (Patients from the area with tertiary or quaternary needs will continue to go to Lurie Children's downtown for care.) For the past four years, an annual average of **989 patient admissions** from the West Region with less than tertiary or quaternary needs have been hospitalized downtown. In the future, 100% of these patients will be admitted to the hospital in Downers Grove.

- 2) *Pediatric patients residing in the West Region who were pediatric observation cases at Lurie Children's - Streeterville.*

For the past four years, 17% of total observation cases downtown were from the West Region. As shown in the attached table, this contributes **871 annual observation cases** to be cared for at the hospital in Downers Grove.

- 3) *Significant out-migration of West Region pediatric patients admitted to pediatric beds.*

As reported in the Purpose of the Project section, the majority of admissions of pediatric residents are at facilities outside the West Region. Not counting tertiary and quaternary patients and not including the 989 annual patients at Lurie Children already counted in #1 above, the annual average number of residents admitted outside the West Region facilities is 5,973 patients. A very conservative estimate of this volume which can utilize the new hospital in Downers Grove is 20%, or **1,194 pediatric admissions**.

- 4) *Denied requests for transfers of West Region patients to Lurie Children's - Streeterville.*

These denials averaged 667 patients per year, approaching two per day. These were mostly due to lack of pediatric bed availability at the downtown hospital. A conservative estimate is that 25% of these requests, or **167 patient admissions**, can be accommodated at the proposed hospital in Downers Grove.

- 5) *Shift of inpatients residing in the West Region and cared for at other hospitals in the area.*

It is likely that closures and downsizing of pediatric units will continue, as many hospitals prioritize adult inpatient care over pediatrics due to the increased need for adult care, declining birth rates, and the cost of pediatricians. (The Purpose of the Project section of this permit application includes research and professional papers on this topic; see also Section 1110.200(b)(1) above.) Lurie Children's makes no prediction on what future specific closures and downsizing may occur in the West Region. The fact that there are seven hospitals in the West Region with designated pediatric units and four of the seven each have an ADC of less than 1.0 patient may indicate that future unit closures will happen.

The projected volume of cases at the proposed hospital in Downers Grove includes a conservative estimate of patients from other hospitals – either from hospitals with pediatric units or from the 11 hospitals in the region that serve pediatric patients but do not have designated pediatric beds.

According to IHA COMPdata, there was an annual historical average of 4,124 inpatient admissions of patients from the West Region presenting with low to medium acuity. Assuming a conservative shift of 9% of admissions from these area hospitals results in **366 patient admissions** as part of the projected utilization at the Downers Grove Hospital.

- 6) *Shift of observation patients residing in the West Region and cared for at other hospitals in the area.*

Similarly, there was an average of 2,790 observation cases of patients from the West Region receiving care at hospitals in the West Region with licensed pediatric units. A shift of 5% of these cases would contribute a volume of **153 observation cases** as part of the projected utilization at Downers Grove.

In summary, there are a total of 2,715 inpatient admissions and 1,024 observation cases associated with the above six factors. The historical average length of stay for admissions is 5.0 days; the ALOS for observation cases is 1.2 days. Consequently, these factors total 14,809 patient days, or an Average Daily Census of 40.6 beds. 40.6 ADC is an occupancy of 84.6% of the proposed 48 bed unit.

Factors Contributing to Future Projected Utilization – Pediatric Beds
Lurie Children’s – Downers Grove Hospital & Outpatient Center

	Historical Cases						Projected Utilization								
Factor	2022	2023	2024	2025	4-Year Avg	Projection Factor	2026	2027	2028	2029	2030	2031	ALOS	Patient Days (2031)	ADC (2031)
							(Hospital under construction)								
1) IP Admits from Lurie Children's - Streeterville (Low/Med Acuity, West Region Patients)	924	1,008	1,010	1,012	989	100% Shift	989	989	989	989	989	989	5.0	4,945	13.5
2) Observation Cases from Lurie Children's - Streeterville (West Region Patients)	1,013	967	774	731	871	100% Shift	871	871	871	871	871	871	1.2	1,045	2.9
3) Outmigration (West Region Patients leaving West Region, IP Low/Med Acuity, excl Lurie)	6,100	5,987	5,895	5,911	5,973	20% Shift	1,194	1,194	1,194	1,194	1,194	1,194	5.0	5,970	12.3
4) Denied Bed Transfers of West Region Patients, Hospitals in/outside West Region	787	1,217	463	199	667	25% Shift	167	167	167	167	167	167	5.0	835	2.3
5) Anticipated IP Admits from Area Hospitals (Low/Med Acuity, West Region)	3,781	4,452	4,286	3,976	4,124	9% Shift	366	366	366	366	366	366	5.0	1,830	8.3
6) Anticipated Obs Cases from Area Hospitals (West Region Patients)	2,755	2,814	2,641	2,950	2,790	5% Shift	153	153	153	153	153	153	1.2	184	1.3
Total Projected Volume														14,809	40.6

Sources/Filters:

- Factors 1, 2) Lurie Children’s Enterprise Decision Support Database; Aggregate encounter data used for IDPH AHQ Surveys; Inpatient and Observation; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry, Intermediate Care Unit; Observation Days = Observation Hours / 24
- Factors 3, 5, 6) IHA COMPdata, CY2022 – CY2025 through Q3; Inpatient only; Excludes admissions from Lurie Children’s; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation < =2.5; Planning Region defined by patient ZIP code
- Factor 4) Lurie Children’s Epic Database, FY2022-FY2026; DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled

Historical and projected referrals are documented in referral letters from 10 pediatric practices in the West Region as well as Lurie Children's Medical Group, Inc. Collectively, these practices referred 893 pediatric patients from the West Region for admission to Lurie Children's in 2025. These letters are included in [Appendix B](#) at the end of this permit application. As stated in the letters, these practices commit to refer 902 patients to the Lurie Children's new hospital in Downers Grove in 2031, the second year after project opening.

Committed Referrals by Pediatric Practice

Pediatric Practice	Number of Providers	Committed 2031 referrals
Bedrose Pediatrics, SC	5	8
DuPage Pediatrics, Ltd.	6	42
FGM Pediatrics	2	10
Milestone Pediatrics	3	18
North Arlington Pediatrics	5	10
Oak Park Pediatrics, Ltd.	6	53
Pediatric Health Associates, Ltd.	19	115
Pedios, Ltd.	4	65
Schwartz Pediatrics	3	20
Children's Health Partners, SC	4	13
Lurie Children's Medical Group, Inc.	278	548
Total		902

These historical referral volume counts were obtained from Lurie Children's medical records. Many of the practices do not keep centralized records on referral practices, only documentation in their patients' files. Providing this information in support of the permit application proved to be a challenge for many of the practices and individual physicians. This situation assuredly limited the counts of referrals and is for that reason a very conservative estimate of future referrals. In requesting this data on referrals, Lurie Children's initially requested that the practices provide information on referrals to other hospital pediatric units located both inside and outside the West Region. But without recordkeeping by the practices to support responding to that request, documentation in the permit application is limited to commitment of referrals for admission at Lurie Children's - Streeterville. Lurie Children's is the recipient of the largest volume of admissions of pediatric residents of the West Region who are not hospitalized within the region.

An additional table shows the relatively constant/slightly increasing admissions of West Region pediatric patients at Lurie Children's - Streeterville. The volumes are not inclusive of those admissions from the area that are tertiary or quaternary patients that will continue to be hospitalized at Lurie Children's - Streeterville downtown.

Lurie Children's Admissions by Patient Planning Region, 2019-2024

West Region Service Areas	2019	2020	2021	2022	2023	2024
West-Primary	609	528	613	621	631	681
West Primary Service Area Subtotal	609	528	613	621	631	681
West Region Secondary Service Area						
West-Naperville	99	80	81	108	130	118
West-Central	232	200	219	183	229	235
West-Aurora	118	127	118	110	129	145
West Secondary Service Area Subtotal	449	407	418	401	488	498
West Region Grand Total	1,058	935	1,031	1,022	1,119	1,179
Non-West Planning Regions						
Chicago	2,051	2,058	2,124	2,306	2,426	2,721
North Region	696	676	636	543	586	671
Northwest Region	304	362	357	361	364	471
South Region	531	546	583	619	687	729
Outside Market Area	692	756	700	620	851	832
Non-West Planning Region Subtotal	4,274	4,398	4,400	4,449	4,914	5,424
IP Medical/Surgical Admissions Subtotal	5,332	5,333	5,431	5,471	6,033	6,603
All Other Lurie Children's Admissions	5,857	4,260	4,464	4,513	4,335	5,093
Lurie Children's Admission Grand Total	11,189	9,593	9,895	9,984	10,368	11,696

Sources/Filters:

- Lurie Children's Enterprise Decision Support Database; Aggregate encounter data used for IDPH AHQ Surveys; Inpatient; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry

1110.200(b)(5) Planning Area Need – Service Accessibility

This section documents several factors that supplement the physician commitment letters. These factors include:

- a) documentation that more pediatric residents of the area receive care outside of the West Region than at hospitals in the region;
- b) there have been a significant number of pediatric unit closures and reductions of pediatric beds in the past decade;
- c) requests for patient transfers have been denied due to lack of bed availability; and
- d) increasing capacity constraints at Lurie Children's - Streeterville support the need for additional capacity.

The location and utilization of other area providers is documented in the table following this page. As reported earlier in this section, there are 19 community and teaching hospitals located in the West Region. The majority (11) of these hospitals have no authorized pediatric beds (no pediatric inpatient unit), although they admit pediatric patients. The eight hospitals with pediatric units have a total of 135 authorized pediatric beds. Four of these seven hospitals have a total of 49 of the 135 authorized pediatric beds. Yet, each of the four has an average pediatric daily census of 1.0 or less. This means that the remaining four hospitals with a total of 86 authorized pediatric beds provide the bulk of pediatric care (Central DuPage Hospital, Loyola University Medical Center, Saint Alexius Medical Center, and Edward Hospital). 86 beds for a pediatric population of 539,000 in the West Region is indicative of limited resources, especially during the late fall peak months.

Inpatient Pediatric Admissions by Hospital Planning Area, 2021-2024

	HPA	2021				2022				2023				2024			
		Beds	Admits	Days	ADC	Beds	Admits	Days	ADC	Beds	Admits	Days	ADC	Beds	Admits	Days	ADC
Licensed pediatric units																	
Loyola Univ Med Ctr	A-06	34	784	3,958	10.8	34	852	3,775	10.3	34	712	3,363	9.2	34	690	3,180	8.7
Central DuPage Hospital	A-05	28	572	1,767	4.8	28	1,046	3,011	8.2	28	994	2,915	8.0	28	901	2,468	6.7
Edward Hospital	A-05	7	613	1,524	4.2	7	763	2,196	6.0	7	829	2,100	5.8	7	806	2,260	6.2
Saint Alexius Med Ctr	A-07	17	636	1,563	4.3	17	772	2,479	6.8	17	814	2,474	6.8	17	717	2,112	5.8
Licensed Pediatric Beds, Census < 1.0																	
UChicago Medicine AdventHealth Hinsdale	A-05	18	538	3,945	10.8	18	227	486	1.3	18	227	486	1.3	18	158	278	0.8
Mercy Medical Center - Aurora	A-12	16	9	22	0.1	16	65	106	0.3	16	30	62	0.2	16	14	30	0.1
MacNeal Hospital	A-06	10	47	123	0.3	10	41	109	0.3	10	23	59	0.2	10	38	51	0.1
West Suburban Medical Center	A-06	5	1	1	0.0	5	14	24	0.1	5	17	33	0.0	5	9	23	0.0
Hospitals with no authorized ped beds																	
Rush Copley Medical Center	A-12	-	309	448	1.2	-	384	533	1.5	-	339	484	1.3	-	354	538	1.5
Elmhurst Hospital	A-07	-	50	98	0.3	-	44	108	0.3	-	41	66	0.2	-	48	167	0.5
Delnor Community Hospital	A-12	-	52	104	0.3	-	57	120	0.3	-	48	73	0.2	-	58	123	0.3
Advocate Sherman Hospital	A-11	-	43	90	0.2	-	44	89	0.2	-	47	90	0.2	-	45	87	0.2
Good Samaritan - Advocate	A-05	-	58	238	0.7	-	47	100	0.3	-	37	93	0.3	-	34	69	0.2
Rush Oak Park Hospital	A-06	-	18	28	0.1	-	11	17	0.0	-	35	72	0.2	-	26	65	0.2
Alexian Brothers Medical Center	A-07	-	15	46	0.1	-	19	43	0.1	-	20	47	0.1	-	15	30	0.1
UChicago Medicine AdventHealth Bolingbrook	A-13	-	14	30	0.1	-	25	43	0.1	-	30	54	0.1	-	28	52	0.1
UChicago Medicine AdventHealth LaGrange	A-04	-	6	10	0.0	-	14	18	0.0	-	22	30	0.1	-	17	26	0.1
Gottlieb Memorial Hospital	A-06	4	11	41	0.1	4	12	28	0.1	-	14	22	0.1	-	11	14	0.0
Saint Joseph Hospital-Elgin	A-11	-	5	11	0.0	-	15	21	0.1	-	7	13	0.0	-	7	12	0.0
Specialty Hospitals																	
Shriners Hospital for Children-Chicago	A-01	48	424	1,445	4.0	48	413	1,748	4.8	48	59	344	0.9	48	455	1,834	5.0
Marianjoy Rehab	A-05	-	45	621	1.7	-	51	771	2.1	-	52	720	2.0	-	54	873	2.4
UChicago Medicine AdventHealth GlenOaks	A-05	-	6	17	0.0	-	10	20	0.1	-	9	25	0.1	-	17	30	0.1
Linden Oaks Hospital (Behavioral Health)	A-05	-	1	2	0.0	-	-	-	-	-	-	-	-	-	2	12	0.0
Alexian Brothers Behavioral Health Hospital	A-07	-	2	12	0.0	-	-	-	-	-	3	18	0.0	-	3	18	0.0
Riveredge Hospital	A-06	-	309	448	1.2	-	2	17	0.0	-	-	-	-	-	1	11	0.0
Totals		187	4,568	16,592	45.5	187	4,928	15,862	43.5	183	4,409	13,643	37.3	183	4,508	14,363	39.2

Sources/Filters:

- IDPH AHQ Data Files, 2021-2024; Fields: CON Authorized Beds, Pediatric; Pediatric Admissions, Pediatric Patient Days; 2021-2023 ADC = Patient Days / 365, 2024 ADC = Patient Days / 366
- Missing information regarding pediatric activity has been supplemented with information from IHA COMPdata, CY2021-CY2024. This pertains to the following hospitals:
 - Mercy Medical Center-Aurora, Alexian Brothers (incl Behavioral Health), and Saint Joseph Hospital-Elgin, Rush Copley and Oak Park, Elmhurst Hospital, Delnor Hospital and MarianJoy Rehab, Advocate Sherman and Good Samaritan, UChicago Bolingbrook, LaGrange, and Glen Oaks, Loyola MacNeal and Gottlieb, Shriners, Riveredge
 - IHA COMPdata Filters: Inpatient only, Age = 0-18; MS-DRG Tertiary Designation <= 2.5; Patient County = Cook, DuPage, Lake McHenry, Kane, Kendall, Will

More pediatric residents of the area receive care outside of the West Region than at hospitals in the region.

The table below provides information on where pediatric residents of the West Region were hospitalized for pediatric care. The source is IHA COMPdata, and includes all inpatient pediatric admissions and does not filter out higher acuity care cases. (Thus, its volume numbers are slightly higher compared to volumes reported in the Annual Hospital Questionnaires.) The patient counts do not include acute mental illness admissions or NICU patients. The analysis is limited to residents of the West Region, so these volumes are a subset of total pediatric volumes at the hospitals; patients from outside the West Region are not counted.

Based on information from IHA COMPdata, 4,286 (52%) of hospitalizations of West Region pediatric patients in 2024 were hospitalized out of the area. 42.2% of those who left the area were cared for at Lurie Children's - Streeterville. The data show: a) there is significant outmigration of pediatric patients residing in the West Region; and b) more of these patients are going to Lurie Children's - Streeterville than any other hospital.

Location of Pediatric Inpatient Care for Residents of West Planning Region

West Region Hospitals		Non-West Region Hospitals	
<i>Licensed Pediatric Units</i>	Admits		Admits
Central DuPage Hospital	1,298	Lurie Children's	1,808
Edward Hospital	890	Lutheran General Hospital – Advocate	933
Loyola University Medical Center	679	Rush University Medical Center	518
Saint Alexius Medical Center	624	Shirley Ryan Abilitylab	45
		UChicago Medical Center	406
<i>Licensed Pediatrics Beds, census <1</i>		Advocate Christ Medical Center	370
UChicago Medicine AdventHealth Hinsdale	140	University of Illinois Hospital and Clinics	62
Mercy Medical Center - Aurora	9	John H Stroger, Jr. Hospital	21
MacNeal Hospital	6	Prentice/Memorial Hospital	18
West Suburban Medical Center	1	La Rabida Children's Hospital	17
		St Anthony Hospital-Chicago	14
<i>Hospitals with no authorized peds beds</i>		Saint Joseph Medical Center - Joliet	14
Rush Copley Medical Center	85	The Carle Foundation Hospital	9
Delnor Hospital	18	NM Huntley	7
Advocate Sherman Hospital	14	Northwest Community Hospital	6
Good Samaritan Hospital – Advocate	21	St. Anthony Medical Center - Rockford	5
Elmhurst Hospital	28	Saint Joseph Hospital - Chicago	5
Rush Oak Park Hospital	11	St. Francis Medical Center - Peoria	4
Alexian Brothers Medical Center	8	Carle BroMenn Medical Center	3
UChicago Medicine AdventHealth Bolingbrook	5	Evanston Hospital	3
UChicago Medicine AdventHealth La Grange	4	Mount Sinai Hospital	3
Gottlieb Memorial Hospital	3	Illinois Masonic Medical Center-Advocate	2
Saint Joseph Hospital – Elgin	2	St John's Hospital-HSHS	2
		NM Kishwaukee Hospital	2
<i>Specialty Hospitals</i>		Silver Cross Hospital	1
Shriners Hospital for Children - Chicago	64	Humboldt Park Health	1
MarianJoy Rehab	41	CGH Medical Center	1
UChicago Medicine AdventHealth GlenOaks	8	Saint Francis Hospital – Evanston	1
Linden Oaks Hospital (Behavioral Health)	1	Kindred Hospital – Sycamore	1
Riveredge Hospital	1	SwedishAmerican Hospital-UW	1
Alexian Brothers Behavioral Health Hospital	1	Anderson Hospital	1
		NM Lake Forest Hospital	1
		Javon Bea Hospital – Riverside	1
Total Admissions	3,962	Total Admissions	4,286

Sources/Filters:

- IHA COMPdata, CY2024; Inpatient only; Age: 0-18; Medical/Surgical Specialties; Patient and Hospital Planning Regions based on ZIP code

Closures of pediatric units and reductions of pediatric beds in the West Region have reduced access in the last 13 years.

Closures and reduction of beds are likely contributing to the outmigration of residents of the West Region for inpatient hospitalization. As is the case in Illinois and throughout the US, metropolitan Chicago has seen a significant number of pediatric unit closures and reductions of unit sizes over the past decade. 27 hospitals in the metropolitan area with a total of 319 authorized pediatric beds closed their units since 2013. Of these, six closed hospital pediatric units with a total of 54 beds are located in the West Region: Elmhurst Hospital (6 beds, 2019), Good Samaritan Hospital – Advocate (7 beds, 2019), Advocate Sherman Hospital (8 beds, 2021), Alexian Brothers Medical Center (16 beds, 2018), Gottlieb Memorial Hospital (4 beds, 2023), and Saint Joseph Hospital – Elgin (13 beds, 2025) as part of a plan to shift pediatrics to Edward Hospital in Naperville. A 5-bed pediatric unit was discontinued as part of the total closure of Westlake Hospital. These closures are documented below.

Discontinuations of Pediatric Inpatient Services, Chicago Metropolitan Area

(Highlighted rows indicate hospitals located in the West Region)

Hospital Name	State Planning Area	Number of beds	Month / Year Discontinued or Approved for Discontinuation
Saint Joseph Hospital – Elgin	A-13	13	April, 2025
Palos Community Hospital	A-04	8	July, 2024
Gottlieb Memorial Hospital	A-06	4	March, 2023
Prime Saints Mary & Elizabeth Hospital	A-02	14	July, 2021
Advocate Condell Medical Center	A-09	16	January, 2021
Advocate Sherman Hospital	A-11	8	January, 2021
St. Bernard Hospital	A-03	6	October, 2019
Elmhurst Hospital	A-05	6	October, 2019
Ingalls Memorial Hospital – UChicago	A-04	17	September, 2019
Illinois Masonic Medical Center - Advocate	A-01	14	April, 2019
Highland Park Hospital	A-09	6	March, 2019
Good Samaritan Hospital – Advocate	A-05	7	2019
Good Shepherd Hospital – Advocate	A-09	8	2019
Westlake Hospital	A-06	5	hospital closed 2019
OSF Little Company of Mary Hospital	A-04	20	November, 2018
Humboldt Park Health	A-02	5	February, 2018
Alexian Brothers Med Center	A-07	16	January, 2018
Advocate South Suburban Hospital	A-04	10	November, 2017
Mount Sinai Hospital	A-02	31	2017
Franciscan St. James Health - Chicago Heights	A-04	10	March, 2016
Insight Hospital (Mercy-Chicago)	A-03	37	2016
Loretto Hospital	A-02	10	2015
South Shore Hospital	A-03	6	2015
Skokie Hospital	A-08	2	2015
Riverside Medical Center	A-14	18	2014
Prime St. Francis	A-08	12	2013
NM Lake Forest Hospital	A-09	10	2013
Total Beds		319	

Sources:

- *Inventory of Health Facilities and Services and Need Determinations, December 2023; Addendum Inventory of Health Care Facilities, March 31, 2026.*
- Lurie Children's internal dataset

An additional net reduction of 46 pediatric beds is attributed to units that were downsized but not closed in metropolitan Chicago during the same timeframe. The following table documents these changes.

Changes in Pediatric Beds (not discontinuations of pediatric units), Chicago Metropolitan Area

Hospital Name	State Planning Area	Beds Added	Date Added	Beds Reduced	Date Reduced	2025 Total
Lurie Children's	A-01	4	9/20/2019	2	1/1/2024	126
John H Stroger, Jr. Hospital	A-02			14	2016	26
Rush University Medical Center	A-02			2	12/15/2015	20
St. Anthony Hospital	A-02	6	2018			18
University of Illinois Hospital and Clinics	A-02			12	2/28/2018	20
University of Illinois Hospital and Clinics	A-02			12	6/11/2021	20
Palos Community Hospital	A-04			7	4/1/2022	8
UChicago Medicine AdventHealth Hinsdale	A-05			1	2014	18
Central DuPage Hospital	A-05	12	2014			28
Central DuPage Hospital	A-05	6	10/29/2020			28
Vista Medical Center East	A-09			10	2013	11
Vista Medical Center East	A-09			14	8/25/2015	11
Total Beds		28		74		

Sources:

- *Inventory of Health Facilities and Services and Need Determinations, December 2025; Addendum Inventory of Health Care Facilities, December 31, 2025.*
- Lurie Children's internal dataset

Requests for patient transfers have been denied due to lack of bed availability.

Capacity constraints at Lurie Children's - Streeterville have resulted in not being able to accommodate requests for transfer of patients from other hospitals. Serving as a regional referral destination is one of the main roles of Lurie Children's. In 2023, 2,434 patient transfer requests were denied; 463 were denied in 2024, and 199 denied in 2025. Discounting the unusually high volume in 2023 as an atypical year results in 1,217 patient transfer denials for purpose of the calculation. These denials averaged 626 per year for the past four years and were mostly due to unavailability of pediatrics beds at Lurie Children's - Streeterville. A conservative estimate is that 25% of these requests can be accommodated at Downers Grove, resulting in 167 admissions annually. These are counted as part of the new volume to be accommodated at Downers Grove.

Increasing capacity constraints at Lurie Children's - Streeterville downtown supports the need for additional capacity.

The table presented in the Purpose of the Project shows the annual utilization of inpatient and outpatient services at Lurie Children's for the past nine years, based on the hospital's Annual Hospital Questionnaires, 2017 through 2025. Growth in most clinical services has been dramatic and supports the concern that the hospital will be at capacity by the end of this decade. Admissions have grown by 20% over the 9 years; patient days by 16%. Occupancies have been in the high 70s for the past four years, with facility constraints causing a plateauing of volume. The 64 neonatal beds averaged 90.2% for the past five years, with an occupancy of 93% last year; the ICU service has been consistently above the State standard of 60%, with 126 beds now in service.

The development of the hospital in Downers Grove will allow for residents of the West Region to receive their care closer to home. The volume forecasts anticipate that approximately 1,000 annual downtown admissions from the area will receive care in Downers Grove. That will relieve some of the volume pressure downtown. It is likely that more admissions from the western part of Chicago and other Lurie Children's regions will utilize the hospital in Downers Grove.

1110.200(c) Unnecessary Duplication/Maldistribution

1) Duplication

The project does not result in unnecessary duplication of pediatric beds. The 10-mile radius around the project site in Downers Grove has a resident population of 282,755 persons, age 0 – 18. The following table shows the distribution of the pediatric population by ZIP code. The ZIP codes are totally or partially located within the area defined by the 10-mile radius. The source of population data is Claritas Pop-Facts 2025 from Sg2 Analytics.

There are three hospitals with pediatric units with authorized pediatric beds in the area defined by the 10-mile radius:

- Central DuPage Hospital
25 N. Winfield Rd Winfield, IL 60190
28 pediatric beds; Year 2024 ADC 10.0, occupancy 38.6%
- Edward Hospital
801 S. Washington St. Naperville, IL 60540
7 pediatric beds; Year 2024 ADC 6.0, occupancy 88.5%
- UChicago Medicine AdventHealth Hinsdale
120 N. Oak St. Hinsdale, IL 60521
18 pediatric beds; Year 2024 ADC 1.0, occupancy 5.2%

Population of ZIP Codes Within 10 Miles of Lurie Children's - Downers Grove, Age 0-18 and 0-100

West Region Primary					
Service Area	ZIP Code	City	County	Population 0-18	Population 0-100
West-Primary	60148	Lombard	DuPage	11,084	52,696
	60126	Elmhurst	DuPage	11,782	48,001
	60188	Carol Stream	DuPage	9,116	41,904
	60137	Glen Ellyn	DuPage	9,774	38,921
	60101	Addison	DuPage	7,953	36,016
	60517	Woodridge	DuPage	7,140	32,578
	60139	Glendale Heights	DuPage	7,303	31,957
	60525	La Grange	Cook	7,043	30,719
	60187	Wheaton	DuPage	6,865	29,729
	60181	Villa Park	DuPage	6,365	29,287
	60189	Wheaton	DuPage	6,713	29,136
	60515	Downers Grove	DuPage	6,263	28,959
	60527	Willowbrook	DuPage	5,459	28,925
	60516	Downers Grove	DuPage	5,859	28,700
	60532	Lisle	DuPage	5,495	28,541
	60559	Westmont	DuPage	5,092	24,329
	60108	Bloomingtondale	DuPage	4,454	23,278
	60160	Melrose Park	Cook	6,000	23,251
	60153	Maywood	Cook	5,570	22,290
	60561	Darien	DuPage	4,071	21,881
	60164	Melrose Park	Cook	4,852	21,460
	60106	Bensenville	DuPage	4,671	20,277
	60513	Brookfield	Cook	4,426	18,442
	60521	Hinsdale	DuPage	5,097	18,250
	60104	Bellwood	Cook	3,876	17,740
	60131	Franklin Park	Cook	3,769	17,141
	Other West-Primary ZIP Codes			29,888	141,142
West-Naperville	60440	Bolingbrook	Will	11,865	51,374
	60540	Naperville	DuPage	9,918	43,323
	60565	Naperville	DuPage	9,299	39,351
	60563	Naperville	DuPage	8,692	38,998
	60490	Bolingbrook	Will	5,361	21,664
	60555	Warrenville	DuPage	3,228	14,453
West-Central	60190	Winfield	DuPage	2,608	12,060
West-Aurora	60504	Aurora	DuPage	9,939	39,593
West Region Subtotal				256,890	1,146,366
South Region					
ZIP Code	City	County	Population 0-18	Population 0-100	
60446	Romeoville	Will	9,650	40,912	
60439	Lemont	Cook	5,022	23,595	
60455	Bridgeview	Cook	3,799	16,016	
60458	Justice	Cook	3,442	13,764	
60501	Summit Argo	Cook	2,960	11,021	
60480	Willow Springs	Cook	994	5,247	
Grand Total				282,757	1,256,921

Sources/Filters:

- Pediatric Population: Claritas Pop-Facts 2025, Sg2 Analytics; Population Age: 0-18 by ZIP code

2) Maldistribution of Service

One of the tests for maldistribution is if the ratio of beds to population exceeds one and one half times the State average.

- There are 993 pediatric beds in Illinois (Source: Illinois Statewide Hospital Profile, Data Year 2024, pg 1). According to *Population Projections for Illinois, Chicago and Illinois Counties by Age and Sex, July 1, 2020 – July 1, 2035*, 2023 Edition, the 2025 population of persons age 0 – 18 is 2,833,179. (Added cohorts 0-4, 5-9, 10-14, and interpolated 15-19 to age through 18.)
- For Illinois, the ratio of pediatric beds per 1,000 population is $993 / 2,833,179 = 0.350$.
- One and one half times $0.350 = 0.525$.
- In the 10-mile radius area, the ratio of beds per 1,000 is $53 / 282,755 = 0.187$.
- The addition of 48 beds increases the count of pediatric beds in the area to 101 beds.
- $101 / 282,755 = 0.357$.
- Because 0.357 is less than 0.525 (one and one half times the State average of 0.350), maldistribution is not a result of the project.

3) Impact on Area Providers

The Justification of Beds Needed – Overview earlier in this section documented the sources of projected patient volume. Over 85% of the projected inpatient pediatric volume is attributed to: shifting of admissions and observation patients who are residents of the West Region and hospitalized at Lurie Children's - Streeterville; shifting of residents of the West Region who are hospitalized outside of the region; and accommodating requests for transfer that have been denied in the past. These are based on documented historical volumes. None of these patients are cared for by hospitals located in the West Region, so the impact of this project on area hospitals is minimal.

Pediatric physician practices in the West Region that have referred to Lurie Children's pediatric specialists downtown may in the future refer directly to those physicians at the Downers Grove hospital. It is expected that the new hospital will have minimal impact on the pediatric services at Edward Hospital and UChicago Medicine AdventHealth Hinsdale.

Lurie Children's has partner relationships with several hospitals throughout metropolitan Chicago. For over 2 decades, Northwestern Medicine and Lurie Children's have worked together to provide pediatric care in the western suburbs. Together, both institutions established a pediatric emergency care department, inpatient units, and multispecialty outpatient clinics at Central DuPage Hospital, as well as an outpatient clinic and neonatal and pediatric imaging at Delnor Hospital. These facilities have provided exceptional care to thousands of pediatric patients and their families since 2006. The collaboration is shifting to better serve families in the communities we support and to respond to a changing healthcare landscape. Throughout this transition and after the new facility opens, Lurie Children's will continue to collaborate to address the needs of the patients it serves.

1110.200(e) Staffing Availability

The Lurie Children's hospital in Downers Grove is proposed to have 48 medical/surgical beds located on two floors. The table shows the planned staffing for the units.

Inpatient Staffing

<u>Position</u>	<u>FTE Need</u>
Medical Director	0.5
Nursing Director	1.0
Manager Patient Care Operations	4.0
Physician/APP	18.0
Charge RN	8.4
Registered Nurse	50.4
Respiratory Therapy	8.4
Certified Nursing Assistant/Patient Safety Associate	29.4
APP Director/Manager	1.0
Nursing Professional Development	1.0
Clinical Quality Coordinator RN	1.0
Child Life	1.0
Social Work	2.0
Case Management	2.0
Dietician	2.0
Total	130.10

Physician Recruitment

Physician recruitment at Lurie Children's is an ongoing rigorous process. The development of the new hospital included an assessment of the resources required to meet the needs of the inpatients and observation cases, and to support each medical staff appointment. All medical staff will be employed members of the Lurie Children's Medical Group, Inc., a Lurie Children's affiliate. Lurie Children's academic partner, Northwestern University Feinberg School of Medicine, applies strict guidelines to ensure that academic integrity is incorporated into the recruitment process. These positions are hospital-based, requiring all candidates to be board-eligible or board-certified and demonstrate academic productivity as well as clinical excellence.

Filling the positions at the new hospital in Downers Grove will include a multi-faceted approach, including relocating some physicians from Lurie Children's - Streeterville (who will help impart Lurie Children's values and best practices in the new setting), and recruiting new staff members through regional and national searches. The methods include verbal outreach to individual candidates, recruiting at relevant conferences, and mass emails to leading medical centers in North America.

Lurie Children's has had great success in recruiting physicians, bolstered by active pediatric practice in an academic medical setting, and the draw of working and living in Chicago and the Chicago area.

Advanced Practice Nurse (APN) Recruitment

Lurie Children's has an established APN/Physician Assistant (PA) Council that includes a diverse group of specialties trained with both acute care and primary care specialties. Lurie Children's Human Resources Department has skilled recruiters who focus on APN recruitment. After positions are approved, the average recruitment process takes about three to four months, followed by credentialing and privileging processes taking 90 – 120 days. Four to six months of orientation follow. This timeframe will allow recruitment and training to take place starting well in advance of the opening of the new facility.

The current Lurie Children's registered nurse staff, who will be finishing their master's degree work and sit for the APN licensing board, constitute a great pool of talent and recruitment opportunity. The new facility also provides the opportunity to reassign some of the APNs from Lurie Children's - Streeterville to Downers Grove, which is especially appealing to those professionals living in the western suburbs.

Registered Nurse (RN) Recruitment

There are RN candidates currently working in the hospital in other positions who, once they have completed their RN training, approach nursing leaders for assistance in placement in new positions.

Available positions are posted on Lurie Children's website and are advertised in professional journals and at national organization meetings and conferences. Lurie Children's also has a nationally respected nurse internship program, which provides a four- to six-month orientation process to best prepare the new graduate to step into the role of a Lurie Children's nurse. Once needed positions are approved, recruitment, hiring and training will take place to ensure that nursing is at full complement at the time of opening of the new facility in Downers Grove.

The opportunity also exists for Lurie Children's nurses to relocate from Lurie Children's - Streeterville, or transition from the outpatient center in Westchester which will be closed upon the opening of Lurie Children's hospital in Downers Grove or at other Lurie Children's facilities. This opportunity has special appeal for nurses living in the western suburbs.

1110.200(f) Performance Requirements – Bed Capacity Minimum

For pediatric units in a Metropolitan Statistical Area, the minimum size is 4 beds. The 48-bed unit meets this standard.

1110.200(g) Assurances

The letter on the following page acknowledges the understanding by Lurie Children's that the hospital in Downers Grove will meet the State's occupancy standard for the pediatric service by the end of its second year of operation.

May 19, 2026

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

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

Re: Assurance, 1110.200(g)
Proposed Lurie Children's Hospital and Outpatient Center in Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

Consistent with the requirements of 1110.200(g), I hereby attest that it is my understanding that by the second year of operation, the project's pediatric inpatient beds will achieve the occupancy standard of 80%, as set forth in 77 Ill. Adm. Code 1110.

If you have any questions, please contact Ann Sherline, Senior Associate General Counsel, Ann & Robert H. Lurie Children's Hospital of Chicago at asherline@luriechildrens.org.

Sincerely



Thomas Shanley, MD
President and Chief Executive Officer
Ann & Robert H. Lurie Children's Hospital of Chicago
225 E. Chicago Avenue
Chicago, IL 60611

Subscribed and sworn to before me
this 19th day of May, 2026.



Signature of Notary Public



Seal

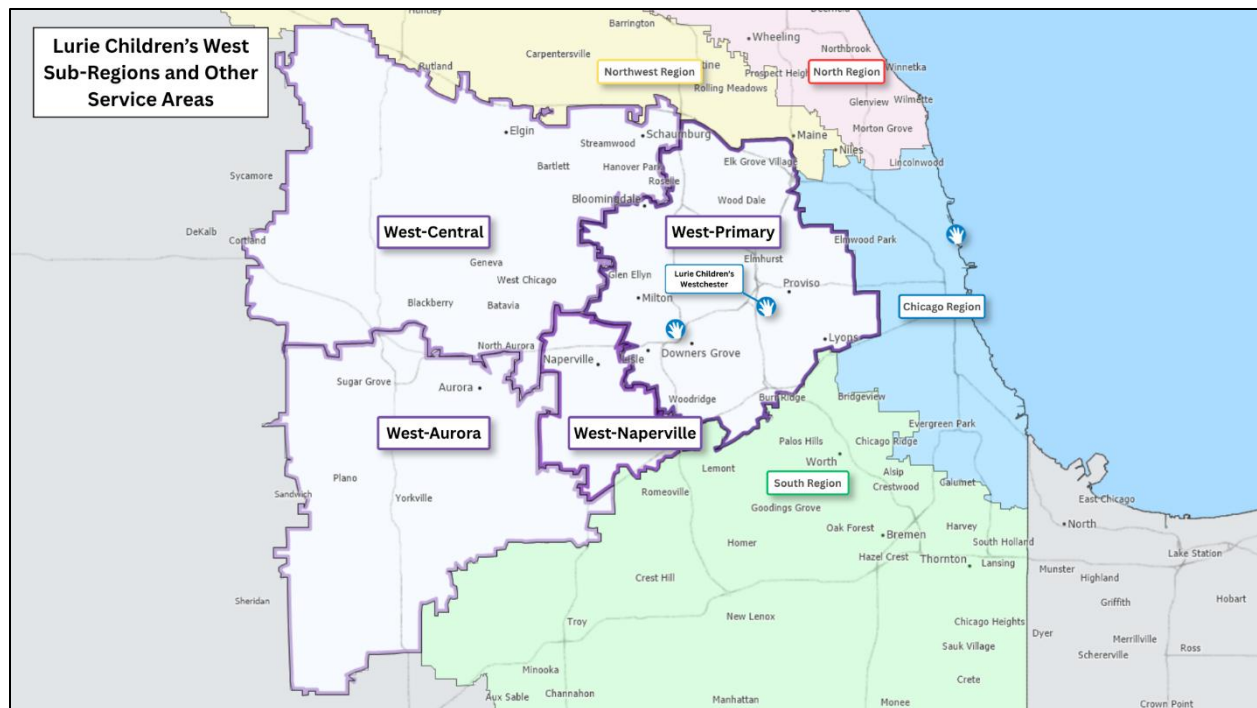
1110.270 – Clinical Service Areas Other than Categories of Service

Service	# Existing Key Rooms	# Proposed Key Rooms/Units
Surgery	0	6 ORs
Emergency Department	0	35 stations
Outpatient Clinic	0	50 exam/treatment rooms
Diagnostic Imaging		
X-Ray	0	3
Fluoroscopy	0	1
Orth/EOS	0	1
Ultrasound	0	2
MRI	0	2
CT	0	1
Ancillary Testing		
Electrocardiogram (ECG)	0	1
Echocardiogram (ECHO)	0	1
Pulmonary Function	0	1
Electroencephalogram (EEG)	0	1
Video EEG	0	1
Sleep Studies	0	4
Infusion	0	10
Rehabilitation		
PT/OT, Gym	0	1
Lab	0	2
Pharmacy	0	1

1110.270(b)(1) Need Determination – Establishment; Service to Planning Area Residents

The above table outlines the clinical services areas that are planned in the hospital and clinics building at Downers Grove. The Planning Area was defined in Section 1110.200 of this permit application as the “West Region,” one of five Ann & Robert H. Lurie Children’s Hospital of Chicago (“**Lurie Children’s**”) regions in metropolitan Chicago. The West Region includes a Primary Service Area (West-Primary) and three sub-regions of the remaining West Region that constitute a Secondary Service Area: West-Naperville, West-Aurora, and West-Central. See the map on the next page.

It is projected that the West Region Planning Area will be the source of 80% of inpatients and outpatients utilizing the proposed hospital and clinics building. In aggregate, 80% of the volume associated with the clinical services that are not categories of service will be from the West Region Planning Area.



1110.270(b)(2) Need Determination – Establishment; Service Demand

Lurie Children's has prepared forecasts of utilization for each of the clinical service areas. The forecasts are shown on individual tables that present factors used to make the projections, historical utilization for the factors, and projected volumes for 2031, two years after project completion.

The factors used to make projections incorporate Lurie Children's past and current experience in the West Region. For example, inpatient admissions, observation cases and emergency department ("ED") visits at Lurie Children's associated with pediatric residents of the West Region are expected to shift to the new hospital in Downers Grove. These patient counts are considered *Referrals from an Inpatient Base*, and their historical volumes are documented in the tables. Similarly, outpatient clinic visits and ambulatory surgery volumes at Lurie Children's Hospital Outpatient Center in Westchester will shift to Downers Grove, upon the planned closure of the Westchester facility upon the approval and opening of the Downers Grove project. Forecasts of diagnostic imaging and ancillary testing utilize ratios of procedures and tests associated with current utilization by Lurie Children's inpatients, observation cases, ED visits and clinic visits. Various other factors behind the projected volumes include service to patients who leave the West Region for hospitalization, and documented requests for transfer to facilities that cannot accommodate the transfers due to lack of capacity at the time of request.

For this section of the permit application, Lurie Children's developed a standard format to present the data. The left column of each table lists the factors driving projected utilization. For most factors, there are four years of historical utilization, 2022 through 2025, recognizing that the COVID years 2020 and 2021 were unusual years, often characterized by lower pediatric patient volumes. For most of the tables, the historical volumes are summarized in a column displaying 4-year averages. In many cases, the average introduces conservative projections, compared to historical years of increasing patient volumes. The tables show for most of the factors the percentages of patients that are expected to shift to Downers Grove. Finally, the columns on the right side of the table show projected year volumes. Each table has footnotes documenting the sources of information. Lurie Children's has strived for consistency in the use of data across the tables. For example, the four-year average for inpatient admissions (used to justify pediatric beds in 1110.200) is the same volume to which use rates are applied for projecting diagnostic tests on inpatients.

A. Surgical Cases and Hours

The project plans to have 6 operating rooms ("ORs") and no procedure rooms in the surgical department. Factors displayed in the table include 100% shift of the surgery cases in the ASTC at Lurie Children's Hospital Outpatient Center in Westchester, which will be closed; surgery for residents of the West Region who have traveled to Lurie Children's main hospital in the Streeterville neighborhood of Chicago ("Lurie Children's - Streeterville") and Lurie Children's Northbrook, and some percentage of residents of the nearby south region who have gone to Lurie Children's - Streeterville or Northbrook. See Table A.

The projected volume of 7,974 hours justifies 5.3 ORs (6) based on 1,500 hours per OR per year.

B. Emergency Visits

The project plans to build 35 stations for emergency care. Factors contributing to the projections are: shifting of ED cases for residents of the West Region who traveled to Lurie Children's - Streeterville for care; residents of the West Region's sub-areas who traveled out of the West Region for care (shift percentages vary by sub-region); a 25% shift of patients who receive ED care at hospitals in the West Region that have no inpatient pediatric beds. These factors result in a projected volume of 36,248 visits. Lurie Children's has experienced consistent peak utilization of ED services in October, November and December. The peaks are about 20.5% higher than the average months, which could be viewed as a seasonal adjustment of an additional 7,400 annual visits. This would imply an annual volume of about 44,000 visits. Table B presents projected ED visit volumes.

Lurie Children's obtained data from the Children's Hospital Association on ED volumes and throughput. For the 68 children's hospitals in the US that reported, the average volume was 1,344 visits per ED station per year in 2024. This breaks down between main campus children's hospitals and satellite hospitals as follows:

Main Campus	Satellite Hospitals	Combined Total
49 facilities	19 facilities	68 facilities
3,045,052 ED visits	753,868 ED visits	3,798,920 ED visits
2,151 stations	676 stations	2,827 stations
1,416 visits/station/year	1,115 visits/station/year	1,344 visits/station/yr

Lurie Children's practice is to have an ED room ready as soon as possible after a patient arrives, rather than have patients and family members experience lengthy waits in the ED waiting area. The goal is to have care start and proceed as quickly as possible, but when waiting is necessary, waiting in a room provides more privacy and comfort than the public waiting area affords. The room count is sized in part for this purpose.

C. Diagnostic Imaging

C(1) X-Ray

Lurie Children's plans for three X-Ray machines in the new facility: one in the imaging department, one in the ED, and one in the outpatient clinics building. The projected volumes are derived from several sources: Outpatient clinic visits, inpatient admissions and observation cases, and ED visits.

- X-Ray Procedures Based on Outpatient Clinic Visits:
 - A shift of 20% of outpatient clinic volumes (documented in Table D) from Lurie Children's satellite locations to Downers Grove projects clinic visits to reach 71,371 visits by 2031. Lurie Children's experienced utilization rate is 0.23 X-Rays per clinic visit, resulting in 16,498 X-Rays by 2031. Assuming a conservative reduction of 30% of procedures results in a forecast of **11,491 clinic visit X-Rays** by 2031.
- X-Ray Procedures Based on Low/Medium Acuity Inpatient Admissions and Observation Cases:
 - Projected inpatient volume at the proposed hospital is based on an annual historical average of 15,414 admissions and observation cases (Referenced in Section 1110.200: *Future Projected Utilization – Pediatric Beds*) based on the following factors:
 - 989 Inpatient Admissions of Low/Medium Acuity at Lurie Children's - Streeterville for patients residing in the West Region

- 871 Observation Cases at Lurie Children's - Streeterville for patients residing in the West Region
- 5,973 West Region patients leaving the region for care. (Excluding the 989 patients from Lurie Children's - Streeterville)
- 667 Denied Requests for transfer for hospitalization of West Region residents
- 4,124 Anticipated Inpatient Admissions of Low/Medium Acuity from West Region hospitals of West Region patients
- 2,790 Anticipated Observation Cases from West Region hospitals of West Region patients

15,414 historical admissions and observation cases at Lurie Children's - Streeterville

- Table C(1) shows in aggregate, 29% of these admissions and cases are anticipated to utilize the Downers Grove hospital comprised of the following: 100% of inpatient (989) and observation cases (871) from West Region residents; 20% of West Region residents returning to the region for care at Downers Grove (1,194); 25% of denied transfers of West Region residents (167); 9% of anticipated inpatient admissions from West Region hospitals of West Region patients (366); and 5% of anticipated observation cases from West Region hospitals of West Region patients (153). These factors amount to 3,740 annual admissions and observation cases by 2031. Lurie Children's experienced utilization rate is 1.10 X-Rays per inpatient and observation case. Assuming a conservative reduction of 40% of procedures results in **2,468 inpatient and observation X-Rays** by 2031.
- X-Ray Procedures Based on ED Visits:
 - Table B of this section (*Future Projected Utilization – Emergency Visits*) reports that among all West Region pediatric patients that visited an ED, 6,296 received ED care at Lurie Children's - Streeterville, annual average of 14,241 patients left the West Region for ED care, and 83,767 pediatric ED visits occurred at West Region hospitals without authorized pediatric beds. These total 104,304 ED visits (See: *Table C(1), row 3*).
 - Of these 104,304 historical ED visits 36,248 are projected at the Downers Grove hospital in 2031: 5,666 ED visits from West Region patients at Lurie Children's - Streeterville, 5,452 ED visits from patients returning to the region for ED care, and 25,130 (30%) of pediatric ED visits at West Region hospitals without authorized pediatric beds. Lurie Children's experienced utilization rate is 0.24 X-Rays per ED visit. Assuming a conservative reduction of 40% of procedures results in **5,220 ED visit X-Rays** by 2031.

Based on these factors, it is projected that there will be **19,178 X-Rays** completed at Lurie Children's hospital in Downers Grove by 2031. (Refer to *Table C(1)* for additional detail.) This methodology of historical utilization and clinical volumes is applicable to other service areas that are dependent on the patient setting.

C(2) Fluoroscopy

The projection of **1,875** fluoroscopy patients in 2031 is based on counts of Lurie Children's patients having had appointments at all Lurie Children's satellite locations: 100% of patients residing in the West Region and 30% of patients residing in the South Region. Historical data is included on patients residing in all other regions, but they are not expected to utilize the unit at Downers Grove. See table C(2).

C(3) Ultrasound

Lurie Children's plans two ultrasound units in the new facility. Similar to projections for X-Ray procedures (See: C(1) above) the projected volumes are derived from several factors:

- A shift of 20% of clinic volumes at Lurie Children's satellite locations to Downers Grove; use rate of 0.07 ultrasound procedures per clinic visit: **3,497 ultrasound procedures** in 2031.
- Low/medium acuity inpatients and observation cases at the proposed hospital; use rate of 0.34 ultrasound procedures per associated patient case: **763 ultrasound procedures** in 2031.
- ED visits at the proposed hospital; use rate of 0.09 per ED visit: **2,284 ultrasound procedures** in 2031.

Assuming a conservative reduction of 30%, the components sum to a total of **6,544 ultrasound procedures** by 2031. See table C(3).

C(4) MRI

There are two MRI units proposed at the new facility. The projected volumes are based on the following factors: Shift of 100% of volumes performed at Westchester and Northbrook outpatient centers for residents of the West Region; 60% of outpatient MRIs performed at Lurie Children's - Streeterville on West Region residents. The total projected 2031 volume of MRI procedures is **3,770**. See table C(4).

C(5) CT

One unit is planned in the new facility. As with X-Ray and Ultrasound procedures (See: C(1) and C(3) above) the projected volume is derived from the following factors:

- A shift of 20% of clinic volumes at Lurie Children's satellite locations to Downers Grove; use rate of 0.06 CT scans per clinic visit: **4,282 CT scans** by 2031.
- Low/medium acuity inpatients and observation cases at the proposed hospital; use rate of 0.13 CT procedures per associated patient case: **486 CT scans** by 2031.
- ED visits at the proposed hospital; use rate of 0.03 per ED visit: **2,320 CT scans** by 2031.
- The components add to a total of **7,088 CT scans** by 2031. See table C(5).

C(6) Ortho EOS

This new technology is similar to x-ray but is specialized for spine and hip-to-ankle patients and will be exclusive to these patients in its use. The technology is new to Lurie Children's and will be first implemented in Downers Grove. It will significantly enhance patient safety, quality of care and precision. The projected volumes are 2,449 procedures in 2030 and **2,735** in 2031. The volumes are based on replacing current volumes for spine and hip-to-ankle x-rays at Lurie Children's Clark/Deming outpatient center in Lincoln Park. There is no table for this technology.

D. Outpatient Clinic Visits

Lurie Children's has satellite clinic services throughout the metropolitan area. Table D displays the historical volumes at the Lurie Children's Outpatient Center in Westchester, as well as at satellite sites in the West Region and South Region, and at other area hospitals where Lurie Children's provides inpatient and outpatient pediatric services. Collectively, these are the locations for approximately 90,000 clinic visits. An additional 167,000 visits are at locations in other Lurie Children's Planning Regions. All regional areas have been growing, with annual rates between 5% and

8%. The exception is the Westchester Outpatient Center, with facility restrictions limiting annual average growth to 2%.

Based on the historical volumes and growth rates shown in Table D, it is expected that volumes at the Downers Grove clinics building will be about 68,000 in 2030 and **71,400** in 2031. Ongoing growth in patient volumes thereafter is anticipated.

E. Ancillary testing

Table E displays historical volumes and use-rates for ECG, ECHO and pulmonary function tests at the Westchester outpatient center. Volumes for EEG and sleep studies are based on information on ambulatory encounters recorded in Lurie Children's database and input from Lurie Children's providers. In the aggregate, it is forecast that there will be approximately **5,100** ancillary tests at the new facility in year 2031.

F. Infusion

The project will take some of the volume pressure off the infusion program at Lurie Children's - Streeterville that has averaged over 9,000 annual infusions for the past four years; an average of 2,150 from the West Region. 70% of these West Region patients will receive infusions in Downers Grove. 30% of Lurie Children's patients in the South Region are likely to prefer the Downers Grove program to commuting to Lurie Children's - Streeterville, as well as 5% of the patients from other regions. West Region hospitals where Lurie Children's provides infusion services are also projected to shift 20% to the Downers Grove hospital. The 2031 projected volume of **3,701** patients is an anticipated caseload of 14 patients per day in the 10-room infusion center. See Table F.

G. Rehabilitation

Table G presents historical volumes and annual growth rates at the Lurie Children's Hospital Outpatient Center in Westchester. The annual average 8% increase in PT appointments and 4% in speech therapy visits are expected to continue. OT, prosthetics/orthotics and audiology are relatively constant. All rehabilitation services in Westchester will be relocated to the clinics building in Downers Grove. The projected volume of rehabilitation services is **15,506** by 2031.

H. Laboratory

The projected volumes of lab services are based on projected volumes of outpatient clinic visits, low to medium acuity inpatient admissions and observation cases, and ED visits. Utilization rates of laboratory services and conservative projections of clinical volumes were used to determine projected laboratory services at Lurie Children's hospital in Downers Grove.

- A shift of 20% of clinic volumes at Lurie Children's satellite locations to Downers Grove; laboratory use rate of 0.26 per clinic visit: **18,556** by 2031.
- Low/medium acuity inpatients and observation cases at the proposed hospital; laboratory use rate of 25.76 per associated patient case: **96,319** by 2031.
- ED visits at the proposed hospital; laboratory use rate of 1.51 per ED visit: **54,735** by 2031.
- These components result in projected laboratory volume of **169,610** by 2031. See table H.

I. Pharmacy

The projected volumes of pharmacy services are based on projected volumes of outpatient clinic visits, low to medium acuity inpatient admissions and observation cases, and ED visits. Utilization rates of pharmacy services and conservative projections of clinical volumes were used to determine pharmacy utilization at Lurie Children's hospital in Downers Grove in 2031.

- A shift of 20% of clinic volumes at Lurie Children's satellite locations to Downers Grove; pharmacy use rate of 0.05 per clinic visit: **3,569** by 2031.
- Low/medium acuity inpatients and observation cases at the proposed hospital; pharmacy use rate of 64.49 per associated patient case: **241,135** by 2031.
- ED visits at the proposed hospital; pharmacy use rate of 1.36 per ED visit: **49,297** by 2031.
- These components result in projected pharmacy volume of **294,001** by 2031. See table H.

1110.270(b)(3) Need Determination – Establishment; Impact of the Proposed Project on Other Area Providers

As documented in Section 1110.200(f) of this permit application, there are three hospitals with pediatric units within the 10-mile radius of the Downers Grove project site:

- Central DuPage Hospital
25 N. Winfield Rd
Winfield, IL 60190
- Edward Hospital
801 S. Washington St.
Naperville, IL 60540
- UChicago Medicine AdventHealth Hinsdale
120 N. Oak St.
Hinsdale, IL 60521

The Justification of Beds Needed – Overview earlier in Section 1110.200 documented the sources of projected inpatient volume. Over 85% of the projected inpatient pediatric volume is attributed to: shifting of admissions and observation patients from Lurie Children's - Streeterville, who are residents of the West Region; shifting of residents from the West Region who are hospitalized outside of that region; and accommodating requests for transfer that have been denied in the past. None of the patients in these groups are cared for by the hospitals in the West Region.

Because a significant volume relating to the clinical services that are not categories of service are Referrals from an Inpatient Base, it is likely that the service to patients in these groups will have minimal impact on the pediatric services at Edward Hospital and UChicago Medicine AdventHealth Hinsdale.

Lurie Children's has relationships with several hospitals throughout metropolitan Chicago. For over 2 decades, Northwestern Medicine and Lurie Children's have worked together to provide pediatric care in the western suburbs. Together, they established a pediatric emergency care department

("ED"), inpatient units, and multispecialty outpatient clinics at Central DuPage Hospital, as well as an outpatient clinic and neonatal and pediatric imaging at Delnor Hospital. These facilities have provided exceptional care to thousands of pediatric patients and their families since 2006. That collaboration is shifting to better serve families in the communities they support and to respond to a changing healthcare landscape. Throughout this transition and after the new facility opens, they will continue to collaborate to address the needs of the patients they serve.

1110.270(b)(4) Need Determination – Establishment; Utilization

The following tables document the utilization of each of the clinical services that are not categories of service, incorporating projections presented in the tables A through I for year 2031, two years after project completion. The referenced tables follow this page.

There are two services that do not meet the State standards: The ED and the clinic exam/treatment rooms.

The documentation submitted in support of the ED provides data on 68 hospitals that are members of the Children's Hospital Association. The data shows that average utilization for the 68 hospital ERs is 1,344 visits/station/year. Of the 68 facilities, 19 are satellite hospitals, similar to Downers Grove, that average 1,115 visits/station/year. The ED at Downers Grove is projected to accommodate 36,248 visits an equivalent 43,679 visits per year, when adjusted for peak months. This adjusted average of 1,200 visits per station per year exceeds the national average for satellite children's hospitals.

The clinic volume projection of 71,371 visits is an average of 1,428 visits per room per year. This level of utilization compares to the visit volumes at other Lurie Children's outpatient facilities in metropolitan Chicago.

**Summary of Volumes – Clinical Services that are Not Categories of Service
Lurie Children’s – Downers Grove Hospital & Outpatient Center**

Service	Proposed Key Rooms/Units	Projected 2031 Volume	State Standard	Meets Standard?
Surgery	6 ORs	7,974 hours	1,500 hrs/rm/year	Yes
Emergency Department	35 stations	36,248 visits	2,000 visits/station/year	No
		43,679 with seasonality adjustment		
Outpatient Clinic	50 exam/treatment rooms	71,371 visits (sized for future growth)	2,000 visits/room/year	No
Diagnostic Imaging				
X-Ray	3	19,178	8,000 procedures/yr/unit	Yes
Fluoroscopy	1	1,875	6,500 procedures/yr/unit	Yes
Orth/EOS	1	2,735	6,500 procedures/yr/unit	Yes
Ultrasound	2	6,544	3,100 visits/yr/unit	Yes
MRI	2	3,770	2,500 visits/yr/unit	Yes
CT	1	7,088	7,000 visits/yr/unit	Yes
Ancillary Testing				
Electrocardiogram (ECG)	1	810	NA	-
Echocardiogram (ECHO)	1	425	NA	-
Pulmonary Function	1	315	NA	-
Electroencephalogram (EEG)	1	2,080	NA	-
Video EEG	1	468	NA	-
Sleep Studies	4	1,040	NA	-
Infusion	10	3,701	NA	-
Rehabilitation				
PT/OT,Gym	1	15,506	NA	-
Lab	2	169,610	NA	-
Pharmacy	1	294,001	NA	-

**Table A: Factors Contributing to Future Projected Utilization – Pediatric Surgical Cases and Hours
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Surgical Cases						Projected Surgical Cases				Projected Surgical Hours		
Surgery Center and Patient Planning Region	2022	2023	2024	2025	4-Year Avg	Projected Shift to Downers Grove	2026 - 2029	2030	2031	Avg Surgical Time (hrs)	2026 – 2029	2030	2031
							(Hospital under construction)				(Hospital under construction)		
1) Total Surgical Cases from Lurie Children’s Hospital Outpatient Center in Westchester	2,335	2,834	2,998	2,621	2,697								
West Region	1,050	1,181	1,202	1,048	1,120	100%	1,120	1,120	1,120	1.3	1,456	1,456	1,456
All Other Regions	1,285	1,653	1,796	1,573	1,577	100%	1,577	1,577	1,577	1.3	2,050	2,050	2,050
2) Total Surgical Cases from Lurie Children’s Hospital Outpatient Center in Northbrook	2,603	3,461	3,573	3,813	3,363								
West Region	389	537	539	534	500	100%	500	500	500	1.3	650	650	650
South Region	94	129	113	140	119	30%	36	36	36	1.3	46	46	46
All Other Regions	2,120	2,795	2,921	3,139	2,744	0%	-	-	-	-	-	-	-
3) Total Outpatient Surgical Cases from Lurie Children’s - Streeterville Campus	13,841	15,046	13,872	14,922	14,420								
West Region	2,982	3,253	2,768	3,062	3,016	80%	2,413	2,413	2,413	1.3	3,137	3,137	3,137
South Region	1,557	1,688	1,620	1,647	1,628	30%	488	488	488	1.3	635	635	635
All Other Regions	9,302	10,105	9,484	10,213	9,776	0%	-	-	-	-	-	-	-
Total Projected Surgeries							6,134	6,134	6,134	1.3	7,974	7,974	7,974

Sources/Filters:

- Factors 1, 2, 3) Lurie Children's Enterprise Surgical Database, CY2022 - CY2025; Surgical times based on IDPH ASTC Survey, Lurie Children's Westchester & Northbrook, CY2025; for OP Surgical Cases at Lurie Children's - Streeterville: ASA < 4; OR services excluded: Cardiology, CV Surgery, Neurosurgery, Transplant
- IHA COMPdata, CY2022-CY2025 through Q3; Total Pediatric Surgeries; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

**Table B: Factors Contributing to Future Projected Utilization – Emergency Visits
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Cases						Projected Cases					
Factor	2022	2023	2024	2025	Avg	Projection Factor	2026	2027	2028	2029	2030	2031
							(Hospital under construction)					
1) ED Visits at Lurie Children's - Streeterville (West Region Patients)	6,600	6,637	5,819	6,128	6,296	90% Shift to Downers Grove	5,666	5,666	5,666	5,666	5,666	5,666
2) Total Outmigration of Patients from the West Region Seeking Care in Other Regions (incl Lurie Children's - Streeterville)	20,758	21,211	19,893	20,284	20,537							
Total Outmigration (excl Lurie Children's - Streeterville)	14,158	14,574	14,074	14,156	14,241		5,452	5,452	5,452	5,452	5,452	5,452
Chicago Region (excl Lurie Children's)	4,736	5,003	4,427	4,236	4,601	50%	2,300	2,300	2,300	2,300	2,300	2,300
Northwest Region	6,171	6,305	6,481	6,714	6,418	30%	1,925	1,925	1,925	1,925	1,925	1,925
North Region	353	314	302	333	326	15%	49	49	49	49	49	49
South Region	1,261	1,381	1,359	1,420	1,355	30%	407	407	407	407	407	407
Outside Market Area	1,637	1,571	1,505	1,453	1,542	50%	771	771	771	771	771	771
3) ED Visits at Hospitals in the West Region Without Authorized Pediatric Beds	90,240	84,888	81,622	78,316	83,767	30%	25,130	25,130	25,130	25,130	25,130	25,130
Subtotal Projected ED Visits at Downers Grove							36,248	36,248	36,248	36,248	36,248	36,248
4) Seasonality Adjustment for 3-Month Peak												
Average Monthly Volume (12 months)	14,561	14,041	13,323	13,684	13,902							
Average Peak Volume (3 months)	19,257	16,007	15,135	16,582	16,745							
Difference	4,696	1,966	1,812	2,898	2,843	3-Month Peak Adjustment 20.5%	7,431	7,431	7,431	7,431	7,431	7,431
Total Projected ED Visits at Downers Grove (incl Seasonality Adjustment)							43,679	43,679	43,679	43,679	43,679	43,679

Sources/Filters:

- Factors 1, 2, 4) IHA COMPdata, CY2022 – CY2025 through Q3; ED Visits; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will
- Factor 3) IHA COMPdata, CY2022 – CY2025 through Q3; ED Visits; Age: 0-18; Select hospitals with pediatric ED visits but no authorized pediatric ED beds; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

**Table C(1): Factors Contributing to Future Projected Diagnostic Utilization – X-Ray Exams by Patient Setting
Lurie Children's – Downers Grove Hospital & Outpatient Center**

X-Ray Exams	4-Year Historical Average (2022-2025)	Projected Clinical Vol Shift to Downers Grove	Projected Clinical Volume*						X-Ray Utilization Rate	Projected Diagnostic X-Ray Volume					
			2026	2027	2028	2029	2030	2031		2026	2027	2028	2029	2030	2031
1) Ambulatory (Clinic Visits)	276,063 OP Visits	20%	55,930	58,644	61,534	64,608	67,884	71,371	0.23	9,005	9,442	9,907	10,402	10,929	11,491
2) Inpatient & Observation Cases (Low/Med Acuity)	8,500 Cases	29%	3,740	3,740	3,740	3,740	3,740	3,740	1.10	2,468	2,468	2,468	2,468	2,468	2,468
3) ED Visits	104,304 ED Visits	27%	36,248	36,248	36,248	36,248	36,248	36,248	0.24	5,220	5,220	5,220	5,220	5,220	5,220
Total Projected X-Rays										16,692	17,129	17,594	18,090	18,617	19,178

Sources/Filters:

- Factor 1) Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions only
- Factor 2) Lurie Children's Enterprise Decision Support Database; IHA COMPdata, CY2022 – CY2025 through Q3; Lurie Children's Epic Database, FY2022-FY2025
 - Enterprise Data: Inpatient & Observation Days (Low/Med Acuity); Aggregate encounter data used for IDPH AHQ Surveys; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry
 - IHA COMPdata: Inpatient and Observation; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation <= 2.5; Planning Region defined by patient ZIP code
 - Epic Data: DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled
- Factor 3) IHA COMPdata, CY2022-CY2025 through Q3; ED Visits; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

***Projected Clinical Volume:**

- Average Historical Growth Rate* is a simple average of the distinct volume growth rates from all satellite locations and is not weighted by individual location volume.
- Projected Shift to Downers Grove* is a composite metric reflecting the varying proportions of volume projected to shift from each existing satellite to Lurie Children's Downers Grove.

Imaging Utilization Rates:

- Ambulatory imaging utilization is based on the ratio of ambulatory imaging encounters to total completed outpatient visit appointments. (Refer to Section 1110.270, Table D)
- Inpatient/Observation imaging utilization is based on the ratio of inpatient & observation imaging encounters to total inpatient & observation bed charges at Lurie Children's - Streeterville. (Refer to Section 1110.200, Attachment #19)
- Emergency Department imaging utilization is based on the ratio of ED imaging encounters to total ED charges at Lurie Children's - Streeterville. (Refer to Section 1110.270, Table B)

**Table C(2): Factors Contributing to Future Projected Diagnostic Utilization – Fluoroscopy Procedures by Patient Origin
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Diagnostic Imaging Volume							Projected Diagnostic Imaging Volume					
Fluoroscopy Procedures	2022	2023	2024	2025	4-Year Avg	Avg Annual Growth Rate	Projected Shift to Downers Grove	2026	2027	2028	2029	2030	2031
								(Hospital under construction)					
1) West Region Patients	811	905	997	973	922	6%	100%	981	1,044	1,112	1,183	1,260	1,341
2) South Region Patients	510	654	567	802	633	19%	30%	226	268	318	378	449	534
3) Patients from All Other Regions	3,290	3,124	3,380	3,724	3,380	-	-	-	-	-	-	-	-
Total Projected Volume								1,207	1,312	1,430	1,561	1,709	1,875

Sources/Filters:

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient Fluoroscopy appointments at all Lurie Children's locations (includes satellite locations and Main Campus); Patient Planning Region based on ZIP code

**Table C(3): Factors Contributing to Future Projected Diagnostic Utilization – Ultrasound Scans by Patient Setting
Lurie Children's – Downers Grove Hospital & Outpatient Center**

Ultrasound Scans	4-Year Historical Average (2022-2025)	Projected Clinical Vol Shift to Downers Grove	Projected Clinical Volume*						Ultrasound Utilization Rate	Projected Diagnostic Ultrasound Volume					
			2026	2027	2028	2029	2030	2031		2026	2027	2028	2029	2030	2031
										(Hospital under construction)					
1) Ambulatory (Clinic Visits)	276,063	20%	55,930	58,644	61,534	64,608	67,884	71,371	0.07	2,741	2,874	3,015	3,166	3,326	3,497
2) Inpatient & Observation Cases (Low/Med Acuity)	8,500 Cases	29%	3,740	3,740	3,740	3,740	3,740	3,740	0.34	763	763	763	763	763	763
3) ED Visits	104,304	27%	36,248	36,248	36,248	36,248	36,248	36,248	0.09	2,284	2,284	2,284	2,284	2,284	2,284
Total Projected Ultrasounds										5,798	5,920	6,062	6,212	6,373	6,544

Sources/Filters:

- Factor 1) Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions only
- Factor 2) Lurie Children's Enterprise Decision Support Database; IHA COMPdata, CY2022 – CY2025 through Q3; Lurie Children's Epic Database, FY2022-FY2025
 - Enterprise Data: Inpatient & Observation Days (Low/Med Acuity); Aggregate encounter data used for IDPH AHQ Surveys; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry
 - IHA COMPdata: Inpatient and Observation; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation <= 2.5; Planning Region defined by patient ZIP code
 - Epic Data: DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled
- Factor 3) IHA COMPdata, CY2022-CY2025 through Q3; ED Visits; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

***Projected Clinical Volume:**

- Average Historical Growth Rate* is a simple average of the distinct volume growth rates from all satellite locations and is not weighted by individual location volume.
- Projected Shift to Downers Grove* is a composite metric reflecting the varying proportions of volume projected to shift from each existing satellite to Lurie Children's Downers Grove.

Imaging Utilization Rates:

- Ambulatory imaging utilization is based on the ratio of ambulatory imaging encounters to total completed outpatient visit appointments. (Refer to Section 1110.270, Table D)
- Inpatient/Observation imaging utilization is based on the ratio of inpatient & observation imaging encounters to total inpatient & observation bed charges at Lurie Children's - Streeterville. (Refer to Section 1110.200, Attachment #19)
- Emergency Department imaging utilization is based on the ratio of ED imaging encounters to total ED charges at Lurie Children's - Streeterville. (Refer to Section 1110.270, Table B)

Table C(4): Factors Contributing to Future Projected Diagnostic Utilization – MRI Scans by Patient Origin
Lurie Children's – Downers Grove Hospital & Outpatient Center

	Historical Diagnostic Imaging Volume							Projected Diagnostic Imaging Volume					
MRI Scans	2022	2023	2024	2025	4-Year Avg	Avg Annual Growth Rate	Projected Shift to Downers Grove	2026	2027	2028	2029	2030	2031
								(Hospital under construction)					
1) Westchester MRIs, West Region Patients	682	697	657	888	731	11%	100%	808	893	987	1,091	1,206	1,334
2) Northbrook MRIs, West Region Patients	244	292	227	295	265	9%	100%	289	315	344	375	409	447
3) Lurie Children’s Ambulatory MRIs, West Region Patients	2,542	2,733	2,773	2,806	2,714	3%	60%	1,683	1,740	1,799	1,860	1,923	1,989
Total Projected MRI Scans								2,780	2,948	3,130	3,326	3,538	3,770

Sources/Filters:

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient MRI appointments at Lurie Children's satellite locations (includes activity at area hospitals); new or returning patients; medical/surgical divisions only

Table C(5): Factors Contributing to Future Projected Utilization - CT Scans by Patient Setting
Lurie Children's – Downers Grove Hospital & Outpatient Center

CT Scans	4-Year Historical Average (2022-2025)	Projected Shift to Downers Grove*	Projected Clinical Volume						CT Utilization Rate	Projected Diagnostic CT Volume					
			2026	2027	2028	2029	2030	2031		2026	2027	2028	2029	2030	2031
1) Ambulatory (Clinic Visits)	276,063	20%	55,930	58,644	61,534	64,608	67,884	71,371	0.06	3,356	3,519	3,692	3,876	4,073	4,282
2) Inpatient & Observation Cases (Low/Med Acuity)	8,500 Cases	29%	3,740	3,740	3,740	3,740	3,740	3,740	0.13	486	486	486	486	486	486
3) ED Visits	104,304	27%	36,248	36,248	36,248	36,248	36,248	36,248	0.06	2,320	2,320	2,320	2,320	2,320	2,320
Total Projected CT Scans										6,162	6,325	6,498	6,682	6,879	7,088

Sources/Filters:

- Factor 1) Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions only
- Factor 2) Lurie Children's Enterprise Decision Support Database; IHA COMPdata, CY2022 – CY2025 through Q3; Lurie Children's Epic Database, FY2022-FY2025
 - Enterprise Data: Inpatient & Observation Days (Low/Med Acuity); Aggregate encounter data used for IDPH AHQ Surveys; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry
 - IHA COMPdata: Inpatient and Observation; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation <= 2.5; Planning Region defined by patient ZIP code
 - Epic Data: DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled
- Factor 3) IHA COMPdata, CY2022-CY2025 through Q3; ED Visits; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

***Projected Clinical Volume:**

- Average Historical Growth Rate* is a simple average of the distinct volume growth rates from all satellite locations and is not weighted by individual location volume.
- Projected Shift to Downers Grove* is a composite metric reflecting the varying proportions of volume projected to shift from each existing satellite to Lurie Children's Downers Grove.

Imaging Utilization Rates:

- Ambulatory imaging utilization is based on the ratio of ambulatory imaging encounters to total completed outpatient visit appointments. (Refer to Section 1110.270, Table D)
- Inpatient/Observation imaging utilization is based on the ratio of inpatient & observation imaging encounters to total inpatient & observation bed charges at Lurie Children's - Streeterville. (Refer to Section 1110.200, Attachment #19)
- Emergency Department imaging utilization is based on the ratio of ED imaging encounters to total ED charges at Lurie Children's - Streeterville. (Refer to Section 1110.270, Table B)

Table D: Factors Contributing to Future Projected Utilization - Outpatient Clinic Visits by Patient Origin
Lurie Children's – Downers Grove Hospital & Outpatient Center

	Historical Clinic Visit Volume							Projected Clinic Visit Volume					
Factor	2022	2023	2024	2025	4-Year Avg	Avg Annual Growth Rate	Projected Shift to Downers Grove	2026	2027	2028	2029	2030	2031
								(Hospital under construction)					
1) Westchester Outpatient Center	14,784	16,374	16,830	16,480	16,117	2%	100%	16,424	16,736	17,054	17,378	17,709	18,046
2) Other Lurie Satellite Locations	221,755	236,537	242,884	260,307	240,371	6%							
West Region	39,468	42,460	45,546	49,308	44,196	8%	50%	23,800	25,633	27,608	29,734	32,025	34,491
South Region	25,870	28,575	29,397	31,199	28,760	5%	10%	3,010	3,151	3,298	3,452	3,613	3,782
All Other Regions	156,417	165,502	167,941	179,800	167,415	5%	5%	8,771	9,190	9,630	10,090	10,573	11,078
3) Anticipated Clinic Visits from Area Hospitals	19,552	19,722	19,335	19,690	19,575	0%	20%	3,925	3,934	3,944	3,954	3,964	3,974
Total Clinic Visits	256,091	272,633	279,049	296,477	276,063			55,930	58,644	61,534	64,608	67,884	71,371

Sources/Filters:

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations (includes activity at area hospitals); new or returning patients; medical/surgical divisions only

**Table E: Factors Contributing to Future Projected Utilization – Ancillary Testing
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Cases					Projection Factor	Projected Cases					
Factor	2022	2023	2024	2025	4-Year Avg		2026	2027	2028	2029	2030	2031
							(Hospital under construction)					
Outpatient Cardiology Visits - Westchester	508	547	646	672	593	Division to Visit Ratio	605	616	628	640	652	664
						0.04						
1) Electrocardiograms (ECG)	676	679	743	788	722	Procedure to Visit Ratio	738	752	766	781	795	810
						1.22						
2) Echocardiograms (ECHO)	350	350	388	431	380	0.64	387	394	402	410	417	425
Outpatient Pulmonology Visits - Westchester	391	397	402	371	390	Division to Visit Ratio	398	405	413	421	429	437
						0.02						
3) Pulmonary Function Tests (PFT)	286	290	285	268	282	0.72	287	292	297	303	309	315
4) Electroencephalograms (EEG)						Projected Cases per Week (52 Weeks)	2,080	2,080	2,080	2,080	2,080	2,080
						40						
5) Video EEGs						9	468	468	468	468	468	468
6) Sleep Studies						20	1,040	1,040	1,040	1,040	1,040	1,040
Total Projected Volume							5,000	5,026	5,053	5,082	5,109	5,138

Sources/Filters (All Factors):

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025
 - Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions unless otherwise specified
 - ECG and ECHO ratios are based on completed Cardiology procedures at Lurie Children's Hospital Outpatient Center in Westchester
 - PFT ratio is based on completed Pulmonary Medicine procedures at Lurie Children's Hospital Outpatient Center in Westchester
 - EEG projections are based on 2 rooms being utilized by 4 patients per day, 5 days per week
 - vEEG projections are based on 9 procedures per week
 - Sleep Study projections are based on 4 studies per day, 5 days per week
- **Projected Ancillary Tests (Factors 1-3):** *Projected Cases = "Procedure to Visit Ratio" * "Outpatient Clinic Visits by Division"*
- **Projected Cardiology and Pulmonary Cases:** After determining the proportion of Cardiology (0.04) and Pulmonology (0.02) visits at Lurie Children's Westchester, this ratio was multiplied by projections in the "Projected Outpatient Clinic Visits" table to calculate projected cases for each division

**Table F: Factors Contributing to Future Projected Utilization – Infusion Services
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Cases							Projected Cases					
Factor	2022	2023	2024	2025	4-Year Avg	Average Annual Growth Rate	Projected Shift to Downers Grove	2026	2027	2028	2029	2030	2031
								(Hospital under construction)					
1) Total Ambulatory Infusions at Lurie Children's - Streeterville Campus	8,461	9,274	9,092	9,654	9,120	5%		2,269	2,378	2,493	2,613	2,739	2,871
West Region Patients	1,975	2,082	2,282	2,259	2,150	5%	70%	1,575	1,649	1,726	1,806	1,891	1,979
South Region Patients	1,164	1,364	1,133	1,319	1,245	6%	30%	394	416	439	464	489	517
All Other Regions	5,322	5,828	5,677	6,076	5,726	5%	5%	300	314	328	343	359	376
2) Total Ambulatory Infusions at Area Hospitals	-	-	-	4,149	4,149	0%	20%	830	830	830	830	830	830
Total Projected Volume	8,461	9,274	9,092	13,803	13,269			3,099	3,208	3,323	3,443	3,569	3,701

Sources/Filters:

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's Ambulatory Infusion Center; excludes Stem Cell, TAC, first infusions, and infusions over 6 hours
- Area Hospital Service Line Report, FY2025; Outpatient appointments, includes: Chemo IV Push, Chemo Infusion, Hydration, Non-Chemo Infusion, IV Push, Blood Product Transfusion, and Cancer Center Transfusions

**Table G: Factors Contributing to Future Projected Utilization – Rehabilitation Services
Lurie Children's – Downers Grove Hospital & Outpatient Center**

	Historical Cases						Projected Cases					
Factor	2022	2023	2024	2025	4-Year Avg	Average Annual Growth Rate	2026	2027	2028	2029	2030	2031
							(Hospital under construction)					
1) Physical Therapy	3,552	4,151	4,088	4,457	4,062	8%	4,392	4,749	5,135	5,552	6,003	6,490
2) Occupational Therapy	1,286	1,133	1,239	1,178	1,209	-2%	1,179	1,150	1,121	1,093	1,066	1,039
3) Orthotics/Prosthetics	1,536	1,319	1,175	1,433	1,366	-1%	1,352	1,338	1,324	1,310	1,297	1,284
4) Speech Therapy	2,462	2,676	2,435	2,714	2,572	4%	2,667	2,766	2,869	2,976	3,086	3,201
5) Audiology	3,182	3,499	3,355	3,244	3,320	1%	3,348	3,376	3,405	3,434	3,463	3,492
Total Projected Volume	12,018	12,778	12,292	13,026	12,529		12,938	13,378	13,854	14,365	14,915	15,506

Sources/Filters (All Factors):

- Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's Hospital Outpatient Center in Westchester; new or returning patients; medical/surgical divisions only

**Table H: Factors Contributing to Future Projected Utilization – Laboratory Services by Patient Setting
Lurie Children's – Downers Grove Hospital & Outpatient Center**

Laboratory Services	4-Year Historical Average (2022-2025)	Projected Shift to Downers Grove	Projected Clinical Volume						Lab Utilization Rate	Projected Laboratory Volume					
			2026	2027	2028	2029	2030	2031		2026	2027	2028	2029	2030	2031
1) Ambulatory (Clinic Visits)	276,063	20%	55,930	58,644	61,534	64,608	67,884	71,371	0.26	14,542	15,247	15,999	16,798	17,650	18,556
2) Inpatient & Observation Cases (Low/Med Acuity)	8,500 Cases	29%	3,740	3,740	3,740	3,740	3,740	3,740	25.76	96,319	96,319	96,319	96,319	96,319	96,319
3) ED Visits	104,303	27%	36,248	36,248	36,248	36,248	36,248	36,248	1.51	54,735	54,735	54,735	54,735	54,735	54,735
Total Projected Labs										165,596	166,301	167,053	167,852	168,703	169,610

Sources/Filters:

- Factor 1) Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions only
- Factor 2) Lurie Children's Enterprise Decision Support Database; IHA COMPdata, CY2022 – CY2025 through Q3; Lurie Children's Epic Database, FY2022-FY2025
 - Enterprise Data: Inpatient & Observation Days (Low/Med Acuity); Aggregate encounter data used for IDPH AHQ Surveys; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry
 - IHA COMPdata: Inpatient and Observation; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation <= 2.5; Planning Region defined by patient ZIP code
 - Epic Data: DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled
- Factor 3) IHA COMPdata, CY2022-CY2025 through Q3; ED Visits; Age: 0-18; 7-County Service Area: Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

***Projected Clinical Volume:**

- Average Historical Growth Rate* is a simple average of the distinct volume growth rates from all satellite locations and is not weighted by individual location volume.
- Projected Shift to Downers Grove* is a composite metric reflecting the varying proportions of volume projected to shift from each existing satellite to Lurie Children's Downers Grove.

Imaging Utilization Rates:

- Ambulatory imaging utilization is based on the ratio of ambulatory imaging encounters to total completed outpatient visit appointments. (Refer to Section 1110.270, Table D)
- Inpatient/Observation imaging utilization is based on the ratio of inpatient & observation imaging encounters to total inpatient & observation bed charges at Lurie Children's - Streeterville. (Refer to Section 1110.200, Attachment #19)
- Emergency Department imaging utilization is based on the ratio of ED imaging encounters to total ED charges at Lurie Children's - Streeterville. (Refer to Section 1110.270, Table B)

**Table I: Factors Contributing to Future Projected Utilization – Pharmacy Services by Patient Setting
Lurie Children's – Downers Grove Hospital & Outpatient Center**

Pharmacy Services	4-Year Historical Average (2022-2025)	Projected Shift to Downers Grove	Projected Clinical Volume						Pharmacy Utilization Rate	Projected Pharmacy Volume					
			2026	2027	2028	2029	2030	2031		2026	2027	2028	2029	2030	2031
										(Hospital under construction)					
1) Ambulatory (Clinic Visits)	276,063	20%	55,930	58,644	61,534	64,608	67,884	71,371	0.05	2,797	2,932	3,077	3,230	3,394	3,569
2) Inpatient & Observation Cases (Low/Med Acuity)	8,500 Cases	29%	3,740	3,740	3,740	3,740	3,740	3,740	64.49	241,135	241,135	241,135	241,135	241,135	241,135
3) ED Visits	104,303	27%	36,248	36,248	36,248	36,248	36,248	36,248	1.36	49,297	49,297	49,297	49,297	49,297	49,297
Total Projected Pharmacy										293,229	293,364	293,509	293,663	293,826	294,001

Sources/Filters:

- Factor 1) Lurie Children's Ambulatory Encounter and Scheduling Database, FY2022-FY2025; Completed outpatient appointments at Lurie Children's satellite locations; new or returning patients; medical/surgical divisions only
- Factor 2) Lurie Children's Enterprise Decision Support Database; IHA COMPdata, CY2022 – CY2025 through Q3; Lurie Children's Epic Database, FY2022-FY2025
 - Enterprise Data: Inpatient & Observation Days (Low/Med Acuity); Aggregate encounter data used for IDPH AHQ Surveys; Planning Region defined by patient ZIP code; Departments excluded: NICU, PICU, Neuro/Endo, Cardiac Care, Psychiatry
 - IHA COMPdata: Inpatient and Observation; Age: 0-18; Low/Med Acuity based on MS-DRG Tertiary Designation <= 2.5; Planning Region defined by patient ZIP code
 - Epic Data: DenialFlag is Yes; Denials > 0; Transfer Request Status is Canceled
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- Inpatient/Observation imaging utilization is based on the ratio of inpatient & observation imaging encounters to total inpatient & observation bed charges at Lurie Children's - Streeterville. (Refer to Section 1110.200, Attachment #19)
- Emergency Department imaging utilization is based on the ratio of ED imaging encounters to total ED charges at Lurie Children's - Streeterville. (Refer to Section 1110.270, Table B)

1120.120 Availability of Funds

Attached are:

- 1) CON form table listing the sources of project funding;
- 2) The most recent Audited Financial Statements for Children's Hospital of Chicago Medical Center and Affiliated Corporations, August 31, 2024 and 2025.

Attachment 34

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]:

\$180,102,903	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.
\$100,000,000	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
\$200,000,000 (bonds)	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.
\$480,102,903	TOTAL FUNDS AVAILABLE

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

Children's Hospital of Chicago Medical Center and Affiliated Corporations

**Consolidated Financial Statements
August 31, 2025 and 2024**

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Independent Auditor's Report

RSM US LLP

Board of Directors
Children's Hospital of Chicago Medical Center

Opinion

We have audited the consolidated financial statements of Children's Hospital of Chicago Medical Center and Affiliated Corporations (the Medical Center), which comprise the consolidated balance sheets as of August 31, 2025 and 2024, the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively, the financial statements).

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Medical Center as of August 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 Medical Center and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the 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 from 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 Medical Center's ability to continue as a going concern within one year after the date that the financial statements are issued or available to be 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 from 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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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 Medical Center's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Medical Center's ability to continue as a going concern for a reasonable period of time.

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations and changes in net assets of the individual companies and is 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 consolidating 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 GAAS. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

RSM US LLP

Chicago, Illinois
December 18, 2025

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations
Consolidated Balance Sheets
August 31, 2025 and 2024
(Dollars in Thousands)**

	2025	2024
Assets		
Current assets		
Cash and cash equivalents	\$ 65,301	\$ 38,672
Current portion of self-insurance trust	35,566	31,699
Patient accounts receivable	315,711	355,957
Other current assets	167,440	199,642
Total current assets	584,018	625,970
Investments	2,107,375	1,971,480
Property and equipment, at cost		
Land	79,559	79,421
Buildings and improvements	1,443,867	1,366,502
Equipment	632,419	579,748
Construction in progress	57,930	77,607
Total property and equipment, at cost	2,213,775	2,103,278
Less: Accumulated depreciation	1,062,133	982,489
Property and equipment	1,151,642	1,120,789
Operating lease right-of-use assets	23,836	30,965
Other assets		
Pledges receivable restricted by donors	35,906	44,064
Other	2,352	6,111
Total other assets	38,258	50,175
Total assets	\$ 3,905,129	\$ 3,799,379
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt	\$ 7,200	\$ 6,860
Accounts payable and accrued expenses	252,275	381,830
Current portion of self-insurance liability	35,566	31,699
Due to third-party payors	165,152	162,264
Current portion of operating lease liabilities	10,134	9,702
Total current liabilities	470,327	592,355
Long-term debt, less current portion	313,633	321,379
Self-insurance liability, less current portion	214,568	201,620
Operating lease liabilities, less current portion	27,286	38,514
Other noncurrent liabilities	25,912	26,324
Total liabilities	1,051,726	1,180,192
Net assets		
Without donor restrictions	2,231,227	2,032,369
With donor restrictions	622,176	586,818
Total net assets	2,853,403	2,619,187
Total liabilities and net assets	\$ 3,905,129	\$ 3,799,379

The accompanying notes are an integral part of these consolidated financial statements.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Consolidated Statements of Operations and Changes in Net Assets
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

	2025	2024
Operating revenue		
Patient service revenue	\$ 1,593,068	\$ 1,454,344
Net assets released from restriction		
Contributions and philanthropy used for program purposes	54,230	53,899
Grants and other restricted income used for program purposes	105,998	97,484
Board-designated endowment income	20,702	22,638
Other operating revenue	109,221	102,969
Total operating revenue	<u>1,883,219</u>	<u>1,731,334</u>
Operating expenses		
Salaries, wages and employee benefits	1,132,107	1,104,516
Supplies and services	488,655	496,894
Insurance	43,880	43,850
Medicaid assessment	30,721	30,433
Depreciation and amortization	90,845	83,396
Interest and financing costs	16,193	17,006
Total operating expenses	<u>1,802,401</u>	<u>1,776,095</u>
Income (loss) from operations	<u>80,818</u>	<u>(44,761)</u>
Nonoperating income (expense)		
Investment return	120,701	174,179
Unrestricted contributions and bequests	24,408	25,059
Fundraising expense	(21,116)	(21,201)
Other	(18,396)	(11,770)
Total nonoperating income	<u>105,597</u>	<u>166,267</u>
Excess of revenue over expenses	<u>\$ 186,415</u>	<u>\$ 121,506</u>

(Continued)

The accompanying notes are an integral part of these consolidated financial statements.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Consolidated Statements of Operations and Changes in Net Assets (Continued)
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

	2025	2024
Net assets without donor restrictions		
Excess of revenue over expenses	\$ 186,415	\$ 121,506
Net assets released from restriction used for purchase and construction of property and equipment	494	316
Retirement plan-related changes other than net periodic retirement cost	8,614	(595)
Other	3,335	1,248
Change in net assets without donor restrictions	198,858	122,475
Net assets with donor restrictions		
Contributions	51,688	36,758
Grants and other restricted income	118,528	103,388
Change in fair value of perpetual trusts	1,128	3,159
Investment return	27,900	40,823
Pledge receivable write-offs, net of change in allowance	171	93
Net assets released from restriction		
Contributions and philanthropy used for program purposes	(54,230)	(53,899)
Grants and other restricted income used for program purposes	(105,998)	(97,484)
Purchase and construction of property and equipment	(494)	(316)
Other	(3,335)	(1,248)
Change in net assets with donor restrictions	35,358	31,274
Change in net assets	234,216	153,749
Net assets		
Beginning of year	2,619,187	2,465,438
End of year	\$ 2,853,403	\$ 2,619,187

The accompanying notes are an integral part of these consolidated financial statements.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Consolidated Statements of Cash Flows
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

	2025	2024
Cash flows from operating activities		
Change in net assets	\$ 234,216	\$ 153,749
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Realized and unrealized gains on investments	(120,701)	(174,179)
Restricted contributions and restricted investment return, net	(37,693)	(48,978)
Loss (gain) on disposal of property and equipment	1,387	(29)
Receipt of contributed securities	(8,254)	(4,683)
Investment loss - joint ventures	3,442	4,978
Retirement plan related changes other than net periodic retirement cost	(8,614)	595
Depreciation and amortization	90,845	83,396
Reduction in operating lease right-of-use assets	7,129	7,222
Net changes in assets and liabilities		
Accounts receivable	40,246	(34,671)
Accounts payable and accrued expenses	(127,393)	122,516
Due to third-party payors	2,888	40,506
Self-insurance liability	16,815	26,034
Other assets	44,118	(39,843)
Other liabilities	(2,596)	(5,823)
Net cash provided by operating activities	<u>135,835</u>	<u>130,790</u>
Cash flows from investing activities		
Capital expenditures	(125,789)	(207,700)
Sales of investments	2,974,369	5,115,842
Purchases of investments	(2,964,312)	(5,081,342)
Net cash used in investing activities	<u>(115,732)</u>	<u>(173,200)</u>
Cash flows from financing activities		
Principal payments under long-term debt obligations	(6,860)	(6,530)
Proceeds from line of credit	-	25,000
Payment of line of credit	-	(25,000)
Proceeds from restricted contributions and restricted investment return	<u>13,386</u>	<u>9,414</u>
Net cash provided by financing activities	<u>6,526</u>	<u>2,884</u>
Increase (decrease) in cash and cash equivalents	<u>26,629</u>	<u>(39,526)</u>
Cash and cash equivalents		
Beginning of year	38,672	78,198
End of year	<u>\$ 65,301</u>	<u>\$ 38,672</u>
Supplemental disclosures of cash flow information		
Cash paid during the year for interest	\$ 13,122	\$ 13,451
Noncash additions to property and equipment	10,291	12,449
Operating lease right-of-use assets obtained in exchange for lease obligations	2,088	3,391

The accompanying notes are an integral part of these consolidated financial statements.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

1. Organization and Nature of Operations

Children's Hospital of Chicago Medical Center (the 'Medical Center'), an Illinois not-for-profit corporation, is the sole corporate member of Ann & Robert H. Lurie Children's Hospital of Chicago (the 'Hospital'), an Illinois not-for-profit corporation. The Hospital was founded in 1882 by Julia Foster Porter to provide medical care for all children. Today, the Medical Center and its affiliates comprise an independent, freestanding academic institution dedicated to the health and well-being of all children. The Medical Center is also the sole corporate member of Ann & Robert H. Lurie Children's Hospital of Chicago Foundation ('Foundation'), Stanley Manne Children's Research Institute ('Research Institute'), Lurie Children's Medical Group, Inc. ('LCMG'), and Almost Home Kids ('AHK'), all Illinois not-for-profit corporations. Lurie Children's Health Services ('LCHS') is an Illinois limited liability company whose sole member is the Medical Center. The Medical Center is also the parent of CMMC Insurance Co. Ltd. ('CMMC Insurance'), a captive, offshore insurance entity organized under the laws of the Cayman Islands. The Hospital, Foundation, Research Institute, LCMG, AHK, LCHS, and CMMC Insurance are collectively referred to herein as the Affiliated Corporations.

On April 10, 2024, the Medical Center Board of Directors unanimously approved the merger of its subsidiary medical groups into a single, multispecialty pediatric faculty practice, LCMG, which took effect on January 1, 2025. As a result of the transaction, Pediatric Faculty Foundation, Inc. ('PFF'), Lurie Children's Surgical Foundation, Inc. ('LCSF'), Lurie Children's Pediatric Anesthesia Associates ('LCPAA'), Lurie Children's Medical Group, LLC ('LCMG LLC'), and Lurie Children's Primary Care, LLC ('LCPC'), along with Children's Hospital of Chicago Faculty Practice Plan, Inc. ('FPP'), ceased their separate existence. LCMG is a not-for-profit, tax-exempt corporation, whose sole corporate member is the Medical Center. This new single integrated medical group model is designed to enhance the delivery of patient-centered, multidisciplinary care and more effectively support our faculty and physicians through a further coordinated operational infrastructure.

The Hospital owns and operates a pediatric hospital in Chicago, Illinois, with 364 licensed beds as of August 31, 2025. The Hospital provides a complete range of pediatric health care services, including pediatric inpatient medical and surgical care, tertiary and quaternary care services, and emergency services. The Hospital operates more than 50 specialty and primary care outpatient clinics at its main campus in the Streeterville neighborhood of Chicago and throughout the metro Chicago area, as well as two Ambulatory Surgical Treatment Centers ('ASTC') facilities and 17 outpatient specialty centers in the surrounding metro Chicago area.

The Foundation carries out fundraising and other related development activities in support of the Medical Center and its affiliates. The Foundation supports comprehensive capital campaigns aligned with the Medical Center's strategic plans. Restricted contributions support specific programs, recruitments, and research, in addition to unrestricted contributions which, not only offset fundraising expense, but also contribute to the Hospital's greatest areas of need.

The Research Institute was established to improve pediatric health and health care services through research and education. Its role is to build a scientific community in support of treatments and cures within pediatric medicine which span the laboratory bench to the patient's bedside. The Medical Center in conjunction with Northwestern University completed and commissioned the research facility at the Simpson Querrey Biomedical Research Center in Chicago in June 2019.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
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AHK is a unique organization providing transitional and respite care for medically complex children outside the acute care setting.

LCHS exists for the provision and coordination of medical care of medically complex children, contracting with Managed Care Organizations ('MCOs') and commercial health plans to provide care coordination services to children within their plans that have complex medical needs.

CMMC Insurance is a captive, offshore insurance entity whose sole function is to purchase reinsurance for the purpose of reducing risk and cost. It currently does not retain risk. CMMC Insurance has no employees and is managed on behalf of the Hospital by an independent Cayman Islands-based management company.

In June 2014, the Medical Center, Children's Community Physicians Association ('CCPA'), and FPP formed Lurie Children's Health Partners Clinically Integrated Network, LLC, an Illinois limited liability company (the 'CIN'). The CIN is an integrated health care network focused on creating value-based reimbursement programs with payors that support improving the health and well-being of children and their families. The CIN has a 12-member board of which CCPA appoints six, LCMG, Inc. (as successor to FPP) appoints four, and the Medical Center appoints two members. CCPA is committed to a 3% capital position, while the Medical Center and LCMG, Inc. are committed to a 97% capital position. The Medical Center's share of the losses were approximately \$3,900 and \$4,400 for the years ended August 31, 2025 and 2024, respectively. As the Medical Center does not have governance control, the CIN is not a consolidating entity but rather accounted for under the equity method.

Consolidation

The accompanying consolidated financial statements of the Medical Center include the accounts of the Hospital, the Foundation, the Research Institute, LCMG, AHK, the Medical Center, CMMC Insurance and LCHS. Intercompany transactions and accounts have been eliminated.

The accompanying consolidating balance sheets and consolidating statements of operations and changes in net assets without donor restrictions by entity as of and for the years ended August 31, 2025 and 2024, are provided for purposes of additional analysis and are not required as part of the consolidated financial statements. They have been prepared in a manner consistent with accounting principles generally accepted in the United States of America ('U.S. GAAP') and are presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The supplemental consolidating financial information was derived from the accounting records used to prepare the consolidated financial statements. All intercompany eliminations have been recorded.

2. Income Taxes

Under Section 501(c)(3) of the Internal Revenue Code, the Medical Center, the Hospital, the Research Institute, the Foundation, LCMG and AHK, are all Illinois not-for-profit organizations exempt from federal and state income taxes.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
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Certain activities of the Hospital are taxable as unrelated business. For the years ended August 31, 2025 and 2024, \$140 and \$547, respectively, was recorded as provision for unrelated business income tax and included in other nonoperating expense in the consolidated statements of operations and changes in net assets. For the year ended August 31, 2025, LCHS is a disregarded entity treated as a division of the Medical Center for the Internal Revenue Service (IRS) reporting. For the year ended August 31, 2024, LCMG, LCHS and LCPC were disregarded entities treated as divisions of the Medical Center for the IRS reporting.

3. Summary of Significant Accounting Policies

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. GAAP requires management of the Medical Center to make assumptions, estimates, and judgments that affect the amounts reported in the consolidated financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. The Medical Center considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its consolidated financial statements, including but not limited to the following: recognition of patient accounts receivable and patient service revenue, both of which include contractual allowances and third-party payor settlements; reserves for losses and expenses related to health care professional and general liabilities; valuation of alternative investments; and accrued self-insurance related costs. Management relies on historical experience, other assumptions believed to be reasonable under the circumstances, and recommendations made by the Medical Center external advisors and actuaries in making its judgments and estimates. Actual results could differ from these estimates.

Cash and Cash Equivalents

Cash and cash equivalents include cash balances as well as unrestricted, undesignated marketable securities with original maturities of three months or less that are held for short-term cash management. Cash and cash equivalents are reported at cost which approximates their fair value due to their nature and liquidity.

Current Portion of Self-Insurance Revocable Trust

Current portion of self-insurance trust represents investment assets earmarked for self-insurance trust payments due within a year. See Note 7 for additional disclosures.

Patient Accounts Receivable

Patient accounts receivable consists primarily of amounts owed by various governmental agencies, insurance companies and patients. The Medical Center manages these receivables by regularly reviewing the accounts and contracts and by recording appropriate price concessions. The Medical Center reports accounts receivable at an amount equal to the consideration it expects to receive in exchange for providing health care services to its patients, which is estimated using contractual provisions associated with specific payors, historical reimbursement rates and analysis of past experience to estimate potential adjustments. The Medical Center writes off amounts that have been deemed to be uncollectible because of circumstances that affect the ability of payors to make payments as they occur. See Note 4. Patients accounts receivable was \$355,957 and \$321,286 as of August 31, 2024 and August 31, 2023, respectively.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
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(Dollars in Thousands)

Inventories

Inventories, which primarily consist of medical supplies and pharmaceuticals used for patient care, are stated at the lower of cost or net realizable value, using the first-in, first-out method. Inventories are included in other current assets.

Investments

The Medical Center pools its donor-restricted, self-insurance, undesignated and board-designated investments. Investment returns are allocated among net assets without donor restrictions and net assets with donor restrictions based on the pro-rata share of the balance in each fund to the total investment pool as of the end of each accounting period.

A portion of the investment income earned on certain funds that are board-designated for patient care, education and the self-insurance trust is allocated at a fixed rate and reported as other operating revenue. All other investment income and losses (including interest and dividends, realized gains and losses, and unrealized gains and losses) are reported as nonoperating income (expenses) unless the income or loss is restricted by donor or law. Investment returns on net assets with restrictions are allocated to the purposes specified by the donor or law, either as net assets with donor restrictions or net assets without donor restrictions, as applicable.

Property and Equipment

Property and equipment are recorded at cost. Internal labor and interest expense incurred during the period of construction of significant capital projects are capitalized as a component of the cost of the asset.

Depreciation is calculated using the straight-line method over the estimated useful life of the assets. Typical useful lives are 20 to 80 years for buildings, 15 to 20 years for building improvements, 5 to 20 years for equipment and 3 to 5 years for computer hardware and software. One-half year's depreciation is taken in the year of acquisition, except for significant asset additions such as the Hospital's facility, which is depreciated based on the actual date placed into service.

In 2025 and 2024, the Medical Center disposed of fully depreciated property, equipment and software that were no longer in use totaling \$13,250 and \$95, respectively. The carrying amount of the assets and accumulated depreciation were removed from the accounts. When factors indicate that an asset should be evaluated for possible impairment, the Medical Center uses an estimate of the undiscounted cash flows over the remaining life of the asset in measuring whether the asset is recoverable. Repair and maintenance costs are expensed as incurred.

Operating Lease Right-of-Use Assets and Lease Liabilities

The Medical Center evaluates whether an arrangement is, or contains, a lease at inception. Leases result in the recognition of a right-of-use asset and lease liability in the accompanying consolidated balance sheets. Right-of-use assets represent the right to use an underlying asset for the lease term, and lease liabilities represent the obligation to make lease payments arising from the lease, measured on a discounted basis. The Medical Center determines the lease classification at the lease commencement date.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
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(Dollars in Thousands)

The lease liability is measured at the present value of the future lease payments over the lease term. The right-of-use asset equals the lease liability adjusted for any lease payments made at or before the commencement date and initial direct costs. The Medical Center uses the rate implicit in the lease, if readily determinable, as the discount rate. If that rate is not readily determinable, the Medical Center has elected to use a risk-free rate using a period comparable with the lease term. The Medical Center has also elected a policy to combine lease and non-lease components. The lease term will include options to extend the lease if the Medical Center is reasonably certain to exercise the option. Lease expense is recognized on a straight-line basis over the lease term.

Pledges Receivable Restricted by Donors

As of August 31, 2025, approximately 36% of pledges restricted by donors are receivable within one year, 64% between two and five years. Pledges are recorded at the present value of estimated future cash flows, net of allowances for uncollectible pledges of \$2,049 and \$1,707 at August 31, 2025 and 2024, respectively, and present value discounts of \$20,299 and \$23,105 at August 31, 2025 and 2024, respectively. Estimated future cash flows due after one year are discounted using interest rates of 4.5% to 7%.

Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses represent payables owed in the ordinary course of business and expenses incurred but not yet paid by the Medical Center, including payroll incurred by the Medical Center and its affiliates, and insurance payables incurred but not yet paid.

Current and Noncurrent Portions of Self-Insurance Liability

The self-insurance trust and corresponding liability are reviewed annually by an independent actuary. The Medical Center contributes to the self-insurance trust estimated amounts determined by the actuary to be sufficient to pay for expected future losses. Provisions for the professional liability are based on an actuarial estimate of losses using the Medical Center's actual loss data adjusted for industry trends and current conditions. The provision includes estimates of costs for both reported claims and claims incurred but not reported. See Note 13.

Due to Third-Party Payors

Due to third-party payors represents accruals for settlements with third-party payors, any agency that contracts with the Medical Center or its affiliates and patients to pay for the care of covered patients. Accruals are made based on estimates of amounts to be received or paid under the terms of the respective contracts and related settlement principles and regulations of the State Medicaid program, the Blue Cross Plan of Illinois and the Federal Medicare program.

Bond Issuance Costs

Bond issuance costs are deferred and amortized using the effective interest method over the life of the related debt as an increase to interest expense. These costs include items such as document preparation costs, underwriting fees, and other external, incremental expenses paid to advisors that directly relate to the financing. Unamortized bond issuance costs are reported within long-term debt.

Net Assets

Net assets are classified based upon donor restrictions, if any, as follows: Net assets without donor restrictions and net assets with donor restrictions.

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Notes to Consolidated Financial Statements
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

Net assets that bear no external restriction as to use or purpose are classified as net assets without donor restrictions. This represents net assets which are free of donor-imposed restrictions, including all revenues, expenses, gains, and losses. Also included in this classification are assets whose use is limited under board-designated funds for mission-related activities in support of the Medical Center.

Net assets with donor restrictions represent net assets whose use is limited by donor-imposed restrictions, time restrictions and those stipulations that can be fulfilled or otherwise removed by actions of the Medical Center. Net assets with donor restrictions include endowment funds primarily related to pledges receivable, grants, research, medical education, program support and net assets whose use is limited by donor-imposed stipulations that neither expire with the passage of time nor can be fulfilled or otherwise removed by actions of the Medical Center. Refer to Note 9 for further disclosure on endowments and related investment and spending policies.

Patient Service Revenue

The Medical Center provides health care services through various inpatient, outpatient, and ambulatory care facilities. The performance obligation is measured from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Outpatient services are performance obligations generally satisfied over time and revenue is recognized when goods or services are provided. The Medical Center believes that this method provides a fair depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligations. The Medical Center recognizes inpatient revenue over time (on a daily basis) at the amount that reflects the consideration to which it expects to be paid for providing such care. These amounts are due from patients, third-party payors (including health insurers and government programs) and others and include variable consideration for retroactive adjustments due to settlement of audits and reviews by Illinois Medicaid and other third-party payors, and amounts received under various state Medicaid hospital assessment and disproportionate share programs. These amounts are recognized net of contractual allowances from various third-party arrangements and after consideration of patients' ability to pay the self-pay portion of the charges. The Medical Center and affiliates bill patients and third-party payors after goods and services are provided and/or when a patient is discharged.

The Medical Center, the Hospital or any of the affiliated entities are entitled to a payment from the insurer, and a related deductible or coinsurance payment from the patient, for all goods and services related to the inpatient stay or outpatient services.

Because all of the performance obligations relate to contracts with a duration of less than one year, the Medical Center has elected to apply the optional exemption provided in Financial Accounting Standards Board ('FASB') Accounting Standards Codification 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially satisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which typically occurs within days or weeks of the end of the Medical Center's reporting period.

**Children's Hospital of Chicago Medical Center and
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Notes to Consolidated Financial Statements
Years Ended August 31, 2025 and 2024
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The Medical Center has agreements with third-party payors that provide payments at amounts different from its established rates. The Medical Center determines the transaction price based on standard charges for goods and services provided to patients reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with the Medical Center's policy, and/or implicit price concessions provided to uninsured and underinsured patients. It determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Medical Center determines its estimate of implicit price concessions based on the aging of its patient accounts receivable, historical collection experience with uninsured and underinsured patients, and other relevant factors.

The Medical Center 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, outpatient, and physician professional and outpatient revenue. Based on historical collection trends and other relevant factors, the Medical Center believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach was used.

Grants and Contributions

Unrestricted contributions are included in nonoperating income when an unconditional pledge is made or the contribution is received. Donor-restricted contributions whose restrictions are met in the same fiscal year in which the contribution is recorded are reported as unrestricted contributions. Unrestricted pledges of amounts to be received in future periods are recorded as net assets with donor restrictions based on an implicit time restriction and are released from restriction when payments are received. Grants and contributions restricted for a specific operating purpose are recorded as net assets with donor restrictions and reported as operating revenue when the funds are expended in accordance with the specifications of the grantor or donor. Contributions for capital expenditures, recorded as net assets with donor restrictions when received, are reported as net assets released from restriction when expended and placed into service. Conditional promises are recorded when donor stipulations are substantially met.

Interest in Trustee-Held Funds

The Medical Center recognizes an interest in trustee-held funds held at various financial institutions in which the Medical Center has a beneficial interest. Annually, the financial institutions distribute a portion of the income earned on these funds to the Medical Center to be used in support of operations. As of August 31, 2025 and 2024, the Medical Center's interests in these trustee-held funds at fair value totaled \$35,435 and \$34,308, respectively, and are included in net assets with donor restrictions.

Excess of Revenue Over Expenses

Excess of revenue over expenses is the performance indicator and includes income (loss) from operations in addition to investment return, unrestricted contributions and bequests, fundraising expense, and other miscellaneous nonoperating income and expenses.

**Children's Hospital of Chicago Medical Center and
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Changes in Net Assets

Net asset without donor restrictions changes includes the net activity of the consolidated statements of operations and changes in net assets as well as the release from restriction for purchase and construction of property and equipment and other than net periodic retirement plan expense changes.

Net assets with donor restrictions changes includes receipts of contributions restricted by time or purpose and restricted funds, grants, investment returns, pledge receivable write-offs and change in the fair value of perpetual trusts. Also included are releases of philanthropic or grant funds for use in program services to cover expenses on the consolidated statements of operations and changes in net assets.

Reclassifications

Certain 2024 amount have been classified to conform to the 2025 consolidated financial statement presentation.

4. Patient Service Revenue and Patient Accounts Receivable

A summary of the payment arrangements with major third-party payors is as follows:

Illinois Medicaid and Medicaid Managed Care Organizations

Reimbursement for services rendered to Medicaid program beneficiaries includes prospectively determined rates per discharge, per diem payments and fee schedules.

The State of Illinois' Medicaid program has operated with budget deficits. The deficits include the continued practice of deferring Illinois Medicaid bills to future periods and have led to the State of Illinois' slowdown in claims processing and payments.

As of August 31, 2025 and 2024, the Medical Center's patient accounts receivable included amounts due from Illinois Medicaid and Medicaid Managed Care Organizations of \$81,386 and \$125,832, respectively, both representing approximately 26% and 35%, respectively, of outstanding patient accounts receivable.

Managed Care, Commercial Insurance and Other

Reimbursement for services to certain patients is received from commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement includes prospectively determined rates per discharge, discounts from established charges, prospectively determined per diem rates, and fee schedules.

Commercial and Medicaid health insurers are entering into various fee-for-value reimbursement programs with qualifying providers. In 2025 and 2024, the Medical Center, through CIN, participated in several commercial Accountable Care Organization ('ACO') programs that provide limited risk and gain sharing based on performance of an attributed population of children compared to established cost, quality and patient satisfaction related goals. Risk sharing is limited to less than 1% of patient service revenue. CIN obtains reinsurance to reduce the risk of loss related to sharing programs and conducts a number of programs intended to improve performance under these programs, including providing care coordination to certain members.

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The composition of patient service revenue by payor for the fiscal years ended August 31, 2025 and 2024, is as follows:

	2025	2024
Medicaid	\$ 114,558	\$ 114,016
Commercial	897,531	802,538
Medicaid Managed Care	548,993	490,296
Patient Self-Pay	3,776	6,025
Other	28,210	41,469
	<u>\$ 1,593,068</u>	<u>\$ 1,454,344</u>

The Medical Center and affiliates grant credit without collateral to their patients, most of whom are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at August 31, 2025 and 2024, is as follows:

	2025	2024
Managed Care	66%	56%
Medicaid	5	11
Medicaid Managed Care	21	24
Patient Self-Pay	4	3
Other	4	6
	<u>100%</u>	<u>100%</u>

One managed care payor accounted for 36% and 26% of the Medical Center's patient accounts receivable at August 31, 2025 and 2024, respectively.

The composition of patient service revenue by service line for the fiscal years ended August 31, 2025 and 2024, is as follows:

	2025	2024
Hospital inpatient services	\$ 776,488	\$ 693,902
Hospital outpatient services	542,055	510,994
Physician professional fees	266,953	239,749
Other	7,572	9,699
	<u>\$ 1,593,068</u>	<u>\$ 1,454,344</u>

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory action, including fines, penalties, and/or exclusion from the Medicare and Medicaid programs. As a result, there is at least a reasonable possibility that recorded estimates may change in the near term.

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The Medical Center recognizes changes in accounting estimates related to patient service revenue and third-party payor settlements in the year such changes are known. Adjustments to prior year estimates for these items resulted in an increase in patient service revenue of approximately \$2,760 and \$1,716 in fiscal years 2025 and 2024, respectively.

Approximately 42% of the Medical Center's patient service revenue in fiscal years 2025 and 2024, was derived from the Illinois Medicaid program, including Medicaid MCOs.

In December 2008, the Centers for Medicare and Medicaid Services ('CMS') approved the Assessment Program to improve Medicaid reimbursement for Illinois hospitals. This original program included the Illinois Hospital Provider Assessment and subsequent enhancements. Due to the tax assessment provisions contained in the legislation, implementation of the program affected both operating revenues and expenses in the consolidated statements of operations and changes in net assets.

The Medical Center is obligated under Illinois Public Act 95-859 to participate in the State of Illinois' Hospital Assessment Program ('HAP') that assists in financing the State's Medicaid Program. The revised program is approved through December 31, 2026. For the years ended August 31, 2025 and 2024, the Medical Center recognized supplemental HAP and related reimbursement of \$169,182 and \$139,598, respectively, which is recorded as a component of patient service revenue in the consolidated statements of operations and changes in net assets. For the years ended August 31, 2025 and 2024, the Medical Center recognized HAP related fees of \$30,721 and \$30,433, respectively, in the consolidated statements of operations and changes in net assets.

The Medicaid Assessment Program payments described above are shown in the following table.

	2025	2024
For years ended August 31		
Tax assessment, included in		
patient service revenue	\$ 169,182	\$ 139,598
Medicaid assessment	<u>(30,721)</u>	<u>(30,433)</u>
Net statement of operations impact	<u>\$ 138,461</u>	<u>\$ 109,165</u>

In fiscal year 2026, the State of Illinois received federal approval for additional funding under the HAP and issued supplemental payments to participating hospitals. The supplemental revenue and corresponding assessment expense were recognized when program amounts and eligibility were confirmed.

The Medical Center also received federal and state disproportionate share and add-on payments. The amount of disproportionate share and other special payments from Medicaid, if any, that will be made to hospitals in the future, is uncertain.

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In fiscal years 2025 and 2024, the Medical Center received \$11,100 and \$10,780, respectively, in graduate medical education reimbursement. The Children's Hospital Graduate Medical Education ('CHGME') program provides federal funds to freestanding children's hospitals to aid in maintaining graduate medical programs that train resident physicians. The program is administered by the Health Resources and Services Administration, a branch of the U.S. Department of Health and Human Services. The amount of future graduate medical education reimbursement funding is uncertain.

5. Community Benefit

Consistent with its mission, the Medical Center maintains a policy that sets forth the criteria pursuant to which health care services are provided free of charge or at a reduced rate to children whose families are unable to pay for the charges associated with their medical care. These services represent charity care. Such amounts determined to qualify as charity care are not reported as patient service revenue. The Medical Center grants credit without collateral to its patients, most of whom are local residents.

The Medical Center also provides a broad range of services and activities to support its charitable mission. These services include participation in the Medicaid program at a loss (net reimbursement less allocated cost incurred); support of community medical needs through a variety of outreach programs and educational programs; comprehensive research programs specifically targeted toward pediatric health to advance knowledge about the causes, treatment and prevention of childhood diseases; and training of medical students, pediatric residents, fellows and sub-specialists.

Funding for the services above comes from Hospital operating income, Foundation philanthropy, government awards and grants. The Medical Center maintains records to identify and monitor the level of charity provided. These records include the estimated cost of unreimbursed services provided under its charity care policy and the excess of cost over reimbursement for Medicaid patients. The Medical Center also monitors the unreimbursed cost of patient bad debts. Because the Illinois All Kids program provides coverage for most Illinois uninsured children, the Medical Center has a relatively low number of requests for charity care.

The Medical Center determines the costs associated with providing charity care by aggregating the overall cost to charge ratio, including salaries, wages, benefits, supplies, and other operating expenses. The cost to charge ratio is then applied to the charity care charges to calculate the estimated costs and expenses incurred to provide charity care reported below.

The cost of providing charity care was \$1,286 and \$1,215 for the years ended August 31, 2025 and 2024, respectively. The Medical Center also received certain funds of \$5,832 and \$6,009 for the years ended August 31, 2025 and 2024, respectively, to offset or subsidize charity care services provided. In the Annual Non-Profit Hospital Community Benefits Plan Report filed with the Illinois Attorney General for the year ended August 31, 2024, the Medical Center reported a total community benefit of \$249,992 (unaudited), including the unreimbursed cost of charity care of \$757, which is calculated using a different methodology than that used for the consolidated financial statements. Management is currently collecting the information needed to file the 2025 report.

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6. Other Current and Noncurrent Assets and Liabilities

Other current and noncurrent assets consist of the following:

	2025	2024
Other current assets:		
Prepaid expenses	\$ 36,071	\$ 32,015
Inventory	17,767	17,158
Insurance receivables	19,779	19,193
Pledges receivable	20,197	16,298
Other receivables:		
Outreach program receivables	5,241	7,906
Pending investment settlement receivables	7,481	40,491
Other receivables	48,793	49,947
Other	12,111	16,634
	<u>73,626</u>	<u>114,978</u>
Total other current assets	<u>\$ 167,440</u>	<u>\$ 199,642</u>
Other assets (noncurrent)	<u>\$ 2,352</u>	<u>\$ 6,111</u>

Other noncurrent liabilities consist of the following:

	2025	2024
Accrued pension liabilities	\$ 18,433	\$ 19,008
Other	<u>7,479</u>	<u>7,316</u>
Total other noncurrent liabilities	<u>\$ 25,912</u>	<u>\$ 26,324</u>

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7. Investments

The Medical Center maintains a diversified asset allocation that places an emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

As of August 31, 2025 and 2024, investments consisted of the following, which includes the current portion of the self-insurance trust of \$35,566 and \$31,699, respectively:

	2025	2024
Short-term investments	\$ 132,437	\$ 27,687
Common stock/mutual funds and common collective trusts	734,809	611,660
Alternative investments	891,774	883,600
U.S. Government and agency securities	166,067	154,063
Corporate and municipal bonds	215,865	325,023
Investment in CIN	1,989	1,146
Total investments	<u>\$ 2,142,941</u>	<u>\$ 2,003,179</u>

Short-term investments include cash and cash equivalents, certificates of deposit, money market funds, and securities with maturities due within one year.

Common stock and mutual funds include public equities traded in both domestic and international markets. Common collective trusts include investment products that pool fiduciary client assets into a portfolio of stocks, bonds, or other securities and real assets.

Alternative investments include hedge funds, private credit and private equity investments. These include credit-oriented strategies, multi-strategy funds where the manager has a broad mandate to invest opportunistically, and event driven funds where managers seek opportunity in various forms of arbitrage strategies as well as in corporate activities such as mergers and acquisitions. The Medical Center's investment in private equity and private credit is committed under contract to periodically advance additional funding as capital calls are exercised. See Note 15.

U.S. Government and agency securities include debt obligations issued by the U.S. Government or U.S. Government agencies. Corporate and municipal bonds include investment grade debt obligations issued by U.S. or foreign corporations, U.S. state and local governments or U.S. territories.

All Medical Center investments are invested with external managers.

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The Medical Center pools its investments without donor restrictions, board-designated and donor-restricted investments. As of August 31, 2025 and 2024, donor-restricted and investments without donor restrictions are as follows:

	2025	2024
Donor-restricted investments and other assets limited as to use		
Endowments	\$ 335,154	\$ 303,829
Specific purpose	200,429	195,770
Self-insurance trust	200,874	184,412
Interest in trustee-held funds	35,435	34,308
Interest in joint venture	1,420	818
Interest in Clinically Integrated Network	328	328
Total investments with donor restrictions and other assets limited as to use	<u>773,640</u>	<u>719,465</u>
Investments without donor restrictions		
Undesignated and board-designated investments	<u>1,369,301</u>	<u>1,283,714</u>
Total investments without donor restrictions	<u>1,369,301</u>	<u>1,283,714</u>
Total investments	<u>\$ 2,142,941</u>	<u>\$ 2,003,179</u>

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The composition and presentation of investment return as reflected in the accompanying consolidated statements of operations and changes in net assets for the years ended August 31, 2025 and 2024, are as follows:

	2025	2024
Unrestricted investment return		
Interest and dividend income	\$ 25,623	\$ 28,173
Investment fees	(2,175)	(1,623)
Realized gains on sales of investments	129,325	66,900
Unrealized (gains) losses on investments	(6,449)	108,902
Total unrestricted investment return	<u>\$ 146,324</u>	<u>\$ 202,352</u>
Reported as		
Board-designated endowment income	\$ 20,702	\$ 22,638
Other operating revenue	4,921	5,535
Nonoperating investment return	120,701	174,179
Total unrestricted investment return	<u>146,324</u>	<u>202,352</u>
Donor-restricted investment return		
Interest and dividend income	4,504	4,092
Net realized and unrealized gains on investments	24,524	39,890
Total donor-restricted investment return	<u>29,028</u>	<u>43,982</u>
Total investment return	<u>\$ 175,352</u>	<u>\$ 246,334</u>

Typical redemption terms by asset class and type of investments include short-term investments; common stock and mutual funds; alternative investments; and U.S. Government and agency securities; corporate and municipal bonds and common collective trusts. Short-term investments and U.S. Government and agency securities, and corporate and municipal bonds, have daily redemption terms and no restrictions. Common stock, common collective trusts and mutual funds have daily to monthly redemption terms with notice periods of one to 10 days with no redemption restrictions. Alternative investments have monthly to annual redemption terms with varying notice periods, lock-up provisions ranging up to three years, and include private equity investments. A portion of hedge funds (alternative investments) are in side pockets with no redemptions permitted.

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8. Fair Value Measurements

The Medical Center follows the provisions of the FASB pronouncement on fair value measurements for financial instruments. The pronouncement establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entity's own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Medical Center for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 Quoted prices in active markets for identical assets or liabilities.
- Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the same term of the assets or liabilities.
- Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Medical Center uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

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The following table presents the investments carried at fair value as of August 31, 2025, by caption, including the current portion of the self-insurance trust of \$35,566, by the valuation hierarchy defined above:

	Level 1	Level 2	Level 3	Investments Measured at NAV or Equivalent	Total
Assets					
Investments					
Short-term investments	\$ 132,437	\$ -	\$ -	\$ -	\$ 132,437
Common stock/collective trust and mutual funds	650,424	715	-	83,670	734,809
Alternative investments	-	-	1,165	890,609	891,774
U.S. Government and agency securities	-	166,067	-	-	166,067
Corporate and municipal bonds	-	215,865	-	-	215,865
Total assets at fair value	<u>\$ 782,861</u>	<u>\$ 382,647</u>	<u>\$ 1,165</u>	<u>\$ 974,279</u>	<u>\$ 2,140,952</u>

The following table presents the investments carried at fair value as of August 31, 2024, by caption, including the current portion of the self-insurance trust of \$31,699, by the valuation hierarchy defined above:

	Level 1	Level 2	Level 3	Investments Measured at NAV or Equivalent	Total
Assets					
Investments					
Short-term investments	\$ 27,688	\$ -	\$ -	\$ -	\$ 27,688
Common stock/collective trust and mutual funds	540,608	871	-	70,180	611,659
Alternative investments	-	-	880	882,719	883,599
U.S. Government and agency securities	-	154,064	-	-	154,064
Corporate and municipal bonds	-	325,023	-	-	325,023
Total assets at fair value	<u>\$ 568,296</u>	<u>\$ 479,958</u>	<u>\$ 880</u>	<u>\$ 952,899</u>	<u>\$ 2,002,033</u>

The tables above do not include the Medical Center's interests in a joint venture and CIN of \$1,989 and \$1,146 as of August 31, 2025 and 2024, respectively.

Investments measured at fair value using net asset value ('NAV') per share (or equivalent) as a practical expedient were not classified in the fair value hierarchy; rather, the amounts are presented to enable reconciliation of the fair value tables to the investments fair value line items presented in the consolidated balance sheets.

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The Medical Center maintains certain investments in alternative investment funds as part of its overall investment portfolio. These alternative funds are managed by external investment advisors and pursue strategies that differ from traditional equity and fixed-income investments. They are intended to provide portfolio diversification, enhanced returns, and reduced volatility over market cycles. Alternative investment funds are generally structured as limited partnerships, limited liability companies, or commingled investment vehicles.

As of August 31, 2025, and 2024, alternative investments recorded at NAV consisted of the following:

	2025	2024	Unfunded Commitment	Redemption Frequency (if currently eligible)	Redemption Notice Period
Private Equity, Venture Capital, and Private Credit Funds	\$ 576,274	\$ 519,439	\$ 177,541	N/A	N/A
Hedge Funds - A	203,220	262,701	-	Monthly / Quarterly	45 - 60 - 90 Days
Hedge Funds - B	64,077	59,583	-	Rolling 3-Year	45 Days
Real Assets Funds	45,499	39,292	40,524	N/A	N/A
Other	1,539	1,704	-		
	<u>\$ 890,609</u>	<u>\$ 882,719</u>	<u>\$ 218,065</u>		

Alternative investment funds held by the Medical Center may include, but are not limited to, the following:

Private Equity and Venture Capital Funds – These funds invest in privately held companies across a range of stages, from early-stage and emerging businesses to more mature operating companies. Strategies may include buyout, growth equity, and venture capital investments. These funds typically make equity or minority equity investments with long-term holding periods, limited liquidity, and multi-year lock-up commitments. Returns are generally realized through strategic sales, recapitalizations, or public offerings, and investments often carry elevated risk due to reliance on future financing events and market conditions.

Hedge Funds - Funds employing strategies such as long/short equity, event-driven, macroeconomic, and relative value approaches. These funds may utilize derivatives, leverage, and short selling to achieve their investment objectives and generally offer more frequent redemption terms than private equity or Venture Capital funds, though terms vary by fund.

Real Assets Funds – Funds that invest in tangible or physical assets such as commercial real estate, infrastructure, natural resources, or commodities. Returns are generated through a combination of income and asset appreciation.

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The Medical Center's exposure to these funds is subject to various risks, including liquidity risk, market risk, credit risk, valuation uncertainty, and risks associated with the use of leverage and derivative instruments within the funds. Redemptions from certain funds may be limited by lock-up provisions, notice requirements, gates, or other fund-specific restrictions.

No single alternative investment fund represents a material concentration of risk to the Medical Center.

The following table is a rollforward of the August 31, 2025 and 2024, consolidated balance sheet amounts for financial instruments classified by the Medical Center within Level 3 of the fair value hierarchy.

	Level 3 Assets	
	2025	2024
Balances at beginning of year	\$ 880	\$ 1,153
Total net unrealized gain	27	36
Purchases and sales, net	258	(309)
Balances at end of year	\$ 1,165	\$ 880

The following is a description of the Medical Center's valuation methodologies for investments measured at fair value.

Fair value for short-term investments, corporate stocks, international stocks, and mutual funds is measured using quoted market prices or NAV per share at the reporting date multiplied by the quantity held.

U.S. Government bonds and agency securities, corporate bonds, municipal bonds and mortgage and asset-backed securities are measured using recent bid prices or average of bid/ask prices. Common collective trusts are measured using NAV.

The Medical Center has certain investments, principally limited liability corporations, partnerships, and absolute return strategy funds for which a portion of quoted market prices are not available. These investments are classified as alternative investments. The value of these alternative investments represents the ownership interest in the net asset value of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are based on appraisals, or other estimates that require varying degrees of judgment.

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The Medical Center's investments are exposed to various kinds and levels of risk. Equity securities and equity mutual funds expose the Medical Center to market risk, performance risk and liquidity risk. 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 Medical Center 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 methods described above may produce a fair value calculation that may not be indicative of net realizable value nor reflective of future fair values. While the Medical Center believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value as of the reporting date. The significant unobservable inputs used in the fair value measurement of the Medical Center's partnership investments include a combination of cost, discounted cash flow analysis, industry comparable and outside appraisals. Significant increases or decreases in any inputs used by investment managers in determining net asset values in isolation would result in a significantly lower or higher fair value measurement. Management has not developed quantitative inputs nor adjusted the fair values obtained from general partners for the alternative investments.

9. Endowments

The Medical Center's endowment fund consists of individual donor-restricted endowment funds and funds designated by its Board to function as endowments. The net assets associated with endowment funds, including those funds designated by the Board to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Illinois passed the 'Uniform Prudent Management of Institutional Funds Act' ('UPMIFA'). The Medical Center has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment fund absent explicit donor stipulations to the contrary. As a result of this interpretation, the Medical Center classifies as net assets with donor restrictions, (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. Where the Board designates unrestricted funds to function as endowments they are classified as net assets without donor restriction.

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The Medical Center had the following board-designated without donor restriction and donor-restricted endowment balances during the year ended August 31, 2025, delineated by net asset class:

	Board- Designated Endowment Funds	Donor-Restricted Endowment Funds	Total
Endowment net assets at beginning of year	\$ 179,999	\$ 303,829	\$ 483,828
Investment return			
Investment income	-	4,504	4,504
Realized and unrealized gain	10,699	23,361	34,060
Total investment return	10,699	27,865	38,564
Contributions	47,274	10,784	58,058
Spend rate allocation	7,036	-	7,036
Appropriation of endowment assets for expenditure	(8,003)	(8,317)	(16,320)
Other	538	993	1,531
Endowment net assets at end of year	\$ 237,543	\$ 335,154	\$ 572,697

The Medical Center had the following board-designated without donor restriction and donor-restricted endowment balances during the year ended August 31, 2024, delineated by net asset class:

	Board- Designated Endowment Funds	Donor-Restricted Endowment Funds	Total
Endowment net assets at beginning of year	\$ 179,249	\$ 265,458	\$ 444,707
Investment return			
Investment income	-	4,092	4,092
Realized and unrealized gain	-	36,695	36,695
Total investment return	-	40,787	40,787
Contributions	1,200	6,391	7,591
Spend rate allocation	7,034	-	7,034
Appropriation of endowment assets for expenditure	(7,484)	(9,961)	(17,445)
Other	-	1,154	1,154
Endowment net assets at end of year	\$ 179,999	\$ 303,829	\$ 483,828

Descriptions of amounts classified, purpose and appropriations of board-designated net assets without donor-imposed restrictions as of August 31, 2025 and 2024, are as follows:

	2025	2024
Appropriations for Research	\$ 1,613	\$ 1,639
Appropriations for Pediatric Programs	6,390	5,845
	\$ 8,003	\$ 7,484

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Descriptions of amounts classified as net assets with donor restrictions (endowments only) as of August 31, 2025 and 2024, are as follows:

	2025	2024
Restricted for Research	\$ 106,415	\$ 101,252
Restricted for Pediatric Programs	228,739	202,577
	<u>\$ 335,154</u>	<u>\$ 303,829</u>

Underwater Endowment Funds

From time to time, the fair value of net assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires to retain as a fund of perpetual duration. Such deficiencies generally result from unfavorable market fluctuations that occurred shortly after the investment of new donor restricted contributions to the endowment funds and continued appropriation for certain programs that was deemed prudent by the Board of Directors. There were no deficiencies as of August 31, 2025 and 2024.

Investment and Spend Rate Policies

The Medical Center has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs while seeking to maintain the purchasing power of endowment assets. To achieve its long-term rate of return objectives, the Medical Center relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). An endowment spend rate is established by management and approved annually by the Investment Committee of the Board of the Medical Center, which considers the following factors, specified by UPMIFA:

- The duration and preservation of the endowment
- The Medical Center's institutional mission and purpose of its endowed funds
- General economic conditions
- The possible effect of inflation or deflation
- The expected total return from income and appreciation of investments
- Other available resources of the Medical Center
- The investment policy of the Medical Center

The spend rate for endowment funds in fiscal years 2025 and 2024 was 4%. The spend rate is applied to a three-year rolling average of the fund balance as of August 31, which incorporates all returns. For new endowed funds (not more than five years old), the Investment Committee may in one or more particular years apply a lower spend rate and/or appreciation allocation, if the Investment Committee deems it prudent to do so.

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Substantially all net assets with donor restriction are restricted for research and programs.
Substantially all net assets released from restrictions in fiscal years 2025 and 2024 were related to expenses incurred for research and programs.

10. Retirement Plans

The Medical Center has retirement plans covering substantially all full-time employees, including employees of affiliated corporations. The Medical Center has two defined contribution plans available to eligible employees and a frozen noncontributory defined benefit plan, the Value Growth Plan ("VGP").

There are two 403(b) defined contribution plans available only to eligible pediatric faculty within LCMG, Inc., a mandatory plan and a voluntary plan, and the Hospital's plan available to all other eligible employees of the Medical Center. Participants of the LCMG, Inc. plan are required to make mandatory contributions of 5% of compensation. Each year that a mandatory contribution is made by a participant, LCMG, Inc. will make a matching contribution up to 10% of compensation. LCMG, Inc. faculty who are not eligible for the mandatory plan or who have not reached the IRS limits may participate in the voluntary plan with no match.

All non-LCMG, Inc. employees, who elect to contribute, are considered participants of the Hospital's plan. Participants of the Hospital plan may participate in a 403(b) defined contribution plan by entering into a salary reduction agreement to contribute a percentage of their compensation to the plan. New employees are automatically enrolled 60 days after hire at 2% if they have not already made an election. The Hospital matches 100% of the employee's contribution up to 5% of compensation. Employees must be employed three years to be vested in the Hospital match. The Hospital match was reduced to 2% as of July 3, 2024, due to the adverse financial effect of the cybersecurity incident (see Note 17). The Hospital match was increased back to 5% effective September 12, 2024.

The Medical Center's matching expense under both defined contribution plans totaled \$46,879 and \$41,553 in fiscal years 2025 and 2024, respectively.

The Medical Center also offers Executive and Physician 457(b) Income Deferral Plans, which are 100% employee funded. The plan assets and liabilities for August 31, 2025 and 2024, are \$9,216 and \$11,693, respectively. The plan assets are invested in mutual funds, which are Level 1 fair value measurements. The plan assets are included in investments and the plan liabilities are included in other noncurrent liabilities in the accompanying consolidated balance sheets.

The VGP defined benefit plan is a cash balance plan and was frozen effective January 1, 2014. Previously accrued balances will continue to accrue interest; however, no further credits to these balances will be made. The interest, or earnings credit rate, is generally 4.5% annually.

The Medical Center also used to sponsor two nonqualified supplemental defined benefit retirement plans ("SERP"); a defined benefit plan ("DB SERP") and a defined contribution plan ("DC SERP") plan for certain key executives. The DB SERP plan was not funded and, therefore, had no plan assets. Benefits under the DB SERP were paid when incurred from the Medical Center's unrestricted net assets. As of August 31, 2024, there are no longer any participants in the DB SERP.

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Further, increases in the DB SERP of \$28 were recognized which represented a portion of the previously unrecognized gain of the plan as of August 31, 2024.

Effective January 1, 2017, the Medical Center sponsors a nonqualified DC SERP for certain key executives. Under this plan, the accrued obligations are determined as of December 31 of each year using 14% of participants' gross pay reduced by an employer match on the qualified plan. The plan has a vesting service period of five years or attainment of age 62.

Effective January 1, 2019, LCSF received a transfer of the cash balance defined benefit retirement plan from Children's Surgical Foundation as a result of the affiliation agreement. The cash balance plan was established effective January 1, 2017. Participants are 100% vested after three years of service. Interest credit of 4%, compounded annually, based on 10% of the participant's compensation is credited to each participant's account. In July 2024, the Board of Directors approved the termination of the cash balance defined benefit retirement plan as of January 1, 2025.

Effective January 1, 2019, LCPAA acquired a new cash balance defined benefit retirement plan. Principal credits are ranging from 1.5% to 10% of annual compensation depending on the years of service and credited to each participant's account. Plan interest credit is stated at 5%. Eligibility is based on completion of two years of service. However, this requirement is waived for participants employed on January 1, 2019. In July 2024, the Board of Directors approved the termination of the cash balance defined benefit retirement plan as of January 1, 2025.

Pension expense (credit) for the nonqualified DB SERP plan, the VGP plan, and for the LCSF and LCPAA cash balance pension plans, as determined by an independent actuary, includes the following components as of August 31, 2025:

	DB SERP	VGP	LCSF (Terminated)	LCPAA (Terminated)
Service cost, benefits earned during the year	\$ -	\$ -	\$ 1,147	\$ 158
Interest on projected benefit obligation	-	7,566	889	77
Expected return on assets	-	(7,505)	(1,255)	(99)
Amortization of actuarial loss (gain)	-	1,164	181	161
Amortization of prior service cost	-	110	-	-
Settlements	-	3,296	8,687	-
Total pension expense (credit)	\$ -	\$ 4,631	\$ 9,649	\$ 297

Pension expense (credit) for the nonqualified DB SERP plan, the VGP plan, and for the LCSF and LCPAA cash balance pension plans, as determined by an independent actuary, includes the following components as of August 31, 2024:

	DB SERP	VGP	LCSF	LCPAA
Service cost, benefits earned during the year	\$ -	\$ -	\$ 3,218	\$ 463
Interest on projected benefit obligation	10	7,727	978	89
Expected return on assets	-	(7,768)	(1,381)	(114)
Amortization of actuarial loss (gain)	(25)	1,139	220	(3)
Amortization of prior service cost	(28)	110	-	-
Total pension expense (credit)	\$ (43)	\$ 1,208	\$ 3,035	\$ 435

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The funded status of the nonqualified DC SERP plan and the VGP plan at the end of fiscal year 2025 was as follows:

	<u>DC SERP</u>	<u>VGP</u>
Funded status at end of year		
Projected benefit obligation	\$ (4,802)	\$ (144,678)
Plan assets at fair value	-	141,819
Pay and Interest Accruals	(1,557)	-
Deficiency of plan assets over projected benefit obligation	<u>\$ (6,359)</u>	<u>\$ (2,859)</u>
Amounts recognized in the consolidated balance sheets consist of		
Noncurrent liabilities	<u>\$ (6,359)</u>	<u>\$ (2,858)</u>
	<u>\$ (6,359)</u>	<u>\$ (2,858)</u>

The LCSF and LCPAA cash balance plans had no remaining balance at August 31, 2025 as a result of their termination on January 1, 2025.

The funded status of the nonqualified DC SERP plan, the VGP plan, and the LCSF and LCPAA cash balance pension plans at the end of fiscal year 2024 was as follows:

	<u>DC SERP</u>	<u>VGP</u>	<u>LCSF</u>	<u>LCPAA</u>
Funded status at end of year				
Projected benefit obligation	\$ (5,537)	\$ (152,186)	\$ (26,546)	\$ (2,249)
Plan assets at fair value	-	151,007	26,322	1,875
Deficiency of plan assets over projected benefit obligation	<u>\$ (5,537)</u>	<u>\$ (1,179)</u>	<u>\$ (224)</u>	<u>\$ (374)</u>
Amounts recognized in the consolidated balance sheets consist of				
Noncurrent liabilities	<u>\$ (5,537)</u>	<u>\$ (1,179)</u>	<u>\$ -</u>	<u>\$ -</u>
	<u>\$ (5,537)</u>	<u>\$ (1,179)</u>	<u>\$ (224)</u>	<u>\$ (374)</u>

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The change in the projected benefit obligation during the years ended August 31, 2025 and 2024 are summarized as follows:

	DB SERP	VGP	LCSF (Terminated)	LCPAA (Terminated)
Projected benefit obligation at August 31, 2023	\$ 330	\$ 144,651	\$ 22,046	\$ 1,829
Service cost	-	-	3,218	463
Interest cost	10	7,727	978	89
Actuarial loss	-	7,734	870	115
Benefits paid	-	(7,926)	(566)	(247)
Settlements	(340)	-	-	-
Projected benefit obligation at August 31, 2024	-	152,186	26,546	2,249
Service cost	-	-	1,146	158
Interest cost	-	7,566	889	77
Actuarial (gain) loss	-	(3,555)	2,748	183
Benefits paid	-	(2,133)	(165)	(23)
Settlements	-	(9,387)	(31,164)	(2,644)
Projected benefit obligation at August 31, 2025	\$ -	\$ 144,677	\$ -	\$ -

The change in VGP and LCSF plan assets during the years ended August 31, 2025 and 2024 are summarized as follows:

	VGP	LCSF (Terminated)
Plan assets, at fair value at August 31, 2023	\$ 145,394	\$ 22,222
Actual return on plan assets	13,539	1,420
Employer contributions	-	3,246
Benefits paid	(7,926)	(566)
Plan assets, at fair value at August 31, 2024	151,007	26,322
Actual return on plan assets	2,332	894
Employer contributions	-	4,114
Benefits paid	(2,133)	(166)
Settlements	(9,387)	(31,164)
Plan assets, at fair value at August 31, 2025	\$ 141,819	\$ -

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The VGP plan assets are invested in Common Collective Trust funds of \$141,819 and \$151,007 that are valued at NAV as of August 31, 2025 and 2024, respectively.

The LCSF cash balance plan investments were \$0 as of August 31, 2025 resulting from plan termination.

The following table presents the LCSF cash balance plan investments carried at fair value as of August 31, 2024, by caption, by the valuation hierarchy defined in Note 8:

	Level 1	Level 2	Level 3	Investments Measured at NAV or Equivalent	Total
Assets					
Investments					
Short-term investments	\$ -	\$ -	\$ -	\$ 26,322	\$ 26,322
Total assets at fair value	\$ -	\$ -	\$ -	\$ 26,322	\$ 26,322

The LCPAA cash balance plan investments were \$0 as of August 31, 2025 resulting from plan termination.

The following table presents the LCPAA cash balance plan investments carried at fair value as of August 31, 2024, by caption, by the valuation hierarchy defined in Note 8:

	Level 1	Level 2	Level 3	Investments Measured at NAV or Equivalent	Total
Assets					
Investments					
Short-term investments	\$ -	\$ -	\$ -	\$ 1,875	\$ 1,875
Total assets at fair value	\$ -	\$ -	\$ -	\$ 1,875	\$ 1,875

Investments measured at fair value using NAV per share (or equivalent) as a practical expedient were not classified in the fair value hierarchy, rather the amounts are presented to enable reconciliation of the fair value tables to the investments fair value line items presented in the plan assets.

The Medical Center's VGP pension plan weighted-average asset allocation at August 31, 2025 and 2024, by asset category is as follows:

	2025	2024
Asset category		
Return-seeking assets	10 %	9 %
Liability-hedging assets	90	91
	<u>100 %</u>	<u>100 %</u>

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The Medical Center's VGP pension plan assets are invested with external managers and asset allocation is determined using a liability-hedging approach. Pension plan assets are invested in two pools: return-seeking assets and liability-hedging assets. The target allocation between return-seeking assets and liability-hedging assets changes based on a predetermined glide path policy as the plan's funded status changes.

The objective of the return-seeking assets is to generate long-term asset growth for the pension plan. Return-seeking assets generally consist of equity securities, including public equities traded in both domestic and international markets, invested in accordance with the target allocations listed below:

The objective of holding liability-hedging assets is to dampen the plan's surplus volatility. High-quality investment grade bonds with durations that approximate the durations of the liabilities are most commonly used for liability-hedging assets.

Estimated future pension benefit payments are as follows:

	DC SERP	VGP	Total
Years Ending August 31,			
2026	\$ -	\$ 12,394	\$ 12,394
2027	-	9,134	9,134
2028	2,205	9,030	11,235
2029	690	9,496	10,186
2030	2,596	9,435	12,031
2031-2044	20,762	44,142	64,904
	<u>\$ 26,253</u>	<u>\$ 93,631</u>	<u>\$ 119,884</u>

Weighted-average assumptions used to determine benefit obligations at August 31, 2025 are as follows:

	DC SERP	VGP
Discount rate	0.0 %	5.6 %
Rate of compensation increase	4.0	0.0

Weighted-average assumptions used to determine benefit obligations at August 31, 2024 are as follows:

	DC SERP	VGP	LCSF	LCPPA
Discount rate	0.0 %	5.6 %	5.0 %	5.2 %
Rate of compensation increase	4.0	0.0	3.0	3.0

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In fiscal years 2025 and 2024, the discount rate was determined by constructing hypothetical yield curves based on yields of corporate bonds rated AA quality. The expected rate of return on plan assets was determined by using the historical return on the various asset classes in which the plan invests. The weighted-average assumptions were used to determine net periodic pension benefit cost.

11. Long-Term Debt

In May 2017, the Illinois Finance Authority issued \$135,480 of Revenue Refunding Bonds, ('Series 2017') at a premium totaling \$13,416 with an equity contribution of \$11,411 on behalf of the Hospital. The proceeds of the Series 2017 bonds were used to refund the \$148,900 par amount of the Series 2008B bonds.

In January 2018, the Illinois Finance Authority issued \$223,550 of Taxable Revenue Refunding Bonds ('Series 2018') at par value on behalf of the Hospital. The proceeds of the Series 2018 bonds were used to refund the \$212,000 par amount of the Series 2008A bonds. The Medical Center's long-term bonds are issued under a Master Trust Indenture ('Indenture') dated May 1, 2008, as amended and restated. There are no significant changes to the underlying covenants in the Indenture. Obligations under the Indenture are collateralized by a pledge of the unrestricted receivables and assignable general intangibles of the Obligated Group, which consists of the Hospital and the Foundation (the 'Obligated Group'). Series 2017 and 2018 are the only outstanding bonds of the Medical Center.

The chart below outlines debt as of August 31, 2025 and 2024:

	2025	2024
Illinois Finance Authority revenue bonds, Series 2017, fixed interest rate ranging from 4.00% to 5.00% (premium based on imputed interest rate of 3.62%), maturing annually in principal amounts ranging from \$7,200 in August 2026 to \$13,695 in August 2039.	\$ 93,820	\$ 100,680
Illinois Finance Authority taxable revenue bonds, Series 2018, fixed interest rate ranging from 3.50% to 3.95%, maturing annually in principal amounts ranging from \$4,840 in August 2028 to \$22,850 in August 2047.	223,550	223,550
Total debt outstanding	317,370	324,230
Unamortized premium	5,700	6,452
Less: Unamortized bond issuance costs	(2,237)	(2,443)
Long-term debt	<u>\$ 320,833</u>	<u>\$ 328,239</u>

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Future maturities of total outstanding debt at August 31, 2025, are as follows:

Years Ending August 31,

2026	\$	7,200
2027		7,560
2028		9,545
2029		10,875
2030		11,260
Thereafter		270,930
	\$	<u>317,370</u>

The Obligated Group is subject to various nonfinancial and financial covenants. The Obligated Group was in compliance with its debt covenants as of August 31, 2025 and 2024.

As of August 31, 2025, the Medical Center had line of credit agreements with three commercial banks for \$45,000, \$30,000 and \$25,000. The lines of credit provide for interest rates based on various spreads to the Secured Overnight Financing Rate. There were no amounts outstanding or borrowings made under the lines of credit as of and for the year ended August 31, 2025.

Borrowings made under the lines of credit were \$25,000 for the year ended August 31, 2024 with no amounts remaining outstanding as of August 31, 2024.

On November 25, 2025, Medical Center drew \$99.9 million on its line of credit on to support prior qualifying capital spending. On December 11, 2025, the Illinois Finance Authority issued \$130,230 of Taxable Revenue Bonds on behalf of the Hospital. The proceeds were used to refinance the outstanding line-of-credit balance, with the remainder reimbursing the Medical Center for prior qualifying capital spending.

12. Leases

The Medical Center leases office and clinical space as well as real estate with lease terms ranging from 1 to 10 years with some options to extend. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheets.

The depreciable lives of assets are limited by the expected lease terms. The majority of leases do not provide an implicit rate; therefore, the Medical Center has elected to use a risk-free rate of return as the discount rate. The Medical Center used the risk-free rate of return on September 1, 2020, for operating leases that commenced prior to that date.

Termination of these leases is generally prohibited unless there is a violation under the lease agreement.

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Operating leases are classified as follows within the accompanying consolidated balance sheets at August 31, 2025 and 2024:

	<u>Classification</u>	<u>2025</u>	<u>2024</u>
Assets			
Noncurrent			
Operating	Operating lease right-of-use assets	\$ 23,836	\$ 30,965
Total lease assets		<u>\$ 23,836</u>	<u>\$ 30,965</u>
Liabilities			
Current			
Operating	Operating lease liabilities	\$ 10,134	\$ 9,702
Noncurrent			
Operating	Operating lease liabilities	27,286	38,514
Total lease liabilities		<u>\$ 37,420</u>	<u>\$ 48,216</u>

On June 4, 2024, the Medical Center acquired a building in which the Medical Center previously leased space for a total purchase price of \$99,500. On July 24, 2024, the Medical Center acquired a building in which the Medical Center previously leased space for a total purchase price of \$30,400. These acquisitions resulted in a reduction in operating lease right-of-use assets and operating lease liabilities during the year ended August 31, 2024 of \$24,620 and \$34,683, respectively.

Lease costs are classified as follows within the accompanying consolidated statements of operations and changes in net assets for the years ended August 31, 2025 and 2024:

<u>Lease Cost</u>	<u>Classification</u>	<u>2025</u>	<u>2024</u>
Operating lease cost	Supplies and services	\$ 15,656	\$ 18,844
Short-term lease cost	Supplies and services	229	128
Variable lease cost	Supplies and services	3,518	73
Total lease cost		<u>\$ 19,403</u>	<u>\$ 19,045</u>

Lease-terms, discount rates and other supplemental information as of and for the years ended August 31, 2025 and 2024, are as follows:

	<u>2025</u>	<u>2024</u>
Weighted-average remaining lease term (in years)		
Operating	4.92	5.76
Weighted-average discount rate		
Operating	1.19%	1.16%
Cash paid for amounts included in the measurement of operating lease liabilities		
Operating cash flows from operating leases	\$ 10,796	\$ 10,719

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

2026	\$	10,451
2027		9,978
2028		5,955
2029		2,906
2030		2,512
Thereafter		6,844
Future minimum lease payments		38,646
Less: Remaining imputed interest		1,226
Total	\$	37,420

13. Professional and General Liability Insurance

The Medical Center maintains a program of self-insurance for professional and general liability risks. This program is maintained on behalf of all Medical Center affiliates and employees, including the employed physicians of LCMG. More than 800 hospital-based physicians are covered by this program.

The Medical Center self-insures the first losses for both professional and general liability claims. The estimated liability for self-insured claims and the required funding for the trust are determined annually by an independent actuary and are based upon case reserves and actuarial estimates for claims that have been incurred but not yet reported. The self-insured portion of the program is administered by an independent trustee.

The Medical Center incurred \$33,000 in expense for fiscal years 2025 and 2024 for self-insured professional and general liability risk. The Medical Center's self-insurance liability has been discounted at 4% at August 31, 2025 and 2024. The effect of discounting the value of estimated liabilities was \$36,225 and \$31,875 at August 31, 2025 and 2024, respectively. Further, the Medical Center recorded an estimated liability of \$250,055 and \$233,319 at August 31, 2025 and 2024, respectively, for self-insured professional and general liability risk. Part of the liability represents the potential impact from the Illinois Senate Bill 72 (Illinois Prejudgment Interest Act), which was effective July 1, 2021.

In addition to the self-insured portion, the Medical Center purchases commercial excess reinsurance policies for claims in excess of the self-insurance limits to manage potential losses of the self-insured portion. These excess insurance policies, which are claims-made, are purchased through CMMC Insurance.

CMMC Insurance writes the professional and general liability insurance for the Hospital and its affiliates. CMMC Insurance, in turn, purchases reinsurance equal to 100% of its exposure and, therefore, holds no risk on its own books. For the years ended August 31, 2025 and 2024, premiums ceded to reinsurers were \$4,162 and \$3,619, respectively. Reinsurance recoveries receivable on unpaid losses on an undiscounted basis, were \$19,779 and \$19,193, at August 31, 2025 and 2024, respectively. CMMC Insurance is operated to break even after all expenses.

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14. Functional Expense Classification

The Medical Center provides health care services to children and conducts research and programs within its geographic region. Expenses, excluding interest and including fundraising (which are reported as nonoperating activities), related to providing these services, research, and programs by functional classification were as follows:

Functional Expenses

	Patient Care Services	General and Administrative	Research and Mission-Related Programs	Fundraising	Total
August 31, 2025					
Salaries, wages and employee benefits	\$ 945,788	\$ 123,463	\$ 62,856	\$ 13,666	\$ 1,145,773
Supplies and services	325,968	99,202	63,485	7,450	496,105
Insurance	43,880	-	-	-	43,880
Medicaid assessment	30,721	-	-	-	30,721
Depreciation	76,410	14,435	-	-	90,845
Interest and financing costs	-	16,193	-	-	16,193
	<u>\$ 1,422,767</u>	<u>\$ 253,293</u>	<u>\$ 126,341</u>	<u>\$ 21,116</u>	<u>\$ 1,823,517</u>

	Patient Care Services	General and Administrative	Research and Mission-Related Programs	Fundraising	Total
August 31, 2024					
Salaries, wages and employee benefits	\$ 918,575	\$ 128,587	\$ 57,354	\$ 13,527	\$ 1,118,043
Supplies and services	318,181	106,665	72,048	7,674	504,568
Insurance	43,850	-	-	-	43,850
Medicaid assessment	30,433	-	-	-	30,433
Depreciation	73,451	9,938	7	-	83,396
Interest and financing costs	-	17,006	-	-	17,006
	<u>\$ 1,384,490</u>	<u>\$ 262,196</u>	<u>\$ 129,409</u>	<u>\$ 21,201</u>	<u>\$ 1,797,296</u>

15. Commitments and Contingencies

Health Care Regulation

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations create a possibility of repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Management believes that the Medical Center is in compliance, in all material respects, with fraud and abuse statutes, as well as with other applicable government laws and regulations. While no regulatory inquiries that are expected to have a material effect on the consolidated financial statements have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

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Litigation

There are lawsuits, pending claims, and incidents that occurred in the past whereby claims have been made and may be asserted against the Medical Center for which the ultimate liability, if any, cannot be reasonably estimated. Management believes that the ultimate resolution of these claims will not have a material adverse effect upon the Medical Center's consolidated financial position or results of operations. See Note 17 regarding litigation resulting from the January 2024 cybersecurity incident.

Investments

The Medical Center has contractual commitments totaling \$712,800 with its private equity investment funds. As of August 31, 2025, the Medical Center's remaining capital commitments are \$218,065. Future capital calls are expected to occur over the next several years and will be initiated by the general partner of the investment as investments are made by the funds.

Asset Retirement Obligation

An asset retirement obligation represents a legal obligation associated with the retirement of a tangible long-lived asset that is incurred upon the acquisition, construction, development, or normal operation of that long-lived asset. The asset retirement obligations are accreted to their present value at the end of each reporting period. The associated estimated asset retirement costs are capitalized as part of the carrying amount of the long-lived asset and depreciated over its useful life.

The Medical Center has evaluated its leased and owned properties for potential asset retirement obligations. Based on this review, the Medical Center identified obligations primarily related to the removal of certain materials previously utilized in the construction process. The total retirement obligation of \$4,342 was recognized as of August 31, 2025 and 2024 which was recorded as other noncurrent liabilities in the consolidated balance sheets.

16. Liquidity

Financial assets available for general expenditure within one year of the consolidated balance sheet date comprise the following at August 31:

	2025	2024
Cash and cash equivalents	\$ 65,301	\$ 38,672
Patient accounts receivable	315,711	355,957
Pledges receivable	27,975	26,745
Other receivables	73,626	114,978
Investments	1,419,986	1,351,461
	<u>\$ 1,902,599</u>	<u>\$ 1,887,813</u>

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17. Cybersecurity Incident, Litigation, and Regulatory Matters

In January 2024, the Medical Center experienced a cybersecurity attack that impacted certain of its information technology systems, electronic environment, and data. The matter did not materially impact the Medical Center's ability to provide patient care services.

For the relevant period of time, the Medical Center maintained insurance, including coverage for certain cyber-related losses subject to aggregate policy limitations of \$20,000, after certain deductibles. For the years ended August 31, 2025, and August 31, 2024, insurance recoveries for business interruption losses in connection with the January 2024 cybersecurity matter were recorded in other operating revenue totaling \$18,000 and \$2,000, respectively.

On June 27, 2024, the Medical Center began notifying regulators and individuals whose data was impacted during the cybersecurity attack. Following engagement with at least thirteen (13) regulators, the Medical Center is not actively engaged in any correspondence with respect to the cybersecurity attack. In August 2025, the U.S. Department of Health and Human Services Office for Civil Rights informed the Medical Center that it was closing its investigation into the cybersecurity attack without further action.

In 2024, twenty-two separate purported class action lawsuits were filed against the Medical Center or its subsidiaries in connection with the cybersecurity attack in the United States Court for the Northern District of Illinois and the Circuit Court for Cook County Illinois. Nine (9) cases were filed in federal court and thirteen (13) cases were filed in state court. As of November 5, 2025, claims asserted against the Medical Center in state court are proceeding in *In re Lurie Children's Data Breach* Litigation, Case No. 2024CH00869, under a single second amended consolidated class action complaint, which is subject to the Medical Center's fully briefed and argued motion to dismiss. All previously filed individual state court complaints have been dismissed by court order. As of December 18, 2025, claims asserted against the Medical Center in federal court are proceeding in *In re Lurie Children's Hospital Data Security Litigation*, Case No. 1:24-cv-05503, under a single consolidated amended class action complaint; the claims asserted against the Medical Center in federal court were narrowed in a ruling on the Medical Center's motion to dismiss. The Medical Center believes it has meritorious defenses to the allegations and claims asserted in both the state and federal complaints and intends to defend itself in those proceedings.

In accordance with the applicable accounting guidance, an accrual for a loss contingency has been recorded in self-insurance liability in the accompanying consolidated financial statements.

18. Subsequent Events

The Medical Center has evaluated all events and transactions that occurred after the consolidated balance sheet date and through the date that the consolidated financial statements were issued. See footnotes 4 and 11 for subsequent events through this date.

Supplemental Information

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	Ann & Robert H. Lurie Children's Hospital of Chicago	Ann & Robert H. Lurie Children's Hospital of Chicago Foundation	Obligated Group	Stanley Manne Children's Research Institute	Lurie Children's Medical Group, Inc.	Almost Home Kids	Children's Hospital of Chicago Medical Center	CMHC Insurance Co. Ltd	Lurie Children's Health Services, LLC	Eliminating Entries	Total
Assets											
Current assets											
Cash and cash equivalents	\$ 65,301	\$ -	\$ 65,301	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 65,301
Current portion of self-insurance trust	35,566	-	35,566	-	-	-	-	-	-	-	35,566
Patient accounts receivable	286,926	-	286,926	-	27,391	1,116	-	-	-	-	315,711
Other current assets	132,823	927	133,750	1,029	12,733	60	152	23,941	278	(4,225)	167,440
Total current assets	520,616	927	521,543	1,029	40,124	1,176	152	23,941	278	(4,225)	584,018
Investments	2,107,134	-	2,107,134	-	1,100	-	153	241	-	(1,255)	2,107,375
Property and equipment, at cost	2,016,645	1,615	2,018,260	192,658	-	2,957	-	-	-	-	2,213,775
Less: Accumulated depreciation	993,213	1,615	994,828	65,026	-	1,279	-	-	-	-	1,062,133
Total property and equipment	1,023,432	-	1,023,432	126,532	-	1,678	-	-	-	-	1,151,642
Operating lease right-of-use assets	18,313	-	18,313	-	5,313	210	-	-	-	-	23,836
Other assets	35,906	-	35,906	-	-	-	-	-	-	-	35,906
Pledges receivable restricted by donors	934	-	934	-	1,418	-	-	-	-	-	2,352
Total other assets	36,840	-	36,840	-	1,418	-	-	-	-	-	38,258
Total assets	\$ 3,706,335	\$ 927	\$ 3,707,262	\$ 127,561	\$ 47,955	\$ 3,064	\$ 305	\$ 24,182	\$ 278	\$ (5,476)	\$ 3,905,129
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	\$ 7,200	\$ -	\$ 7,200	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 7,200
Accounts payable and accrued expenses	209,233	2,734	211,967	5,232	32,312	314	1,116	4,250	1,309	(4,225)	252,275
Current portion of self-insurance liability	35,566	-	35,566	-	-	-	-	-	-	-	35,566
Due to third-party payors	162,440	-	162,440	-	2,712	-	-	-	-	-	165,152
Current portion of operating lease liabilities	9,450	-	9,450	-	441	243	-	-	-	-	10,134
Total current liabilities	423,889	2,734	426,623	5,232	35,465	557	1,116	4,250	1,309	(4,225)	470,327
Long-term debt, less current portion	313,633	-	313,633	-	-	-	-	-	-	-	313,633
Self-insurance liability, less current portion	194,789	-	194,789	-	-	-	-	-	-	-	214,568
Operating lease liability, less current portion	21,288	-	21,288	-	5,998	-	-	19,779	-	-	27,286
Other noncurrent liabilities	25,519	-	25,519	-	-	393	-	-	-	-	25,912
Total liabilities	979,118	2,734	981,852	5,232	41,463	950	1,116	24,029	1,309	(4,225)	1,051,728
Stockholder's equity											
Common stock	-	-	-	-	-	-	-	-	-	-	-
Retained earnings	-	-	-	-	-	-	-	-	-	-	-
Total stockholder's equity	-	-	-	-	-	-	-	-	-	-	-
Net assets											
Without donor restrictions	2,105,041	(1,807)	2,103,234	122,329	6,492	2,114	(811)	-	(1,031)	(1,100)	2,231,227
With donor restrictions	622,176	-	622,176	-	-	-	-	-	-	-	622,176
Total net assets	2,727,217	(1,807)	2,725,410	122,329	6,492	2,114	(811)	-	(1,031)	(1,100)	2,853,403
Total liabilities and net assets	\$ 3,706,335	\$ 927	\$ 3,707,262	\$ 127,561	\$ 47,955	\$ 3,064	\$ 305	\$ 24,182	\$ 278	\$ (5,476)	\$ 3,905,129

Children's Hospital of Chicago Medical Center and Affiliated Corporations
Consolidating Balance Sheet
August 31, 2024
(Dollars in Thousands)

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	Ann & Robert H. Lurie Children's Hospital of Chicago	Ann & Robert H. Lurie Children's Hospital of Chicago Foundation	Obligated Group	Stanley Manne Children's Research Institute	Lurie Children's Medical Group, Inc.	Almost Home Kids	Children's Hospital of Chicago Medical Center	CMMC Insurance Co. Ltd	Lurie Children's Health Services, LLC	Eliminating Entries	Total
Assets											
Current assets	\$ 31,417	\$ -	\$ 31,417	\$ -	\$ 7,255	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 38,672
Cash and cash equivalents	31,699	-	31,699	-	-	-	-	-	-	-	31,699
Current portion of self-insurance trust	324,225	-	324,225	-	-	-	-	-	-	-	355,957
Patient accounts receivable	-	2,621	-	-	30,393	895	-	-	444	-	199,642
Other current assets	163,179	-	165,800	807	13,507	178	222	22,812	2	(3,684)	625,970
Total current assets	550,520	2,621	553,141	807	51,155	1,071	222	22,812	446	(3,684)	1,971,480
Investments	1,952,775	-	1,952,775	-	19,487	-	146	238	-	(1,146)	2,103,278
Property and equipment, at cost	1,901,776	1,615	1,903,391	192,142	4,371	2,948	-	-	426	-	982,489
Less: Accumulated depreciation	918,200	1,615	919,815	58,096	3,407	1,168	-	-	3	-	1,120,789
Total property and equipment	983,576	-	983,576	134,046	964	1,780	-	-	423	-	30,965
Operating lease right-of-use assets	21,335	-	21,335	-	6,154	1,179	-	-	2,297	-	44,064
Other assets	44,064	-	44,064	-	-	-	-	-	-	-	6,111
Pledges receivable restricted by donors	934	-	934	-	1,418	-	-	-	3,759	-	50,175
Total other assets	44,998	-	44,998	-	1,418	-	-	-	3,759	-	3,799,379
Total assets	3,553,204	2,621	3,555,825	134,853	79,158	4,030	368	23,050	6,925	(4,830)	
Liabilities and Net Assets											
Current liabilities	\$ 6,860	\$ -	\$ 6,860	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,860
Current portion of long-term debt	332,103	2,552	334,655	4,453	41,627	233	214	3,711	621	(3,684)	381,830
Accounts payable and accrued expenses	31,699	-	31,699	-	-	-	-	-	-	-	31,699
Current portion of self-insurance liability	159,552	-	159,552	-	2,712	-	-	-	-	-	162,264
Due to third-party payors	8,983	-	8,983	-	252	-	-	-	231	-	9,702
Current portion of operating lease liabilities	539,197	2,552	541,749	4,453	44,591	469	214	3,711	852	(3,684)	592,355
Total current liabilities	321,379	-	321,379	-	-	-	-	-	-	-	321,379
Long-term debt, less current portion	182,427	-	182,427	-	-	-	-	19,193	-	-	201,620
Self-insurance liability, less current portion	28,872	-	28,872	-	6,438	1,029	-	-	2,175	-	38,514
Operating lease liabilities, less current portion	25,267	-	25,267	-	598	459	-	-	-	-	26,324
Other noncurrent liabilities	1,097,142	2,552	1,099,694	4,453	51,627	1,957	214	22,304	3,027	(3,684)	1,180,192
Total liabilities	-	-	-	-	-	-	-	-	-	-	-
Stockholder's equity	-	-	-	-	-	-	-	-	-	-	-
Common stock	-	-	-	-	-	-	-	-	-	-	-
Retained earnings	-	-	-	-	-	-	-	-	-	-	-
Total stockholder's equity	-	-	-	-	-	-	-	-	-	-	-
Net assets	1,859,244	69	1,860,313	130,400	27,531	2,073	154	-	3,898	(1,000)	2,032,369
Without donor restrictions	566,818	-	566,818	-	-	-	-	-	-	-	566,818
With donor restrictions	2,455,062	69	2,455,131	130,400	27,531	2,073	154	-	3,898	(1,000)	2,619,187
Total net assets	3,553,204	2,621	3,555,825	134,853	79,158	4,030	368	23,050	6,925	(4,830)	3,799,379
Total liabilities and net assets											

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Children's Hospital of Chicago Medical Center and Affiliated Corporations
Consolidating Statement of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended August 31, 2025
(Dollars in Thousands)

	Ann & Robert H. Lurie Children's Hospital of Chicago	Ann & Robert H. Lurie Children's Hospital of Chicago Foundation	Eliminating Entries	Obligated Group	Stanley Manne Children's Research Institute	Lurie Children's Medical Group, Inc.	Almost Home Kids	Children's Hospital of Chicago Medical Center	CMMC Insurance Co. Ltd	Lurie Children's Health Services, LLC	Eliminating Entries	Total
Operating revenue	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Patient service revenue	1,318,543	-	-	1,318,543	-	268,953	4,723	-	-	3,046	(197)	1,593,068
Net assets released from restriction												
Contributions and philanthropy used for program purposes	54,230	-	-	54,230	13,730	4,533	4	-	-	310	(18,577)	54,230
Grants and other restricted income used for program purposes	105,998	-	-	105,998	31,594	1,068	-	-	-	-	(32,662)	105,998
Board-designated endowment income	20,702	-	-	20,702	1,319	3,654	-	-	-	-	(4,973)	20,702
Other operating revenue	75,915	265	(265)	75,915	1,378	110,369	684	-	140	289	(79,564)	109,221
	1,575,388	265	(265)	1,575,388	48,021	386,577	5,411	-	140	3,655	(135,973)	1,883,219
Operating expenses												
Salaries, wages and employee benefits	695,471	13,666	(13,666)	695,471	55,242	428,628	7,226	1,830	-	7,603	(63,893)	1,132,107
Supplies and services	484,680	8,109	(7,624)	465,165	8,572	77,258	1,024	487	133	8,096	(72,080)	486,655
Insurance	19,861	-	-	19,861	-	24,019	-	-	-	-	-	43,880
Medical assessment	30,721	-	-	30,721	-	-	-	-	-	-	-	30,721
Depreciation and amortization	81,300	-	-	81,300	9,316	59	112	-	-	58	-	90,845
Interest and financing costs	16,193	-	-	16,193	-	-	-	-	-	-	-	16,193
	1,308,226	21,775	(21,290)	1,308,711	73,130	529,964	8,362	2,317	133	15,757	(135,973)	1,802,401
Total operating expenses												
Income (loss) from operations	267,162	(21,510)	21,025	266,677	(25,109)	(143,387)	(2,951)	(2,317)	7	(12,102)	-	80,818
Nonoperating income (expense)												
Investment return	120,180	-	-	120,180	-	521	-	7	-	-	(7)	120,701
Unrestricted contributions and bequests	-	23,845	-	23,845	-	-	563	-	-	-	-	24,408
Fundraising expense	-	(8,739)	(21,025)	(21,025)	(4)	(8,641)	(91)	-	-	(978)	-	(21,116)
Other			-	(6,739)			66		-		(100)	(18,396)
Total nonoperating income (expense)	111,441	23,845	(21,025)	114,261	(4)	(8,120)	538	7	-	(978)	(107)	105,597
Excess (deficiency) of revenue over expenses	378,603	2,335	-	380,938	(25,113)	(151,507)	(2,413)	(2,310)	7	(13,080)	(107)	186,415
Net assets released from restrictions used for purchase and construction of property and equipment	494	-	-	494	-	-	-	-	-	-	-	494
Retirement plan-related change other than net periodic retirement plan cost	2,953	-	-	2,953	-	5,661	-	-	-	-	-	8,614
Other	3,335	-	-	3,335	-	-	-	-	-	-	-	3,335
Transfers (to) from affiliates	(149,587)	(4,211)	-	(153,798)	17,041	124,808	2,454	1,344	-	8,151	-	-
Change in net assets without donor restrictions	235,798	(1,876)	-	233,922	(8,072)	(21,038)	41	(966)	7	(4,929)	(107)	198,858

Children's Hospital of Chicago Medical Center and Affiliated Corporations
Consolidating Statement of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended August 31, 2024
(Dollars in Thousands)

	Ann & Robert H. Lurie Children's Hospital of Chicago Foundation	Ann & Robert H. Lurie Children's Hospital of Chicago	Ann & Robert H. Lurie Children's Hospital of Chicago Foundation	Eliminating Entries	Obligated Group	Stanley Manne Children's Research Institute	Lurie Children's Medical Group LLC	Almost Home Kids	Children's Hospital of Chicago Medical Center	CMMC Insurance Co. Ltd	Lurie Children's Health Services, LLC	Eliminating Entries	Total
Operating revenue													
Net assets released from restriction	\$ 1,204,896	\$ -	\$ -	\$ -	\$ 1,204,896	\$ -	\$ 239,749	\$ 6,542	\$ -	\$ -	\$ 3,547	\$ (390)	\$ 1,454,344
Contributions and philanthropy used for program purposes		53,898			53,898	18,290	3,835	66			310	(22,500)	53,899
Grants and other restricted income used for program purposes		97,484			97,484	28,626	1,177					(29,803)	97,484
Board-designated endowment income		22,639			22,639	1,099	1,145					(2,245)	22,638
Other operating revenue		57,311	332	(332)	57,311	1,023	129,340	632		132	325	(85,794)	102,969
Total operating revenue	1,436,228	1,436,228	332	(332)	1,436,228	49,038	375,246	7,240	-	132	4,182	(140,732)	1,731,334
Operating expenses													
Salaries, wages and employee benefits		740,402	13,527	(13,527)	740,402	49,396	367,487	10,342	606		7,702	(71,419)	1,104,516
Supplies and services		456,520	7,298	(7,298)	456,520	11,701	94,525	1,055	915	139	1,351	(69,312)	496,894
Insurance		20,657			20,657		23,193						43,850
Medical assessment		30,433			30,433								30,433
Depreciation and amortization		73,736			73,736	9,315	172	117			56		83,396
Interest and financing costs		17,006			17,006								17,006
Total operating expenses	1,338,754	1,338,754	20,825	(20,825)	1,338,754	70,412	485,377	11,514	1,521	139	9,109	(140,731)	1,776,085
Income (loss) from operations	97,474	97,474	(20,493)	20,493	97,474	(21,374)	(110,131)	(4,274)	(1,521)	(7)	(4,927)	(1)	(44,761)
Nonoperating income (expense)													
Investment return (loss)		171,692			171,692		2,487		(7)			7	174,179
Unrestricted contributions and bequests			23,924	(20,493)	23,924			1,135					25,059
Fundraising expense					(20,493)		(500)	(208)					(21,201)
Other		(11,953)			(11,953)		211	72				(100)	(11,770)
Total nonoperating income (expense)	159,739	159,739	23,924	(20,493)	163,170	-	2,198	999	(7)	-	-	(93)	166,267
Excess (deficiency) of revenue over expenses	257,213	257,213	3,431	-	260,644	(21,374)	(107,933)	(3,275)	(1,528)	(7)	(4,927)	(94)	121,506
Net assets released from restrictions used for purchase and construction of property and equipment		316			316								316
Retirement plan-related change other than net periodic retirement plan cost		151			151		(756)						(595)
Other		1,365	(117)		1,248								1,248
Transfers (to) from affiliates	(123,374)	(123,374)	(1,612)	-	(124,986)	14,112	101,701	3,612	2,114	-	3,447	-	-
Change in net assets without donor restrictions	135,661	135,661	1,702	-	137,363	(7,262)	(6,988)	337	586	(7)	(1,480)	(94)	122,475

**Children's Hospital of Chicago Medical Center and
Affiliated Corporations**
Note to Supplementary Information
Years Ended August 31, 2025 and 2024
(Dollars in Thousands)

Note 1. Basis of Presentation

The consolidating balance sheets and consolidating statements of operations and changes in net assets without donor restrictions reflect the activity of Lurie Children's Medical Group, Inc. in a single column as of and for the years ended August 31, 2025 and 2024. For the period from September 1, 2023 through January 1, 2025, the activity comprising this column was conducted by the following legal entities:

- Pediatric Faculty Foundation, Inc.
- Lurie Children's Surgical Foundation, Inc.
- Lurie Children's Pediatric Anesthesia Associates
- Lurie Children's Medical Group, LLC
- Lurie Children's Primary Care, LLC; and
- Children's Hospital of Chicago Faculty Practice Plan, Inc.

Effective January 1, 2025, the activities of the medical groups was merged into a single, multispecialty pediatric faculty practice (Lurie Children's Medical Group, Inc.). While the merger didn't occur until January 1, 2025, the activity is presented in a single column within this supplemental information using the naming convention of Lurie Children's Medical Group, Inc. to aid in comparison of results between the two periods presented.

1120.130 Financial Viability

Attached is the Fitch Rating Agency Report from April, 2026, affirming that Ann & Robert H. Lurie Children's Hospital of Chicago has a AA Bond rating. Accordingly, Lurie Children's claims the financial viability waiver and is not required to submit viability ratio tests.

RATING ACTION COMMENTARY

Fitch Affirms Lurie Children's Hospital (IL) at 'AA'; Outlook Stable

Mon 20 Apr, 2026 - 5:09 PM ET

Fitch Ratings - Chicago - 20 Apr 2026: Fitch Ratings has affirmed the 'AA' Issuer Default Rating (IDR) and revenue bond rating on the outstanding bonds issued by the Illinois Finance Authority on behalf of Ann & Robert H. Lurie Children's Hospital of Chicago (Lurie Children's).

The Rating Outlook is Stable.

RATING ACTIONS

ENTITY / DEBT ⬆	RATING ⬆			PRIOR ⬆
Lurie Children's Hospital (IL)	LT IDR	AA Rating Outlook Stable		AA Rating Outlook Stable
	Affirmed			
Lurie Children's Hospital (IL) /General Revenues/1 LT	LT	AA Rating Outlook Stable	Affirmed	AA Rating Outlook Stable

[VIEW ADDITIONAL RATING DETAILS](#)

Lurie Children's 'AA' ratings continue to be supported by its very strong balance sheet with low leverage ratios from modest debt and strengthening operations. Fitch expects Lurie Children's to preserve balance sheet strength as operating recovery is underway and capital spending rises. The affirmation reflects Lurie Children's leading pediatric market

position, improving operating performance, and strong liquidity despite recent disruption from labor pressure and the 2024 cyberattack.

SECURITY

Bond payments are secured by a pledge of the gross receipts of the obligated group.

KEY RATING DRIVERS

Revenue Defensibility - 'bbb'

Leading Market Share Reinforced by High-Acuity Specialty Offerings

Lurie Children's is the leading provider of pediatric services in the Chicago area, particularly for high-acuity specialties, and serves as a destination center for complex pediatric care. The hospital's competitive position is enhanced by its close affiliation and physical proximity to Northwestern Memorial Hospital (NMH) and Northwestern University's Feinberg School of Medicine (FSM). Lurie Children's is the pediatric training facility for FSM.

Market share remains sound, with inpatient and observation distribution slightly above 32% in 2025. About 85% of inpatient volume comes from the seven-county Chicago area, which supports demand stability. Lurie's inpatient and observation service area distribution are supported by its affiliations with Northwestern Medicine, RUSH System for Health, and existing relationships with other hospital partners. These affiliations and relationships are an important part of Lurie Children's strategic outreach and enhance its clinical presence. Revenue defensibility remains consistent with the midrange assessment despite the hospital's high Medicaid exposure, which is typical for children's hospitals and creates some funding risk if federal or state support weakens.

Operating Risk - 'a'

Operating Cashflow Showing Signs of Recovery

Operating performance improved in FY25 (Aug. 31 FYE), with operating EBITDA rising to 9.7% after pressure from inflation, labor shortages, and the January 2024 cyberattack. Results continued to recover through the first six months ended Feb. 28, 2026, when operating EBITDA reached 18.5 %. Fitch expects margins to remain strong as volume grows, payor contracts improve, and management advances initiatives in throughput, care model design, revenue cycle, workforce stability, and cost control. Expected gains in

volumes, favorable payor contract negotiations, and temporary enhanced supplemental state funding could support operating margins at very strong levels. Challenging this expectation are possible impacts to H.R.1, which add uncertainty to state and federal reimbursement.

Fitch expects Lurie Children's to fund a large capital plan while preserving operating flexibility. Planned spending includes expansion of the west region, featuring a new hospital in Downers Grove, and capital projects to its existing satellite and main campuses. The Downers Grove hospital is anticipated to serve as a hub for care in Lurie's "west region," providing care locally, while freeing up high-acuity capacity at its flagship hospital. The new facility is expected to generate significant positive cash flow once fully stabilized.

Lurie Children's recently opened its Schaumburg outpatient center in 4Q25, which includes specialty care, ancillary therapeutic, diagnostic and infusion services. A specialty pharmacy will open in 2026. Fitch views the capital program as manageable because of the hospital's fundraising strength, improving cash flow, and reasonable average age of plant of 11.7 years at FYE25. The operating risk assessment remains strong, supported by recovery in cashflow and sustained demand for high-acuity services.

Financial Profile - 'aa'

Robust Liquidity and Low Debt Burden

Lurie Children's financial profile is very strong, supported by low leverage and substantial liquidity. Even with anticipated capital spending, leverage remains consistent with the 'aa' assessment in Fitch's forward-looking stress case. Liquidity was about \$1.8 billion as of Feb. 28, 2026, and cash-to-adjusted debt was about 375%. Fitch expects cash-to-adjusted debt to decline with the capital spending, but remain at very strong levels.

Asymmetric Additional Risk Considerations

No asymmetric additional risk considerations were applied to this rating.

RATING SENSITIVITIES

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

--A larger-than-expected debt issuance or a decline in liquidity such that cash-to-adjusted debt remains below 180%;

--Operating EBITDA does not remain at or above 8% over the Outlook period, and/or unexpected capital needs result in a lower operating risk assessment;

--While not expected, rating pressure could also arise from very significant unfavorable changes in Lurie Children's supplemental funding stream or a material increase in account receivable pressure from the state's Medicaid program.

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

--Given additional capital spending to support strategic capital expansion, positive rating momentum is not likely in the foreseeable future.

PROFILE

Lurie Children's operates a 368-bed pediatric hospital in Chicago. It is Illinois' only freestanding pediatric hospital and Level I pediatric trauma center. Additional operations include 11 outpatient centers, physician groups, research, and foundation activities.

Sources of Information

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

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

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1120.140 Economic Feasibility

This section contains the following:

- A. Reasonable of Financing Arrangements, and
- B. Conditions of Debt Financing

See attached May 12, 2026 letter from Alex P. Miller, SVP and Chief Financial Officer, Ann & Robert H. Lurie Children's Hospital of Chicago

- C. Reasonableness of Project and Related Costs

See Table C displaying construction cost per sq for reach functional area in the project.

See Table Project Costs and Sources of Funds and supporting narrative showing how clinical cost line items compare to State standards.

- D. Projected Operating Costs

See attached table.

- E. Total Effect of the Project on Capital Costs

See attached table.

May 12, 2026

Ms. Debra Savage, Chair
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: 1120.140(B) Conditions of Debt Financing
Proposed Lurie Children's Hospital and Outpatient Center in Downers Grove, IL

Dear Ms. Savage:

Ann & Robert H. Lurie Children's Hospital of Chicago's (Lurie Children's) proposed hospital and outpatient center will be funded by cash and securities, philanthropy and debt. Of the total project cost, \$200 million in debt will be obtained through the issuance of bonds. On behalf of Lurie Children's, I attest that the debt will be secured at the lowest net cost available.

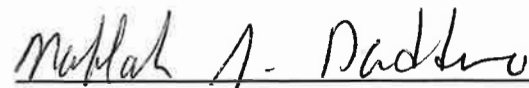
If you have any questions, please contact Nicola Byrne, Controller, at nbyrne@luriechildrens.org.

Sincerely,



Alex P. Miller
SVP and Chief Financial Officer
Ann & Robert H. Lurie Children's Hospital of Chicago
225 E. Chiago Avenue
Chicago, IL 60611

Subscribed and sworn to before me
this 12 day of May, 2026.



Signature of Notary Public

Seal

Cost and Gross Square Feet by Department or Service
Lurie Children's – Downers Grove Hospital & Outpatient Center

Department	A	B	C	D	E	F	G	H		As Is
	Cost / Sq Ft		DGSF		DGSF		Const \$	Mod \$	Total Cost	Sq Ft
	New	Mod	New	Circ %	Mod	Circ %	(A x C)	(B x E)	(G + H)	
CLINICAL										
Pediatric beds	\$ 800		31,171	22%			\$ 24,936,800		\$ 24,936,800	
Emergency Department	\$ 950		23,803	25%			\$ 22,612,850		\$ 22,612,850	
Surgery	\$ 1,051		28,280	25%			\$ 29,711,659		\$ 29,711,659	
Imaging										
X-ray	\$ 750		2,396	23%			\$ 1,797,000		\$ 1,797,000	
Ortho EOS	\$ 850		599	23%			\$ 509,150		\$ 509,150	
Fluoroscopy	\$ 950		803	23%			\$ 762,850		\$ 762,850	
Ultrasound	\$ 600		638	23%			\$ 382,800		\$ 382,800	
MRI	\$ 1,300		2,894	23%			\$ 3,762,200		\$ 3,762,200	
CT	\$ 1,000		950	23%			\$ 950,000		\$ 950,000	
Exam/treatment	\$ 850		17,578	24%			\$ 14,941,300		\$ 14,941,300	
Ancillary testing	\$ 775		5,740	24%			\$ 4,448,500		\$ 4,448,500	
Infusion	\$ 775		3,314	24%			\$ 2,568,350		\$ 2,568,350	
Sleep LabSleep lab	\$ 775		2,978	24%			\$ 2,307,950		\$ 2,307,950	
Rehabilitation - PT/OT, gym	\$ 775		4,205	25%			\$ 3,258,875		\$ 3,258,875	
Lab	\$ 850		4,286	21%			\$ 3,643,100		\$ 3,643,100	
Pharmacy	\$ 850		2,942	21%			\$ 2,500,700		\$ 2,500,700	
Subtotal clinical	\$ 898		132,577				\$ 119,094,084		\$ 119,094,084	
NON-CLINICAL										
Support/work stations	\$ 690		9,009	25%			\$ 6,216,210		\$ 6,216,210	
Food service (kitchen, dining)	\$ 940		8,157	28%			\$ 7,667,580		\$ 7,667,580	
Reception, registration, waiting	\$ 610		25,513	30%			\$ 15,562,930		\$ 15,562,930	
Supplies/storage	\$ 520		18,238	22%			\$ 9,483,760		\$ 9,483,760	
Mech, building syst, hskp	\$ 1,295		78,737	25%			\$ 101,928,822		\$ 101,928,822	
Administration	\$ 640		6,983	22%			\$ 4,469,120		\$ 4,469,120	
Lockers/lounges	\$ 620		12,515	22%			\$ 7,759,300		\$ 7,759,300	
Restrooms	\$ 840		6,940	20%			\$ 5,829,600		\$ 5,829,600	
Subtotal Non-clinical	\$ 957		166,092				\$ 158,917,322		\$ 158,917,322	
TOTAL	\$ 931		298,669				\$ 278,011,406		\$ 278,011,406	

Project Costs and Sources of Funds
Lurie Children's – Downers Grove Hospital & Outpatient Center

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	\$ 2,031,487	\$ 1,512,284	\$ 3,543,771
Site Survey and Soil Investigation	\$ 30,000	\$ 45,000	\$ 75,000
Site Preparation	\$ 6,184,689	\$ 16,474,668	\$ 22,659,357
Off Site Work	-	-	-
New Construction Contracts	\$ 119,094,084	\$ 158,917,322	\$ 278,011,406
Modernization Contracts	-	-	-
Contingencies	\$ 11,700,000	\$ 49,487,845	\$ 61,187,845
Architect/Engineering Fees	\$ 6,371,000	\$ 13,972,929	\$ 20,343,929
Consulting and Other Fees	\$ 13,816,540	\$ 9,211,027	\$ 23,027,567
Moveable or Other Equipment			
- Furnishings	\$ 3,084,500	\$ 1,890,500	\$ 4,975,000
- Equipment	\$ 29,259,672	\$ 17,933,348	\$ 47,193,020
Bond Issuance Expense	\$ 66,667	\$ 66,666	\$ 133,333
Net Interest Expense During Construction	-	-	-
FMV of Leased Space or Equipment	-	-	-
Other Costs to be Capitalized	-	-	-
- Artwork	\$ 243,000	\$ 725,175	\$ 968,175
- Dietary Equipment	-	\$ 1,600,000	\$ 1,600,000
- Technology/AV	\$ 9,250,500	\$ 7,134,000	\$ 16,384,500
Acquisition of Building or Other Property (excl land)	-	-	-
TOTAL USES OF FUNDS	\$ 201,132,139	\$ 278,970,764	\$ 480,102,903

SOURCE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Cash and Securities	\$ 51,132,139	\$ 128,970,764	\$ 180,102,903
Pledges	-	-	-
Gifts and Bequests - philanthropy	\$ 50,000,000	\$ 50,000,000	\$ 100,000,000
Bond Issues (project related)	\$ 100,000,000	\$ 100,000,000	\$ 200,000,000
Mortgages	-	-	-
Leases (fair market value)	-	-	-
Government Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$ 201,132,139	\$ 278,970,764	\$ 480,102,903

Project Costs and Sources of Funds
Lurie Children's – Downers Grove Hospital & Outpatient Center

Narrative Descriptions of Line Items

Item 1. Preplanning Costs - \$3,543,771

Market studies, feasibility studies and background work, real estate analysis and site selection; Phase 1 cultural and environmental assessments; initial traffic and parking studies; legal and zoning investigation.

Preplanning costs assigned to clinical uses total \$2,031,487. This amount is 1.2% of \$163,138,256 the total of \$119,094,084 for clinical construction plus \$11,700,000 clinical contingency plus \$32,344,172 for clinical equipment and furnishings. 1.2% meets the State standard, under 1.8%.

Item 2. Site survey and soil investigation - \$75,000

Soil testing and geotechnical work; property survey. \$30,000 of this amount is assigned to clinical cost.

Item 3. Site Preparation - \$22,659,357

Site work includes earthwork and grade leveling, utility infrastructure installation, irrigation and drainage systems, retention pond configuration, asphalt paving, and landscaping; access road construction; improvement to adjacent streets and right-of-way including turn lanes; signage and signalization. Site work includes helipad construction. Site work assigned to clinical costs is \$6,184,689.

Item 4. Off-site work - \$0

There is no off-site work for this project.

The total site related work items 2, 3 and 4 is \$22,734,357, of which \$6,214,689 is assigned to clinical. \$6,214,689 is 4.8% of \$130,794,084, the sum of clinical construction (\$119,094,084) plus clinical contingency (\$11,700,000). 4.8% meets the State standard, under 5.0%.

Item 5. New Construction Contracts - \$278,011,406

The project is the construction of a four story plus lower level and penthouse (hospital) and connected two story clinic building, totaling 298,669 sq ft. Of this total, 132,577 sq ft is clinical. Construction costs include foundation and slab, core and shell, roofing, doors and windows, thermal and moisture protection, fixed equipment (other than medical equipment referenced below), interior buildout and finishings, and contractor's overhead. Electrical, plumbing and heating and air conditioning systems are included.

Of the total construction cost, \$119,094,084 is allocated to clinical uses. Cost per sq ft for clinical construction is \$898.28.

There are several characteristics of this project that contribute to construction costs above the RSMeans standard. The following items result in higher costs for pediatric inpatient care, several of which differentiate pediatrics from adult care, that are not factored into RSMeans calculations. Based on recent experience of the project's healthcare facility consultants with comparable pediatric projects, the associated premiums are estimated for the following factors:

- Larger patient rooms, mostly to accommodate family member visiting and overnight stays, 3 – 6%
 - Pediatric rooms are typically designed to support family-centered care, including sleeper sofas and in-room storage for overnight accommodations. Benchmark comparisons from recent children's hospital projects show room sizes increasing from 15 to 30% over adult equivalents, directly impacting overall building area and cost per bed. The upper part of the range includes dedicated caregiver space for charting and supplies.
- Increased design complexity (theming, custom finishes), 2 – 4%
 - Pediatric environments often incorporate themed interiors, interactive elements and custom millwork to create a more supportive, homelike and less clinical atmosphere. Examples include wall graphics, specialty lighting and play features in waiting and treatment areas. These elements are typically excluded from RSMeans-type baselines, which assume more standardized healthcare finishes, and are increasingly common in children's fit-out packages.
- Specialized/flexible equipment accommodations, 2 – 5%
 - This factor relates to additional space provided on the pediatric units, diagnostic imaging, and surgery for a range of equipment and supplies sized to fit ranges of infants and children, rather than adult sizes that are more standard. Examples include headwalls designed for multiple acuity levels, adjustable exam tables, and imaging equipment with pediatric protocols. Recent pediatric imaging and OR projects have provided space and allowances for specialized accommodations.
- Enhanced safety and security requirements, 1 – 3%
 - Pediatric facilities require additional layers of security and safety, including infant protection systems, controlled access zones, anti-ligature hardware, tamper resistant devices, and lockdown capability. Certain units require infant monitoring and tracking. Increasing regulations and security standards contribute to unit cost increases.
- Reduced standardization – greater room type variability, 2 – 4%
 - While the pediatric rooms are sized the same for stacking on the two-unit floors, and uniformity is conducive to efficient patient care staffing operations, there is individual variability within the rooms. Unlike adult facilities where room types are often highly repeatable, pediatric facilities require a broader mix of room configurations to support different age groups and care models. This factor reduces construction efficiency and limits some prefabrication opportunities.
- More durable/high performance materials, 1 – 3%
 - Materials in pediatric environments are typically selected for higher durability due to increased wear from patients, families and staff. Examples include impact-resistant wall protection, higher-grade flooring systems, and cleanable infection-control-driven finishes. These selections exceed standards RSMeans assumptions for commercial and basic healthcare construction.

- Higher infrastructure demands, 5 – 10%
 - Operating rooms, imaging and procedure-based spaces have higher MEP requirements than other outpatient and lower acuity clinical areas. This includes medical gases, redundancy in electrical power systems, specialized ventilation, air handling and cooling to support operational requirements. Certain of the rooms require multiple gas outlets and higher air change rates compared to adult med/surg.

While each of these factors independently contributes modest cost increases, collectively they can reasonably result in an overall premium that is 15 – 35% higher than the RSMeans standard of \$572.74 selected for this project. Collectively, the costs associated with these factors could add about \$200.00 per sq ft above the standard (at the 35% high end).

In addition to the above, the inpatient units with 48 pediatric beds are sized as ICUs. 12 of the 48 rooms are built out for ICU use, although they are pediatric rooms, and if conversion to ICU in the future is needed, it will require separate CON review and approval. These 12 rooms have sliding glass doors, medical gases and electric support for functioning as ICU rooms with a minimum of extra future cost. They are not equipped as ICU rooms. The sizing of all 48 as ICU is driven by efficiencies in construction, such as stacking requirements. This decision was made to provide flexibility for the future. The capital cost of this flexibility now is much less than reconstructing (and disrupting) the area in the future.

Having all rooms built at ICU size adds 32 clinical sq ft per room, and \$39.42 to the cost per sq ft of the pediatric units, as shown in the following calculations:

- 1,671 additional sq ft on level 3 + 1,841 on level 4 = 3,512 sq ft larger pediatric units.
- 3,512 / 48 pediatric rooms = additional 73 sq ft per pediatric room (per bed)
- 73 sq ft x (132,577 sq ft clinical / 298,669 sq ft total) = 73 x 0.44 = 32 clinical sq ft per room
- 32 sq ft x 48 x \$800 per sq ft for pediatric clinical construction = extra cost of \$1,228,800.
- \$1,228,800 / 31,171 sq ft for pediatrics = **\$39.42**, the cost per sq ft added to the pediatric units.
- (\$1,228,800 / 132,577 total sq ft clinical = \$9.27, the cost per sq ft added to the entire project)

An additional construction cost is associated with building out 12 of the 48 pediatric rooms as ICU-capable. These rooms will have ICU sliding glass doors, headwalls with medical gases and meeting ICU power requirements, etc. They will not be used as ICUs, but as pediatric rooms. They are capable of being converted to ICUs if the need evolves in the future, and subject to specific review and approval for future conversion to ICU. The cost of these features is estimated to be \$30,000 per room, or \$360,000 for the 12 rooms. This additional cost, spread over the pediatric units, is **\$46.20** per sq ft.

- \$360,000 / 7,793 sq ft for 12 pediatric rooms = \$46.20 per sq ft.
- (\$360,000 / 132,577 total sq ft clinical = \$2.72, the cost per sq ft added to the entire project)

Considering these factors including the sizing of pediatric rooms as ICU rooms and building out 12 rooms for potential possible future conversion to ICU, the clinical construction cost of \$898.30 per sq ft includes \$212.00 in cost premiums (\$200.00 + \$9.27 + \$2.72) above the RSMeans standard of \$572.74. These factors explain \$212.00 of the \$325.56 difference between the project construction cost of \$898.30 per sq ft and the RSMeans standard of \$572.74.

Item 7. Contingencies - \$61,187,845

Contingencies are allowances for unforeseen circumstances, such as delays in shipping and receipt of materials and supplies that affect the construction schedule, escalation above anticipated pricing of materials and labor, or site conditions resulting in plan modification.

\$11,700,000 is the contingency allocated to clinical uses. \$11,700,000 is 9.8% of clinical construction costs of \$119,094,084, thereby meeting the State standard of below 10%.

Item 8. Architectural and Engineering Fees - \$20,343,929

A/E fees include the functional program and space plan, preliminary design, schematic design, design development, construction document services, bidding and negotiation, and construction administration services. The costs of A/E services for construction are \$20,343,929, of which \$6,371,000 is allocated to clinical uses.

A/E contingency of \$6,371,000 is 4.87% of the clinical construction cost \$119,094,084 plus clinical contingency of \$11,700,000. This amount is consistent with the State standard range of 3.59% - 5.39% for construction and contingency for amounts over \$100 million.

Item 9. Consulting and Other Fees - \$23,027,567

This work includes legal fees, environmental evaluation, utilities during construction, builder's risk insurance policy premiums, and equipment planning. It also includes regulatory and permit fees, including Certificate of Need consulting and IDPH fees, as well as commissioning fees.

Of the \$23,027,567, \$13,816,539 is allocated to clinical costs.

Item 10. Moveable Equipment and furnishings not in construction contracts - \$52,168,020

The equipment list for the new hospital and clinic building is extensive, spanning over 2,800 rows and listing items from MRI and CT scanners to waste receptacles and glove boxes. The total amount for equipment is \$47,193,020, of which \$29,259,672 is clinical and \$17,933,348 is non-clinical. In addition, the furnishings budget is \$4,975,000, of which \$3,084,500 is clinical and \$1,890,500 is non-clinical.

Major equipment that individually or collectively exceeds \$200,000 is listed by functional area in the following table.

**Preliminary Estimated
Major Equipment Costs by Functional Area
Lurie Children's – Downers Grove Hospital & Outpatient Center**

FUNCTIONAL AREA	COST	
Surgery, Prep, Recovery, Central Sterilization	\$ 13,119,336	
- Washer/cart	\$	220,500
- Sterilizers (2)	\$	238,140
- Washer/disinfector (3)	\$	198,450
- Portable C-Arm	\$	330,750
- Integration Controller (6)	\$	992,250
- Anesthesia Atlan 350XL (6)	\$	496,125
- Equipment Boom S-Series (6)	\$	429,975
- Anesthesia Boom (6)	\$	396,900
- PYXIS drug dispensing system (6)	\$	396,900
- Surgical tables (6)	\$	369,944
- Supply dispensing unit (6)	\$	330,750
- Surgical light w flat panel arm (18)	\$	754,110
- Camera Head (12)	\$	317,520
- Prep/Recovery Physiological Monitor (22)	\$	521,483
- Stretchers (22)	\$	242,550
Imaging	\$ 11,528,855	
- CT Scanner	\$	2,976,750
- MRI 3.0T	\$	2,866,500
- MRI 1.5T	\$	2,535,750
- Digital Fluoroscopy	\$	628,425
- X-Ray	\$	385,875
- EOS-Ortho	\$	400,000
- Ultrasound Scanner	\$	220,500
Emergency Department	\$ 5,445,113	
- X-Ray	\$	220,500
- Ultrasound Scanner	\$	220,500
- Physiological Monitor (23)	\$	456,435
- Stretchers (23)	\$	253,575
Inpatient Pediatric Units	\$ 5,151,831	
- Physiological Monitor (44)	\$	1,018,710
- Electric beds (44)	\$	873,180
- Patient Headwall (22)	\$	242,550
Laboratory	\$ 1,431,139	
- Automated analyzer - hematology	\$	496,125
- Automated analyzer - chemistry (2)	\$	352,800
Outpatient Clinics	\$ 6,422,588	
- Ophthalmology	\$	264,600
- ENT Cart, video 9805T (4)	\$	926,100
- PYXIS Drug Dispensing Units (7)	\$	501,618
- Supply Dispensing Unit (4)	\$	220,500
Rehabilitation	\$ 741,773	
- Audiology booth (2)	\$	277,830
Engineering, MEP Systems, Maintenance	\$ 631,269	
Sleep / EEG	\$ 687,560	
Pharmacy	\$ 571,608	
All other spaces	\$ 1,461,948	
EQUIPMENT COST TOTAL	\$ 47,193,020	

**Note: Only includes equipment that individually or collectively exceeds \$200,000.*

Additional clinical equipment with relatively smaller aggregate costs constitute the remainder of the clinical equipment budget. The balance of the equipment budget includes a large volume of equipment located in exam rooms and other non-clinical areas. Examples of these items are: procedure carts, mobile workstations, exam tables, exam stools, medical gas carts, defibrillators and AEDs, video procedure carts, microscopes, wheelchairs and wheelchair scales, sharps containers, and nebulizers.

Furnishings include tables and chairs for waiting areas, conference rooms, and administrative and staff areas, desks and workstations.

Item 11. Bond Issuance Expense - \$133,333

Lurie Children's will be issuing bonds for several capital projects, including the Downers Grove hospital and clinic building. Arrangements have not been finalized at this time. The project-related bond issuance expense is estimated to be \$133,333 for this project, split equally between clinical and non-clinical use.

Item 12. Net Interest Expense During Construction - \$0

Interest on the bonds will be treated as a cost of operations and is not being capitalized.

Item 13. FMV of Leased Space or Equipment -\$0

There is no leased space or equipment in the project.

Item 14. Other Costs to be Capitalized - \$18,952,675

Information technology, incl computers, switches, cabling, low voltage, audio/visual	\$ 16,384,500
Artwork for lobby and public areas, waiting, exam rooms	\$ 968,175
Dietary equipment	\$ 1,600,000

Projected Operating Costs – FY2031
Lurie Children’s – Downers Grove Hospital & Outpatient Center

	Project FY 2031
Total Operating Costs	\$ 229,180,753
Equivalent Patient Days	46,895
Direct Cost per Equivalent Patient Day	\$ 4,887

Total Effect of the Project on Capital Costs – FY2031
Lurie Children's – Downers Grove Hospital & Outpatient Center

	Project FY 2031	Total Ann & Robert H. Lurie Children's Hospital of Chicago
Equivalent Patient Days (all Lurie Children's)	--	263,183
Total Project Cost	\$ 480,102,903	--
Useful Life	36	--
Total Annual Depreciation	\$ 17,396,141	\$ 131,740,754
Direct Cost per Equivalent Patient Day	\$ 371	\$ 501

SECTION X. SAFETY NET IMPACT STATEMENT**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.**

Ann & Robert H. Lurie Children Hospital of Chicago (“Lurie Children’s”) provides more pediatric patient care than any other hospital in Illinois in nearly every pediatric and surgical specialty. Lurie Children’s is the largest provider of Medicaid pediatric services in the State of Illinois. Over 58% of our inpatients are insured by Medicaid or the Children’s Health Insurance Program (CHIP). Lurie Children’s is one of the 32 “safety net hospitals” in Illinois as defined in statute. In CY2024, Lurie Children’s cared for more than 70% of the pediatric patients discharged from a safety net hospital in Illinois. From CY2022-2024, 1 in 3 pediatric Medicaid days in Illinois occurred at Lurie Children’s on average (33.2%). The hospital plans to continue to provide the same access to all patients at all locations.

Lurie Children’s treats all children regardless of their family's ability to pay. For the fiscal year ended August 31, 2025, Lurie Children’s total unreimbursed care and community benefit was \$187.3 million, including: \$127.5 million for charity care and unreimbursed cost of providing Medicaid services; \$706 thousand for financial assistance, \$6.7 million for education; \$25.1 million for research; \$3.5 million for language assistance / translation services; \$18.2 million for subsidized health services and \$5.5 million for bad debt that was not able to be collected.

As access to healthcare remains a challenge for patients, Lurie Children’s development of a pediatric community hospital in Downers Grove furthers the commitment to our patients by bringing world-class pediatric care to families in Chicago’s western suburbs. This will reduce the burden on patients and their families as it relates to transportation challenges, appointment availability, and reduced anxiety due to the ease of obtaining emergency, inpatient and outpatient pediatric services. The opening of a pediatric community hospital in the western suburbs will not inhibit Lurie Children’s ability to provide safety net services but, rather, will expand the provision of these services and improve health care disparities for all in this region.

The payor mix for Lurie Children’s hospital in Downers Grove is projected as follows:

Payor	Projected Mix %
Commercial	50.3%
Medicare	0.2%
Medicaid	48.0%
Other Public	0.6%
Self-Pay	0.9%

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.*

Other area hospitals provide emergency care, inpatient psychiatry and other services they consider safety net services. They also provide surgical services similar to the proposed Project, although none are dedicated to the unique and specialized needs of children. The proposed pediatric hospital in Downers Grove is not designed to, and to our knowledge, will not prevent another provider from providing essential safety net services. The new hospital will serve existing patient volumes now seen at Lurie Children's in the Streeterville neighborhood of Chicago and at Lurie Children's hospital outpatient center and ambulatory surgery treatment center in Westchester.

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

Not applicable as this project is the establishment of a new inpatient and ambulatory care facility in Downers Grove. A related but separate project is the discontinuation of Lurie Children's hospital outpatient center and ambulatory surgery treatment center in Westchester, which services will be incorporated in the new facility in Downers Grove. A separate permit application for the discontinuation of the Westchester facility addresses the impact of that discontinuation.

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

Patient Care Related Safety Net Services

In FY25, Lurie Children's cared for 266,613 individual children from almost every county in Illinois, 50 states and 50 countries. Lurie Children's is dedicated to making health care services accessible to pediatric patients without discrimination based on race, religion, gender, national origin, sexual orientation, or ability to pay.

As the premier pediatric Level 1 trauma center in the Chicago area, Lurie Children's provides acute care for all sick and injured children, with more than 1.1 million patient visits in FY25. The Emergency Department ("ED") is staffed 24 hours a day by board-certified pediatric emergency medicine specialists and fellows and is supported by a broad range of pediatric medical and surgical subspecialties and state-of-the-art diagnostic services. Experienced physicians and nurses are appointed around-the-clock to handle even the most complicated, life-threatening cases.

Many of the children Lurie Children's serves are transferred from other hospitals by Lurie Children's Transport Team, a Midwest leader in neonatal and pediatric transport. The Transport Team recently received accreditation from the [Commission on Accreditation of Medical Transport Systems \(CAMTS\)](#), making Lurie Children's the first neonatal-pediatric specialty transport team in Illinois and the region, and one of only 13 in the country, to obtain this prestigious recognition of quality.

Lurie Children's also operates a Level III Neonatal Nursery that serves as a regional referral center for the State of Illinois' Perinatal Network. This nursery has cared for more than twice the number of children with life-threatening conditions than any other pediatric hospital in Illinois. The hospital's ability to treat the most critically ill infants is demonstrated by the fact that in FY25, 53 percent of all transports into its neonatal intensive care unit were from other Level III nurseries in the Chicago metropolitan area.

For almost 60 years, the Pritzker Department of Psychiatry and Behavioral Health at Lurie Children's has provided psychiatric and psychological services to families and children of all ages, from every social and economic background. In FY2025, Lurie Children's specialists provided mental health evaluation and care during more than 35,000 outpatient visits; 422 inpatient psychiatric admissions; and served 140 children in the Partial Hospitalization Program. In addition, Lurie Children's provided more than 1,000 psychiatric consultations in the ED and the hospital inpatient pediatric and surgical services.

Lurie Children's provides comprehensive family support services to patients and their families. An interdisciplinary team of social workers, chaplains and child life specialists are available 24 hours a day, seven days a week. Most of these services are funded through philanthropic support.

Lurie Children's operates numerous hospital outpatient specialty clinics in various locations throughout the Chicago metropolitan area, increasing convenient access to the scarce pediatric specialty and subspecialty services that would not otherwise be immediately available. Lurie Children's also provides physician coverage through neonatologists, pediatric intensivists, pediatric hospitalists and pediatric emergency care medicine physicians at 10 other hospitals located in Chicago and suburban areas. Due to these partnerships, in 2025, Lurie Children's experts were on-site and available at more than 30 percent of the live births in the seven-county region.

Lurie Children's is consistently recognized for providing the highest level of safe and quality care. For example:

- In 2025, Lurie Children's was ranked by U.S. News & World Report as the top children's hospital in Illinois, ranking in 11 specialties.
- In 2025, Newsweek ranked Lurie Children's as #5 in pediatrics globally and #1 in cardiology and cardiac surgery.
- In 2025, Lurie Children's was honored by the American Medical Association as a "Joy in Medicine" organization honoring its commitment to physician well-being.
- In 2025, Lurie Children's earned the American Nurses Credentialing Center's Magnet Recognition for Nursing Excellence and Quality Patient Care for the sixth time; one of only a few hospitals in the country have been recognized six times.
- Lurie children's has been designated as a level I pediatric surgery center by the American College of Surgeons, becoming the first children's hospital in Illinois and the third in the country to earn this status.
- Lurie Children's is certified by the Illinois Department of Public Health and the Emergency Medical Services for Children program as both a Pediatric Critical Care Center (PCCC) and an Emergency Department Approved for Pediatrics (EDAP). Together, these certifications signify that Lurie Children's has the essential resources and capabilities in place to meet the emergency and critical care needs of seriously ill and injured children.

Education-Related Safety Net Services

Lurie Children's is one of the major pediatric teaching hospitals in the U.S., serving as the pediatric teaching facility and the primary pediatric practice site of Northwestern University Feinberg School of Medicine ("NUFSM") for resident physicians, fellows and medical students in pediatric specialties and sub-specialties. This program is consistently one of the most sought after in the country. McGaw Medical Center of Northwestern University ("McGaw") manages the training of hundreds of resident-

level trainees and trainees at the fellow level. Of those, Lurie Children's is the primary teaching site for approximately 100 pediatric residents and over 100 pediatric subspecialty fellows. In addition, trainees from the adult programs of McGaw rotate to Lurie Children's for varying lengths of time to fulfill the pediatric component of their training program. Lurie Children's invested nearly \$11 million in these educational programs in FY25.

Among the training opportunities for residents, supervised by attending physicians, is to provide pediatric primary care at the Uptown Clinic in Chicago. This clinic is a medical home for more than 3,000 children who speak 19 different languages. More than 200 of these children have conditions that the State considers "medically complex" or "highly medically complex." These conditions include spina bifida, cystic fibrosis, spastic quadriplegia cerebral palsy, seizure disorder, Down syndrome, chronic lung disease, neuromuscular scoliosis, hypo/hyperthyroidism and obstructive sleep apnea. Since 2015, this clinic has been recognized as a Patient-Centered Medical Home Program by the National Committee for Quality Assurance. These primary care services would not otherwise be available to patients treated at the site. The operating costs attributable to the primary care and dentistry clinics in FY25 are more than \$2 million. Both programs are operated despite financial losses to the organization. The clinics provide healthcare to a largely underserved community.

In addition to training medical students, residents and fellows of NUFSM and other institutions, Lurie Children's offers clinical experiences in pediatrics to nursing students and students in other allied health fields including respiratory therapy, exercise physiology, rehabilitation services, social work, nutrition, radiology, pharmacy, child life, art therapy, and psychiatry-related studies. Students training to be operating room technicians and cardiac perfusion technicians also have clinical placements at Lurie Children's. Students in clinical placements must be candidates for a degree in their particular field of study.

Research Related Safety Net

Advances in research lead to better outcomes for all children, regardless of their family income or demographics. Lurie Children's has been committed to generating new knowledge about the prevention and treatment of disease since its founding in 1882. More than 360 Lurie Children's researchers receive more than \$104 million in external funding annually to advance their discoveries, 75% of that from the National Institutes of Health (NIH) or other federal government sources. Researchers are currently participating in approximately 175 industry-sponsored clinical trials to uncover new cures and treatments for childhood diseases.

In addition to clinical and fundamental laboratory-based research, Lurie Children's conducts population-based and public health research that drives policy and community-based interventions that has garnered in excess of \$5 million in grants and contracts. These studies address the most pressing issues faced by our city's most vulnerable children. Lurie Children's Mary Ann & J. Milburn Smith Child Health Research Program researchers focus on issues including violence, obesity, and unintentional injury.

Community Outreach Related Safety Net Services

Lurie Children's safety net activities extend well beyond the hospital walls. For decades, experts from Lurie Children's have partnered closely with community leaders and organizations, linking our clinical work with their grassroots expertise to help communities thrive. This work is conducted through the Patrick M. Magoon Institute for Healthy Communities, the hub for community-focused

initiatives at Lurie Children's. Our community health efforts are informed by our Community Health Needs Assessment, and include the following initiatives and areas of focus:

Food, Activity and Nutrition (FAN): FAN, formerly the Consortium to Lower Childhood Obesity in Chicago (CLOCC), collaborates with local, state-wide and national partners to support healthy eating and physical activity for youth and their families. Projects include local food pantry support, home-delivery of medically-tailored meals for patients experiencing food insecurity, and convening and training organizations to increase WIC program enrollment.

Linking Clinic and Community: Through our Mobile Health program, Lurie Children's physicians and allied health professionals provide evidence-based health education and expert clinical care, such as wellness visits, vaccinations, asthma care, NICU follow-up, preventive cardiology and more. They provide these services through a state-of-the-art, accessible unit that visits Chicago Public Schools and other community partner settings, based on community need. Lurie Children's is also an affiliate of Project ADAM, a national organization that aims to increase survival from Sudden Cardiac Arrest by helping schools achieve Heart Safe School designation.

Austin HOPE Center: Lurie Children's has partnered with Stone Community Development Corporation, a trusted organization in Chicago's Austin community, in developing the Austin HOPE Center, a facility that will provide youth and families access to high-quality pediatric specialty physical and behavioral care and community-based services. Community input has been essential to our planning process, and the design and construction of this facility will promote healing and focus on advancing health equity on the West Side of Chicago. The Austin HOPE Center is tentatively scheduled to open in Fall 2026.

Journal of Health Advocacy: The Journal of Health Advocacy is the first of its kind peer-reviewed open access journal that bridges the gap between knowledge and action to empower individuals and groups to address real-world challenges to health equity. The journal publishes health advocacy research, scholarship and perspectives focused on improving the health and well-being of individuals and communities.

Maternal and Child Health: We house the Schreiber Family Center for Early Childhood Health and Wellness, whose programs focus on building safe, stable and nurturing relationships during the most important years of development - starting in the womb to age five. To help protect and improve the health of pregnant and birthing people, our Connect Home Visiting Chicago and West Side Healthy Parents and Babies programs connect expectant parents to supports like home visiting, doulas and care coordination.

Unintentional Injury Prevention: Lurie Children's Injury Prevention and Research Center addresses the leading causes of injury to Illinois children and adolescents through behavioral risk reduction and the promotion of safe physical and social environments in collaboration with a broad network of community partners. Our Buckle Up program's Child Passenger Safety technicians lead car seat installation workshops and inspections and provide reduced-cost car seats to eligible families. Our Safe Sleep program promotes safe infant sleep practices working closely with community partners in training Safe Sleep Ambassadors and distributing Safe Sleep Kits and portable cribs to communities experiencing high rates of sleep-related infant death.

Mentorship and Workforce Development: Our Mentorship and Workforce Development programs recruit youth from Chicago Public Schools to participate in apprenticeships, internships and professional development opportunities. We offer 13 programs for students ranging from middle school to graduate level, and serve more than 500 students per year.

Violence Prevention: Lurie Children's is home to Strengthening Chicago's Youth (SCY), a collaborative that builds capacity among public and private stakeholders to connect and mobilize towards common sense approaches to gun violence prevention. SCY's Juvenile Justice Collaborative aims to minimize further involvement of arrested youth in the justice system by facilitating and coordinating access to comprehensive support services that meet adolescents' developmental needs. SCY has also partnered with Lurie Children's Pritzker Department of Psychiatry and Behavioral Health and Communities United, a community-based organization, in Healing Through Justice, a youth-led effort to reshape the mental health system to better meet the needs of young people.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2023	2024	2025
Inpatient	634	437	495
Outpatient	311	256	379
Total	945	693	874
Charity (cost in dollars)			
Inpatient	\$ 1,289,383	\$ 672,214	\$ 542,872
Outpatient	\$ 633,569	\$ 394,739	\$ 415,377
Total	\$ 1,922,952	\$ 1,066,953	\$ 958,249
MEDICAID			
Medicaid (# of patients)	2023	2024	2025
Inpatient	3,733	4,031	4,389
Outpatient	95,678	96,394	96,514
Total	99,411	100,425	100,903
Medicaid (revenue)			
Inpatient	\$ 1,092,032,945	\$ 1,208,137,798	\$ 1,244,788,937
Outpatient	\$ 768,474,143	\$ 784,932,384	\$ 889,209,463
Total	\$ 1,860,507,088	\$ 1,993,070,182	\$ 2,133,998,400

SECTION XI. CHARITY CARE INFORMATION

CHARITY CARE			
Charity Care – Ann & Robert H. Lurie Children's Hospital of Chicago			
Charity Care	2023	2024	2025
Net Patient Revenue for the Hospital	\$ 1,168,670,090	\$ 1,204,895,862	\$ 1,318,542,614
Amount of Charity Care Charges	\$ 6,688,528	\$ 3,583,988	\$ 3,695,521
Cost of Charity Care Charges	\$ 1,922,952	\$ 1,066,953	\$ 958,249

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: Ann & Robert H. Lurie Children's Hospital of Chicago 225 E. Chicago Avenue
 Chicago (Name) IL 60611 312-227-4000 (Address)
 (City) (State) (ZIP Code) (Telephone Number)

2. Project Location: Lacey Road at Woodcreek Drive Downers Grove, IL 60515
 (Address) (City) (State)
DuPage
 (County) (Township) (Section)

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

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

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

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

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

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

National Flood Hazard Layer FIRMMette



88°2'10"W 41°49'52"N

271



88°1'33"W 41°49'25"N

Basemap Imagery Source: USGS National Map 2023

Legend

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

SPECIAL FLOOD HAZARD AREAS



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*



OTHER AREAS OF FLOOD HAZARD



OTHER AREAS



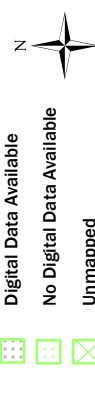
GENERAL STRUCTURES



Cross Sections with 1% Annual Chance



OTHER FEATURES



MAP PANELS



The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

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 **1/11/2026 at 11:36 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.

26.026

LETTERS OF SUPPORT

(Received as of June 2, 2026)

Ken Hedley, President, NM Central DuPage Hospital

Sean Casten, U.S. House of Representatives, 6th District Illinois

Deborah A. Conroy, DuPage County Board Chair

Anne Stava, State Representative, 81st District

Margaret A. DeLaRosa, State Representative, 42nd District

Marti Deuter, State Representative, 45th District

Laura Ellman, State Senator, 21st District

Appendix A



Central DuPage Hospital
25 N Winfield Road
Winfield, Illinois 60190
nm.org

Letter of Support and Commitment - CDH

May 20, 2026

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

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

Re: Letter of support for Proposed Lurie Children's Hospital and Outpatient Center in Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

I am writing in support of the project proposed by Ann & Robert H. Lurie Children's Hospital of Chicago (Lurie Children's) to construct a new pediatric hospital and outpatient center in Downers Grove.

Northwestern Medicine (NM) and NM Central DuPage Hospital have valued its long-standing partnership with Lurie Children's and is wholeheartedly in support of a Lurie Children's pediatric hospital and outpatient center in Downers Grove. This plan will greatly increase local access to care, making pediatric health services more available and convenient for patients and families residing in the area. The new hospital and outpatient center will facilitate convenient access to high quality pediatric care.

NM has long had a deep commitment to pediatric care, and it is wonderful to see Lurie expanding its reach into the western suburbs.

I encourage the Illinois Health Facilities and Services Review Board to approve this critically important project.

Sincerely

Ken Hedley
President
NM Central DuPage Hospital
Address
Phone number

Cc: Richard Lehmuth

SEAN CASTEN
6TH DISTRICT, ILLINOIS



HOUSE SCIENCE, SPACE, AND TECHNOLOGY
COMMITTEE

WASHINGTON, DC OFFICE
2440 Rayburn House Office Building
Washington, DC 20515
(202) 225-4561

HOUSE FINANCIAL SERVICES COMMITTEE
Subcommittee On Capital Markets
Subcommittee On Financial Institutions And Monetary Policy
Subcommittee On Digital Assets, Financial Technology, And Inclusion

Congress of the United States
House of Representatives
Washington, DC 20515-1306

March 17, 2026

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

Re: Proposed Lurie Children's Hospital and Outpatient Center Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery,

As the representative of the 6th District of Illinois, I enthusiastically support the project by Ann & Robert H. Lurie Children's Hospital of Chicago to construct a new pediatric hospital and outpatient center in Downers Grove.

From its location in downtown Chicago, Ann & Robert H. Lurie Children's Hospital of Chicago has played a critical role in health care for families in the western suburbs. It has accepted referrals from pediatricians and hospitals in the western area when children needed specialized medical and surgical care. The physicians and administrative leadership have established strong and positive working relationships with health care providers in all the communities they serve.

I am aware that the services downtown have grown significantly since the hospital moved from Lincoln Park to Streeterville in 2012, and that the hospital is occasionally at capacity. Having a pediatric hospital and outpatient center here locally will address that issue and make Lurie Children's care much more available and convenient for patients and their families residing in the area. It will also counter the trend that has seen 7 hospitals in the western suburbs close their pediatric units in the last dozen or so years. In FY 2025, Lurie Children's served 36,241 patient encounters (visits and admissions) from my district.

Lurie Children's is an outstanding organization, committed to strengthening health care throughout metropolitan Chicago. They excel at collaborating with partner hospitals and pediatric practices and investing in the numerous communities they serve. I am aware that they accept all payors, including providing an impressive volume of Medicaid services. The new hospital and outpatient center will facilitate convenient access to high quality pediatric care.

I respectfully ask the Illinois Health Facilities and Services Review Board to give Ann & Robert H. Lurie Children's Hospital of Chicago full and fair consideration for this necessary project.

Sincerely,

Congressman Sean Casten
U.S. House of Representatives
6th District of Illinois



**DUPAGE
COUNTY**

DEBORAH A. CONROY
County Board Chair

630-407-6060
chair@dupagecounty.gov

April 30, 2026

Ms. Debra Savage, Chairwoman & Mr. John Kniery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield IL 62761

Re: Letter of Support
Proposed Lurie Children's Hospital and Outpatient Center
Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

As the DuPage County Chair, I whole-heartedly support the project by Ann & Robert H. Lurie Children's Hospital of Chicago to construct a new pediatric hospital, emergency room and outpatient center in Downers Grove. I request that this letter of support be included in the public hearing record.

As a regional specialty hospital, Ann & Robert H. Lurie Children's Hospital of Chicago has the privilege of caring for critically ill and injured children from every corner of Illinois, 44 other states and 47 countries. Nearly 60 percent of patients are insured by Medicaid and the Children's Health Insurance Program. Lurie Children's has played a critical role in the health care for families in DuPage County. It has been available to accept referrals from pediatricians and hospitals in the county when children need specialized medical and surgical care. The physicians and administrative leadership have established strong and positive working relationships with health care providers in all the communities they serve, including municipalities in DuPage County.

Having a pediatric hospital and outpatient center in DuPage County will make Lurie Children's care much more available and convenient for patients and their families residing in the area. It will also counter the trend that seven hospitals in the western suburbs have closed their pediatric units in the last dozen or so years.

I have had the honor of collaborating with Lurie Children's for ten years while I served in the Illinois General Assembly. Lurie Children's is an outstanding organization, committed to strengthening health care for Illinois' children and families. They excel at collaborating with partner hospitals and pediatric practices and investing in the numerous communities they serve. The hospital accepts all payors, and they are the largest provider of pediatric Medicaid services in the state of Illinois. The new hospital and outpatient center will facilitate convenient access to high quality pediatric care.



DUPAGE
COUNTY

DEBORAH A. CONROY
County Board Chair

630-407-6060
chair@dupagecounty.gov

I respectfully ask the Illinois Health Facilities and Services Review Board to approve this essential project for the children and families of DuPage County.

Sincerely,

A handwritten signature in cursive script, reading "Deborah A. Conroy".

Deborah A. Conroy
DuPage County Board Chair

DISTRICT OFFICE

633 ROGERS STREET
SUITE 110
DOWNERS GROVE, IL 60515
(630) 605-0595

**26-026****SPRINGFIELD OFFICE**

200-3S STRATTON
OFFICE BUILDING
SPRINGFIELD, IL 62706
(217) 782-6578

ANNE STAVA
STATE REPRESENTATIVE • 81ST DISTRICT

May 12, 2026

Ms. Debra Savage, Chairwoman Mr. John Kniery, Administrator
Illinois Health Facilities and Illinois Health Facilities and
Services Review Board Services Review Board
525 West Jefferson Street - 2 nd Floor 525 West Jefferson Street – 2nd Floor
Springfield, IL 62761

Re: Letter of Support
Proposed Lurie Children's Hospital and Outpatient Center
Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

As the state representative of the 81 st District of Illinois, I strongly support the project by Ann & Robert H. Lurie Children's Hospital of Chicago to build a new pediatric hospital, emergency room and outpatient center in Downers Grove.

I have met with Lurie Children' and I am looking forward to working with the hospital's management team as the planning for this new hospital begins.

As a legislator, I am aware that Lurie Children's is consistently ranked the top pediatric hospital in our State. I have experienced the knowledge and expertise of their physicians and clinical staff first-hand. From its location in downtown Chicago, Lurie Children's Hospital has played a critical role in the health care for families in Downers Grove and the western suburbs. It has been available to accept referrals from pediatricians and hospitals in the western area where children need specialized medical and surgical care.

In FY 2025, Lurie Children's had 4,679 patient encounters (visits and admissions) from my district. Many of the patients and families cared for at Lurie Children's main location in Streeterville have expressed interest in more services in a location closer to their homes. Having a pediatric hospital, emergency room and outpatient center here locally will address that issue and make Lurie Children's care much more available and convenient for patients and their families residing in the area. It will also counter the trend that 7 hospitals in the western suburbs have closed their pediatric units in the last dozen or so years.

Lurie Children's is an outstanding organization, committed to strengthening health care throughout metropolitan Chicago. They excel at collaborating with partner hospitals and pediatric practices and investing in the numerous communities they serve. I am aware that they accept all payors, including providing the largest amount of pediatric care to children enrolled in Medicaid in the state.

I urge the Illinois Health Facilities and Services Review Board to approve this necessary project. Thank you for your consideration of this request.

Sincerely,

A handwritten signature in black ink, appearing to read "Anna Stava", is written on a light blue rectangular background.

Representative Anna Stava
81 st District

Springfield Office:
253-S Stratton Office Building
Springfield, IL 62706
217-782-8037

ILLINOIS HOUSE OF REPRESENTATIVES



Margaret A. DeLaRosa
Representative • 42nd District

26-026

District Office:
913 S. Main St.
Lombard, IL 60148
(630) 812-9292

April 21, 2026

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

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

Re: Letter of Support
Proposed Lurie Children's Hospital and Outpatient Center
Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

As the state representative of the 42nd District of Illinois, I wholeheartedly support the project by Ann & Robert H. Lurie Children's Hospital of Chicago to build a new pediatric hospital, emergency room and outpatient center in Downers Grove.

I have met with Lurie Children' and I am looking forward to working with the hospital's management team as the planning for this new hospital begins.

As a legislator, I am aware that Lurie Children's is consistently ranked the top pediatric hospital in our State. I have experienced the knowledge and expertise of their physicians and clinical staff first-hand. From its location in downtown Chicago, Lurie Children's Hospital has played a critical role in the health care for families in Downers Grove and the western suburbs. It has been available to accept referrals from pediatricians and hospitals in the western area where children need specialized medical and surgical care.

I am aware that the services downtown have grown significantly since the hospital moved from Lincoln Park to Streeterville in 2012, and that the hospital occasionally is at capacity. Having a pediatric hospital and outpatient center here in my community will address that issue and make Lurie Children's care much more available and convenient for patients and their families residing in the area. It will also counter the trend that 7 hospitals in the western suburbs have close their pediatric units in the last dozen or so years. Lurie Children's served 6,575 patient encounters from my district alone in FY 2025.

Lurie Children's is an outstanding organization, committed to strengthening health care throughout metropolitan Chicago. They excel at collaborating with partner hospitals and pediatric practices and

investing in the numerous communities they serve. I am aware that they accept all payors, including providing the largest amount of pediatric care to children enrolled in Medicaid in the state.

I respectfully urge the Illinois Health Facilities and Services Review Board to approve this necessary project.

Thank you for your consideration of this request.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret DeLaRosa". The signature is fluid and cursive, with the first name "Margaret" written in a larger, more prominent script than the last name "DeLaRosa".

IL State Rep. Margaret DeLaRosa
District 42

ILLINOIS HOUSE OF REPRESENTATIVES

DISTRICT OFFICE:
1 S. Cass Ave., Suite 104
Westmont, IL 60559
630-413-1080
office@repmartideuter.com



SPRINGFIELD OFFICE:
240A-W Stratton Building
Springfield, IL 62706
217-782-1448
www.repmartideuter.com

MARTI DEUTER
STATE REPRESENTATIVE

April 23rd, 2026

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

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

Re: Letter of Support
Proposed Lurie Children's Hospital and Outpatient Center
Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

As the state representative of the 45th District of Illinois, I strongly support the project by Ann & Robert H. Lurie Children's Hospital of Chicago to construct a new pediatric hospital and outpatient center in Downers Grove.

Lurie Children's has been providing life-saving care to the sickest children in our State for 140 years. Due to the breadth and depth of specialty services Lurie Children's provides, it is the only hospital that serves children from every legislative district in Illinois.

In FY 2025, Lurie Children's served 7,019 patient encounters (visits and admissions) from my district. Many of the patients and families cared for at Lurie Children's main location in Streeterville have expressed interest in more services in a location closer to their homes. Having a pediatric hospital, emergency room and outpatient center here locally will address that issue and make Lurie Children's care much more available and convenient for patients and their families residing in the area. It will also counter the trend that seven hospitals in the western suburbs have closed their pediatric units in the last dozen or so years.

Lurie Children's is an outstanding organization, committed to strengthening health care throughout metropolitan Chicago. Lurie Children's is the largest provider of pediatric Medicaid services in the State. They excel at collaborating with partner hospitals and pediatric practices and investing in the numerous communities they serve. I am aware that they accept all payors. The new hospital, emergency room and outpatient center will facilitate convenient access to high quality pediatric care.

I respectfully ask the Illinois Health Facilities and Services Review Board to approve this necessary project.

Sincerely,

State Representative Marti Deuter
Illinois House District 45

ILLINOIS SENATE

DISTRICT OFFICE:
24 W 500 MAPLE AVENUE
SUITE 215
NAPERVILLE, IL 60540
(630) 601-9961

STRATTON OFFICE BUILDING
SECTION C, ROOM D
SPRINGFIELD, IL 62706
(217) 782-8192

**SENATOR LAURA ELLMAN**STATE SENATOR • 21ST DISTRICT

April 29, 2026

Ms. Debra Savage, Chairwoman
*Illinois Health Facilities and
Services Review Board*
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

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

Re: Letter of Support
Proposed Lurie Children's Hospital and Outpatient Center
Downers Grove, IL

Dear Chairwoman Savage and Mr. Kniery:

As the state senator of the 21st District of Illinois, I want to share my strong support for the project by Ann & Robert H. Lurie Children's Hospital of Chicago to construct a new pediatric hospital and outpatient center in Downers Grove. I request that this letter of support be included in the public hearing record.

Lurie Children's is a critical partner with the State of Illinois. As a result of the depth and breadth of pediatric specialty services offered, hospitals throughout the State refer their most challenging and complex cases to Lurie Children's. In addition, Lurie Children's is the largest provider of pediatric Medicaid services in the state of Illinois. It is the only hospital that serves children from every corner of the state. In my District alone, there were 6,711 patient encounters in FY 25.

Building the new hospital in my district will provide an invaluable pediatric health care resource for residents of Downers Grove and the surrounding communities. Residents appreciate the close proximity of high-quality pediatric care as an alternative to traveling to the premier medical center downtown.

The new pediatric hospital and outpatient center in Downers Grove will ensure that the children of Illinois have access to the best care in pediatric medicine. I respectfully urge the Illinois Health Facilities and Services Review Board to approve this proposed project.

Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Laura Ellman', with a stylized, cursive script.

State Senator Laura Ellman
Illinois Senate District 21

LETTERS – COMMITMENT TO REFER PATIENTS

Pediatric Practice	Number of Providers	Committed 2031 referrals
Bedrose Pediatrics, SC	5	8
DuPage Pediatrics, Ltd.	6	42
FGM Pediatrics	2	10
Milestone Pediatrics	3	18
North Arlington Pediatrics	5	10
Oak Park Pediatrics, Ltd.	6	53
Pediatric Health Associates, Ltd.	19	115
Pedios, Ltd.	4	65
Schwartz Pediatrics	3	20
Children's Health Partners, SC	4	13
Lurie Children's Medical Group, Inc.	278	548
Total		902

APPENDIX B

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Bedrose Pediatrics, SC, specializing in pediatric primary care. The practice has a total of 5 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 8 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 8 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 8 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

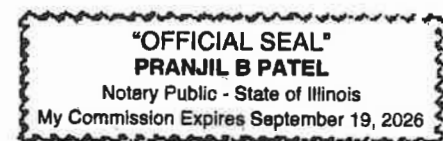
Please contact me if you have any questions.

Sincerely,



Debora S. Rosewell, MD
 2500 W. Higgins Rd. Suite 440
 Hoffman Estates, IL 60169
 847-839-0400

NOTARY SEAL



Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Debora S. Rosewell	6	5		
Shannon K. Nourbash	1	1		
Krystal Rosewell		1		
Agathangelos Louvros		1		
Eraj Din	1			
Totals	8	8		
				8

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60107	Streamwood		3	1
60169	Hoffman Estates		2	1
60101	Addison		1	1
60177	South Elgin		1	1
60103	Bartlett			1
60193	Schaumburg			1
60194	Schaumburg		1	
60120	Elgin			1
60139	Glendale Heights			1
TOTAL			8	8

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of DuPage Pediatrics Ltd, specializing in pediatric primary care. The practice has a total of 6 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 39 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 46 patients for inpatient pediatric medical/surgical care.

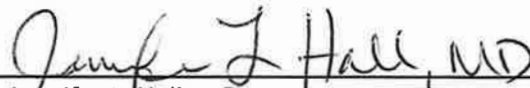
The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 42 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

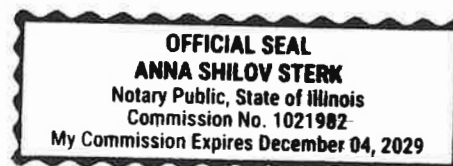
Sincerely,


 Jennifer L. Hall, MD
 1306 Plainfield Rd.
 Darien, IL 60561
 630-810-0900

5-6-26

NOTARY SEAL

 5-6-26



Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Jennifer L. Hall	13	11		
Deepa M. Joseph	12	11		
Anita L. Kewalramani	15	6		
Stephanie H. Sage	3	4		
Nazneen Ather	2	3		
Hunter Eason	1	4		
Totals	46	39		
				42

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60516	Downers Grove		13	5
60514	Clarendon Hills		5	8
60521	Hinsdale		5	5
60139	Glendale Heights		4	3
60561	Darien		4	3
60527	Willowbrook		1	5
60515	Downers Grove		1	3
60546	Riverside		3	
All Other Zip Codes			10	7
TOTAL			46	39

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of FGM Pediatrics, specializing in pediatric primary care. The practice has a total of 2 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 10 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 9 patients for inpatient pediatric medical/surgical care.

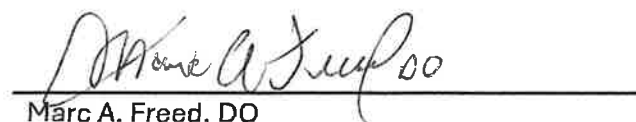
The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 10 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

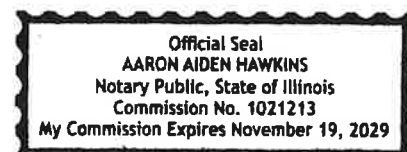
Please contact me if you have any questions.

Sincerely,



Marc A. Freed, DO
 8711 W. Cermak Rd.
 North Riverside, IL 60546
 708-442-7979

NOTARY SEAL



 APRIL 27, 2026

Appendix B

Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

[illegible]

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

[illegible]

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Milestone Pediatrics, specializing in pediatric primary care. The practice has a total of 3 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 18 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 14 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 18 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,



Michael J. Reicherts, MD
 4043 State Route 59
 Naperville, IL 60564
 630-420-4275



NOTARY SEAL



Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

[illegible]

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

[illegible]

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of North Arlington Pediatrics, SC, specializing in pediatric primary care. The practice has a total of 5 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 4 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 16 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 10 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,



David S. Dobkin, MD
 1430 N. Arlington Height Rd.
 Arlington Heights, IL 60004
 847-253-3600

NOTARY SEAL

Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Suzanne Alfano	5	2		
David S. Dobkin	4	1		
Timothy A. Geleske	3			
Nan O. Walicki	2	1		
Michele L. Lawhun	2			
Totals	16	4		
				10

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60193	Schaumburg		4	
60169	Hoffman Estates		2	1
60143	Itasca		2	
60103	Bartlett		1	1
60106	Bensenville		1	1
60565	Naperville		2	
60108	Bloomington			1
All Other Zip Codes			4	
TOTAL			16	4

[illegible]

Used for states (AL, AZ, CO, CT, DE, GA, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, OK, OR, RI, SC, SD, TN, VA, VT, WV, WI, WY)



**OAK PARK
PEDIATRICS**

1107 Chicago Avenue
Oak Park, Illinois 60302
708.383.2900 phone
708.383.2969 fax

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Oak Park Pediatrics Ltd, specializing in pediatric primary care. The practice has a total of 6 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 53 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 46 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 53 patients to the proposed hospital in 2031, the second year after completion of the new facility.

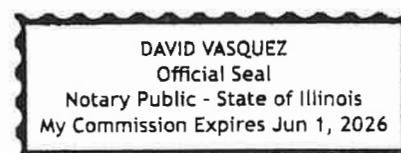
These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,

Erin M. Taback, MD
1107 Chicago Ave.
Oak Park, IL 60302
708-383-2900

NOTARY SEAL



David Vasquez 4/23/26

Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Abigail L Hodges	17	12		
Lauren A Knight	11	10		
Tara Brito	10	9		
Erin M. Taback	3	11		
Elan H. Green	5	5		
Katherine Martin		6		
Totals	46	53		
				53

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60302	Oak Park		11	25
60546	Riverside		10	5
60707	Elmwood Park		4	6
60402	Berwyn		6	2
60305	River Forest		5	3
All Other Zip Codes			10	12
TOTAL			46	53

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Pediatric Health Associates, Ltd, specializing in pediatric primary care. The practice has a total of 19 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 115 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 105 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 115 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,



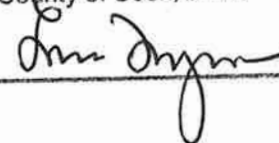
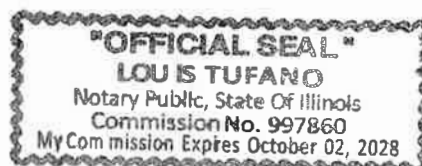
Jihad Shoshara, MD
 636 Raymond Dr. Suite 205
 Naperville, IL 60563
 630-717-2300

NOTARY SEAL

Subscribed and sworn to before me

this 14th day of MAY, 2026
 at Chicago, County of Cook, State of Illinois.

Notary Public

Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Jihad Shoshara	19	11		
Tara E. Doman	14	13		
Sofia Shakir	12	12		
Julian H. Tang	5	17		
Jerome O. Gronli	6	10		
Nancy T. Thomas	9	7		
Virginia G. Kash	4	8		
Shelly V. Flais	5	7		
Rebecca Smeraglinolo	6	5		
Vanessa Rivas-Lopez	4	6		
All Other Providers	21	19		
Totals	105	115		
				115

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60505	Aurora		13	10
60185	West Chicago		9	13
60440	Bolingbrook		4	13
60543	Oswego		5	9
60107	Streamwood		7	7
60504	Aurora		10	3
60555	Warrenville		2	8
60502	Aurora		3	6
60563	Naperville		4	5
60565	Naperville		6	3
60538	Montgomery		4	4
60585	Plainfield		2	4
60532	Lisle		2	3
60540	Naperville		2	3
60503	Aurora		2	2
60564	Naperville		3	1
60187	Wheaton		4	
All Other Zip Codes			23	21
TOTAL			105	115

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Pedios, Ltd, specializing in pediatric primary care. The practice has a total of 4 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 65 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 49 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 65 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,



Heather Haukness, MD
260 Chicago Ave.
Oak Park, IL 60302
708-383-8070

Kristy Pineda
NOTARY SEAL 4/29/2024



65

22

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Schwartz Pediatrics, specializing in pediatric primary care. The practice has a total of 3 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 20 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 18 patients for inpatient pediatric medical/surgical care.

The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 20 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,

NOTARY SEAL

David M. Schwartz, MD
 257 S. Main St.
 Bartlett, IL 60103
 630-289-8800



Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

[illegible]

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name		Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
			2024	2025
60103	Bartlett		3	4
60193	Schaumburg		4	
60188	Carol Stream		2	1
60123	Elgin		1	2
60120	Elgin			2
60402	Berwyn			2
60194	Schaumburg			2
60172	Roselle		2	
60107	Streamwood		2	
60169	Hoffman Estates		2	
60140	Hampshire			1
60190	Winfield			1
All Other Zip Codes			2	5
TOTAL			18	20

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the practice leader of Children's Health Partners, SC, specializing in pediatric primary care. The practice has a total of 6 providers, the majority of whom have been referring patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 13 pediatric patients for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 5 patients for inpatient pediatric medical/surgical care.

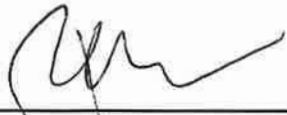
The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 13 patients to the proposed hospital in 2031, the second year after completion of the new facility.

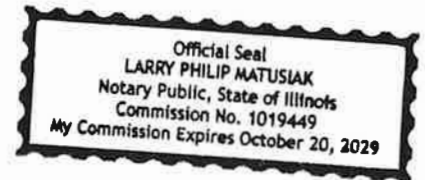
These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,



Radhika Choksi Shah, MD
 1247 Rickert Dr. Suite 101
 Naperville, IL 60540
 630-848-1700



NOTARY SEAL

NOTARY Larry Philip Matusiak


Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 Commitments
Laurel M. George		5		
Brooke D. Scherer	2	3		
Michelle L Pierce	3	1		
Janie Canner		4		
Totals	5	13		
				13

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

[illegible]

April 24, 2026

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

Re: Letter of commitment to refer patients to the proposed Lurie Children's Hospital in Downers Grove

Dear Mr. Kniery,

I am the President of Lurie Children's Medical Group, Inc., a physician group practice comprised of pediatric subspecialist and primary care providers. The practice has a total of more than 275 providers, the majority of whom refer patients for inpatient care to Ann & Robert H. Lurie Children's Hospital of Chicago. I support the proposal to establish a pediatric hospital, including a medical/surgical service in Downers Grove. The proposed new hospital will enable many of our patients to receive care much closer to their homes.

In 2025, the practice referred or admitted 548 pediatric patients from the West Region (as defined in the CON permit application for Lurie Children's Downers Grove) for inpatient care in a pediatric medical/surgical unit. In 2024, members of the practice referred or admitted 456 patients from the West Region for inpatient pediatric medical/surgical care.

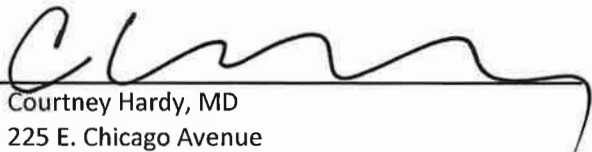
The attached table lists the referrals or admissions by individual members of the practice in 2025 and 2024. The second attachment lists the zip codes of residence for these patients and the hospitals at which they were admitted in 2025.

I estimate that the practice will refer or admit 548 patients to the proposed hospital in 2031, the second year after completion of the new facility.

These referral counts have not been used to support another permit application for any other hospital's pediatric medical/surgical service.

Please contact me if you have any questions.

Sincerely,


Courtney Hardy, MD
225 E. Chicago Avenue
Box 1
Chicago, IL 60611

NOTARY SEAL

Nahlah J Daddino



April 24, 2026

Attachment 1. Inpatient Pediatric Referrals/Admissions by practice members

Provider Name	Inpatient Pediatric referrals / admissions			
	2024	2025		2031 commitments
Reichek, Jennifer L., MD	6	37		
Sokol, Elizabeth Anne, MD	6	27		
Walz, Amy Leanne, MD	7	15		
Garcia Pierce, Joanna I, MD	16	6		
Raghupatruni, Preethi L., MD	8	10		
Garcia-Sosa, Rebecca Maria, MD	9	8		
Tennant, Amy, APRN-NP	10	5		
Morgan, Elaine Ruth, MD	9	6		
Sanchez, Robert John, MD	4	11		
Gambetta, Katheryn Ellen, MD	3	11		
Akani, Damilola, MD	9	5		
Bruton, Lucas Baughn, MD	4	10		
Tatachar, Priyamvada, MD	8	5		
Lambajian-Drummond, Natalie, MD	8	4		
Lockart, Barbara A., APRN-NP	6	6		
Joseph, Suja Anne, MD	5	7		
Morris, Savannah Ariel, APRN-NP	8	3		
Coyne, Kelly Delaney, APRN-NP	3	7		
Lenzen, Alicia Campbell, MD	5	4		
Havens, Kirsten E, APRN-NP	3	5		
Koopmans, Joy Marie, MD	3	5		
Varma Thomas, Selina, MD MPH	1	7		
Werk, Rachel Sydney, MD	5	3		
Sieciechowicz, Diana, MD	4	4		
Parker, John James Fiske, MD	4	4		
Bicknese, Alma R, MD	2	5		
Baker, Joshua Jack, DO	4	3		
Tomko, Skyler Anne, APRN-NP	3	4		
Soloveychik, Dina, MD	5	2		
Bieber, David A, MD	6	1		
Kelley, Anisa Fatima, MD	6	1		
O'Connor, Sunila, MD	3	4		
Latimer, Tomitra, MD	4	3		
Kan, Kristin Hoi-Yan, MD MPH	2	5		
Nolan, Brian Edward, MD	3	3		
Shoop, Jenny May, APRN-NP	2	4		
Rossoff, Jenna Elizabeth, MD	3	3		
Khaytin, Ilya, MD PhD	3	3		
Venn, Katherine Hentz, APRN-NP	3	3		
Perez, Maria E, DO	1	5		
Weinstein, Joanna L, MD	4	2		
McPartlin, Ashley Funk, APRN-NP	5	1		
O'Brien, Stephanie Mae, APRN-NP	3	3		
Meehan, Meghan Teresa, APRN-NP	6			
Alfieri, Nina Lee, MD	2	4		
Hong, Youn J, MD	4	2		
Wolfe, Madison Leigh, MD	1	4		
Carroll, Meta Loren, MD		5		
Reider, Jaclyn, APRN-NP	1	4		
Desai, Divya Nadkarni, MD	3	2		

Raskin, Jeffrey Steven, MD	1	4		
Habis, Arie Leigh, MD	1	4		
Waanders, Angela Jae, MD	1	4		
Osgood, Peter Thomas, MD	1	4		
Kuo, Mickey Justin Myles, MD		5		
Chapin, Catherine Ann, MD	3	2		
Langga, Cosette, APRN-NP	4	1		
Prada, Carlos Enrique, MD	3	2		
Miller, Jennifer L, MD		5		
Saper, Jennifer K., MD	2	3		
Brewer, Audrey Genniel, MD MPH	4	1		
Hasan, Zeba M, MD	5			
Josefson, Jami L., MD	2	2		
Masters, Megan E, APRN-NP	3	1		
Slattery, Susan M., MD	3	1		
King, Hannah Catherine, MD	4			
McGowan, Bridget Ruth, MD	3	1		
Ortiz Estes, Ixchell Yanet, APRN-NP	3	1		
Nagel, Mary K, APRN-NP	4			
Palla, John Bennett, MD	4			
Kester, Kristen Marsha, MD MPH	1	3		
Kligfeld, Heather, DO	4			
McCauley, Mary Kathryn, MD		4		
Fortunato, John E, MD	1	3		
De Ranieri, Deirdre Ita, MD	3	1		
Rubin, Jennifer P., MD	4			
Vernon, Laura Engel, MD	3	1		
Sanchez, Andrea P, APRN-NP		4		
Nelson, Suzanne P., MD	3	1		
Semp, Melissa C, APRN-NP	1	3		
Sojka, Melanie Lynn, APRN-NP	2	2		
Drelicharz, David J, MD	2	2		
Flores, Allison Deann, APRN-NP	2	1		
Wu, Joyce Y, MD	2	1		
Fant, Colleen Diane, MD MPH	1	2		
Fishbein, Mark H, MD		3		
VanBeckum, Danielle Rose, MD	2	1		
Rastatter, Jeffrey Charles, MD	1	2		
Zielinski, Kathleen A, APRN-NP	2	1		
Madden, Brian A, MD	2	1		
Whittington, Jessica, APRN-NP	1	2		
Lail, Gurnoor Kaur, MD		3		
Torchen, Laura Christine, MD	2	1		
Sondeen Opila, Leslie A, APRN-NP	2	1		
Klein-Gitelman, Marisa S., MD	3			
Stoelinga, Mary K., APRN-NP	1	2		
Schwaede, Abigail Nancy, MD	2	1		
Tam, Sharon S, MD	2	1		
Casali, Gianna M, APRN-NP		3		
Mazur, Kimberly Arvidson, DO		3		
Prozialeck, Joshua Daniel, MD	3			
Brown, Jeffrey B, MD	2	1		
Cohran, Valeria Cornell, MD	2	1		
Thrush, Philip Taylor, MD	2	1		

Blackburn, Joanna Sarah, MD	3			
Chun, Angela Christine, MD	3			
Lynch, Kaitlyn M, APRN-NP	1	2		
Papacek, Ellen M., MD	1	2		
Lieberman, Emily Rose, MD	1	2		
Staskowicz, Jennifer J, APRN-NP	1	1		
Bolton, Elizabeth Miller, MD		2		
Voit, Ashley E, APRN-NP	1	1		
Joong, Anna Gah-Mei, MD	1	1		
Gibly, Romie F, MD PhD		2		
Chidi, Arati Vinod, DO		2		
Caldarelli, Leslie A., MD	2			
Taylor, Madison, MD	1	1		
Carroll, Ryan Clifford, MD	1	1		
Kotagal, Tara, MD		2		
All Other Providers	98	141		
Totals	456	548		548

Attachment 2. Residence of Patients the practice referred or admitted for inpatient medical/surgical care at Lurie Children's

Zip code	Community Name	Number of Patients Referred or Admitted for Medical/Surgical Pediatric Care	
		2024	2025
60804	Cicero	30	21
60440	Bolingbrook	15	12
60148	Lombard	13	14
60515	Downers Grove	6	18
60106	Bensenville	3	22
60402	Berwyn	13	18
60137	Glen Ellyn	13	9
60707	Elmwood Park	17	16
60101	Addison	5	15
60187	Wheaton	1	19
60506	Aurora	7	12
60126	Elmhurst	18	15
60140	Hampshire	10	14
60504	Aurora	8	10
60139	Glendale Heights	9	8
60517	Woodridge	8	9
60133	Hanover Park	7	10
60164	Melrose Park	9	16
60189	Wheaton	4	12
60505	Aurora	7	9
60123	Elgin	11	5
60153	Maywood	5	20
60007	Elk Grove Village	9	6
60169	Hoffman Estates	11	10
60134	Geneva	7	6
60103	Bartlett	6	7
60302	Oak Park	5	9
60171	River Grove	3	9
60545	Plano	2	9
60175	Saint Charles	6	5
60560	Yorkville	9	7
60193	Schaumburg	5	6
60585	Plainfield	8	2
60527	Willowbrook	2	8
60525	La Grange	5	5
60188	Carol Stream	9	7
60104	Bellwood	10	0
60516	Downers Grove	3	7
60565	Naperville	2	10
60543	Oswego	5	4
60018	Des Plaines	5	9
60538	Montgomery	6	9
60510	Batavia	5	9
60107	Streamwood	2	8
60542	North Aurora	6	8
60191	Wood Dale	3	1
60181	Villa Park	0	4
60304	Oak Park	1	2
60305	River Forest	1	2
60514	Clarendon Hills	1	1
60564	Naperville	1	1
All Other Zip Codes		99	73
TOTAL		456	548