

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

JUL 30 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**This Section must be completed for all projects.**HEALTH FACILITIES &
SERVICES REVIEW BOARD**Facility/Project Identification**

Facility Name:	Advocate North Side Health Network d/b/a Advocate Illinois Masonic Medical Center		
Address:	836 West Wellington Avenue, Chicago, IL 60657-5193		
City and Zip Code:	Chicago 60657-5193		
County:	Cook	Health Service Area	6 Health Planning Area: A-01

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Advocate North Side Health Network d/b/a Advocate Illinois Masonic Medical Center		
Address:	2025 Windsor Drive, Oak Brook, IL 60423		
Name of Registered Agent:	Gail D. Hasbrouck		
Name of Chief Executive Officer:	William Santulli		
CEO Address:	2025 Windsor Drive, Oak Brook, IL 60423		
Telephone Number:	(630) 990-5008		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other

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

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 during the review period]**

Name:	Jack Gilbert
Title:	Vice President, Finance & Support Services
Company Name:	Advocate North Side Health Network d/b/a Advocate Illinois Masonic Medical Center
Address:	836 West Wellington Avenue, Chicago, IL 60657-5193
Telephone Number:	(773) 296-7809
E-mail Address:	Jack.Gilbert@advocatehealth.com
Fax Number:	(773) 296-5251

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

Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health Care
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Additional Contact

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

Name:	Joe Ourth
Title	Attorney
Company Name:	Arnstein & Lehr, LLP
Address:	120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606-3910
Telephone Number:	(312) 876-7815
E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-6215

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

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County:	Cook	Health Service Area	6 Health Planning Area: A-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Advocate Health Care Network
Address:	2025 Windsor Drive, Oak Brook, IL 60423
Name of Registered Agent:	Gail D. Hasbrouck
Name of Chief Executive Officer:	James Skogsbergh
CEO Address:	2025 Windsor Drive, Oak Brook, IL 60423
Telephone Number:	(630) 990-5008

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership	
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental	
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/> Other

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

Facility Name:	Advocate North Side Health Network d/b/a Advocate Illinois Masonic Medical Center		
Street Address:	836 West Wellington Avenue		
City and Zip Code:	Chicago 60657-5193		
County:	Cook	Health Service Area	6 Health Planning Area: A-01

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Advocate Health and Hospitals Corporation
Address:	2025 Windsor Drive, Oak Brook, IL 60423
Name of Registered Agent:	Gail D. Hasbrouck
Name of Chief Executive Officer:	James Skogsbergh
CEO Address:	2025 Windsor Drive, Oak Brook, IL 60423
Telephone Number:	(630) 990-5008

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership	
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental	
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/> Other

o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name:	Jack Gilbert
Title:	Vice President, Finance & Support Services
Company Name:	Advocate North Side Health Network do/b/a Advocate Illinois Masonic Medical Center
Address:	836 West Wellington Avenue, Chicago, IL 60657-5193
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E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-6215

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:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health Care
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center
Address of Site Owner:	2025 Windsor Drive, Oak Brook, IL 60523
Street Address or Legal Description of Site:	Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center		
Address:	2025 Windsor Drive, Oak Brook, IL 60523		
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<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Soft Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

Provide (for each co-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 #2005-5 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 #2005-5 (<http://www.hfsrb.illinois.gov>).

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 1110.40 and Part 1120.20(b)]

<p>Part 1110 Classification:</p> <p><input type="checkbox"/> Substantive</p> <p><input checked="" type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input checked="" type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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2. Narrative Description

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

Advocate Health Care Network, Advocate Health and Hospitals Corporation, and Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center, the applicants, propose to construct a three-story building on the site identified as parcels 14-29-212-021-0000 and 14-29-212-002-0000 in Chicago, IL. The site is located in the north-west area of the hospital campus at the corner of Nelson Street and Wilton Avenue. Nelson Street will be closed to through traffic to allow the new building to adjoin the existing hospital.

The building, referred to as the Center for Advanced Care, will house services focused on outpatients needing digestive health care, cancer care, ambulatory surgery, and associated clinical support – such as a pharmacy for infusion medications and pre-surgical care (the “Project” or “Building”). No new beds or new clinical services are in the Project; therefore this is a modernization project. There will be other non-clinical space including physician offices, patient education, and conference space. The structure is designed to accommodate added floors in the future, if and when needed. The Building will be built according to Leadership in Energy and Environmental Design (LEED) standards for sustainability. The Project has also been designed to comply with the Review Board’s criteria for size and utilization.

A rendering and site plan of the proposed building follows this Narrative. Each floor will connect by corridors to the existing hospital. There is no level 2 as the floors must match with the existing hospital. The building will contain the following functions on each level:

Ground Level: Entrance and lobby, Linear Accelerator with CT Simulator, Brachytherapy, non-clinical offices and exam space for physicians to see cancer patients.

Level 1: Waiting area, Infusion Therapy, Satellite Pharmacy, Pre-Surgical Care, Surgical Procedure Suite (Gastrointestinal Endoscopy), Phase II Recovery for Surgical Procedure Suite, and non-clinical space for multi-specialty physicians to see patients, conference rooms, and a patient education/resource center.

Level 3: Waiting area, Ambulatory Surgery Suite, and Phase II Recovery for Ambulatory Surgery.

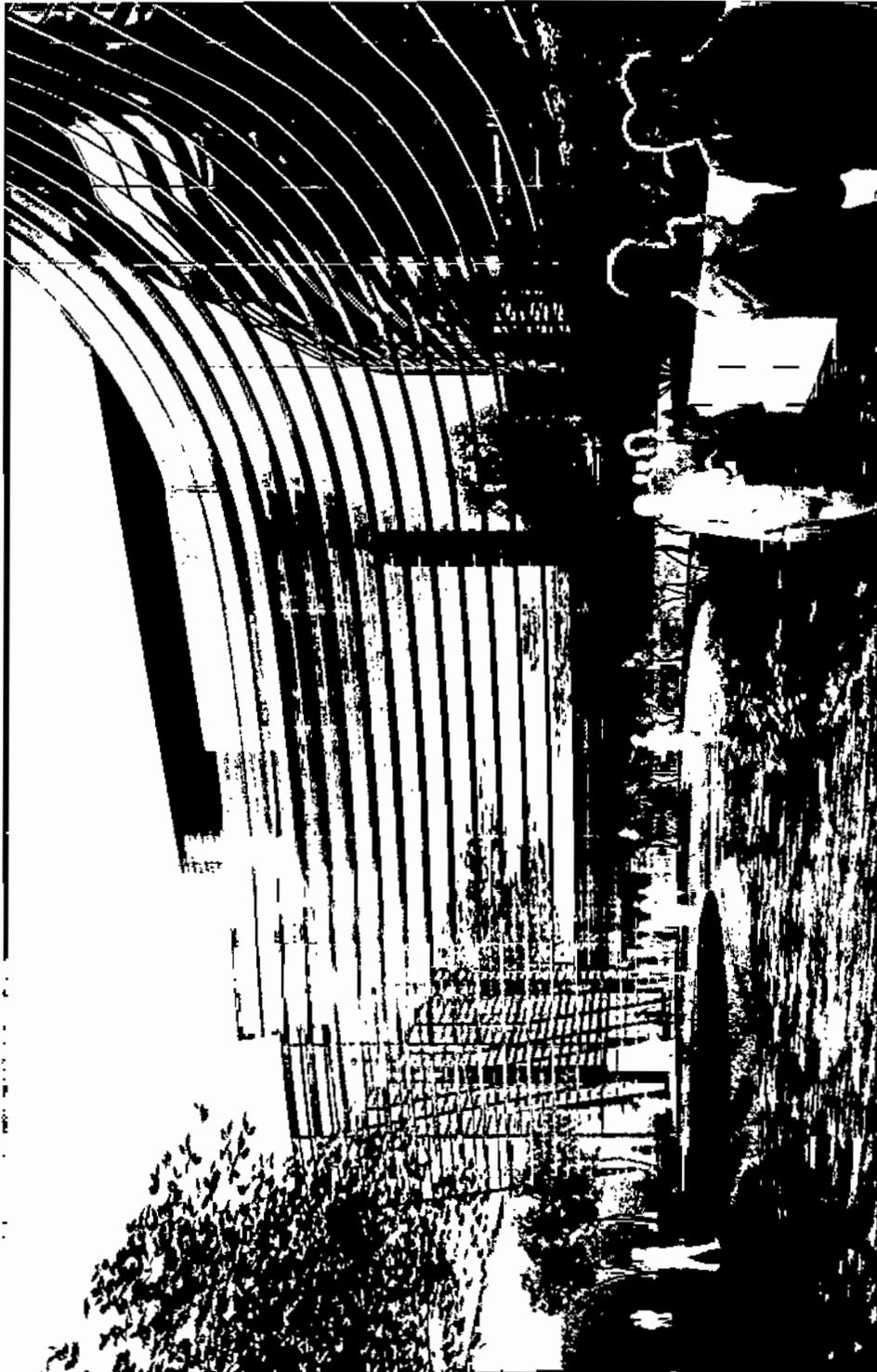
Penthouse: Mechanical equipment.

The building currently housing the Creticos Cancer Center, where medical and radiation oncology is now provided, will be vacated and used for physician offices. The existing endoscopy suite will be vacated and will be used for medical records. Three existing operating rooms will be vacated and the space used for surgical support.

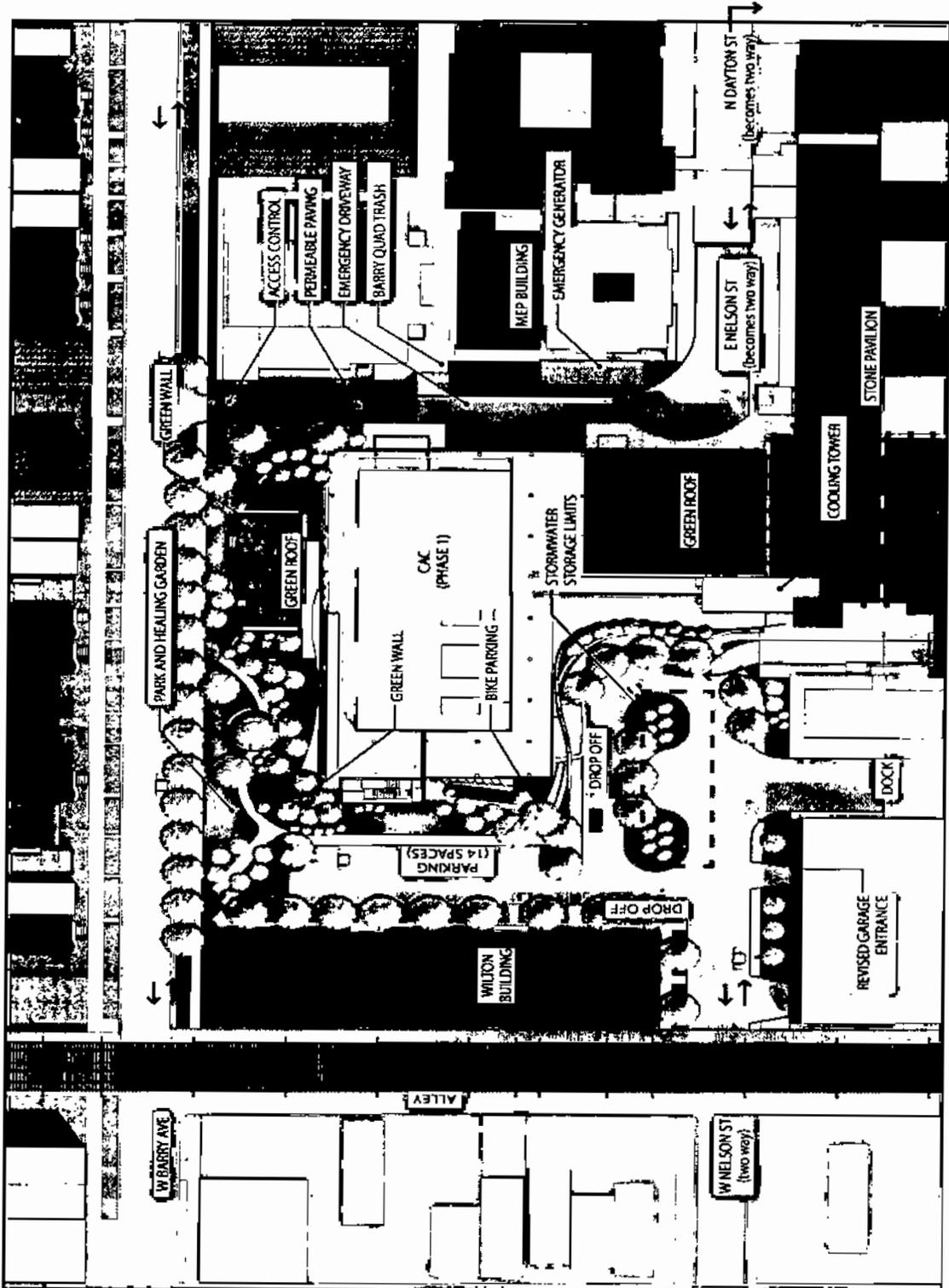
One operating room that has been in the inventory as a urology room is being reclassified as a cystoscopy procedure room, which is consistent with its actual use.

The applicants expect to complete the Building by October 31, 2015. The Project will include 139,791 DGSF of new construction and 4,300 DGSF of modernization. The total Project cost is expected to be \$109,248,973.

In accordance with the Illinois Health Facilities Planning Act, Section 12(8), the Project is classified as non-substantive because it does not propose a 1) new or replacement facility, 2) new or discontinued service, or 3) change in bed capacity or distribution.



SITE INTEGRATED - SITE PLAN



**Advocate Illinois Masonic Medical Center (AIMMC)
Support letters**

PUBLIC OFFICIALS

12th District State Representative Sara Feigenholtz
13th District State Representative Gregory S. Harris
44th Ward Alderman, Thomas M. Tunney

PATIENTS

Bridgjetta Draper, Patient
Anneliese Nitzschke, Patient

COMMUNITY REPRESENTATIVES

Lucy Robles-Aquino, CEO, Hispanocare, Inc.
Jamal Edwards, Esq., CEO, Howard Brown Health Center
Rev. David Abrahamson, Pastor, St. Luke's Ministries
Heather Way, Exec. Director, Lakeview Chamber of Commerce

GOVERNANCE

Andrew W. McCune, Governing Council Chair, AIMMC
Conrad von Peterffy, Chair, AIMMC Charitable Council

PHYSICIANS

Andrew Albert, M.D., Gastroenterologist, ChicagoGastro
Joaquin Estrada, M.D., Colon and Rectal Surgery, Advocate Medical Group
Vijay K. Maker, M.D. Chair, Department of Surgery, AIMMC
Ann M. Mauer, M.D., Medical Director, Oncology, AIMMC
Arturo Olivera, Chief, Section of Gastroenterology, Digestive Health, AIMMC
Ramamoorthy Sundaresan, M.D., Gastroenterologist
William N. Werner, M.D., Vice President, Clinical Transformation, AIMMC
Michael Young, M.D., Chief, Section of Urology, Uropartners, LLC
Robert G. Zadyak, M.D., Vice President, Medical Management, AIMMC

DISTRICT OFFICE:
1051 W. BELMONT AVE.
CHICAGO, ILLINOIS 60657
773/296-4141
773/296-0993 FAX
E-MAIL: SARA@STATEREPSARA.COM

SPRINGFIELD OFFICE:
245-E. STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217/782-8062
217/557-7203 FAX



COMMITTEES:

CHAIRMAN:
APPROPRIATION - HUMAN SERVICES
ADOPTION REFORM
VICE CHAIR:
TOURISM & CONVENTION
MEMBER:
ENVIRONMENT & ENERGY
INSURANCE
MASS TRANSIT

SARA FEIGENHOLTZ
STATE REPRESENTATIVE · 12TH DISTRICT

June 29, 2012

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

Dear Ms. Avery:

I am honored to represent the residents of Illinois' 12th district on Chicago's north side, a vibrant community of families, organizations, businesses, entertainment venues, Wrigley Field, schools, nonprofits, religious congregations and hospitals—including Advocate Illinois Masonic Medical Center. The hospital has been in Lake View for more than a century, serves as Chicago's North Side Level I Trauma Center, is a Certified Stroke Center, and has a Level III NICU for the smallest and most fragile patients.

Illinois Masonic offers a full scope of medical and clinical programs, inpatient units, outpatient care, much-needed behavioral health services, and community wellness programs to keep the neighbors healthy. The hospital has been named a Thomson Reuters 100 Top Hospital for the past three consecutive years for the high quality of care provided. And, on a personal note, my mother served on the Medical Staff of Illinois Masonic for more than four decades.

I am writing to ask the Illinois Health Facilities and Services Review Board to join me in supporting Advocate Illinois Masonic Medical Center's Certificate of Need (CON) application to construct a center for advanced care. This proposed outpatient facility will house the Creticos Cancer Center, same-day surgery and a program to treat people with digestive diseases. It will create an area that is patient-focused and clinically integrated, which translates into improved access to care, continuity among those disciplines, enhanced efficiencies and a better overall patient and family experience.

The medical center is a major employer in my district with 2,500 employees and 900 physicians. Allowing Advocate Illinois Masonic to proceed with the needed facility expansion helps ensure availability of necessary health care services in the years to come, and serve to bolster the economic vitality of our community.

I believe the construction of this outpatient care center is necessary if we are to maintain a strong, healthy community well into the future. I respectfully request that the Planning Board approve Illinois Masonic's CON application.

Very truly yours,

A handwritten signature in cursive script that reads "Sara Feigenholtz".

Sara Feigenholtz
State Representative
12th District

CAPITOL OFFICE:
253 - S STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217/782-3835
Email: greg@greharris.org

DISTRICT OFFICE:
1967 W. MONTROSE
CHICAGO, ILLINOIS 60613
773/348-3434
FAX: 773/348-3475



ILLINOIS HOUSE OF REPRESENTATIVES
GREGORY S. HARRIS
STATE REPRESENTATIVE - 13TH DISTRICT

COMMITTEES:
CHAIR:
· HUMAN SERVICES
VICE CHAIR:
· INSURANCE
· PUBLIC SAFETY APPROPRIATIONS
MEMBER:
· AGING
· HEALTH CARE AVAILABILITY AND ACCESS
· SPECIAL COMMITTEE ON TOURISM AND CONVENTION

June 26, 2012

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

Dear Ms. Avery:

I am writing to ask the Illinois Health Facilities and Services Review Board to approve Advocate Illinois Masonic Medical Center's Certificate of Need (CON) application to construct a Center for Advanced Care on its medical campus in Chicago. A new, 156,000-square-foot outpatient facility will be connected to the main hospital building, and will enable the hospital to centralize cancer care, ambulatory surgery and digestive health services in one location, which translates into improved access to care, continuity among those disciplines, enhanced efficiencies and a better overall patient and family experience.

Advocate Illinois Masonic has been serving my community for more than 100 years. It is Chicago's North Side Level I Trauma Center, providing much-needed medical care for patients with the most critical injuries and illnesses. It also offers a full scope of clinical programs, inpatient units, outpatient services and wellness programs to keep the neighbors healthy. It is consistently ranked a 100 Top Hospital in the nation by Thomson Reuters for the high quality of care provided. Approval of the proposed Center for Advanced Care would allow Advocate Illinois Masonic to continue to provide that level of care to our community.

In addition, with about 2,500 employees and nearly 900 physicians on staff, the medical center is a major employer in our region. And, as one of the state's largest non-university medical teaching programs, the hospital trains about 200 residents and 500 medical students each year. Allowing Advocate Illinois Masonic to proceed with the needed facility redesign helps ensure availability of necessary health care services in the years to come, and serves to bolster the economic vitality of our community.

Illinois hospitals and other health care institutions must prepare to meet the challenges posed by the new environment of health care reform. This project is not only needed to enhance the medical services offered by Advocate Illinois Masonic, it directly addresses the shift of the health care delivery model from inpatient units to the outpatient environment.

I believe the construction of this outpatient care center is necessary if we are to maintain a strong, healthy community well into the future. I respectfully request that the Planning Board join me in supporting Advocate Illinois Masonic's Center for Advanced Care project and approve the CON.

Sincerely,

A handwritten signature in black ink, appearing to be "Greg Harris".

Greg Harris
Representative 13th District



CITY COUNCIL

CITY OF CHICAGO

COUNCIL CHAMBER
CITY HALL—THIRD FLOOR
121 NORTH LA SALLE STREET
CHICAGO, ILLINOIS 60602
TELEPHONE: 312-744-3073
FAX: 312-744-1380

COMMITTEE MEMBERSHIPS

ECONOMIC, CAPITAL AND TECHNOLOGY DEVELOPMENT
(CHAIRMAN)
BUDGET AND GOVERNMENT OPERATIONS
COMMITTEES, RULES AND ETHICS
FINANCE
HEALTH AND ENVIRONMENTAL PROTECTION
LICENSE AND CONSUMER PROTECTION
WORKFORCE DEVELOPMENT AND AUDIT
ZONING, LANDMARKS AND BUILDING STANDARDS

THOMAS M. TUNNEY

ALDERMAN, 44TH WARD
1057 WEST BELMONT AVENUE
CHICAGO, ILLINOIS 60657-3326
TELEPHONE: 773-525-6034
FAX: 773-525-5058
E-MAIL: TTUNNEY@CITYOFCHICAGO.ORG
WEBISTE: 44THWARD.ORG

July 18, 2012

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

Dear Ms. Avery:

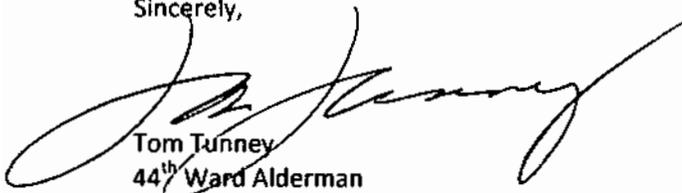
I am writing to ask the Illinois Health Facilities and Services Review Board to join me in support of Advocate Illinois Masonic Medical Center's proposed Center for Advanced Care to be constructed on its medical campus in Chicago's 44th Ward. Illinois Masonic has been serving the citizens of the Lakeview community for more than 100 years. It is Chicago's North Side Level I Trauma Center, providing much-needed medical care for patients with the most critical injuries and illnesses, and a designated Stroke Center. It has Magnet status for nursing excellence and has been recognized as a leader in providing equal health care services for the LGBT community in 2012 by the Human Rights Campaign Foundation's Health Care Equality Index report for a fourth consecutive year.

The hospital offers a full scope of clinical programs, inpatient units, outpatient services and wellness programs, including an annual Senior Health Fair that my office co-sponsors, to keep the neighbors informed, engaged and healthy. Illinois Masonic is consistently ranked a 100 Top Hospital in the nation by Thomson Reuters for the high quality of care provided, and was named Chicago's only 100 Top Hospital in 2012.

In addition, with about 2,500 employees, nearly 900 physicians on staff, roughly 200 residents and 500 medical students each year, the medical center is a major employer in our region and economic driver in the community.

The corporate parent of the hospital, Advocate Health Care, has made a significant capital commitment to build a much-needed outpatient facility in my ward. I respectfully request that the Planning Board approve the Advocate Illinois Masonic Center for Advanced Care CON application so we can proceed with the design of a facility to will further strengthen our ability to maintain a healthy community well into the future.

Sincerely,



Tom Tunney
44th Ward Alderman

July 5, 2012

Courtney R. Avery, Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Courtney,

I was on the job as a forklift operator for the United States Postal Service in Palatine, Ill., when, one day in 2009, I noticed uncontrolled bleeding from my upper leg.

With a referral to the Creticos Cancer Center at Advocate Illinois Masonic Medical Center, it was discovered I had a fibro sarcoma right where my spinal nerves ended which was causing me severe pain. I underwent three surgeries to make sure it was all removed. The tumor was biopsied and, following the last surgery, the surgeon was certain he'd gotten it all.

I then underwent radiation therapy enduring treatment five days a week for seven weeks. I was still working at the time, 2 to 10:30 p.m. in Palatine. I would get up, go to the treatment, eat something—if I could—and drive out to work, taking a nap in my car before I started my shift. There were times that, by the time I got home, I didn't know if I'd be able to make it from the garage into the house. All the while, I was caring for my 76-year-old mother, who was having health issues of her own.

To get through, I sought the help of the Psychosocial Oncology Program at Illinois Masonic. There, I found the support I needed—someone to talk to, other than family, who really understood exactly what I was going through.

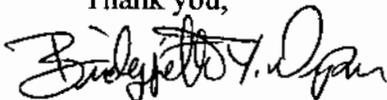
The counselor would just say, 'You have to keep going.' And I did. She helped me to do things that I wouldn't have done. She opened my eyes to a lot of stuff, including that it was OK to tell people that I had cancer and to ask for help.

Now that I'm cancer free, I realize what I learned and gained from the experience. It was emotional. I lived my life in a box for so long. But I was given a second chance.

I write to urge the Illinois Health Facilities and Services Review Board to approve Illinois Masonic's Certificate of Need application to construct a Center for Advanced Care on its medical campus in Chicago.

I will never again lose sight of the fact that life is not promised. I don't believe anyone should.

Thank you,



Bridgette Draper

Courtney Avery
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, Ill. 62761

July 9, 2012

Dear Ms. Avery,

I am writing you to ask the Illinois Health Facilities and Services Review Board to approve Illinois Masonic Medical Center's application for a CON for their Center for Advanced Care. With the hospital providing important therapies, this new center can only help bring the best cancer care to Chicago!

I first underwent treatment for melanoma on my left leg 31 years ago, only to have the condition recur in multiple areas of the same leg in 2009, 2010 and 2011. The disease was spreading and I was running out of options.

Back then, they cut it out—just removed pieces of my leg. When it came back again, I didn't want to lose my leg. I was so afraid of that.

Instead, I found my way to Advocate Illinois Masonic Medical Center, where I was fortunate enough to be the ideal candidate for the first procedure of its kind in Chicago—isolated limb infusion (ILI). The innovative procedure was brought to Chicago by Ajay Maker, MD, at Advocate Illinois Masonic Medical Center.

Dr. Maker said melanoma can recur years after initial diagnosis, and it may spread in the limb without going to other areas of the body. He said the ILI procedure would deliver strong chemotherapy only to my left leg, leaving the rest of my body free of the toxicity of the chemotherapy. He said this procedure is only offered at a few specialized centers around the world.

I responded remarkably well, with absolutely no side effects. All of the tumors had shrunk considerably—some completely disappearing.

I'm so happy, I think about it every day! I can walk and stay active. I hope this can help a lot more people.

This is why I write for your support of Illinois Masonic's new Center for Advanced Care. Innovative treatments like I had are needed in our community.

Thank you,

Anneliese Nitzschke

Anneliese Nitzschke



July 17, 2012

Ms. Courtney R. Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Certificate of Need (CON)

Dear Ms. Avery:

As the Chief Executive Officer of Hispanocare, a not for profit organization, I am pleased to present this letter of support. As an organization, our mission is to provide affordable, quality, cost effective healthcare to Chicago's Latino Community in a culturally sensitive manner. An important part of our mission is to actively participate in community outreach to provide preventive healthcare services and education to the Latino Community.

Hispanocare approaches the issue of cultural competence from a unique perspective which acknowledges its complex, systemic nature. Hispanocare approach places culture within the context of an interwoven network of community relationships--between language and traditions, etc. Consequently, the work of Hispanocare has substantively differed from that of most organizations in the field that tend to deal only with pieces of the puzzle of cultural competence.

As the diversity of the populations that we serve continues to grow, the importance of cultural competency or "cultural and linguistic appropriateness" in the effective delivery of health services is undeniable.

Chicago's Latino Community is especially vulnerable to heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Some other health conditions and risk factors that significantly affect Hispanics are: asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease.

Hispanocare coordinates community health fairs where preventive services such as diabetes screenings, cholesterol checks, blood pressure, prostate, mammography, HIV, hepatitis, asthma, dental, osteoporosis screenings, eye exams, foot exams, thyroid screenings, and much more are offered free of charge to community residents. Hispanocare also offers vaccinations and hosts various symposiums and community education and seminars, free to the public.

Advocate Illinois Masonic Medical Center's proposed Center for Advanced Care, would allow the hospital to centralize cancer care, ambulatory surgery and digestive health—all services of particular importance to the Latino Community—and translates into improved access to care, treatment continuity, and a better overall patient and family experience.

I am writing to ask the Illinois Health Facilities and Services Review Board to approve Advocate Illinois Masonic Medical Center's Certificate of Need (CON) application since it so closely aligns with and supports Hispanocare mission of maintaining a strong, healthy Latino Community well into the future. In this world of diminishing resources, accomplishing these goals to help can only be met through partnerships.

Sincerely,



Lucy Rojas-Aguila
Chief Executive Officer

Serving the Latino Community Since 1988

*Por su salud™
For your health™*

836 W. Wellington, Chicago, Illinois 60657 | Tel: (773) 296-7157 Fax: (773) 327-8208
www.hispanocare.org

HOWARD BROWN HEALTH CENTER

www.howardbrown.org

June 17, 2012

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

Dear Ms. Avery:

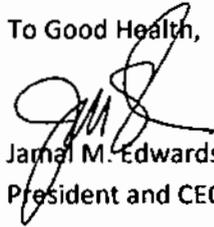
As one of the nation's premier lesbian, gay, bisexual, transgender and queer-focused (LGBTQ) healthcare providers, Howard Brown Health Center (HBHC) fully recognizes that our patients depend on the services we provide and we work every day to ensure they receive the most comprehensive, culturally competent and compassionate care possible.

For nearly 40 years, HBHC has been a trusted healthcare provider to our community, and we have maintained a longstanding partnership with Advocate Illinois Masonic Medical Center to ensure that our patients have access to the full spectrum of services from prevention, detection, treatment and recovery. Our combined medical teams are among the best and most respected medical professionals in the nation and we currently serve clients from 34 states and Canada.

Surpassing milestones and overcoming hurdles, we have exceeded expectations, strengthening our commitment to meet the needs of those we serve and who need us most. As President and CEO, I am committed to ensuring Howard Brown Health Center's sustainability for generations to come. And, with that in mind, I ask that you join me in supporting Advocate Illinois Masonic Medical Center's Certificate of Need (CON) application to construct a Center for Advanced Care on its medical campus, enabling the hospital to centralize cancer care, ambulatory surgery and digestive health services, which translates into improved access to care and a better overall experience for the patients we are privileged to serve.

Approval of the proposed Center for Advanced Care would enable Howard Brown Health Center and Advocate Illinois Masonic to strengthen our partnership in providing the highest level of comprehensive care to our LGBT community.

To Good Health,



Jamal M. Edwards, Esq.
President and CEO

Main Office
4025 N. Sheridan
Chicago, IL 60613
(773) 388-1600
(773) 388-1602(fax)

Triad Health Practice
3000 N. Halsted Suite 711
Chicago, IL 60657
(773) 296-8400
(773) 296-8401(fax)

Broadway Youth Center
3179 N Broadway
Chicago, IL 60657
(773) 935-3151
(773) 935-4739(fax)

Brown Elephant Stores
3651 N Halsted
5404 N Clark
217 W Harrison (Oak Park)
(773) 549-5943



SAINT LUKE MINISTRIES

1500 West Belmont Avenue Chicago, Illinois 60657-3168

Phone 773.472.3383 Fax 773.929.3910

Web Site: www.stlukechicago.org

E-mail: stluke@ais.net

David G. Abrahamson, Pastor

July 19, 2012

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

Dear Ms. Avery:

More than 125 years ago, the congregation of Saint Luke established itself along Belmont Avenue on Chicago's north side. About a decade later, a small hospital opened its doors just about one mile to the east. And now, over a century since then, these two organizations have grown to become cornerstone nonprofit institutions in the Lake View community—Saint Luke Ministries and Advocate Illinois Masonic Medical Center.

I've been affiliated with Saint Luke for 38 years and served as pastor since 1982, and I have personally witnessed the continual transformation of the neighborhood residents, businesses and organizations throughout the decades. Advocate Illinois Masonic has adapted to meet the healthcare needs of the changing community—one renowned example is that it was the first hospital in the Midwest with a dedicated inpatient AIDS unit.

Our nation's hospitals and health care institutions must prepare to meet the challenges posed by the new environment of health care reform and the changing needs of the population. Advocate Illinois Masonic Medical Center is applying to construct the Center for Advanced Care on its medical campus to centralize outpatient cancer care, a digestive diseases program and same-day surgery, which will improve patients' access to care, enhance clinical collaboration and efficiencies, and create a better patient experience.

Since 1974 I have been involved in the community and served in leadership roles with the Lake View Clergy Association, Lake View Chamber of Commerce, Alderman Tunney's Community Directed Development Council, Advocate Illinois Masonic Medical Center's Governing Council, and more. I know first-hand that the hospital's proposed Center for Advanced Care would allow Advocate Illinois Masonic to continue to ensure availability of necessary health care services in the years to come, and serve to bolster the health and economic vitality of our community.

I respectfully request that the Planning Board join me in supporting Advocate Illinois Masonic's CON application for the Center for Advanced Care project.

Regards,

David G. Abrahamson, Pastor

DGA:cas

SAINT LUKE ACADEMY
1500 West Belmont Avenue • Chicago, IL 60657
773.472.3837
Donna Beck, Principal
Pre-School, Kindergarten, Grades 1-8

SAINT LUKE CEMETERY
5300 North Pulaski Road
Chicago, IL 60630
773.588.0049
David Knea, General Manager

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LAKEVIEW CHAMBER OF COMMERCE

June 25, 2012

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

Dear Ms. Avery:

Jobs are created as the hospitals invest money in capital expenditures such as creating new infrastructures, updating current facilities and purchasing cutting-edge technology. I am writing to ask the Illinois Health Facilities and Services Review Board to join the Chamber of Commerce in supporting Advocate Illinois Masonic Medical Center's Certificate of Need (CON) application to construct a Center for Advanced Care on its Lake View campus.

About 11 percent of employees in the metropolitan Chicago area are employed in the health care industry, making it the largest sector of private employment, more than retail trade or manufacturing. With 2,500 employees and 900 physicians, Advocate Illinois Masonic is the largest employer in our area. Full-time hospital employees are paid salaries, on average, more than \$80,000 including benefits. And according to the U.S. Bureau of Labor and Statistics, hospital employees earn almost \$6 more per hour than their counterparts in other areas of health care, such as physicians' offices or nursing homes.

An employment multiplier of 2.0 indicates that if one job is created in an industry, 1.0 additional job is created in other sectors due to business and household spending. Chicago area hospitals create jobs not by simply hiring more staff, but through operating activities and capital investments. In this region, the hospital multiplier is calculated to be 2.4—for every one job at Illinois Masonic, another 1.4 jobs are created in the community.

Chicago area hospitals' operations inject significant cash-flow into local economies. There is a secondary economic impact created when hospitals and their employees spend money in the neighborhood for goods and services from our local businesses—they depend on the patronage of hospital employees, patients and visitors who come to the campus every day to keep their doors open.

I believe the construction of this outpatient care center is necessary if we are to maintain a strong, healthy, and economically viable community. I respectfully request that the Planning Board approve Advocate Illinois Masonic's Center for Advanced Care Certificate of Need application.

Sincerely,

Heather E. Way, IOM
Executive Director

Andrew W. McCune
2230 Chestnut Avenue
Wilmette, Illinois 60091

July 5, 2012

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

Dear Ms. Avery:

I am the Chair of the Governing Council of Advocate Illinois Masonic Medical Center and am writing to ask the Illinois Health Facilities and Services Review Board to approve Advocate Illinois Masonic Medical Center's Certificate of Need ("CON") application to construct a Center for Advanced Care on its medical campus in Chicago. A new, 156,000-square-foot outpatient facility will be connected to the main hospital building that will enable the hospital to centralize cancer care, ambulatory surgery and digestive health services in one location. This facility will result in improved access to care, continuity among those disciplines, enhanced efficiencies and a better overall patient and family experience.

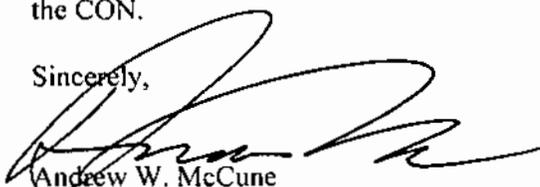
Advocate Illinois Masonic has been serving the community for more than 100 years. It is Chicago's North Side Level I Trauma Center, providing much-needed medical care for patients with the most critical injuries and illnesses. It also offers a full scope of clinical programs, inpatient units, outpatient services and wellness programs to keep the neighbors healthy. The hospital is consistently ranked a 100 Top Hospital in the nation by Thomson Reuters for the high quality of care provided. Approval of the proposed Center for Advanced Care would allow Advocate Illinois Masonic to continue to provide that level of care to our community.

In addition, with about 2,500 employees and nearly 900 physicians on staff, the medical center is a major employer in our region. And, as one of the state's largest non-university medical teaching programs, the hospital trains about 200 residents and 500 medical students each year. Allowing Advocate Illinois Masonic to proceed with the needed facility redesign helps ensure availability of necessary health care services in the years to come, and serves to bolster the economic vitality of our community.

Illinois hospitals and other health care institutions must prepare to meet the challenges posed by the new environment of health care reform. This project is not only needed to enhance the medical services offered by Advocate Illinois Masonic, it directly addresses the shift of the health care delivery model from inpatient units to the outpatient environment.

As a community leader, I feel strongly about the need to provide the most effective and accessible health care to all members of our community. Advocate Illinois Masonic is and has been integral in filling that mission. As community needs evolve, technology changes and the regulatory and economic environment continually shifts, we must enable and support our community institutions, like Advocate Illinois Masonic, to fulfill their missions, and no mission is more critical than providing health care. I believe the construction of this outpatient care center is necessary if we are to maintain a strong, healthy community well into the future. I respectfully request that the Planning Board join me in supporting Advocate Illinois Masonic's Center for Advanced Care project and approve the CON.

Sincerely,



Andrew W. McCune
Governing Council Chair, Advocate Illinois Masonic Medical Center

Conrad von Peterffy

1310 West Schubert Avenue • Chicago, Illinois 60614 • USA

Tel: +(773) 857 3240 • Email: conrad@vonpeterffy.com

Wednesday, July 18, 2012

Courtney R. Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

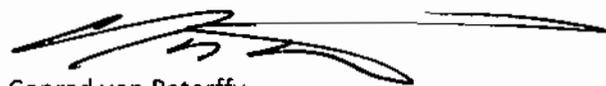
I serve as the chair of the Advocate Illinois Masonic Medical Center Charitable Council and urge you to join me in support of the hospital's CON application and approve the plan for the construction of the Center for Advanced Care.

In my role as Charitable Council Chair, I work with the Foundation staff and administration to raise much needed funds to support the programs, services, and patients of Illinois Masonic—in 2011 we raised a total of more than \$2.8 million. The President's Fund for Special Needs supports medical education, access to care and patient care improvements. Last year 831 donors contributed more than \$614 thousand to the President's Fund, and we are well on our way to achieving this year's goal of raising \$700 thousand.

Advocate Illinois Masonic has been ranked a 100 Top Hospital in the nation by Thomson Reuters for the high quality of care provided for the past three consecutive years, and in 2012 was Chicago's only hospital on the list. It has achieved Magnet status for nursing excellence by the American Nurses Credentialing Center – a feat accomplished by only 15 other hospitals in Illinois. It was just named a Top Chicago Hospital by U.S. News & World Report. Advocate Illinois Masonic was named a leader in providing equal health care services for the LGBT community for 2012 by the Human Rights Campaign Foundation's Health Care Equality Index report for a fourth consecutive year. Additionally, Illinois Medical Center was the first hospital in Chicago to earn the U.S. Environmental Protection Agency's prestigious ENERGY STAR, the national symbol for superior energy efficiency and environmental protection in 2008, and maintains that status today.

CON approval of the proposed Center for Advanced Care would allow Advocate Illinois Masonic to continue to achieve these prestigious awards and designations, and provide the highest level of care to our community. Finally, on a personal note, I am proud to share that I hold a special place in my heart for the physicians, nurses and administrators at Illinois Masonic—both of my sons were born there. So, please join me in support of this project that will enable the hospital to care for future generations.

Sincerely,



Conrad von Peterffy



July 19, 2012

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

Ms. Avery:

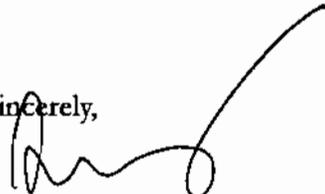
As a gastroenterologist on staff at Illinois Masonic Medical Center, I work with a team of physicians to treat a range of diseases and conditions of the gastrointestinal tract—the stomach, intestines, esophagus, liver, colon and rectum. We use highly advanced diagnostic tools to accurately pinpoint problems and the least invasive treatment methods to achieve the best possible outcomes.

My patients would greatly benefit from the state-of-the-art facilities, improved access to care and continuity among disciplines offered by Illinois Masonic's proposed Center for Advanced Care. This new outpatient facility will enable the hospital to bring together cancer care, same day surgery and GI services in one location. This will help us create a better overall experience for our patients and their loved ones.

Illinois Masonic offers a full scope of clinical programs, inpatient units, outpatient services and wellness programs to keep our patients healthy. It is also a Level I Trauma Center, providing much-needed medical care for patients with the most critical injuries and illnesses. The hospital is consistently ranked a 100 Top Hospital in the nation by Thomson Reuters for the high quality of care provided.

I strongly believe that the Center for Advanced Care is necessary if Illinois Masonic is to continue to provide this high level of care for our community. That is why I am writing to encourage the Planning Board to support this project and approve Illinois Masonic's Certificate of Need for the Center for Advanced Care.

Sincerely,



Andrew Albert, MD
Gastroenterologist
Illinois Masonic Medical Center

836 W. Wellington Avenue
Chicago, Illinois 60657-5193
Telephone 773.975.1600



July 19, 2012

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

Dear Ms. Avery:

I am a Colon and Rectal surgeon on staff at Advocate Illinois Masonic Medical Center, where I provide a broad range of treatment options for many conditions, including laparoscopic and robotic surgical techniques, for the best possible outcomes. These treatments are vital for preserving patient sphincter function, avoiding permanent ostomy, maintaining gastrointestinal continuity and allowing for faster healing times.

It is important that I can offer my patients state-of-the-art facilities that foster collaboration with the other physicians with whom I work closely, including primary care physicians, gastroenterologists, medical oncologists, urologists and gynecologists, and ensure my patients have seamless care. For that reason and many others, I am writing to ask the Illinois Health Facilities and Services Review Board to approve Advocate Illinois Masonic's Certificate of Need (CON) application to construct a Center for Advanced Care on its medical campus.

This new outpatient facility will be connected to the main hospital building and enable the hospital to centralize the cancer center, same day surgery and GI services, which translates into increased access to care, efficiencies and continuity, as well as a better overall patient and family experience.

In addition, the Lake View neighborhood, with its culturally diverse population and strong LGBT community, has an increased need for GI care. The construction of this new facility is a direct response to the community's health care needs.

Advocate Illinois Masonic is consistently ranked a 100 Top Hospital in the nation by Thomson Reuters and recognized as a leader in providing equal health care services for the LGBT community by the Human Rights Campaign Foundation's Health Care Equality Index. Constructing this outpatient care center is a key component in continuing to provide the highest level of care to our patients. I would like to respectfully encourage the Planning Board to join me in supporting Advocate Illinois Masonic's Center for Advanced Care project by approving the CON.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Estrada".

Joaquin J. Estrada, MD
Colon and Rectal Surgery

June 20, 2012

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Ms. Avery:

As Chief of Surgery at Advocate Illinois Masonic Medical Center for over 16 years and a practicing surgeon in the Chicago area for over 35 years, I am writing to share with you that there is a desperate need for a state-of-the-art medical facility in the Lakeview neighborhood to meet the modern standards of patient care.

Advocate Illinois Masonic's proposed Center for Advanced Care outpatient facility will create a space to centralize ambulatory surgery, digestive health services and our Creticos Cancer Center in one location, which translates into improved access to care, continuity among physicians and clinical teams, enhanced efficiencies and a better overall experience for the patients we serve.

We are one of the state's largest non-university medical teaching programs with 14 residencies and fellowships providing ongoing graduate medical education for over 200 physicians. As a major affiliate of three of the area's medical colleges, more than 600 medical students receive their introduction to clinical medicine and specialties on our medical campus each year. We must provide these students and residents with the most current methods of health care delivery as they prepare to practice medicine in a new, dynamic health care environment.

I believe the construction of the Center for Advanced Care is necessary if we are to maintain a strong, healthy community well into the future. I am writing to ask the Illinois Health Facilities and Services Review Board to approve the hospital's Certificate of Need (CON) application.

Sincerely,



~~Vijay K. Maker, M.D., F.A.C.S., F.R.C.S.~~
Chairman, Department of Surgery
Advocate Illinois Masonic Medical Center

VKM/ja

June 19, 2012

Courtney R. Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

I am writing as a resident of the Lake View community where Advocate Illinois Masonic Medical Center has been serving the community's health care needs for more than 100 years. It is Chicago's North Side Level I Trauma Center, and offers a full scope of clinical programs, inpatient units, outpatient services and wellness programs to keep our neighbors healthy.

I am also writing to you as a cancer physician and the medical director of Illinois Masonic's Creticos Cancer Center, and I want to stress the importance of having comprehensive cancer services available here in our community. The hospital is proposing the construction of a Center for Advanced Care on its medical campus that would include space designated for the Creticos Cancer Center. The outpatient facility would be connected to the main hospital building, and enable the hospital to centralize cancer care, as well as ambulatory surgery and digestive health services, in one location. This translates into improved access to care for patients, continuity among those disciplines, enhanced efficiencies and a better overall patient and family experience. The new cancer center will be a patient-centered, healing environment featuring:

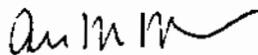
- 14 multidisciplinary patient exam rooms
- 14 infusion stations
- Three patient consultation rooms
- Onsite lab
- Two procedure rooms
- Two TrueBeam linear accelerators
- Direct access for hospitalized patients who require radiation therapy

The new outpatient facility will enable us to provide state-of-the-art cancer care with emerging technologies and expanded services. One of the most critical enhancements will be a dedicated Patient Resource Center and support programs through collaborations with the American Cancer Society and Gilda's Club.

Page 2

I respectfully request that the Planning Board join me in supporting Advocate Illinois Masonic's Center for Advanced Care project and approve the CON application. The hospital has a longstanding commitment to its mission of health and wellness, and I believe the construction of this outpatient care center is necessary if we are to maintain a strong, healthy community well into the future.

Sincerely,



Ann M. Mauer, M.D.
Medical Director, Creticos Cancer Center
Chief, Section of Medical Oncology
Advocate Illinois Masonic Medical Center

Ghazanfari & Olivera Gastroenterology, Ltd
3004 N. Ashland Avenue
Chicago, IL 60657

July 17, 2012

Ms. Courtney R. Avery
Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Second Floor
Springfield, IL 62761

Dear Ms. Avery,

I am writing to ask the Illinois Health Facilities and Services Review Board to approve Advocate Illinois Masonic Medical Center's Certificate of Need application to construct a Center for Advanced Care.

I am chief of the Section of Gastroenterology, Digestive Health, at Advocate Illinois Masonic. Both my patients and I would greatly benefit from the construction of this new outpatient center, which would allow us to bring gastroenterology services, ambulatory surgery and cancer treatment together in a single location. This means we can offer improved access to care for our patients, increase the continuity across these services, and, most importantly, provide a better hospital experience for our patients and their families.

Hospitals and other health care organizations across the country must prepare to meet the challenges posed by health care reform. This project directly addresses the shift of the health care delivery model from inpatient units to the outpatient environment and therefore positions the hospital to continue to enhance its medical services well into the future.

Please join me in supporting this much-needed project so that Advocate Illinois Masonic can continue to provide a high level of care to our patients well into the future.

Sincerely,



Arturo Olivera, Jr., M.D.

Chief, Section of Gastroenterology, Digestive Health

July 17, 2012

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

Dear Ms. Avery:

As a gastroenterologist on the medical staff of Advocate Illinois Masonic Medical Center. I would like to respectfully request that the Illinois Health Facilities and Services Review Board support and approve the hospital's Certificate of Need application to build its proposed Center for Advance Care.

The new outpatient center would offer many benefits for my patients. For example, under this new design, gastroenterology, oncology and ambulatory surgery would be centralized in one location. This would allow for enhanced efficiencies, increased multidisciplinary continuity and better access to care.

In addition, as one of the state's largest non-university medical teaching programs, the hospital trains about 200 residents and 500 medical students each year. Illinois Masonic is also a major employer in our area, with about 2,500 employees and nearly 900 physicians. Allowing Illinois Masonic to proceed with this much-needed facility redesign will help ensure availability of necessary health care services in the years to come, and serves to bolster the economic vitality of our community.

I strongly support the construction of the Center for Advanced Care and believe it is necessary if we are to maintain a strong and healthy community well into the future. For that reason, I encourage the Planning Board to approve the hospital's Certificate of Need.

Sincerely,



Ramamoorthy Sundaresan, M.D.



Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

July 10, 2012

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

Dear Ms. Avery:

This letter is to strongly urge the Illinois Health Facilities and Services Review Board to approve the Certificate of Need requested by Advocate Illinois Masonic Medical Center (AIMMC) to build a new outpatient facility on its Lakeview campus. I am writing this request in my several roles as a physician, medical educator and member of the Chicago healthcare community.

As a physician, I have witnessed the transformation of healthcare delivery from an inpatient, hospital based setting to an ambulatory one with shortening lengths of stay, growth of minimally invasive surgical procedures and advanced imaging technology. AIMMC needs to be able to deliver high quality, state of the art care for digestive diseases, cancer care and ambulatory surgery in an efficient, patient centered environment. The proposed Center for Advanced Care at AIMMC will provide this environment to our patients, medical staff and community.

AIMMC is a major community teaching hospital with 14 residencies and fellowships providing ongoing graduate medical education for over 200 physicians. As a major affiliate of three of the area's medical colleges, more than 600 medical students receive their introduction to clinical medicine and specialties at IMMC each year. AIMMC needs to provide these students and residents with the most current methods of healthcare delivery. The Center for Advanced Care will provide a facility to train these young physicians as they prepare to practice in the 21st century. It will also provide our teaching physicians and medical education programs the capacity to remain competitive in recruiting the best and brightest future doctors for training at AIMMC.

As the American healthcare system undergoes transformational reform, AIMMC, its medical staff and associates are being challenged to provide high quality health outcomes delivered in efficient and effective settings. The current decades old facility does not provide the environment that our providers need to practice the brand of healthcare being demanded by the evolving focus on value rather than volume of services. AIMMC needs a new ambulatory facility to meet the community's expectations under healthcare reform.

Please consider the above facts in your decision regarding AIMMC's request to construct the new Center for Advanced Care. Our community deserves and needs such a facility.

Sincerely,

William N. Werner, M.D., M.P.H., F.A.C.P.
Vice President Clinical Transformation
Designated Intuitional Officer



UROPARTNERS, LLC
MICHAEL J. YOUNG, M.D., F.A.C.S.
PAUL M. YONOVER, M.D.
UROLOGY AND UROLOGICAL SURGERY

July 20, 2012

Ms. Courtney R. Avery

Administrator

Illinois Health Facilities and Services Review Board

525 West Jefferson Street, 2nd Floor

Springfield, IL 62761

Dear Ms. Avery,

Illinois Masonic Medical Center's urology team specializes in treating people urologic conditions—bladder, kidney, urinary and male reproductive system disorders—with a wide range of advanced treatment options.

Our physicians are skilled at diagnosing conditions and helping patients select the best treatment options beginning with the least invasive. We strive to get our patients who require surgery back to their daily routine as safely and quickly as possible.

As chief of the Section of Urology at Advocate Illinois Masonic Medical Center, I would like to respectfully encourage the Illinois Health Facilities and Services Review Board to approve the hospital's Certificate of Need application for its proposed Center for Advanced Care. The design of the new facility will bring oncology services and same-day surgery in one area, fostering collaboration among physicians from different specialties and creating a better experience for our urology and prostate cancer patients.

In addition, the Center for Advanced Care directly addresses the national shift from inpatient treatment to outpatient care and positions Illinois Masonic to meet the growing community need for outpatient services in the new era of health care reform.

I hope you will join me in supporting Illinois Masonic's new Center for Advanced Care and approve the CON application for this project.

Sincerely,

A handwritten signature in black ink that reads "M Young MD". The signature is written in a cursive, flowing style.

Michael J. Young, MD FACS

Chief, Section of Urology

Advocate Illinois Masonic Medical Center



Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

July 9, 2012

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

As the Chief Medical Officer of Advocate Illinois Masonic Medical Center, I ask that you join me in supporting Advocate Illinois Masonic Medical Center's Certificate of Need application to construct a center for advanced care on our medical campus.

A new, outpatient facility will connect to the main hospital building, and enable the hospital to centralize cancer care, ambulatory surgery and digestive health services in one location. This project will allow the coordinated delivery of multidisciplinary care to achieve the best possible diagnoses and treatments for the patients and communities we serve.

We have about 900 physicians on our medical staff, and as one of the state's largest non-university medical teaching programs, the hospital trains over 200 residents and 500 medical students each year. The new facility will enhance our ability to educate and train the next generations of physicians in state-of-the-art health care services.

Hospitals and other health care institutions must adapt to meet the challenges posed by health care reform. This project is not only needed to enhance the medical services offered by Advocate Illinois Masonic, it directly addresses the shift of the health care delivery model from inpatient care to the outpatient environment.

On behalf of Illinois Masonic's physicians and the patients and families entrusted to our care, I respectfully request that the Planning Board approve the Advocate Illinois Masonic Medical Center CON application.

Sincerely,

Robert G. Zadylak, MD
Vice President of Medical Management & Chief Medical Officer
Advocate Illinois Masonic Medical Center
Vice President of Medical Management of AMG City Region
PH 773-296-5888
FAX 773-296-8131



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 equal.

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): October 31, 2015

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- Purchase orders, leases or contracts pertaining to the project have been executed.
 Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
 Project obligation 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

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 department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

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 following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center			CITY: Chicago, IL		
REPORTING PERIOD DATES: From: 1/1/11 to: 12/31/11					
Category of Service	Authorized Beds	Admissions	Patient Days including observation days	Bed Changes	Proposed Beds
Medical/Surgical	225	10,246	45,006	-	225
Obstetrics	51	2,524	6,639	-	51
Pediatrics	14	297	2,018	-	14
Intensive Care	37	1,599	6,911	-	37
Comprehensive Physical Rehabilitation	22	376	4,686	-	22
Acute/Chronic Mental Illness	39	1,475	10,933	-	39
Neonatal Intensive Care	20	404	4,305	-	20
General Long Term Care	0	0	0	-	0
Specialized Long Term Care	0	0	0	-	0
Long Term Acute Care	0	0	0	-	0
Other (Identify)	0	0	0	-	0
TOTALS:	408	16,921	80,498	-	408

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Advocate Health Care Network in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

James H. Skogsbergh
SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

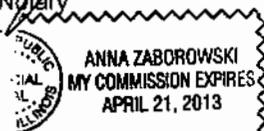
Executive Vice President/COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18TH day of JULY 2012

Notarization:
-Subscribed and sworn to before me
this 18TH day of JULY 2012

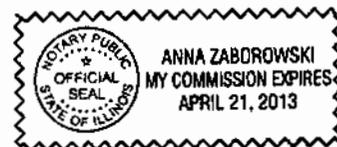
Anna Zaborowski
Signature of Notary

Seal



Anna Zaborowski
Signature of Notary

Seal



*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Advocate Health and Hospitals Corporation, in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

JA Skogsbergh
SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of JULY 2012

Notarization:
Subscribed and sworn to before me
this 18th day of July 2012

Janet M. Hood
Signature of Notary
Seal: **"OFFICIAL SEAL"**
Janet M. Hood
Notary Public, State Of Illinois
My Commission Expires 07/09/13

Janet M. Hood
Signature of Notary
Seal: **"OFFICIAL SEAL"**
Janet M. Hood
Notary Public, State Of Illinois
My Commission Expires 07/09/13

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Advocate North Side Health Network, d/b/a Advocate Illinois Masonic 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

William Santulli
SIGNATURE

William Santulli
PRINTED NAME

Corporation President
PRINTED TITLE

Susan Nordstrom Lopez
SIGNATURE

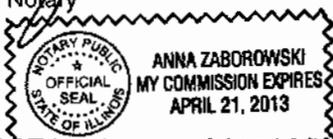
Susan Nordstrom Lopez
PRINTED NAME

Facility President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18TH day of JULY 2012

Notarization:
Subscribed and sworn to before me
this 16TH day of July 2012

Anna Zaborowski
Signature of Notary

Seal 

Gail B. Zator
Signature of Notary

Seal 

*Insert EXACT legal name of the applicant

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

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

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

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 certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. 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.
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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.

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, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as 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 age and condition and 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 Agency 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 of the alternatives to the proposed project:

Alternative options must include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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 1110.234 - 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.**
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;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

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.

R. Criterion 1110.3030 - 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
<input type="checkbox"/>		
<input type="checkbox"/>		

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

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility

APPEND DOCUMENTATION AS ATTACHMENT-37, 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)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: Indicate the dollar amount to be provided from the following sources:

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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 time table 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 time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
TOTAL FUNDS AVAILABLE		

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

IX. 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. All of the projects capital expenditures are completely funded through internal sources
2. 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
3. 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-40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (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.

2. 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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 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 of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	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 -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

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)				
	Inpatient			
	Outpatient			
Total				

APPEND DOCUMENTATION AS **ATTACHMENT-43**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

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 44.

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

APPEND DOCUMENTATION AS **ATTACHMENT-44**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	52-55
2	Site Ownership	56-58
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	59-62
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	63-65
5	Flood Plain Requirements	66-68
6	Historic Preservation Act Requirements	69-70
7	Project and Sources of Funds Itemization	71-72
8	Obligation Document if required	78
9	Cost Space Requirements	74-75
10	Discontinuation	N/A
11	Background of the Applicant	76-82
12	Purpose of the Project	83-94
13	Alternatives to the Project	95-101
14	Size of the Project	102-107
15	Project Service Utilization	108-109
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	N/A
27	Non-Hospital Based Ambulatory Surgery	N/A
28	General Long Term Care	N/A
29	Specialized Long Term Care	N/A
30	Selected Organ Transplantation	N/A
31	Kidney Transplantation	N/A
32	Subacute Care Hospital Model	N/A
33	Post Surgical Recovery Care Center	N/A
34	Children's Community-Based Health Care Center	N/A
35	Community-Based Residential Rehabilitation Center	N/A
36	Long Term Acute Care Hospital	N/A
37	Clinical Service Areas Other than Categories of Service	110-152
38	Freestanding Emergency Center Medical Services	N/A
	Financial and Economic Feasibility:	
39	Availability of Funds	153-173
40	Financial Waiver	174
41	Financial Viability	174
42	Economic Feasibility	175-181
43	Safety Net Impact Statement	182-190
44	Charity Care Information	191

Type of Ownership of Applicant/Co-Applicant

- | | | | | | |
|-------------------------------------|---------------------------|--------------------------|---------------------|--------------------------|-------|
| <input checked="" type="checkbox"/> | Non-profit Corporation | <input type="checkbox"/> | Partnership | | |
| <input type="checkbox"/> | For-profit Corporation | <input type="checkbox"/> | Governmental | | |
| <input type="checkbox"/> | Limited Liability Company | <input type="checkbox"/> | Sole Proprietorship | <input type="checkbox"/> | 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.

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

See Attachment 1, Exhibits 1, 2, and 3.

File Number 1707-692-2



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 14TH day of MAY A.D. 2012 .



Authentication #: 1213501096
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

File Number 1004-695-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 4TH day of MAY A.D. 2012



Authentication #: 1212501084
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

File Number 5237-115-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 2ND day of JULY A.D. 2012 .



Authentication #: 1218401058
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate North Side Health Network, d/b/a Advocate Illinois Medical Center
Address of Site Owner: 2025 Windsor Drive, Oak Brook, IL 60523
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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.

Proof of site ownership is appended as Attachment 2, Exhibit 1.

CHICAGO TITLE INSURANCE COMPANY
OWNER'S POLICY (1992)
SCHEDULE A

POLICY NO.: 1410 008319373 UL

DATE OF POLICY: SEPTSMBER 6, 2006

AMOUNT OF INSURANCE: \$25,000,000.00

1. NAME OF INSURED:

ADVOCATE NORTH SIDE HEALTH NETWORK, DOING BUSINESS AS ADVOCATE ILLINOIS MASONIC
MEDICAL CENTER, AN ILLINOIS NOT-FOR-PROFIT CORPORATION.

2. THE ESTATE OR INTEREST IN THE LAND AND WHICH IS COVERED BY THIS POLICY IS A
FEE SIMPLE, UNLESS OTHERWISE NOTED.

3. TITLE TO SAID ESTATE OR INTEREST AT THE DATE HEREOF IS VESTED IN:

THE INSURED.

4. THE LAND HEREIN DESCRIBED IS ENCUMBERED BY THE FOLLOWING MORTGAGE OR TRUST DEED
AND ASSIGNMENTS:

NONE

AND THE MORTGAGES OR TRUST DEEDS, IF ANY, SHOWN IN SCHEDULE B HEREOF.

THIS POLICY VALID ONLY IF SCHEDULE B IS ATTACHED.

OPOLA192

LAK 09/06/06 13:30:31

CHICAGO TITLE INSURANCE COMPANY
OWNER'S POLICY (1992)
SCHEDULE A (CONTINUED)

POLICY NO.: 1410 008319373 UL

5. THE LAND REFERRED TO IN THIS POLICY IS DESCRIBED AS FOLLOWS:

PARCEL 1: LOTS 1 TO 8 IN LOCKWOOD'S SUBDIVISION OF LOT 15 IN NOBLE'S SUBDIVISION OF BLOCK 4 IN CANAL TRUSTEES SUBDIVISION OF THE EAST 1/2 OF SECTION 29, TOWNSHIP 40 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

PARCEL 2: LOTS 1 TO 6 IN MITCHELL'S SUBDIVISION OF LOT 12 IN NOBLES SUBDIVISION OF BLOCK 4 IN CANAL TRUSTEES SUBDIVISION OF THE EAST 1/2 OF SECTION 29, TOWNSHIP 40 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

PARCEL 3: THE NORTH 1/2 OF THE WEST 100 FEET OF LOT 11 AND THE SOUTH 1/2 OF THE WEST 50 FEET OF LOT 11 (EXCEPT STREET) IN NOBLES SUBDIVISION OF BLOCK 4 IN CANAL TRUSTEES SUBDIVISION OF THE EAST 1/2 OF SECTION 29, TOWNSHIP 40 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

PARCEL 4: LOTS 1 AND 2 IN KRAEMER AND WEBER'S SUBDIVISION OF THE SOUTH 1/2 OF LOTS 7 AND 8 AND (EXCEPT THE WEST 50 FEET) OF THE SOUTH 1/2 OF LOT 11 OF CANAL TRUSTEES SUBDIVISION OF THE EAST 1/2 OF SECTION 29, TOWNSHIP 40 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

PARCEL 5: THE NORTH 1/2 OF VACATED WEST NELSON STREET LYING SOUTH OF AND ADJOINING PARCELS 1, 2, 3 AND 4 AFORESAID

THIS POLICY VALID ONLY IF SCHEDULE B IS ATTACHED.

OPLA1.92

LAK 09/06/06 13:30:31

Operating Identity/Licensee

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

Exact Legal Name: Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center	
Address: 2025 Windsor Drive, Oak Brook, IL 60523	
<input checked="" type="checkbox"/> Non-profit Corporation <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Partnership <input type="checkbox"/> Governmental <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 	
<p>APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</p>	

Certificates of Good Standing for Advocate Health Care Network; Advocate Health and Hospital Corporation; and Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center are appended as Attachment 3, Exhibits 1, 2, and 3.

File Number 1707-692-2



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 14TH day of MAY A.D. 2012 .



Authentication #: 1213501896
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

File Number 1004-695-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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



Authentication #: 1212501084
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 4TH day of MAY A.D. 2012 .

Jesse White

SECRETARY OF STATE

File Number 5237-115-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

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



Authentication #: 1218401068

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 2ND day of JULY A.D. 2012 .

Jesse White

SECRETARY OF STATE

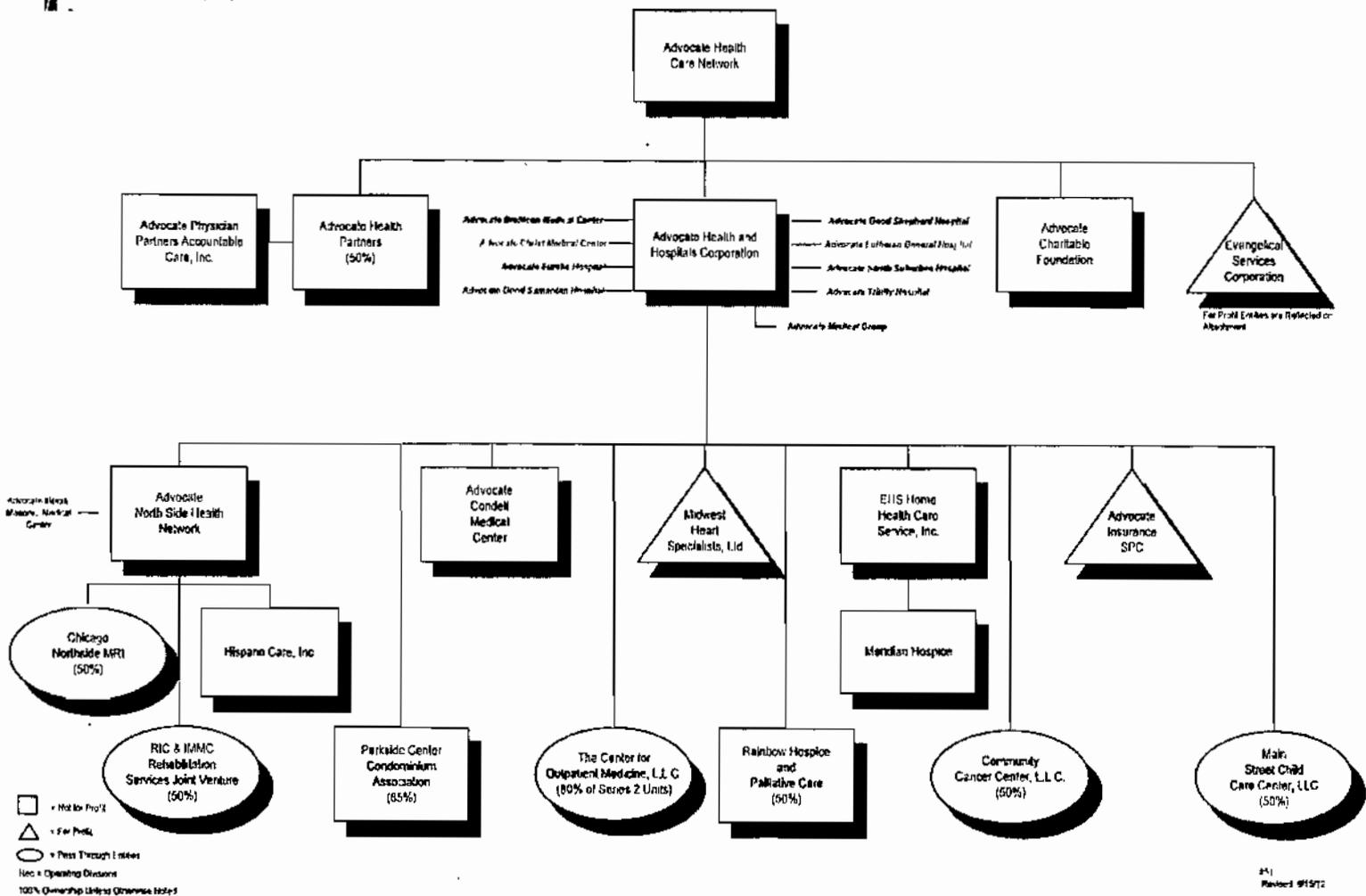
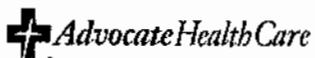
Organizational Relationships

Provide (for each co-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.

Attachment 4, Exhibit 1, is an organization chart of Advocate Health Care and shows all of the relevant organizations including Advocate Health Care Network, Advocate Health and Hospitals Corporation, and Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center.

Attachment 4, Exhibit 2, shows the leadership of Advocate Illinois Masonic Medical Center.



= Not for Profit
 = For Profit
 = Pass Through Entity
 Nec = Operating Division
 100% Ownership Unless Otherwise Indicated

251
Revised 09/2012

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (<http://www.hfsrb.illinois.gov>).

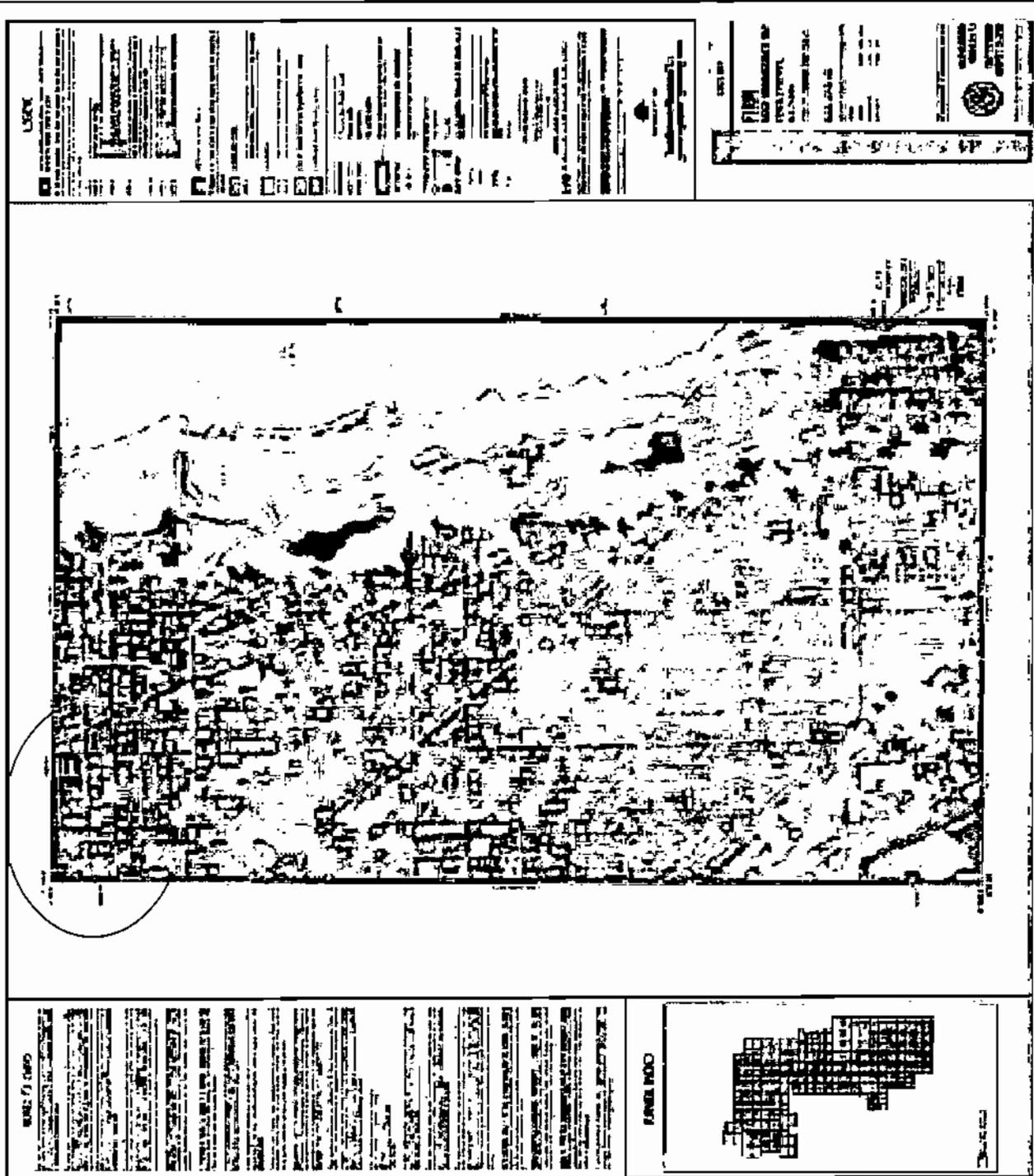
APPEND DOCUMENTATION AS **ATTACHMENT -5**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Attachment 5, exhibit 1, is a copy of the Flood Insurance Rate Map (FIRM) that shows the location on Floodplain Map 17031C0417 where Advocate Illinois Masonic Medical Center is located.

Attachment 5, exhibit 2, is an enlargement of area circled on page 46, which is the exact location on the Floodplain Map 17031C0417J of Advocate Illinois Masonic Medical Center.

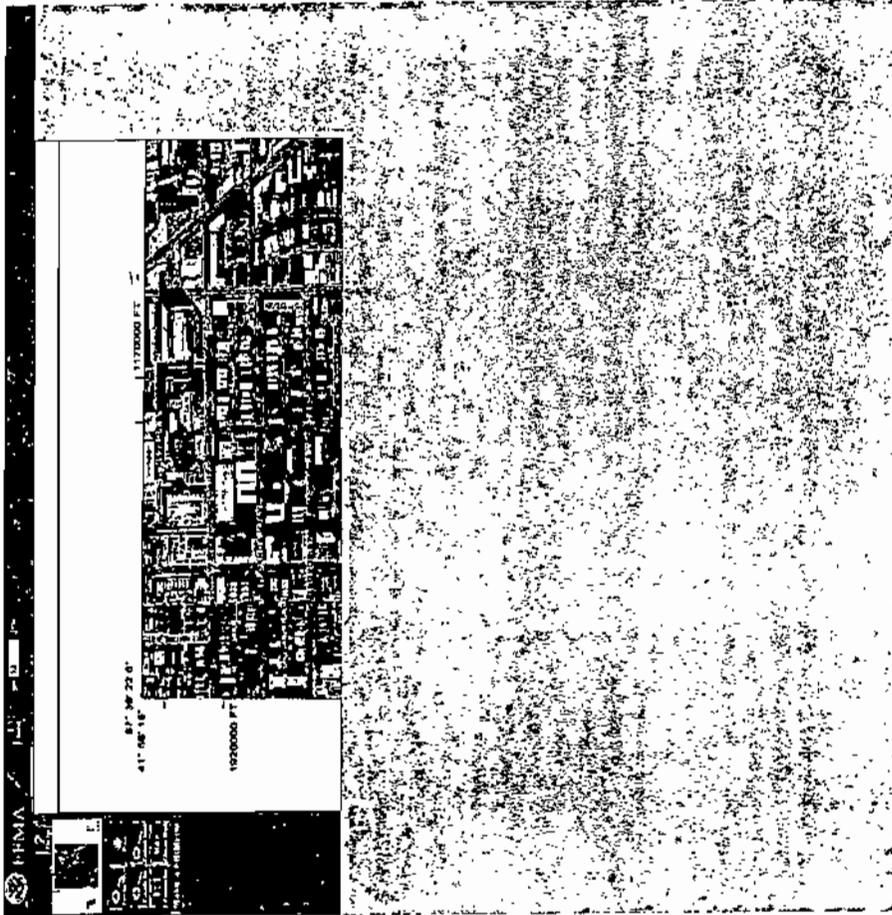
FIRM Floodplain Map showing location of proposed construction.



Enlargement of area circled on page 46, which is the exact location on the Floodplain Map 17031C0417J of Advocate Illinois Masonic Medical Center.

Page 1 of 1

Intranetix Viewer [17031C0417J.png]



http://map1.msc.fema.gov/ldms/IntmView.cg?ROT=0&O_X=6525&O_Y=1634&O_ZM... 6/24/2012

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.

Attachment 6, Exhibit 1, is a letter from the Illinois Historic Preservation Agency which documents that no historic, architectural, or archaeological sites exist within the Project area.



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Cook County
Chicago

New Addition of Center for Advanced Care
836 W. Wellington Ave. (837 W. Barry Ave.)
IHPA Log #011070212

July 5, 2012

Janet Hood
Advocate BroMenn Medical Center
Advocate Eureka Hospital
P.O. Box 2850
Bloomington, IL 61702-2850

Dear Ms. Hood:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two 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 Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker
Deputy State Historic
Preservation Officer

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 equal.

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	CLINICAL	NON CLINICAL	TOTAL
Preplanning Costs	\$ 377,094	\$ 540,293	\$ 917,387
Site Survey and Soil Investigation	\$ 66,282	\$ 94,968	\$ 161,250
Site Preparation	\$ 1,109,842	\$ 1,590,158	\$ 2,700,000
Off Site Work	\$ 1,145,346	\$ 1,641,026	\$ 2,786,372
New Construction Contracts	\$ 27,524,175	\$ 24,433,476	\$ 51,957,650
Modernization Contracts	\$ -	\$ 944,832	\$ 944,832
Contingencies	\$ 2,135,733	\$ 3,060,032	\$ 5,195,765
Architectural/Engineering Fees	\$ 1,264,491	\$ 1,811,734	\$ 3,076,225
Consulting and Other Fees	\$ 2,812,637	\$ 4,029,885	\$ 6,842,522
Movable or Other Equipment (not in construction contracts)	\$ 11,337,653	\$ 4,988,507	\$ 16,326,160
Bond Issuance Expense (project related)	\$ 364,973	\$ 522,926	\$ 887,899
Net Interest Expense During Construction (project related)	\$ 2,574,413	\$ 3,688,561	\$ 6,262,974
Fair Market Value, Leased Space, Equipment	\$ -	\$ -	\$ -
Other Costs To Be Capitalized	\$ 4,599,654	\$ 6,590,283	\$ 11,189,937
Acquisition of Building or Other Property (excluding land)	\$ -	\$ -	\$ -
TOTAL USES OF FUNDS	\$ 55,312,294	\$ 53,936,679	\$ 109,248,973
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$ 35,717,087
Pledges			
Gifts and Requests			
Bond Issues (project related)			\$ 71,031,886
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			\$ 2,500,000
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$ 109,248,973
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Itemization of Costs

Pre-Planning	\$ 917,387
Site and Facility Planning	300,000
Programming thru Conceptual Planning	617,387
Site survey (investigation, titles, traffic)	\$ 161,250
Site Preparation	\$ 2,700,000
Prep Work (Demo, clearing, grading, shoring & Utility Relocation, Power Feed)	1,502,000
Earthwork, drainage, stone, foundation prep	1,198,000
OFF-Site Work	\$ 2,786,372
Site Work: Grading, Prk Lot Lights & Concrete	1,125,589
ComEd - power relocation at Nelson Street	1,291,644
Misc Street and Traffic Upgrades	369,139
New Construction	\$ 51,957,650
Modernization of Existing Stone Building	\$ 944,832
Connection to Existing Stone Building	
Contingencies	\$ 5,195,765
Architect/Eng Fees	\$ 3,076,225
Consulting and Other Fees	\$ 6,842,522
Const Admin & Misc Consultants	1,822,609
A/E RFI + Operational Consultants / Misc Analysis	890,000
Reimbursables/ Renderings / Misc support	615,600
MEP /Envelope, LEED Commissioning	532,000
Peer Review, Equipment planner	676,311
Technology Integration Services	755,880
Miscellaneous	1,550,122
Movable / Equipment	\$ 16,326,160
Surgical	3,443,694
GI Equipment	2,798,546
Imaging	681,491
Cancer Center / Radiation Oncology	4,635,184
Cancer Center / Medical Oncology	906,243
Miscellaneous equipment	3,861,002
Bond Issuance / Finance Expense	\$ 887,899
Net Interest	\$ 6,262,974
Other Costs to be Capitalized	\$ 11,189,937
Modular Units/Furniture/Window Treatments	1,628,975
Utilities / Taps	1,291,644
PACS Hardware / Server / Station Equipment	1,200,000
Data Infrastructure, wireless, telecom	1,899,713
Miscellaneous other costs	5,169,605
TOTAL	\$ 109,248,973

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

- None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): October 31, 2015

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- Purchase orders, leases or contracts pertaining to the project have been executed.
 Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
 Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

No further documentation needed.

Cost Space Requirements

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

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 <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

See Attachment 9, Exhibit 1.

Cost Space Requirements								
Dept. / Area	Total Costs	Department Gross Square Feet		Amount of Proposed Total Department Gross Square Feet That Is:				
		Existing	Proposed	CON New Const.	Modernized	As Is	Vacated Space	Reclassified as Procedure
CLINICAL								
Surgery								
Surgery Operating Rooms	\$ 19,161,795	25,711	43,676	19,742		23,934	1,321	456
Surgery GI Procedure Rooms	\$ 7,453,930	1,978	6,559	6,559			1,978	
Phase II Recovery (Prep/recovery)	\$ 12,158,049	3,715	18,727	16,169		2,558	1,157	
Ambulatory Care Services								
Infusion Therapy	\$ 4,333,991	2,147	5,721	5,721			2,147	
Pre Surgical Care	\$ 1,260,295	0	1,574	1,574				
Diag and Interventional Radiology								
Mammography, Dedicated Needle Loc	\$ 764,505	0	338	338				
Therapeutic Radiology								
Linear Accelerator	\$ 6,647,061	2,148	4,752	4,752			2,148	
CT Simulator	\$ 1,324,040	644	1,663	1,663			644	
Brachytherapy	\$ 1,628,976	0	2,046	2,046				
Pharmacy, Outpatient								
Total Clinical	\$ 55,312,294	36,641	85,721	59,229		26,492	9,693	456
NON CLINICAL Non Reviewable								
Physicians & Multidisciplinary Team Offices (Time Share, Exam, Consultation)	\$ 11,345,158	34,881	37,266	17,184		20,082	14,799	
Patient Ed/Resource Center/Conf	\$ 1,548,955	13,128	15,501	2,373		13,128		
Public Lobby, Waiting, Toilets, Stairs, Elevators, Corridors	\$ 16,761,355	160,000	185,852	25,852		160,000		
Corridors (Modernized Connectors)	\$ 2,139,129	0	4,300	0	4,300			
Mechanical/Electrical/Plumbing	\$ 5,304,420	22,749	29,160	6,411		22,749		
Crawl Area	\$ 5,234,316	0	11,086	11,086				
Penthouse, Air Handlers	\$ 11,603,345	0	17,656	17,656				
Total Non-clinical	\$ 53,936,679	230,758	300,821	80,562	4,300	215,959	14,799	
Total		267,399	386,542	139,791	4,300	242,451	24,492	456
TOTAL NEW CONST+MODERN	\$ 109,248,973			144,091				

Source: AIMMC records.

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

5. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
6. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
7. 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.
8. 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 the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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.

5. The licensing, certification, and accreditation numbers of each organization owned or operated by Advocate Health and Hospitals Corporation, along with relevant identification numbers, are listed below.

Facility	Location	License No.	Joint Commission Accreditation No.
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	1895997	4068

Additional hospitals owned and operated as a part of Advocate Health Care Network:

Facility	Location	License No.	Joint Commission Accreditation No.
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	1756947	4482*
Advocate Christ Medical Center	4440 W. 95 th St. Oak Lawn, IL	1899693	7397
Advocate Condell Medical Center	801 S. Milwaukee Ave. Libertyville, IL	1756928	7372
Advocate Eureka Hospital	101 S. Major Eureka, IL	1756949	4482*
Advocate Good Samaritan Hospital	3815 Highland Ave. Downers Grove, IL	1899765	7329
Advocate Good Shepherd Hospital	450 W. Highway, #22 Barrington, IL	1899765	5190
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	1899780	7405
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	1899779	7356
Advocate Trinity Hospital	2320 E. 93 rd St. Chicago, IL	1927349	7311

*Advocate BroMenn Medical Center and Advocate Eureka Hospital are surveyed under one accreditation number.

5. The license for Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center (Medical Center), is included as Attachment 11, Exhibit 1.

Attachment 11, Exhibits 1 and 2, are current State and City hospital licenses for Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center. The most recent Joint Commission accreditation certificates for the Medical Center and Behavioral Health Care are included as Attachment 11, Exhibits 3 and 4. The Medical Center and Behavioral Health Care were surveyed in July 2010. Advocate Illinois Masonic Medical Center participates in Medicaid and Medicare.

6. Certified Listing of Any Adverse Action Against Any Facility Owned or Operated by the Applicant

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

7. Authorization Permitting IHFPB and DPH to Access Necessary Documentation

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

8. Exception for Filing Multiple Certificates of Need in One Year

Not applicable. This is the first certificate of need filed by Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center in 2012.

State of Illinois 2061092
Department of Public Health

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.

DANON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
11/04/12	BGBW	0005165

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 11/05/11

BUSINESS ADDRESS

ADVOCATE NORTHSIDE HEALTH NETWORK
D/B/A ILLINOIS MASONIC MED. CTR CAMPUS
836 WEST WELLINGTON AVENUE
CHICAGO IL 60657

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

CITY OF CHICAGO

LICENSE CERTIFICATE
NON-TRANSFERABLE

BY THE AUTHORITY OF THE CITY OF CHICAGO, THE FOLLOWING SPECIFIED LICENSE IS HEREBY GRANTED TO

NAME: **ADVOCATE NORTH SIDE HEALTH NETWORK**

ADDRESS: **ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
836 W. WASHINGTON AVE., FLOOR #, Apt./Suite 1
CHICAGO, IL 60657-5147**

LICENSE NO.: **15775** EXPIRES: **1375**

LICENSE TYPE: **Hospital**

1000 Beds Max

PRINTED ON: **02/16/2011** FEE: **\$**2,200.00**

THIS LICENSE IS ISSUED AND ACCEPTED SUBJECT TO THE REPRESENTATIONS MADE ON THE APPLICATION THEREFOR, AND MAY BE SUSPENDED OR REVOKED FOR CAUSE AS PROVIDED BY LAW. LICENSEE SHALL OBSERVE AND COMPLY WITH ALL LAWS, ORDINANCES, RULES AND REGULATIONS OF THE UNITED STATES GOVERNMENT, STATE OF ILLINOIS, COUNTY OF COOK, CITY OF CHICAGO AND ALL AGENCIES THEREOF.

WITNESS THE HANDS OF THE SHERIFF OF SAID CITY AND THE CORPORATE SEAL THIS
15 DAY OF FEBRUARY, 2011

EXPIRATION DATE: **February 15, 2013**

ATTEST:

Richard M. Daley Mayor
Miguel del Valle City Clerk

63145 SUC: 1

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE UPON THE LICENSEE'S PREMISES.

CITY OF CHICAGO - 1831 HENRY STREET - INCORPORATED 1837

CITY OF CHICAGO - 1831 HENRY STREET - INCORPORATED

Advocate Illinois Masonic Medical Center Chicago, IL

has been Accredited by

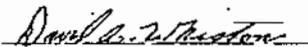


The Joint Commission

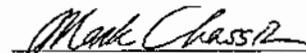
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

February 27, 2010

Accreditation is customarily valid for up to 39 months.


David A. Whitson, D.D.S.
Chairman of the Board

Organization ID #: 4068
Print/Reprint Date: 06/16/10


Mark Chassin, M.D.
President

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



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Advocate Illinois Masonic Medical Center Chicago, IL

has been Accredited by



The Joint Commission

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

Behavioral Health Care Accreditation Program

February 25, 2010

Accreditation is customarily valid for up to 39 months.

David A. Whiston
David A. Whiston, D.D.S.
Chairman of the Board

Organization ID #: 4068
Print/Reprint Date: 06/16/10

Mark Chassin
Mark Chassin, M.D.
President

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



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

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

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

READ THE REVIEW CRITERION and provide the following required information

PURPOSE OF PROJECT

7. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
8. Define the planning area or market area, or other, per the applicant's definition.
9. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
10. Cite the sources of the information provided as documentation.
11. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
12. 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 age and condition and 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 Agency Report.

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

1. The Project Will Provide Health Services That Improve the Health Care or Well-Being of the Market Area Population to be Served

In 2009, Advocate Illinois Masonic Medical Center (Medical Center) embarked on a strategic plan to strengthen its service to Chicago, as a vital tertiary referral center and teaching hospital with select regional destination services. The intent was, and continues to be, to develop a campus plan for the current and long term future that secures health care for Chicago's North Side. There was an immediate need to right size undersized areas and improve functionality and connectivity by beginning to replace aged facilities.

All major services were reviewed and the highest priority services were determined to be **digestive health, cancer, and ambulatory surgery**. All three of these programs are focused on outpatients. Ambulatory care is the fastest growing method of care, which can lower cost, and speed service to the patient. This is a trend that has been in place throughout the health care industry for several years and is well received by the patient, physician, and payor.

- Patients appreciate receiving care in a location that is designed to accommodate easy access, where scheduling of their care is not changed due to the needs of acutely ill inpatients.
- Physicians are better able to provide care where the throughput of patients is more predictable. By having the diagnostic and treatment capacity near their offices, the entire care process is more efficient and improves communications among all parties.
- Payors have long indicated their support for outpatient care because of cost savings when an inpatient stay is not required to accomplish the same treatment or care.

In addition, there will be medical office space in the new construction that will allow physicians from various specialties to see their patients in a multidisciplinary, time-share model. Nurses, therapists, dietitians, counselors, social workers and other health care professionals can all work together with the patients.

Community interest and support for this Project have been evident throughout the planning, as people recognize the importance of the Medical Center to the overall health of the residents. Contacts with long-standing benefactors and new supporters are underway, in order to plan for potential gifts and pledges.

The design of this proposed Project, referred to as the Center for Advanced Care, has been carefully planned to provide a state-of-the-art facility with attention to emerging technology, patient privacy and comfort, efficiency of time and resources, and capacity for the foreseeable future. Those qualities will give Advocate Illinois Masonic Medical Center the ability to improve the health care and well-being of the population it serves.

2. Definition of Planning/Market Area

Advocate Illinois Masonic Medical Center (Medical Center) is a tertiary referral center, teaching hospital, and Level I Trauma Center. It serves the north-east section of Chicago and is located in the Lakeview Community Area. This site is in the middle of the east side of the Illinois Health Facilities and Services Review Board (IHFSRB) Planning Area A-01. See Attachment 12, Exhibit 1 for the Planning Area A-01.

The primary market area defined by the Medical Center is very similar to IHFSRB Planning Area A-01 with a few exceptions. The Medical Center does not consider the O'Hare area or Norwood Park to be a part of its primary or secondary market. However, the Medical Center does extend its services farther north along the Lake to include Avalon Park and Rogers Park. See Attachment 12, Exhibit 2 for a map of the Medical Center's Service Area. As shown below, 68 percent of the inpatients and 70 percent of the outpatients served originate in Planning Area A-01. (See Attachment 12, Exhibit 3 for the detailed admissions by zip code.) It is noteworthy that Advocate Illinois Masonic Medical Center is becoming a referral center for patients from outside its service area.

Patient Origin

2011	Inpatients	%	Outpatients	%
Planning Area A-01	11,599	67.9%	108443	69.8%
Other Primary and Secondary Service Areas	1,456	8.5%	13960	9.0%
Other	4,031	23.6%	33035	21.3%
Total	17,086	100.0%	155438	100.0%

Source: Thomson Reuters

A study of the population projections for the overall Service Area was made, and the projections extended to 2016. See below. Essentially, the population will remain flat for the next five years. However, the impact of the aging baby boomers is clearly shown with a 14.9 percent increase in the 65-84 age range. As people reach that over-65 age, the demand for health care substantially increases.

Population by Age

Population by Age, 2011	<15	15-44	45-64	65-84	85+	Total
Primary Service Area	226,944	580,382	273,165	101,041	17,895	1,199,427
Secondary Service Area	106,929	199,722	79,274	27,973	4,550	418,448

Population by Age, 2016	<15	15-44	45-64	65-84	85+	Total
Primary Service Area	228,814	540,219	292,702	116,121	18,743	1,196,599
Secondary Service Area	107,114	189,284	84,385	30,642	4,596	416,021

Population % Change 2011-2016	<15	15-44	45-64	65-84	85+	Total
Primary Service Area	0.8%	-6.9%	7.2%	14.9%	4.7%	-0.2%
Secondary Service Area	0.2%	-5.2%	6.4%	9.5%	1.0%	-0.6%

Source: Thomson Reuters

A review of the race and ethnicity of the total service area, when compared to the nation, shows a significant increase in persons of Hispanic ethnicity and a decrease in the White Non-Hispanic population. As the chart below shows, the Hispanic population is the largest demographic group in the area. This bears out the reason why Advocate Illinois Masonic Medical Center has a program called "Hispanocare", to address the health and social needs of these patients.

Population by Race/Ethnicity

Race/Ethnicity Total Service Area	2010 Pop	% of Total	USA % of Total
White Non-Hispanic	578,480	35.3%	64.7%
Black Non-Hispanic	223,262	13.6%	12.1%
Hispanic	699,940	42.8%	15.8%
Asian & Pacific Is. Non-Hispanic	93,313	5.7%	4.5%
All Others	41,647	2.5%	2.9%
Total	1,636,642	100.0%	100.0%

Source: Thomson Reuters

3. Existing Problems and Issues That Need to be Addressed

Advocate Illinois Masonic Medical Center (Medical Center) has a long history of caring for people in the Chicago area. The hospital's origin dates back to 1897 with the formation of Union Hospital, which became Illinois Masonic Medical Center in 1921. It ultimately merged with Advocate Health Care in 2000. The Advocate system was rated by Thomson Reuters as one of the top 10 health systems in the United States in 2011.

OUTPATIENT GROWTH FOR THREE SERVICES

As Advocate carries out its mission to serve the health needs of individuals, families, and communities, it has also assessed the Medical Center's operations. It found the physicians to be committed to the hospital and patients to show a preference for Advocate Illinois Masonic Medical Center. The number of outpatients coming to the Medical Center has continued to increase.

History of Outpatient Utilization

	2008	2009	2010	2011	Increase 2008-2011	Ave increase per yr.
Outpatients	147,864	152,422	152,368	155,438	5.1%	1.7%

Source: IDPH Hospital Profiles and 2011 AIMMC Annual Hospital Questionnaire

Outpatient volume for the three services proposed to be included in the new Center for Advanced Care has grown much faster in that same timeframe. See below for evidence of the projected growth.

Growth of Ambulatory Surgery, Endoscopy, and Linear Accelerator Cases

	2008	2009	2010	2011	Increase 2008-2011	Avg increase per yr.
Surgery OP Cases	6,416	7,068	7,686	7,569	18.0%	6.0%
Endoscopy OP Cases	3,478	4,389	4,415	4,290	23.3%	7.8%
Linear Accelerator OP Treatments	5,577	5,819	6,466	8,084	45.0%	15.0%

Source: IDPH Hospital Profiles and 2011 AIMMC Annual Hospital Questionnaire

The implications of the growth of these services underscored the importance of an integrated program for digestive health, cancer, and ambulatory surgery as proposed by the Medical Center.

AGED INFRASTRUCTURE OF HOSPITAL

While the demand for service is apparent, the missing element is the modern facilities to accomplish that care. The main hospital structure is the Stone building, named after the chairman of the Board when it was built in 1970. It is surrounded by buildings that were built in 1908, 1926, 1950, 1957, 1963 and 1984. The aged infrastructure in these buildings makes it very difficult to introduce newer technology or efficiencies.

DIGESTIVE HEALTH/ENDOSCOPY ISSUES

The endoscopy suite (also known as gastrointestinal surgical procedure rooms) is located in a building constructed in 1957. The suite is critical to the support of the Digestive Health

program; however, the current endoscopy suite does not have adequate capacity to accommodate the new physicians' volume and type of procedures. Advocate Illinois Masonic Medical Center has been successful in recruiting new gastroenterologists who are bringing significant new techniques.

Thirty-one percent of the Advocate Illinois Masonic Medical Center patients identified themselves as Hispanic in 2010, compared to less than nine percent state-wide. It follows that the Medical Center is focused on health issues of the Hispanic population they serve. Recent studies have identified an increase in digestive health problems among Hispanics. HealthDay News reported in the May 15, 2012 issue on a new study that shows black and Hispanic Americans are far more likely than whites to develop precancerous colorectal polyps.

Researchers analyzed data from more than 5,000 men and women aged 50 and older who had a first-time colonoscopy screening at New York-Presbyterian Hospital/Columbia University Medical Center in New York City between 2006 and 2010. None of the patients had signs or symptoms of colorectal (colon) cancer at the time of the screening. At least one precancerous polyp was detected in 26 percent of blacks, 22 percent of Hispanics and 19 percent of whites.

The findings add to recent evidence that the rate of colorectal cancer among Hispanics may be increasing as they adopt more mainstream American lifestyle habits, the researchers said. The study also found that blacks and Hispanics are more likely than whites to develop polyps in the upper portion of the colon.

Additionally, the Medical Center serves one of the largest lesbian, gay, bisexual, and transgender (LGBT) communities in the nation. This population has a higher tendency for digestive diseases and they have encouraged the Medical Center to expand its diagnosis and treatment capacity. As a result, the Digestive Health program is developing a reputation at the Medical Center as a destination service. The most limiting factor is the insufficient and outdated endoscopy suite.

Due to the limited capacity of the outdated, small endoscopy suite and insufficient number of Phase II recovery stations, the smooth transition of care is challenging. These challenges are illustrated in the limited ability to efficiently transition the patient from one level of care to another, conduct private provider/patient confidential consultations, and install technology to improve the diagnostic capabilities.

Because of the limited footprint of the current endoscopy suite, the ability to provide basic diagnostic and interventional procedures is difficult. Consequently, with complex patients who require endoscopic retrograde cholangiopancreatography (ERCP) procedures, the patient is transferred to alternative sites of service that increase the cost of care and diminish the efficiencies of staff. This also requires the endoscopy staff to transport bulky equipment, which increases the risk of equipment damage and potential employee injury.

In addition to the bottleneck in patient flow which is a result of the limited number of Phase II recovery areas, the procedural area is too small to accommodate general anesthesia services. All cases requiring general anesthesia must be performed in the main OR which decreases the program's efficiencies. The small size of the patient procedure rooms has limited the expansion

of new procedures to be performed there, due to the size of the new technology equipment required for the procedure.

With the limited number of current endoscopy procedure rooms, it has become very difficult to accommodate new physicians. To accommodate the gastrointestinal endoscopy volume resulting from the newly recruited physicians, a procedure room located in the Stone building has been temporarily assigned as an endoscopy procedure room. A section of the Phase I Recovery (PACU) has been used for pre and post op care of these patients as the volume could not be absorbed in the current endoscopy suite. This is in addition to performing all the Endoscopic Ultrasound System (EUS) cases in an operating room suite to accommodate the Endoscopic Ultrasound System, anesthesia and nursing teams, the electrocautery, and other patient consoles required for the procedure.

As additional new procedures are added to the developing digestive health program, the Medical Center continues to review alternate satellite areas on the hospital campus, noting that each new site adds inefficiencies and decreases patient and physician satisfaction.

SURGICAL SUITE ISSUES

Additionally, the general operating rooms are located in the Stone Pavilion on the third floor. The pre-operative assessment and admission area and Phase II Recovery is on the fifth floor. This bifurcated structure limits the Medical Center's ability to achieve productivity goals and meet the patient/family centered service levels.

Due to the outdated design of the surgery department, the following problems exist:

1. The operating rooms are not large enough to support current technology/equipment that is less invasive, improves patient recovery period, and reduces length of the procedures.
2. A single elevator transports patients from the Phase II Prep and Recovery area to the OR and back. When the elevator has interruptions in service, it impacts the OR schedule and affects patient care.
3. Surgeons and anesthesiologists cannot move easily between Surgery and the Phase II Recovery without special gowning, creating frustrations and interruptions in case start times. Surgeons and anesthesiologists inability to move easily between these areas impacts the communication channels with physician, patient, and family. Travel time between Surgery and Phase II Recovery causes delays with the succession of cases that follow, which impacts the clinical care and service to other patients.
4. The current space does not accommodate the needs of the patients that require pre-operative testing and education. With the increase of the bariatric population and complexity of co-morbidities, it is imperative to adequately prepare the patient for post-operative self care.
5. A lack of adequate Phase II recovery rooms impacts patient recovery during the post operative period.
6. Patient privacy is at risk in the Prep and Phase II recovery area due to the close proximity of the patients.
7. Current operating room size has posed challenges in accommodating new equipment required for state-of-the-art procedures, such as image guided surgery, intraoperative angiograms, endoscopic ultrasound, and endoscopic vein harvesting. The

aforementioned consoles in addition to the routine equipment such as fluoroscopy, microscopes, lasers, homeostasis generators, and drills have been challenging to fit in the current surgery suite while maintaining a sterile patient field.

CANCER CENTER ISSUES

The Creticos Cancer Center is in a building across Wellington Street from the hospital. That makes it necessary for patients, physicians, and staff to go out in the weather to get to the hospital for any service. They must cross a busy street without a traffic signal. Patients to be transported between the Cancer Center and the hospital often require an ambulance. While the Medical Center pays for the ambulance, the patient perceives this as an inconvenience and an expense.

There is no room for a Brachytherapy suite to be located in the existing center. When a Brachytherapy patient is scheduled, the patient and equipment are taken into the Linear Accelerator room for the treatment, thereby rendering that room unavailable for patients who need radiation therapy. The size of the Infusion service is limiting the number of patients that can be cared for in the immediate future.

Most importantly, the radiation therapy program is growing and does not have adequate space to locate or support a second linear accelerator. The current volume of procedures has exceeded the standard for one unit but space does not permit adding a second unit. By being limited to one unit, there is no backup when the unit is down for any reason, either scheduled or unexpected.

4. Source of Information

Information used in this application included the IDPH Hospital Profiles assembled from the Annual Hospital Questionnaires, other reports made to the State and various credentialing organizations, the Medical Center's Facilities Master Plan, and analysis done by external planners, architects, and engineers. Physician experts were consulted as well as independent professionals in relevant disciplines.

The codes used in the design included:

- Chicago Building Code,

- Chicago Electric Code

- Life Safety Code

- IDPH Licensing Act

- 2000 NFPA 101, and, as referenced by the 2000 NFPA 101:

 - 1998 NFPA 10, Standard for Portable Fire Extinguishers

 - 1999 NFPA 13, Standard for the Installation of Sprinkler Systems

 - 1999 NFPA 70, National Electrical Code

 - 1999 NFPA 72, National Fire Alarm Code

 - 1999 NFPA 80, Standard for Fire Doors and Fire Windows

 - 1999 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems

 - 1999 NFPA 99, Standard for Health Care Facilities

 - 1999 NFPA 110, Standard for Emergency and Standby Power Systems

1999 NFPA 220, Standard on Types of Building Construction
2000 NFPA 14, Standard for the Installation of Standpipe, Private Hydrants, and
Hose Systems

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

Advocate Illinois Masonic Medical Center is positioned to expand its services to the markets it serves with additional physicians, new diagnostic methodologies, and new treatment protocols. The development of programs within digestive health, cancer care, and ambulatory surgery has progressed beyond initial expectations. The next step is to house these programs in a state-of-the-art facility. The benefits are numerous:

- Patients will have the opportunity to access care in a setting that has been designed for efficient throughput, saving time for everyone.
- Properly designed facilities will improve confidentiality of patient/provider discussions, and help to insure all the patients' needs are addressed during pre-operative assessment, post-operative education, and physician consultations
- Ease of access, improved traffic patterns, and improved way-finding will be appreciated by all, especially cancer patients who are often debilitated, and their care givers who bring them to the Medical Center.
- Modern, well-designed operating rooms and endoscopy rooms will allow physicians to offer procedures that are not currently available due to limited quarters that prevent the use of newer technology and staff.
- The proposed Project will allow all diagnostic procedures to be performed in a central point of service, eliminating the need to move equipment. This provides a safer work environment for associates, reduces the risk of damage to expensive equipment, and improves the coordination of care to the patient.
- Each operating room will be equipped with a video routing system that enables clear visualization of x-rays, ultrasound, CAT scans, and MRI images in real time during surgery.
- The image routing system will allow other surgeons, pathologists, and more to confer in real time during a surgical procedure
- The proposed Project will offer additional physician office space where physicians can see patients for treatment planning and consultations. For example, when patients have come for their scheduled treatment such as chemotherapy, it will be easier to combine that with a visit to see their physician, when the physician's office is nearby.
- By having multiple specialties of physicians in an integrated model of care, that improves the coordination of diagnosis and treatment plans for all their patients.
- The proposed Project will decompress the inpatient environment thereby improving efficiency and throughput.
- Serving a highly diverse population with the added impact of the aging baby boomer generation, the proposed Project will centralize critical services that address the current and growing health care needs of the community. This Project creates a pathway for patients to obtain the services that support their diagnosis. It will minimize the confusion they presently experience as they navigate the current points of entry. Reducing the

patients' apprehension and anxiety improves the recovery of patients in the healing process.

The new Center for Advanced Care will be linked to the hospital by connecting corridors on each floor. On the third floor, where the operating rooms are located, the corridor access will be limited to surgeons and staff that need to move between the new building and the existing without having to change clothes again each time. The corridor provides contiguous access between the existing surgical suite in the Stone building and the proposed Center for Advanced Care, designed as semi-restricted and limited to surgeons and staff in surgical scrub suits.

The proposed Project is designed by location and structure to accommodate additional floors in the future, as Advocate assesses the need to replace more of the older buildings.

6. Goals with Quantified and Measurable Objectives, with Specific Timeframes to Relate to Achieving the Stated Goals, as Appropriate.

The most pressing goal of the Project is to relocate three major programs into a facility that can offer an expanded level of care to patients coming to the Medical Center for diagnosis and treatment.

- Goal 1 – Implement a carefully conceived plan to build new accommodations for digestive health, cancer care, and ambulatory surgery while keeping the hospital operating, and vehicular traffic moving.
- Goal 2 – Continue to engage the residents of the neighborhoods around the hospital about expansion plans.
- Goal 3 – Make temporary changes to the existing buildings' use, as indicated, to bridge time until the new facility opens.
- Goal 4 – Plan a transition process engaging all clinical and support departments.
- Goal 5 – Relocate departments to the new facility by October 31, 2015.

Modernization note: Most of the Project (97 percent) involves new construction. The only modernization construction proposed is to accommodate the corridor access on each level from the new facilities into the existing.

INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS

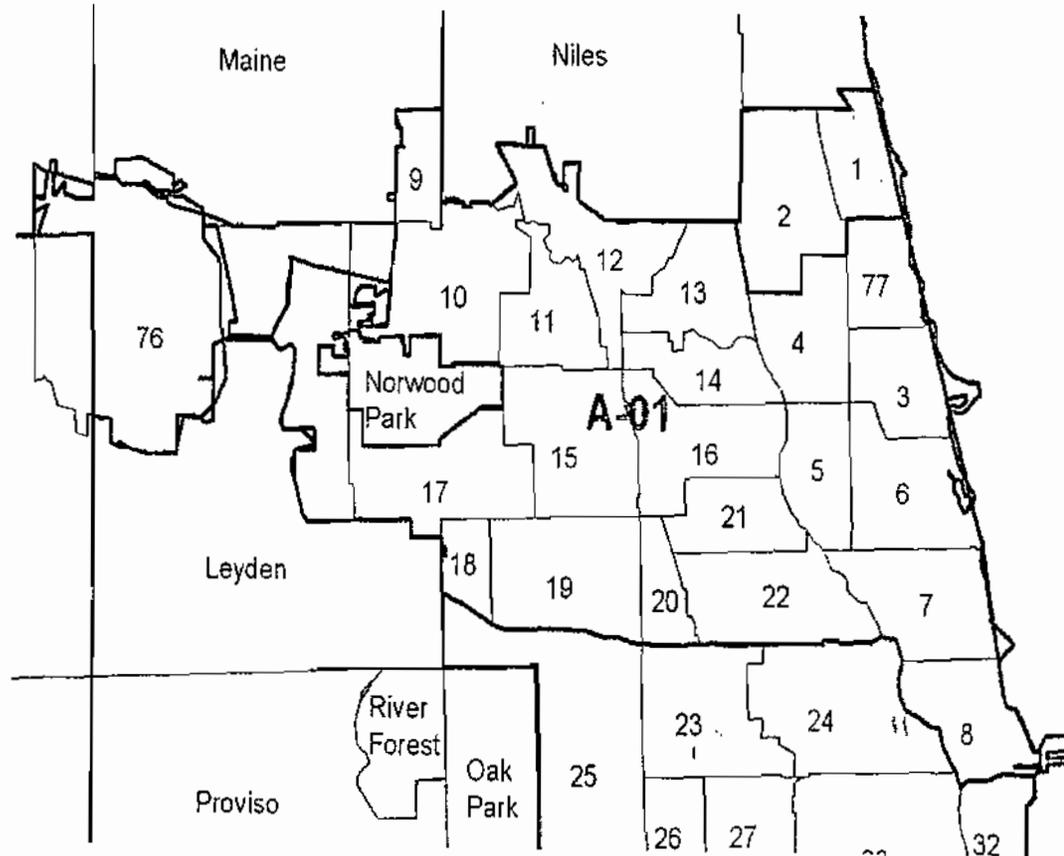
Illinois Department of Public Health
Illinois Health Facilities and Services Review Board

29-Jul-11
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PLANNING AREA A-01

Chicago Community Areas

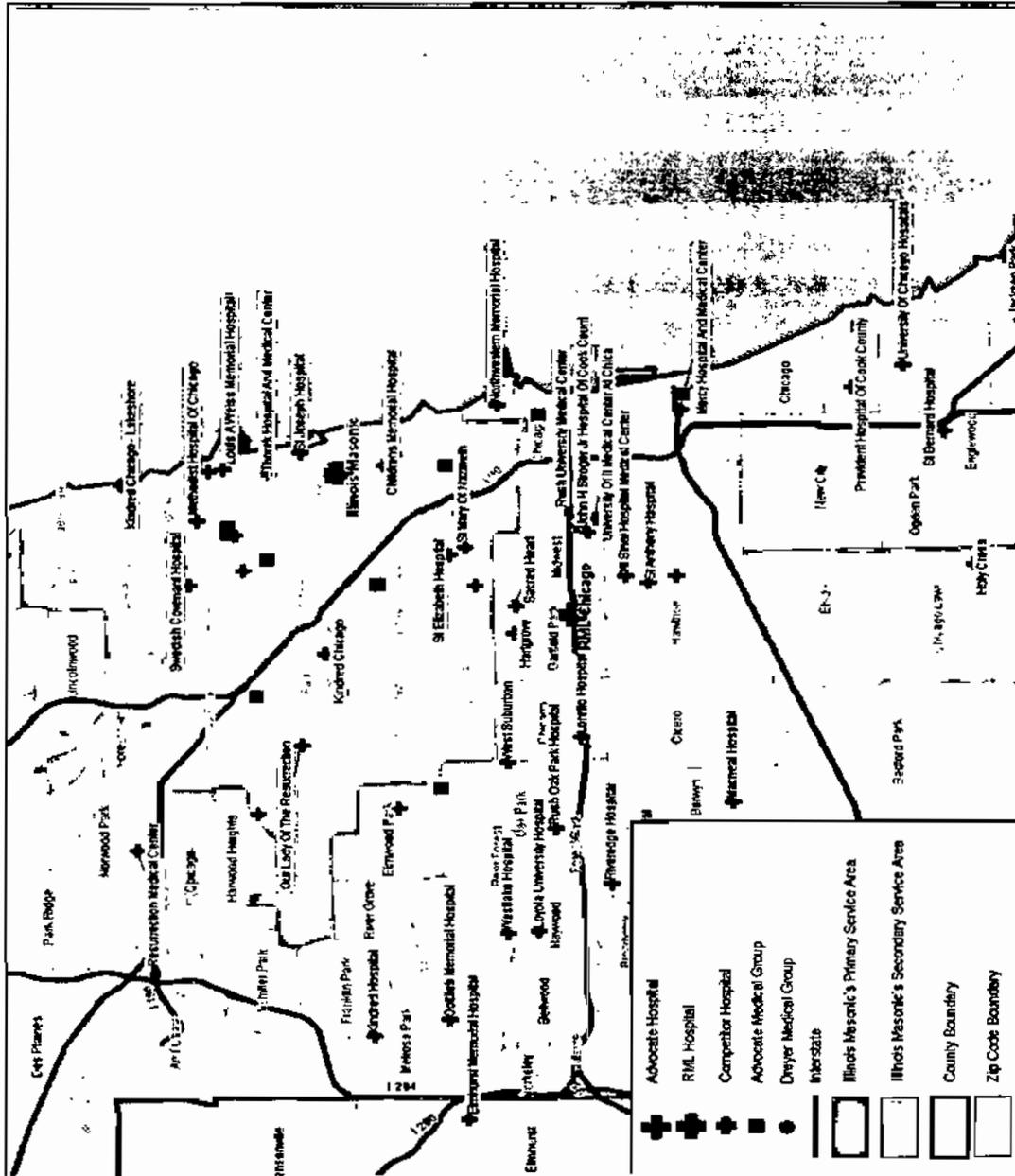
- 3 - Uptown
- 4 - Lincoln Square
- 5 - North Center
- 6 - Lakeview
- 7 - Lincoln Park
- 8 - Near North Side
- 9 - Edison Park
- 10 - Norwood Park
- 11 - Jefferson Park
- 12 - Forest Glen
- 13 - North Park
- 14 - Albany Park
- 15 - Portage Park
- 16 - Irving Park
- 17 - Dunning
- 18 - Montclare
- 19 - Belmont Cragin
- 20 - Hermosa
- 21 - Avondale
- 22 - Logan Square
- 76 - O'Hare
- 77 - Edgewater



IHFSTRB Planning Area A-01 Map

Advocate Illinois Masonic Medical Center–Service Area Map

Advocate Illinois Masonic Medical Center Service Area



Advocate Illinois Masonic Medical Center Patient Origin

2011 Inpatient Data			
Planning Area	Zip Code	Total Discharges	%
A-01	60610	184	
A-01	60611	28	
A-01	60613	712	
A-01	60614	1,251	
A-01	60618	1,653	
A-01	60622	263	
A-01	60625	745	
A-01	60630	330	
A-01	60631	41	
A-01	60634	383	
A-01	60639	738	
A-01	60640	993	
A-01	60641	855	
A-01	60642	72	
A-01	60646	84	
A-01	60647	986	
A-01	60654	17	
A-01	60656	69	
A-01	60657	1,335	
A-01	60659	245	
A-01	60660	473	
A-01	60666	1	
A-01	60707	141	
A-01 Total		11,599	67.9%
Other PSA/SSA	60608	114	
Other PSA/SSA	60623	120	
Other PSA/SSA	60626	437	
Other PSA/SSA	60629	134	
Other PSA/SSA	60632	103	
Other PSA/SSA	60645	235	
Other PSA/SSA	60651	313	
Other PSA/SSA		1,456	8.5%
All Other		4,031	23.6%
IMMC Total		17,086	100.0%

2011 Outpatient Data			
Planning Area	Zip Code	Total Visits	%
A-01	60610	1,984	
A-01	60611	516	
A-01	60613	6,947	
A-01	60614	7,320	
A-01	60618	15,832	
A-01	60622	2,726	
A-01	60625	7,643	
A-01	60630	4,044	
A-01	60631	555	
A-01	60634	4,925	
A-01	60635	17	
A-01	60639	7,285	
A-01	60640	7,728	
A-01	60641	8,555	
A-01	60642	817	
A-01	60646	925	
A-01	60647	9,839	
A-01	60654	315	
A-01	60656	848	
A-01	60657	11,583	
A-01	60659	2,292	
A-01	60660	4,254	
A-01	60707	1,493	
A-01 Total		108,443	69.8%
Other PSA/SSA	60608	1,111	
Other PSA/SSA	60623	955	
Other PSA/SSA	60626	3,998	
Other PSA/SSA	60629	1,270	
Other PSA/SSA	60632	1,301	
Other PSA/SSA	60645	2,387	
Other PSA/SSA	60651	2,938	
Other PSA/SSA		13,960	9.0%
All Other		33,035	21.3%
IMMC Total		155,438	100.0%

PSA=Primary Service Area SSA=Secondary Service Area

Source: AIMMC Records Note these are inpatient discharges, which may vary from admissions during the same period

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

ALTERNATIVES	
1)	Identify <u>ALL</u> of the alternatives to the proposed project: Alternative options <u>must</u> 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.	

Starting in 2009, Advocate Illinois Masonic Medical Center embarked on a strategic plan to address programs of service and a Facility Master Plan was completed in 2010 to accommodate the programs. Consultants were engaged to assist with the assessment. The conclusions of administration were as follows:

- There was an immediate need to right size currently undersized areas and improve functionality and connectivity.
- Investments in the facility were needed to support the incremental growth forecasted.
- The surgical procedure (endoscopy) rooms and the surgical operating rooms require development of an interventional platform with new capacity that meets physician needs and operational efficiencies. Digestive Health service line enhancements cannot be achieved in the current outdated and undersized endoscopy suite.
- Five of eight buildings in the main hospital were deemed “not worthy of further investment” in terms of their physical/structural grade due primarily to their age, design, building systems, and lack of functional space.
- As a result, Advocate Health Care has approved a capital budget allocated to this project, which is proposed with the potential to add additional floors on top and can expand to the west. No other buildable land contiguous to the Medical Center is available, therefore this Project must provide for those eventual campus plan needs. These future expansion plans have not been funded at this time, however they are intended to address the age of the physical plant. Specific components of this Project and their related costs have been incorporated to assure the feasibility of future phases. See Attachment #42 for more details.

1. Over the course of time, there were several alternatives considered.

Alternative One – 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

A possible option was to build or purchase clinical space in various locations in joint ventures with physicians that use the service. An analysis of this option revealed the inefficiencies that would occur if clinical services were divided among various remote sites such as freestanding ambulatory surgical treatment centers and/or independent cancer centers. By putting the services in various locations, physicians would find it harder to confer on challenging cases. Overhead costs would increase as staff, support services, equipment, supplies, records, and common public areas would not be shared. They could not maximize use of specialty staff and testing equipment. It would also be harder for patients to find the location of various buildings rather than sending them to one location.

Cost: The cost was not explored because the option was not viable.

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

The option to refer ambulatory surgery, endoscopy, and cancer cases to another hospital in the service area was not feasible. The physicians seeing these patients are principally located near Advocate Illinois Masonic Medical Center. The Creticos Cancer Center is a significant provider of cancer treatment for the region and would have to send those patients a distance to find comparable service. The patients have a long established pattern of coming to the Medical Center for their comprehensive care.

Cost: No construction cost, but would experience a significant loss of patients

Alternative Three — Proposing a Project of greater scope and cost

A detailed plan was proposed, developed, and considered in 2009 to build a 393,839 square foot, ten story facility adjoining the existing hospital and relocate the following areas:

- Emergency Department
- Mother/Baby Center
- Labor/Delivery
- NICU/Level 2 Nursery
- Obstetric Triage
- Surgical Suite
- Post-Acute Care Unit
- Same Day Surgery
- Intensive Care Unit
- Medical/Surgical (2 floors)
- Support Areas:
 - Central Sterile Processing
 - Respiratory Therapy

- Pharmacy
- Medical Imaging
- Interventional Suite
- New Lobby

Economic conditions resulted in uncertainty about this significant an undertaking and the plan was abandoned for a scaled down project.

Cost: \$310,911,610

Alternative Four — Proposing a Project of lesser scope and cost

In 2011, consideration was given to constructing an outpatient diagnostic and treatment center for digestive health and ambulatory surgery, and relocating the radiation therapy, leaving the medical oncology in the current site across the street from the hospital. The plan was expected to cost \$83,784,000. This plan was ultimately rejected because it divided the key elements of the cancer program, and left 60 percent of the program still remote from the hospital and unable to take advantage of integrated care that is so important to progressive programs.

Cost: \$83,784,000

Alternative Five – Build a new Center for Advanced Care

This option was selected as it allowed the organization to focus its time, energy, and money on getting the programs and services in one setting connected to the existing hospital. This setting would allow for easier patient access, adequate space for newer treatment modalities, and economies of operations. The location selected is highly visible, and accessible to patients and physicians. Furthermore, the site development would be a platform for an eventual replacement of older sections of the existing hospital.

Cost: \$109,248,973

2. Alternatives

Alternative	Description	Patient Access	Quality	Cost	Financial Benefit, Short Range	Financial Benefit, Long Range	Conclusion
1.	Develop stand-alone facilities on sites remote from the hospital	Would involve trips to multiple sites for diagnosis and treatment	Would forgo the advantage for physicians to easily confer	Cost not pursued because not a viable option.	May be able to have joint ownership with physicians in operating the facilities	Would be more costly to operate in various locations, lose advantage of shared staff, support systems	Rejected
2.	Refer patients to other hospitals	Worse, as they would lose their physicians and may have to travel farther.	Worse, as the physicians would not be able to follow their patients.	0 construction costs	Would forgo the construction cost	Would see a significant loss of patients	Rejected
3.	Build a 10 story facility to house 15 departments, including relocating the Emergency Department	Improved	Improved	\$310,911,610	The immediate impact would be a significant investment.	The status of the economy made it harder to forecast the return of such a large investment.	Rejected
4.	Build a facility for Outpatient Surgery, Endoscopy, and the Linear Accelerator while leaving medical oncology remote from the hospital	Problems with access to the existing hospital would continue for medical oncology cancer patients.	The advantages of bringing medical oncologists together with all other physicians would be lost by not being in the same building.	\$83,784,000	The lower cost would be an immediate benefit	This plan would postpone the inevitable expense to add on space to bring medical oncology together with the rest of the three programs.	Rejected
5	Build new facility adjoining the hospital for digestive health, ambulatory surgery, and the Creticos Cancer Center, along with office space for the physicians	Improved by consolidating outpatient services from the hospital and various other locations.	Care significantly improved by having these programs integrated	\$109,248,973	Can build on the synergy by having clinical services and practices in one location, shared staff and support	Can get structure and utilities properly designed and built for both the immediate and future hospital needs	✓ Accepted

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

The recognition for high quality patient care has been given in many ways by outside, independent organizations. The Medical Center has been acknowledged in the following ways:

- **For the third year in a row, Advocate Illinois Masonic Medical Center has been selected by Thomson Reuters as one of the 100 top hospitals in the nation, and is the only hospital in Chicago to receive this distinction in 2012.**
- The Medical Center has also been chosen by Thompson Reuters as one of the 15 best teaching hospitals.
- Recipient of Magnet status for excellence in nursing services by the American Nurses Credentialing Center in 2008 (currently in process of recertification).
- Ranked one of the 50 Best Hospitals in America by *Becker's Hospital Review* in 2011.
- 2010 Everest Award winner from Thomson Reuters.
- Only Chicago hospital to earn the EPA's ENERGY STAR designation, three years running.
- Ranked one of Chicago's Best Hospitals in 2010 and 2011 by *U.S. News & World Report*.
- Recipient of Morehead Associates Workplace of Distinction Award for 2009.
- Recipient of the Medal of Honor from the U.S. Department of Health and Human Services for an organ donation rate of 75 percent or more of eligible donors.
- Chicago's only POD hospital for the Illinois Department of Public Health—one of only 11 in the state.
- Recipient of the Human Rights Campaign (HRC) Foundation award as one of only two hospitals in Illinois — and one of only eight nationwide — as a top performer in the organization's Healthcare Equality Index (HEI). Illinois Masonic earned top marks for its treatment of lesbian, gay, bisexual and transgender patients and staff.
- Consistently ranked in the top 25 of Chicago's largest hospitals by *Crain's Chicago Business*.

The quality of patient care is shown in the programs provided:

- One of the state's largest non-university medical teaching programs affiliated with University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University and Midwestern University.
- Accredited by the American College of Radiology in mammography, breast ultrasound with ultrasound guided biopsy, and OB, gynecological and general ultrasound.
- Accredited with commendation by the American College of Surgeons Commission on Cancer.
- Women's Center for Continence and Pelvic Medicine for surgical and non-surgical treatments provided by Advocate Medical Group (AMG).
- Acute care geriatric unit and cardiac rehabilitation services.
- Neonatologists/Neonatal Intensive Care Unit for high-risk mothers and critically ill babies.
- One of Chicago's largest and most experienced certified nurse midwifery programs (AMG).
- Behavioral Health Center for substance abuse, crisis intervention and multilingual psychiatric services.
- Partnership with the Rehabilitation Institute of Chicago for acute rehabilitation care including advanced physical, occupational and speech therapies, and audiology services.
- Unique nurse residency to assist nurses in the transition from novice to skilled as they begin their professional role.

Advocate Health and Hospitals Corporation (AHHC) was also recognized in 2009, 2010, and 2011 as one of the 10 Top Hospital Systems in the nation. To carry out this pattern of providing the best care, AHHC has established a system-wide monitoring mechanism to track the quality of care provided by Advocate hospitals. Advocate Illinois Masonic Medical Center (Medical Center) takes full advantage of the many monitors to learn about care given at its site, and explores ways across the system of 10 hospitals to find the best demonstrated practice.

To track month to month quality care, Advocate measures such indicators as

- AdvocateCare Index
- Health Outcomes Score
- Complication Index
- Mortality Index
- Length of Stay Days (med/surg)
- Acute Care Readmission Percent
- Clinical Integration Physician Hospital Organization Score
- Healthcare Quality Alliance (HQA) Composite Score*
- Elective Inductions (37-38 weeks) Rate
- ICU Ventilator Days Index
- Society of Thoracic Surgeons Composite Star Rating
- Meaningful Use Compliance

*As an example of the detail in each of the monitors above, the HQA Composite score is made up of the following measures:

- Aspirin prescribed at discharge
- Coronary intervention within 90 min of arrival
- Statin prescribed at discharge
- All discharge instructions given
- Left Ventricular Function assessment
- ACE Inhibitor for Left Ventricular Systolic Dysfunction
- Blood culture 24 hrs prior to/after arrival-Intensive Care Unit
- Blood culture in Emergency Department prior to antibiotic
- Antibiotic selection for non-ICU patients
- Antibiotic within one hour of incision - Overall
- Antibiotic selection - Overall
- Antibiotic discontinued within 24 hrs - Overall
- Cardiac patients 6 am post operative serum glucose
- Appropriate beta blocker therapy
- Recommended venous thromboembolism prophylaxis ordered
- Appropriate beta blocker therapy prophylaxis within 24 hrs prior to/after surgery
- Urinary catheter removed on post-operative day 1 or post-operative day 2
- Perioperative temperature management

Each month's results are reviewed at both the system level and the hospital administrative level. The results are shared with the management team, physicians, and staff to determine how to further improve on outcomes. The programs that are planned to go into the proposed Center for Advanced Care will be monitored with the same intense scrutiny to assure the best care is given.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - 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.
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;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

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.

Size of the Project

The table below demonstrates the proposed Project has met State Standards for physical space for all departments that are regulated regarding size.

Size of Project

Department/Service	Proposed DGSF	State Standard	Difference	Met Standard?
Surgery Operating Rooms	43,676 DGSF/ 18 ORs = 2,426 DGSF per OR	2750 DGSF per OR	-324	Yes
Surgery Procedure Rooms (Endoscopy)	6,559 DGSF/ 6 Rms = 1,093 DGSF per Rm	1,100 DGSF per Procedure Rm	-7	Yes
Phase II Recovery	18,727 DGSF/49 Stations = 382 DGSF per Station	400 DGSF per Recovery Station	-18	Yes
Infusion Therapy	5,721 DGSF/ (27,129 equivalent visits/2,000) = 422 DGSF per 2,000 visits	800 DGSF per 2,000 visits	-378	Yes
Pre-Surgical Care	1,574 DGSF/ (4,491 visits/2,000) = 701 DGSF per 2,000 visits	800 DGSF per 2,000 visits	-99	Yes
Mammography, Dedicated for Surgical Needle Localization Only	338 DGSF /1 unit	900 DGSF per unit	-562	Yes
Linear Accelerator	4,752 DGSF/ 2 units = 2,376 DGSF per unit	2,400 DGSF per unit	-24	Yes
CT Simulator	1,663 DGSF/1 unit = 1,663 DGSF	1800 DGSF per unit	-137	Yes

Source: AIMMC records and Project design

Size of Ambulatory Care Departments

There are two ambulatory care departments planned to go in the proposed Center for Advanced Care: Infusion Therapy and Pre-Surgical Care.

The State Standard is 2,000 visits per year per 800 GSF for Ambulatory Care Services. According to this standard, the term ambulatory care means medical care including the diagnosis, observation, treatment, or rehabilitation that is provided on an outpatient basis. Ambulatory Care includes simple diagnostic procedures such as blood tests; it also includes more complex procedures, such as oncology infusion treatments. Since the guideline appears to cover a wide range of Ambulatory Care that is organized as a service, time per visit varies widely. The time to be processed for a blood test could be 30 minutes or less, while more complex ambulatory visits such as Infusion Therapy have an average time nationally of 3.5 hours.

The Medical Center assumed the average time for an ambulatory visit under the Section 1110. Appendix B guideline could be determined by using the same formula as used for surgery (the

only such calculation in the State Agency Rules) and the number of visits proposed per room. In section 1110.1540, the State Agency Rules propose the following formula for determining hours of operation per surgery room:

$$250 \text{ days per year} \times 7.5 \text{ hours per day} \times 80 \text{ percent occupancy} = 1,500 \text{ hours of surgery per room per year}$$

The Medical Center then divided the hours per room by the number of visits required to justify Ambulatory Care Service.

$$1,500 \text{ hours per room} \div 2,000 \text{ visits per room} = 0.75 \text{ hours or 45 minutes per visit}$$

By using these two factors - hours of time per room and number of visits per room – the Medical Center determined that the average time proposed by the State Standard for ambulatory care was 45 minutes.

Size of the Infusion Therapy Department

A typical Infusion visit at the Medical Center is 3.2 hours, significantly longer than the standard 45 minutes.

$$3.2 \text{ hours} \times 60 \text{ min/hour} = 192 \text{ minutes}$$

$$192 \text{ min} \div 45 \text{ min} = 4.3 \text{ times the standard Ambulatory Care visit}$$

$$6,309 \text{ visits} \times 4.3 = 27,129 \text{ equivalent visits}$$

The allowable size for Ambulatory Care is 800 DGSF/ 2000 visits

$$27,129 \text{ equivalent visits} \div 2,000 = 13.6 \times 800 \text{ DGSF} = 10,851 \text{ DGSF}$$

The actual size proposed for the Infusion Therapy Department is 5,721 DGSF, well below the allowable size. By efficient use of space, there will be 16 infusion stations in the department.

Size of the Pre-Surgical Care Department

Advocate Illinois Masonic Medical Center only in the past year has started a formal department to offer Pre-Surgical Care. For this reason, there is limited historical data of the patients needing this service. Historically, surgeons have their patients' testing done in their primary care physicians' offices or they are sent directly to the laboratory to get their tests completed.

A conservative estimate has been made of the demand for testing that will be done in a dedicated site that is easily accessible. The assumption is that Pre-Surgical Care will see half of those coming for ambulatory surgery/procedure, or coming on the same day as the surgery and expect to be admitted following the case. That assumption resulted in an expectation of 4,491 patients.

The department has been designed with two exam rooms and a share of a nearby waiting room for a total of 1,574 DGSF.

The allowable size for Ambulatory Care is 800 DGSF/ 2000 visits. Therefore, for Pre-Surgical Care, the allowable size would be:

$$4,491 \text{ visits} / 2,000 \text{ visits} = 2.2 \times 800 \text{ DGSF} = 1,760 \text{ DGSF}$$

The proposed size is 1,574, well below the allowable size.

Size of Mammography

The Medical Center currently offers a full range of breast screening and diagnostic procedures. Four mammography units, located on the second floor in a medical office center adjoining the hospital, are used to provide that service. In addition to all the screening and diagnostic work, a patient who is headed to surgery for a breast biopsy or lumpectomy is also sent to the mammography department to have a locator needle placed in the breast at the exact site of the area in question or tumor. That needle is used to guide a surgeon to the site to excise.

In the future, the proposal is for those surgical cases to be done in the new Center for Advanced Care, as they are usually done as an outpatient. However, the distance from the existing mammography units would mean patients would need to travel through the medical office building, then through the hospital and connecting corridors to the proposed surgery suite with a needle in their breast. Patient safety and privacy would be compromised as a result. For the patient who is already apprehensive and afraid, this approach and long transport from one area to another is unexceptionable.

Relocating one of the four units was considered, but all four will be needed to take care of screening and diagnostic procedures. If only one unit were relocated, that would require a portion of the screening work to be done in the Center for Advanced Care and duplicate all of the patient education program that is working well in the women's imaging center.

To address this, the Medical Center is proposing to add one mammography unit, dedicated to supporting surgery by performing the needle localizations close to surgery so no patients will need to travel in public corridors in the midst of procedures.

The allowable size for a mammography unit is 900 GSF/unit. The proposed unit will be only 338 GSF, well below the allowable size, but sufficient for the purpose of needle localizations.

Size of Brachytherapy

There are no State standards for the size of a Brachytherapy service. Brachytherapy is the clinical use of small, encapsulated radioactive sources at a short distance from the target for irradiation of malignant tumors or non-malignant lesions. The Medical Center has been leasing the service and equipment is brought in for each patient when the order is given.

The procedure has been done in the linear accelerator room in the existing Creticos Cancer Center, causing that room to not be available for patients needing traditional radiation treatment. There are certain forms of cancer that respond best to implanted radiation, and an important option for oncologists. Recently, there is growing interest in using Brachytherapy for reducing restenosis

after treatment for vascular diseases. Compared to conventional external beam therapy, the physical advantages of Brachytherapy result from a superior localization of dose to the tumor volume.

In the proposed Center for Advanced Care, a room has been designed to accommodate Brachytherapy, with patient toilets, dressing area and support space. The unit will still be leased, for the foreseeable future, until demand shows the importance of having a unit on site. The department has been designed to be easily accessible for both equipment to be brought in, and patient to access the service.

In the absence of State Standards, direction was obtained from the Facility Guidelines Institute publication, *The Guidelines for Design and Construction of Health Care Facilities*, 2010 edition. In addition, design information was available from the American Association of Physicists in Medicine (AAPM) which helped predict the space needed for treatment planning and delivery equipment, and dedicated space for high dose-rate Brachytherapy treatment. Patient dressing rooms, toilets, care team station, patient prep and waiting are needed, too.

The size of the Brachytherapy will be 2,046 GSF.

Size of the Pharmacy

The Pharmacy size is not defined in Appendix B, so the design has been guided by the American Institute of Architects, Academy of Architecture for Health, a noted resource and authority. The Facility Guidelines Institute publication, *The Guidelines for Design and Construction of Health Care Facilities*, 2010 edition, was consulted.

This Pharmacy service will be located in the Infusion Therapy Center and will prepare infusions and other medications for oncology patients. It is proposed to have 5 small rooms: chemo prep (145 GSF), IV prep (79 GSF), med prep (107 GSF), a workroom for processing orders for infusions, records, shipments of meds (269 GSF), and an ante room (65 GSF) to secure the area as it will contain highly toxic medications. See Attachment 37, F for details.

Size of Satellite Pharmacy

Dept. / Area	Proposed DGSF	Basis for Size
Pharmacy, Satellite	665 DGSF	Space needed to process an average of 3 medications per patient x 6,309 patients)

Source: AIMMC records.

Size of Non Clinical Departments/Areas

The size of the physicians and multidisciplinary team office space (17,184 new DGSF, total proposed 37,266 DGSF) was determined by the patient volume, and number of physicians and professional staff expected. Significant consideration was given to the way patient registration

will be handled and patient throughput time of each physician to determine the number of exam, consultation, and support rooms required.

Patient Education, Research Center, and Conference Room size (2,373 new DGSF, 15,501 total proposed DGSF) and location were based on the support to be provided to the departments, patient education offerings, medical staff, residents and fellows needs, and staff that would use the spaces.

The area of Public Lobby, Waiting, Toilets, Stairs, Elevators, Corridors, (25,852 new GSF, total proposed 185,852 GSF throughout the whole hospital) was determined by Code, as well as volume of patients, visitors, and staff moving through the area.

The modernized Corridors (connectors) are sized (4,300 GSF) to serve as the connections between the Center for Advanced Care and the main building of the existing hospital (also known as the Stone building).

The Mechanical/Electrical/Plumbing space was sized (6,411 new DGSF, Total proposed 29,160 DGSF) by engineers to accommodate the HVAC, electrical systems, medical gases equipment, emergency generators, water and sewer service, auxiliary equipment, and operational support needed.

The Crawl Area (11,086) is unfinished, gravel based, unconditioned and inaccessible. It is located under the first floor of the south section of the Center for Advance Care.

The Penthouse (17,656 DGSF) is the rooftop location of the air handlers and other large mechanical equipment needed to support the building.

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.

The proposed Project involves six departments for which the IHFSRB has established utilization standards:

1. Surgical Operating Suite (Class C)
2. Surgical Procedure Suite (Class B)
3. Infusion Therapy (Ambulatory Care)
4. Pre-Surgery Care (Ambulatory Care)
5. Mammography
6. Linear Accelerator

The utilization of each service has been projected to 2017, two years after the Project is expected to be completed. Four of the departments have reported utilization as a component of the Annual Hospital Questionnaire (AHQ).

Infusion Therapy and Pre-Surgical Care are not a part of the AHQ so it was necessary to rely on internal sources to predict utilization. Infusion Therapy was able to provide reliable data from 2009 that shows their trend in growth. The Medical Center has just recently started to offer structured Pre-Surgical Care so there is no long history. That required some conservative assumptions to be made about how many patients would be seen in that service.

One Mammography unit is proposed to be located close to surgery, and only used for needle localizations. The demand for the current four mammography units supports their remaining in the existing women's health center to be used for screening and diagnosis. Because of the distance between the current units and the new surgery and the need to traverse public corridors, it is not medically advisable to move a patient with a needle in the breast that far. Therefore, the need for a separate mammography unit dedicated to needle localizations is warranted.

The details of each department's utilization is found in Attachment 37

Projected Services Utilization

Department/ Service	Historical Utilization (Hours, visits)		Projected Utilization (Year two)	State Standard	Number Requested	Met Standard ?
	2010	2011	2017			
Surgery Operating Suite, hours	23,642	22,534	27,520	$27,520 / 1,500 = 19$	18 rooms	Yes
Surgery Procedure Suite, hours	3,881	3,487	8,246	$8,246 / 1,500 = 6$	6 rooms	Yes
Infusion Therapy, equivalent visits	19,303	19,801	27,129	$27,129 / 2,000 = 13.6 \times 800 \text{ sf} = 10,851 \text{ DGFSF}$	5,721 DGFSF	Yes
Pre-Surgical Care, visits	Not in operation	3,455	4,491	$4,491 / 2,000 = 2.2 \times 800 \text{ sf} = 1,760 \text{ DGFSF}$	1,574 DGFSF	Yes
Mammography, Dedicated Needle Localization, cases	64	75	260	$260 / 5,000 = 0.1 = 1$	1 unit	Yes
Linear Accelerator, treatments	6,466	8,084	19,775	$19,775 / 7,500 = 2.6 = 3$	2 units	Yes

Source: Annual Hospital Questionnaire, AIMMC

R. Criterion 1110.3030 - 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
<input checked="" type="checkbox"/> Surgical Operating Rooms	16	18
<input checked="" type="checkbox"/> Surgical Procedure Rooms (GI)	4	6
<input checked="" type="checkbox"/> Phase II Recovery	19	47
<input checked="" type="checkbox"/> Infusion Therapy	12	16
<input checked="" type="checkbox"/> Pre-Surgical Care	0	2
<input checked="" type="checkbox"/> Mammography, Dedicated Needle Localization	0	1
<input checked="" type="checkbox"/> Linear Accelerator	1	2
<input checked="" type="checkbox"/> CT Simulator	1	1
<input checked="" type="checkbox"/> Brachytherapy	0	1

See text for more detail

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

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility
APPEND DOCUMENTATION AS <u>ATTACHMENT-37</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria
Advocate Illinois Masonic Medical Center
Center for Advanced Care

List of Clinical (Reviewable) and Non Clinical (Non Reviewable) Departments and Areas

Clinical Service Areas (Reviewable)

- A. Surgery
 - 1. Surgical Operating Suite (Class C) (Ambulatory Surgery)
 - 2. Surgical Procedure Suite (Class B) (Gastrointestinal Endoscopy)
 - 3. Phase II Recovery
- B. Ambulatory Care Services
 - 1. Infusion Therapy
 - 2. Pre-Surgical Care
- C. Diagnostic and Interventional Radiology
 - 1. Mammography (Dedicated Surgical Needle Localization Only)
- D. Therapeutic Radiology
 - 1. Linear Accelerator
 - 2. CT Simulator
 - 3. Brachytherapy
- E. Pharmacy, Satellite

Non Clinical Departments (Non Reviewable)

- F. Physicians and Multidisciplinary Team Offices (Timeshare Space, Exam, and Consultation Rooms)
- G. Patient Education, Resource Center, & Conference Rooms
- H. Public Lobby, Waiting, Toilets, Stairs, Elevators, & Corridors
- I. Corridors, Modernized (Connectors)
- J. Mechanical, Electrical, Plumbing
- K. Crawl Area
- L. Penthouse (Air Handlers, Chillers, Pumps)

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Surgical Operating Suite (Class C)

Clinical List Designation A-1

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not replace surgery operating rooms or equipment that have deteriorated.

2. Necessary Expansion

In 2009, long range planning was initiated to address program and facilities needs at Advocate Illinois Masonic Medical Center. Through an in-depth review process it was determined there was a need to remove the outpatient surgical population from the inpatient environment in order to improve the patient experience and operational efficiencies. The following reasons were cited:

- Decant outpatient services from departments that are currently over capacity limits and undersized, allowing for decompression of these departments and additional outpatient/inpatient growth.
- Provide an enhanced outpatient experience with easy access via a separate entrance.
- Create a flexible and efficient interventional platform for outpatient operating rooms designed on a single floor that will be more efficient and flexible through the use of “universal” operating rooms.

The existing Surgery Department is located in the Stone building, the main section of the hospital, constructed in 1970. As other components were added, they were located on several floors and buildings causing significant inefficiencies and delays. The current general operating rooms are on the third floor of the Stone building. The eye surgery suite is remote from rest of surgery, in a section closer to the ophthalmologists. The same day surgery unit is located on the fifth floor in the Stone building. By having these services separated, there are major barriers to achieving efficiency of procedures and improved patient/family centered service.

Due to the outmoded design of the Surgery Department, consultants have observed that:

- The operating rooms are not large enough to adequately support current technology or equipment that is less invasive, improves patient recovery period and reduces the length of the procedures.
- A single elevator transports patients from Same Day Surgery to the operating room and back. This elevator has frequent interruptions in service and impacts the operating room schedule, affects surgical flow efficiencies, and patient care.
- Surgeons and anesthesiologists cannot move easily between levels of care without special gowning, creating frustrations and interruptions in case start times.

- Lack of sufficient Phase II recovery rooms impacts patient recovery during the post operative period when it causes a bottleneck in the patient flow, increasing the time a patient is cared for in an area with a higher acuity than necessary, and also causes privacy issues.

The accelerating trend toward ambulatory surgery is an important change in industry standards. In medical centers such as Advocate Illinois Masonic Medical Center, where the inpatient and outpatient cases are mixed, trauma and other emergency surgical cases take precedence over elective outpatient cases. Consequently, outpatient cases are delayed and may even be rescheduled. On average this occurs at the Medical Center at least once a week, affecting elective surgery.

The scope of operative services offered at the Medical Center expanded in 2010 as two established neurosurgeons, a new oncology surgeon, and a vascular surgeon were recruited. Each of these surgeons elevated the complexity level of surgery offered at the Medical Center and had a positive impact on surgical volume in their respective specialty area. Their projected volume and expertise is shown below.

Recruited Neurosurgeons

Service	Primary Physician	2010 (Sept Start)	2011	2012 YTD (Jan-June)	Projected 2012	
		Total Cases	Total Cases	Total Cases	Projected Cases	Projected Volume Increase 2011 to 2012
Neuro	Muro-MD, Kenji	19	94	61	120	28%
Neuro	Song-MD, John K	25	121	79	146	21%
Total		44	215	140	266	24%

Source: AIMMC

Dr. Muro and Song both perform cranial and spine neurosurgery. Dr. Song specializes in minimally invasive spine fusion surgery which has attracted a new, younger patient population. Dr. Muro is a renowned cranial neurosurgeon who studied at The Johns Hopkins School of Medicine. His use of image guidance and fluorescence technology during intracranial vascular surgery offers the Medical Center patients the latest in neurosurgical technology. He has partnered with the Creticos Cancer Center to expand neurosurgery service to include therapeutic radiology procedures utilizing stereotaxy and the linear accelerator for intracranial tumor treatment and ablation.

Recruited Vascular Surgeon

		2011 (June Start)	2012 YTD (June)		Projected 2012
Service	Primary Physician	Total Cases	Total Cases	Percent Increase from half of 2011 to half of 2012	Projected Cases
Vascular	Keldahl-MD, Mark	70	102	46%	192

Source: AIMMC

Dr. Mark Keldahl took his fellowship at Northwestern Memorial Hospital, where he specialized in vascular and endovascular surgery. Dr Keldahl is leading the expansion of the endovascular surgery program which was not available at the Medical Center prior to his arrival. Dr. Keldahl has also partnered with interventional radiology to increase outpatient volume providing a new minimally invasive vascular service line to the community. Dr. Keldahl is fluent in Spanish which is a huge asset to the community outreach program.

Recruited General Oncology Surgeon

		2010 Oct Start	2011	2012 YTD (June)	Projected 2012	
Service	Primary Physician	Total Cases	Total Cases	Total Cases	Projected Cases	Projected Volume Increase for 2012
Gen. Surg	Maker-MD, Ajay	13	106	71	132	25%

Source: AIMMC

Dr. Ajay Maker was recruited after his advanced training program and fellowship in Surgical Oncology at Memorial Sloan-Kettering Cancer Center, New York, NY. Additional residency training in General Surgery was conducted at Brigham and Women's Hospital/Harvard Medical School. Dr. Maker's specialization is in General Surgical Oncology. He has created a target market that has brought additional volume to both the Creticos Cancer Center and the surgery area. His isolated limb perfusion has brought him television exposure and new patients to the Medical Center and the Creticos Cancer Center.

Due to Dr. Makers oncology expertise, there will be a two way referral base with the center for digestive diseases. More patients will be treated locally and no longer have to leave the Medical Center for treatment, creating a more comprehensive treatment facility.

Each of these newly recruited surgeons have brought with them new minimally invasive procedures which have increased outpatient volume.

National health care reform will prompt a significant change in industry standards. The newly insured population will have improved access to health care. This increased access to care will likely result in the discovery of more previously undiagnosed conditions that will require surgery. There will be an incentive to treat "preventable hospital admissions" on an outpatient basis. Some surgical procedures currently provided in the inpatient setting will migrate to the outpatient setting.

3. Utilization

A) Major Medical Equipment

N/A. There is no surgery equipment in this Project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

Current Utilization

The utilization of the Medical Center's current operating room complement of 16 rooms is already meeting State Standards and does not leave room for changes in health care that will influence growth in surgery in the future.

Surgery Historical Utilization

Department	Historical Utilization						Annual Increase Projected
	2007	2008	2009	2010	2011	change 2007-2011	
Surgery Hours	21,123	21,626	24,018	25,224	23,970	13.48%	3.37%

Source: Annual Hospital Questionnaires for AIMMC

$$23,970 \text{ hours in 2011} \div 1,500 \text{ hours/room} = 16 \text{ rooms}$$

Projected Utilization

To prepare for anticipated growth, the Medical Center is recommending the following:

Propose one OR be reclassified as a Procedure Room

A close review of all the operating rooms was done and the applicants are recommending that the Urology OR in the current operating room inventory be reclassified as a surgical procedure room for cystoscopy. The actual use of the room has been for cystoscopy cases and in the future should be identified as a Cystoscopy Procedure Room.

In order to see the impact on the remaining OR historic utilization the following calculation was made

Adjusted Surgery Historical Utilization

Department	Historical Utilization						Annual Increase Projected
	2007	2008	2009	2010	2011	change 2007-2011	
Surgery Hours	21,123	21,626	24,018	25,224	23,970	13.48%	3.37%
Less Urology hours (reclassify: Cysto)	1,278	1,635	1,650	1,582	1,436	12.36%	3.09%
Revised Surgery hours	19,845	19,991	22,368	23,642	22,534	13.55%	3.39%

Source: Annual Hospital Questionnaires for AIMMC

The projected utilization of the revised surgery hours, without the Urology hours, using the CAGR method, revealed the following:

Surgery Projected Utilization

CAGR Projected Utilization						
Annual Increase Projected	2012	2013	2014	2015	2016	2017
3.39%	23,297	24,087	24,902	25,746	26,618	27,520

Source: AIMMC

$$27,520 \text{ hours in 2017} \div 1,500 = 18.1 = 19 \text{ rooms}$$

This calculation demonstrates that the historic inventory of 16 ORs for general and eye surgery is certainly not in a position to handle continued growth. Advocate Illinois Masonic Medical Center has recently recruited a Surgical Oncologist, two Neurosurgeons, a Peripheral Vascular Surgeon, and a Colorectal Surgeon. It is imperative that these new surgical specialty physicians have the facilities and equipment needed to serve their patients.

To prepare for the projected growth, the following additional changes are recommended:

Propose three ORs be vacated

Further analysis of the operating room inventory indicates that three more existing rooms should be taken out of inventory (vacated) and the space used for support of the remaining surgery operations. The vacated rooms will be two in the general OR suite and one in eye surgery. This plan is contingent on adding six new outpatient operating rooms in the Center for Advanced Care

The effect of the reclassification of the Urology OR to a Cystoscopy Procedure Room plus the vacation of 3 ORs reduces the existing total ORs from 16 to 12 rooms.

Propose the addition of 6 ORs

The Project proposes to add 6 ORs in the Center for Advanced Care. That would result in a total of 12 existing ORs plus 6 new ORs for a new total of 18 ORs.

While the projections based on the historic utilization anticipate the need for 19 ORs, to be conservative, **the Medical Center is requesting only 18 operating rooms**. These include the 12 rooms that will remain in the existing hospital and 6 additional new rooms in the Center for Advanced Care.

In looking ahead, the Medical Center contemplated a 15 percent growth factor to recognize the impact of national health care reform on future utilization, especially outpatient volume. This factor could increase the projected utilization to be 31,648 hours or the need for 22 rooms in 2017. That underscores the need for the proposed 18 rooms.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

N/A. There is a State Standard for Surgical Operating Suite (Class C). The projections show the Medical Center's volume will exceed that by the second full year of operation.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Clinical List Designation A-2

Surgical Procedure Rooms (Class B) Endoscopy

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

NA. The proposed Project will not replace facilities or equipment that have deteriorated. The Project will add 6 endoscopy rooms in the proposed Center for Advanced Care, and vacate the 4 rooms in the main hospital.

2. Necessary Expansion

Advocate Illinois Masonic Medical Center (Medical Center) has been performing endoscopy since the 1980s. The Surgical Procedure Suite has historically been the department where flexible endoscopy is used to look inside the body for medical reasons using a flexible endoscope (an instrument used to examine the interior of a hollow organ or cavity of the body). Unlike most other medical imaging devices, flexible endoscopes are inserted directly into the organ where direct line of-sight observation is not feasible. A fiber optic light delivery system illuminates the anatomy under examination. The image is projected onto a monitor for the physicians review and pictures can be taken immediately for patient education. A biopsy tool is used to obtain specimens for examination or a homeostasis instrument is used to cauterize bleeding vessels.

While endoscopy is a method to study various parts of the anatomy, such as the respiratory tract, urinary tract, and female reproductive system, the proposed Project will focus on the gastrointestinal (GI) tract. Some additional newer procedures that will be done in the proposed suite involve other digestive tract examination procedures in addition to endoscopy.

In 2009, the Medical Center embarked on a planning process to redefine its mission and vision as a vital community teaching hospital with select regional destination service offerings. Out of this redefinition emerged the need for a Digestive Health program. The goal for the destination programs is to serve the immediate community and provide unique services and offerings. To this end, the Digestive Health program meets specific needs of the patients in the Medical Center's community.

Thirty-one percent of the Advocate Illinois Masonic Medical Center patients identified themselves as Hispanic in 2010, compared to less than nine percent state-wide. Recent studies have identified an increase in digestive health problems among Hispanics. HealthDay News reported in the May 15, 2012 issue on a new study that shows black and Hispanic Americans are far more likely than whites to develop precancerous colorectal polyps.

Researchers analyzed data from more than 5,000 men and women aged 50 and older who had a first-time colonoscopy screening at New York-Presbyterian Hospital/Columbia University

Medical Center in New York City between 2006 and 2010. At least one precancerous polyp was detected in 26 percent of blacks, 22 percent of Hispanics and 19 percent of whites. The findings add to recent evidence that the rate of colorectal cancer among Hispanics may be increasing as they adopt more mainstream American lifestyle habits, the researchers said.

Advocate Illinois Masonic Medical Center sits within one of the largest lesbian, gay, bisexual, and transgender (LGBT) communities in the nation. Members of the LGBT community are at increased risk for a number of health threats when compared to their heterosexual peers, especially digestive diseases.

Because sexual orientation is not usually noted in the patient's record, it has been a challenge to measure the differences in health and associate it to sexual orientation or experiences. Feldman and Meyer reported in the *International Journal of Eating Disorders*, Vol 40, Issue 3, gay and bisexual men were 3.8 times more likely to have symptoms indicative of eating disorders compared to heterosexual men. *Healthy People 2010: Lesbian, Gay, Bisexual and Transgender Health* reported a cohort study of records in cancer registries found gay men to be at excess risk for anal cancer. The *Journal of American Academy of Nurse Practitioners*, 18, 2006, noted the anal cancer rate may be as high as 35 per 100,000 for men who have sex with men (MSM) compared to 0.9 per 100,000 for the general population. This is a population the Medical Center is proud to serve, but currently is not able to provide a full scope of resources required to meet the health needs of the community.

After identifying key needs in the Advocate Illinois Masonic Medical Center community, the following were the priority for Digestive Health:

- An advanced endoscopy center
- A focus on anorectal disease
- A focus on esophageal disease
- A range of services for inflammatory bowel diseases
- A men's health program

From these key findings, the Medical Center spent the rest of 2009 and 2010 doing further analysis which revealed the Medical Center has a good complement of 21 gastroenterologists who are on staff at Advocate Illinois Masonic. Ten gastroenterologists were responsible for 85 percent of the procedures. The major clinical gap at the time was the need for a colorectal surgeon.

In 2011, Advocate Medical Group recruited a fellowship trained colorectal surgeon, Joaquin Estrada, who was finishing his fellowship at Advocate Lutheran General. This was the first step in preparing to better manage the anorectal disease that is present in the service area. Dr. Estrada expects 10-15 percent of his procedures will be done in the Endoscopy Suite and the rest in the Surgical Operating Suite. Dr. Estrada arrived at the Medical Center in August 2011, and his practice volume in colorectal surgery has grown as follows:

Colorectal Surgeon Dr. Estrada's Historical Utilization

Dr. Estrada	2011	2012
	Total last four months	Total first four months
New Patient Visits	96	141
Established Patient Visits	54	94
Inpatient Surgeries	3	11
Outpatient Surgeries	25	57
Endoscopy Procedures	20	44

Source: AIMMC Records

There were additional needs identified beyond surgical services for colon and rectal problems, needs that were more related to advanced gastrointestinal disease. One community need was to recruit a physician with expertise in esophageal disease. Dr. Ohri, a gastroenterologist specializing the management and treatment of Barrett's Esophagus (commonly known as Acid Reflux), has started to grow a larger presence at the Medical Center. His practice in Chicago has tremendous potential and with the demand in the Medical Center community, he has added an associate, Dr. Michael Flicker. Dr. Flicker is finishing his Endoscopic Ultrasound (EUS) fellowship at Northwestern and will join the medical staff at Advocate Illinois Masonic Medical Center in July 2012. Drs. Ohri and Flicker bring expertise and state-of-the-art treatment options for esophageal disease.

Another program need was for the comprehensive diagnostic option Endoscopic Ultrasound (EUS). Endoscopic Ultrasound is a device used to evaluate the lining of the digestive tract as well as the surrounding tissues and organs, enabling the clinician to identify and stage tumors. The Medical Center had been sending patients to Northwestern and Advocate Lutheran General as a part of the clinical care plan. In the fall of 2011, the Medical Center recruited Dr. Alan Halline, Director of Digestive Diseases at University of Illinois Chicago (UIC), to launch EUS services at Illinois Masonic. Endoscopic Ultrasound cannot be done in the current department due to small size of procedure rooms so these procedures are done in the Surgical ORs. Having EUS as an integrated service in the Digestive Health program at the Medical Center will allow patients to stay with the Medical Center for the duration of their treatment plan.

The central issue that will affect the ability to bring a full Digestive Health program to the community is having adequate facilities for physicians to practice. The current Endoscopy Suite is located in one of the Medical Center's older buildings, which was constructed in 1957. The last facility upgrade to Endoscopy was in 1987. The Endoscopy space does not meet current code requirements for minimum square feet and bed clearances and the Medical Center was cited by Joint Commission for privacy and safety issues.

In March 2011, inspectors from the Occupational Safety and Health Administration (OSHA) completed a site visit to the current Endoscopy Suite after receiving a complaint related to the cramped quarters of the unit. The surveyor noted the small size of the unit and the close proximity of the patients during their pre and post procedural care. Additionally, the procedure

and recovery rooms did not meet current code. Finally, the current Endoscopy Suite lacked a sufficient number of prep and recovery rooms. The Medical Center currently has 1.25 recovery rooms to each endoscopy procedure room. Illinois Department of Public Health code calls for a minimum of two recovery rooms per procedure room. These limitations create inefficient throughput and limited the capacity of the department. The size of the existing 4 room department is 1,978 DGSF, which is 55 percent under the state standard of 1,100 GSF per key room or 4,400 GSF for the 4 room suite.

The procedure rooms are so small that complex procedures that require general anesthesia need to be done at a separate location. The room size does not safely accommodate anesthesia, one technician, one nurse, the physician, and the equipment (scope towers) that are needed to perform gastroenterologic procedures. Consequently, the department must perform endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasound (EUS) procedures in an operating room. This practice of utilizing an operating room for gastrointestinal (GI) cases often causes conflicts with surgical cases and causes inefficiencies in patient, staff, and physician flow. Performing GI cases outside the usual GI venue produces challenges because staff are away from their normal working area and supplies. Heavy equipment must be moved to the remote site near the Surgical Operating Suite which takes staff away from the Endoscopy Suite, moves equipment and patients to a remote location, and ultimately is a significant physician, staff, and patient dissatisfier.

Another operational challenge is the small footprint and limited number of stations in the adjoining Phase II Recovery space. See Section A.3 for details on this department. There are only 5 prep/recovery stations to serve the 4 surgical procedure rooms. These are small stations separated by curtains that compromise patient privacy, especially when being interviewed by medical personnel or talking with the physician. The size also limits the family members from being present while the patient recovers from a procedure. Because of the limited capacity of the Phase II Recovery, the Endoscopy department can only fully operate 3 endoscopy rooms in the suite concurrently (the fourth site is the remote location by surgery). There are often delays and bottlenecks in the suite when there are patients who are slow to recover.

As a result of these physical constraints, physicians are challenged with operational inefficiencies such as case delays, difficulty adding patients to the schedule because of limited procedure rooms, and issues with separate locations. Some of the difficulties have been remedied through improved workflow and efficiencies with scheduling and staffing. Plans are underway to temporarily convert the current non-clinical space (manager office, staff lounge) to accommodate 5 additional Phase II Recovery spaces which will allow for greater ease/workflow for staff and physicians and create fewer reasons for delays. These additional 5 spaces will create separate areas for patients preparing for the procedure versus patients in recovery, which allows the patient a certain level of privacy during the prep phase versus the recovery phase of the procedural experience. This reassignment of space is a stopgap effort to support the service until the proposed Project is in place.

The primary deficiencies (small size of procedure rooms; inadequate number of Phase II Recovery stations, and lack of privacy) cannot be fixed in the current facility.

3. Utilization

A) Major Medical Equipment

N/A. There is no endoscopy equipment in this Project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

In 2010 and 2011, there were individual physician scenarios that affected utilization. It was during that time one of the busiest physicians was out on medical leave for four months. Another physician with a large gastroenterology practice was out of the country with family commitments for four months. Having experienced that unexpected loss of busy physicians, and with the possibility of other physicians trending towards retirement, a succession plan was implemented. Also affecting the utilization was the time lost when physicians had difficulties and constraints related to space.

As a result of the recruitment work, the following new members of the medical staff are anticipated to have a significant effect on the utilization as they develop their practices.

Anticipated Additional Procedures

Physicians	Specialty	2011 cases	2012 cases projected	2012 new hours, case = 0.7 hrs
Estrada	Colorectal Surgeon	20 4 Qtr	80	
Patel	Gastroenterologist	183 4 Qtr	540	
Ohri	Esophageal Gastroenterologist		150	
Halline	Endo Ultra Sound Gastroenterologist		45	
Flicker (Starts July 2012)	Esophageal Gastroenterologist		150	
Choua	Gastroenterologist		72	
Hyder	Gastroenterologist		72	
Uzer	Gastroenterologist		72	
Dept. Med Dir	Gastroenterologist		120	
Increased Utilization			1301	911

Source: AIMMC records

Current Utilization

The 2011 utilization of existing 4 endoscopy rooms justifies the need for 3 endoscopy rooms. Due to the insufficient prep and recovery space, only 3 endoscopy rooms are routinely used, with some cases done in a room by surgery. Opening the fourth room is not feasible until the temporary expansion plans are finished, because of the restricted flow of patient's pre and post procedure. Further complicating the process are the advanced endoscopic procedures such as ERCP and EUS that can take twice as long as a

typical procedure. To get a room of adequate size, those procedures take place in the Surgery Suite and 2 hours are required for each case. As a result, some physicians take these cases elsewhere due to the cumbersome workflow model.

GI Endoscopy Surgical Procedure Historical Utilization

Department	Historical Utilization						change 2007- 2011	Annual Increase Projected
	2007	2008	2009	2010	2011			
Surg Procedure Hrs - GI Endoscopy	2,392	2,949	3,923	3,881	3,487	45.78%	11.44%	

Source: AIMMC

$$3,487 \text{ hours in 2011} \div 1,500 = 2.3 = 3 \text{ rooms}$$

Projected Utilization

To project the future demand, utilization trends were prepared using the past 5 year's utilization. Because of the significant number of new physicians and new procedures, the impact of their work was noted in the 2012 utilization. The trend was then projected to 2017 using the CAGR trend lines. That resulted in the following:

GI Endoscopy Surgical Projected Utilization

CAGR Projected Utilization							
Annual Increase Projected	2012	With additional 911 hours from new physicians	2013	2014	2015	2016	2017
11.44%	3,886	4,797	5,346	5,958	6,640	7,400	8,246

Source: AIMMC

$$8,246 \text{ hours in 2017} \div 1,500 = 5.5 = 6 \text{ rooms}$$

The projection supports the need for **6 surgical procedure rooms**, as proposed for this Project.

Future of the Digestive Disease Program:

Other new services recently initiated have not been factored into the utilization but will certainly increase demand for the facilities. The new services included:

- Capsule Endoscopy: (Launched in April 2012). This technology can examine the small bowel from a pill size camera to assess polyps, IBD - Crohns, Ulcers, Tumors, and Bleeding. The Medical Center expects to do 104 cases per year.

- Manometry: (Launched in Fall 2011) This is a technique used to measure contractility in the anus and rectum. The Medical Center expects to do 104 cases per year.
- HALO: Radiofrequency ablation. (Launched in February 2012) A treatment of Barretts Esophagus where cancerous cells line the esophagus, the ablation process takes off the top layer of the lining of the esophagus. The Medical Center expects to do 180 cases per year.

In addition the Medical Center considered a 15 percent growth factor to recognize the impact of national health care reform, especially on outpatient care. This factor could increase the projected utilization to be 9,420 hours or the need for 7 rooms in 2017. With the growth of service from the new physicians as described in 3.B above, the Medical Center is confident the service will meet the target utilization by 2017.

With an aging population, digestive health (education, prevention and treatment) will continue to be a health care focal point and even more important especially in an age of population management. Colorectal cancer is the third most common cancer in both men and women, according to *Cancer Facts & Figures 2012*, American Cancer Society, 2012. Advocate Illinois Masonic Medical Center currently has a robust Gastroenterology section but the facility space is inadequate and there is no dedicated space to manage community health through programming or education. Outreach and education is carried out in a fragmented way.

Many hospitals focus resources and programmatic development around the prominent disease states of cardiology, cancer, neurosciences, and OB/GYN. There are very few hospital-based programs addressing the needs of the digestive tract (a function that affects every person in every community). With the growing complement of gastroenterology physicians and other specialists, emerging technologies and opportunities to partner with diverse communities (notably the LGBT and Hispanic communities which make up a significant part of the patient population), Advocate Illinois Masonic Medical Center has an opportunity to reach out and serve the population with digestive health programs.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

N/A. There is a State Standard for Surgical Procedure Rooms (Class B). The projections show the Medical Center's volume will meet that by the second full year of operation.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Clinical List Designation A-3

Phase II Recovery, Prep/Recovery

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. No deteriorated equipment or facilities is being addressed in this service.

2. Necessary Expansion

In Section A.1, Surgery Operating Rooms (Class C) and Section A.2, Surgery Procedure Rooms (Class B), Advocate Illinois Masonic Medical Center justified the need for 18 general operating rooms and 6 surgical procedure rooms. Of the total, 6 operating rooms and 6 procedure rooms will be in the Center for Advanced Care project. Phase II Recovery (Prep/recovery) stations are needed to support the existing and proposed operating and procedure rooms.

3. Utilization

A) Major Medical Equipment

N/A. There is no Phase II Recovery equipment in this Project that meets or exceeds the major medical equipment threshold

B) Service or Facility

There is no State Standard for utilization of Phase II Recovery (Prep/recovery) stations; rather, the number of stations required is dictated by the number and type of surgical rooms.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

The Medical Center will maintain 18 Post Anesthesia Care Phase I stations to support the 18 ORs, as required by Code.

The Phase II Recovery stations (required where ambulatory surgery is offered, and addressed in the proposed project) will be provided in the number that follows:

Proposed Changes in Phase II Recovery Stations

Current Inventory of Phase II Recovery Stations		Proposed Inventory of Phase II Recovery Stations	
Stations	Location	Stations	Location
6	Eye Surgery	6	Remain with Eye surgery to support the 2 eye ORs. (Code requires 3 stations per OR doing OP work)
8	Existing surgical suite	8	Remain with the existing surgical suite to accommodate the volume of outpatient work (equivalent to two ORs) that will continue to be offered in the existing surgical suite.
		18	Proposed to be in the Center for Advanced Care to support the 6 new outpatient ORs.
5	In the existing GI Endo Suite, all will be vacated	17	Proposed to be in the Center for Advanced Care to support the 6 new surgical procedure rooms. (Code requires 2 stations per OP procedure room)
19	Current total	49	Proposed Total

Source: AIMMC

Clinical Service Area
Infusion Therapy

Clinical List Designation B-1

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not replace infusion facilities or equipment that has deteriorated.

2. Necessary Expansion

At Advocate Illinois Masonic Medical Center (Medical Center) oncology is identified as one of major destination programs and an area of focus for the future. On a system level, Advocate has entered into a partnership with MD Anderson, one of the largest oncology systems in the United States, to enhance Advocate's clinical initiatives and expand its regional presence.

The Creticos Cancer Center was established in 1990 as a full service program with medical oncology and radiation oncology. The program has now expanded to include clinical research, surgical oncology, gynecologic oncology, cancer risk, psychosocial oncology and financial navigation services — all key components of a regionally recognized Cancer Center of Excellence.

One of the key services of the medical oncology section is infusion therapy, which includes chemotherapy. Infusion therapy is usually given intravenously, and over several hours. Patients return for infusion therapy on a specific schedule that may cover several weeks or months. The treatments may be in conjunction with a program of radiation therapy. In the proposed Project, the patients also have opportunities to see their physicians and utilize other support services that are nearby.

At the present time, a chemotherapy outpatient visit includes the following steps: The patient is assigned to a treatment chair; blood is drawn and sent to the lab. While waiting for the laboratory results, vital signs are taken. If the patient's lab results are not within acceptable parameters or if the patient has severe physical complaints, the patient is rescheduled. If the lab results are acceptable and the patient is not experiencing severe symptom management issues, staff contacts the pharmacy to mix the chemotherapy. (This all takes place while the patient is in the treatment chair because the current department does not have an adequate waiting room.) Only then is the IV started, the pre-treatment medications administered, and the infusion completed. Time is also required to set up and clean up the station.

The Creticos Cancer Center is engaged in education and research with nursing and medical residents, as well as social work interns rotating through the Center. To achieve Cancer Center of Excellence status, it will be important to expand the space for more teaching capacity.

3. Utilization

A) Major Medical Equipment

NA. There is no infusion therapy equipment in this Project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

The Infusion Center is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per 800 sf. The following calculations were used to quantify future need for the Infusion Center.

According to the rules, the term ambulatory care means medical care that is provided on an outpatient basis. The care may be a simple lab test or a complex procedure taking several hours, therefore time varies widely.

The Medical Center assumed that the average time for an ambulatory visit under the Section 1110. Appendix B guideline could be determined by taking room utilization time for surgery (the only such calculation in the State Agency Rules) and the number of visits proposed per room. In section 1110.1540, the State Agency Rules propose the following formula for determining hours of operation per surgery room:

$$250 \text{ days per year} \times 7.5 \text{ hours per day} \times 80 \text{ percent occupancy} = 1,500 \text{ hours of surgery per room per year}$$

The Medical Center then divided the hours per room by the number of visits required to justify an Ambulatory Care Service.

$$1,500 \text{ hours per room} \div 2,000 \text{ visits per room} = 0.75 \text{ hours or 45 minutes per visit}$$

By using these two factors - hours of time per room and number of visits per room – the Medical Center determined that the average time proposed by the State Standard for an ambulatory care visit was 45 minutes.

Next, the Medical Center determined that the average treatment time for an infusion patient visit at the Creighton Cancer Center is 3.2 hours. While that may seem long, the Advisory Board Oncology Roundtable "*Blueprint for Growth II*" reported that the average infusion length is 3.5 hours.

The 3.2 hours per visit = 192 minutes. This is 4.3 times longer than the State Standard for an ambulatory visit of 45 minutes.

$$3.2 \text{ hours} \times 60 \text{ minutes per hours} = 192 \text{ minutes} \div 45 \text{ minutes} = 4.3$$

One Infusion visit = 4.3 times longer than the State Standard ambulatory visit

The following calculations were used to quantify the space needed for the Infusion Center.

Current Need

The State Standard for Ambulatory Care Service is 800 sf per 2,000 visits.

Based on current average treatment time, the Medical Center determined that current utilization would justify the following space.

Historical Utilization

	2009	2010	2011	% change 2009-2011	Annual Increase Projected
Infusion Visits	4,157	4,489	4,605	10.78%	5.39%

Source: AIMMC

$$4,605 \text{ visits} \times 4.3 = 19,801 \text{ equivalent visits}$$

$$19,801 \text{ equivalent visits} \div 2,000 = 9.9 \times 800 = 7,920 \text{ DGSF}$$

Projected Utilization

The Medical Center also prepared a CAGR trend line based on data from 2007 to 2011. The CAGR trend line was extended to 2017, the second year of full utilization of the Center for Advanced Care.

CAGR Projected Utilization

Annual Increase Projected	2012	2013	2014	2015	2016	2017
5.39%	4,853	5,115	5,390	5,681	5,987	6,309

Source: AIMMC

$$6,309 \text{ visits} \times 4.3 = 27,129 \text{ equivalent visits}$$

$$27,129 \text{ equivalent visits} \div 2,000 = 13.6 \times 800\text{sf} = 10,851 \text{ DGSF}$$

The department has been designed to be 5,721 DGSF, well below the State Standard.

Future Programming

- Advocate Illinois Masonic Medical Center has recruited Dr. Heidi Memmel, a well-known breast surgeon. This will strengthen the breast program and is expected to contribute to increased volumes for breast cancer patients who will require infusion services.
- The Cancer Center is also planning to create high-risk cancer services for specific tumor sites. A medical oncologist who specializes in genitourinary cancers recently joined the Medical Center physician team and the organization is forging a

partnership with other specialists to develop a high-risk prostate cancer program which is also expected to increase volumes for infusion services.

- The Medical Center contemplated a 15 percent growth factor to account for the implementation of national health care reform. This factor alone could increase the total equivalent visits to 31,201 with a space need for 12,479 DGSF. This reinforced the need for the 5,721 DGSF.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

Infusion Therapy is considered to be an Ambulatory Care Service and has standards that the Medical Center will meet in 2017.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Pre-Surgical Care

Clinical List Designation B-2

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not result in the replacement of equipment or facilities that have deteriorated and need replacement.

2. Necessary Expansion

The process of bringing in patients for an assessment ahead of a surgical procedure or treatment is now commonplace in many facilities. Advocate Illinois Masonic Medical Center has only recently initiated a pre-anesthesia assessment process for a subset of patients. In the majority of cases, physicians send their patients to their primary care provider or other facilities for testing, without adequate coordination of these services by the hospital. The effective coordination and administration of pre-surgery/pre-anesthesia assessment is a current push within the Advocate system as a part of the Safer Surgery Initiative. The reasons for enhancing pre-surgical care are 1) safe surgical preparation, 2) thorough patient education, 3) reduction in day-of-surgery cancellations and delays, 4) increased patient safety through reduction of surgical complications, and 5) reduction of potentially avoidable re-admissions post-surgery.

In the proposed Center for Advanced Care, a specific area known as Pre-Surgical Care has been designed for patients to get that evaluation done in an efficient manner, by appointment, with easy access. Furthermore, the staff in the department will be able to do the pre-surgical education with the patient and family members. As needed, the patient can meet with the anesthesiology staff for an assessment.

The proposed new Pre-Surgical Care department will be located in the Center for Advanced Care on the first floor. Some patients will come early in the morning while still fasting. To gain efficiencies, the department will share waiting space with an adjoining department that has a busier patient load later in the day.

This department is important to further the goals of health reform by reducing the need for early hospital admission before a surgical procedure. By providing appropriate patient and family education, the patient's discharge will be expedited, and there will be a reduction in unnecessary readmissions.

3. Utilization

A) Major Medical Equipment

N/A. There is no pre-surgical care equipment in this Project that meets or exceeds the major medical equipment threshold

B) Service or Facility

Because Pre-Surgical Care has only recently been organized as a service, it has been necessary to forecast the demand. That process involved making assumptions about the likelihood that physicians would refer patients to the department, in order to anticipate the number of exam rooms needed, as shown in the table below:

Pre-Surgical Care Projected Utilization

PRE-SURGICAL CARE		2011	2012	2013	2014	2015	2016	2017
Patient Type Summary								
Inpatients		1,621	1,819	1,901	1,936	1,973	2,010	2,047
Same Day Inpatient Admissions		1,450	1,627	1,701	1,732	1,765	1,798	1,832
23 Hour Outpatient Observations		1,194	1,215	1,386	1,428	1,472	1,516	1,564
Ambulatory Outpatients		4,265	4,341	4,949	5,099	5,257	5,416	5,587
Total Patients		8,530	9,002	9,936	10,195	10,467	10,740	11,030
Medical Center Patients Requiring Pre-Surgery Screening								
Inpatients	0%							
Same Day Inpatient Admissions	50%							
23 Hour Outpatient Observations	50%							
Ambulatory Outpatients	50%							
Patients Requiring Pre-Surgery Screening								
Inpatients, None		-	-	-	-	-	-	-
Same Day Inpatient Admissions		725	814	850	866	883	899	916
23 Hour Outpatient Observations		597	608	693	714	736	758	782
Ambulatory Outpatients		2,133	2,170	2,474	2,549	2,629	2,708	2,793
Total Pre-Surgery Patients		3,455	3,592	4,017	4,129	4,248	4,365	4,491
Approximate Minutes/Patient	60							
Total Pre-Surgery Minutes		207,300	215,520	241,020	247,740	254,880	261,900	269,460
Minutes Available Per Exam Room	124,800							
Pre-Surgical Rooms Required		1.7	1.7	1.9	2.0	2.0	2.1	2.2

Source: AIMMC

The conclusion was that 50 percent of the patients would be referred for the Pre-Surgical Care and based on the data in the table above: at least 2 rooms will be needed by 2017, to accommodate the 4,491 patients coming to the department when the Center for Advanced Care has been open for two years. The predicted time in the department is to accomplish the testing, patient education on pre and post surgical expectations, and an assessment with the anesthesiology staff.

The utilization standards are based on the size of the department per visit. According to the HFSRB rules, Pre-Surgical Care is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per 800 DGSF.

$$4,491 \text{ patients} \div 2,000 \text{ patients} = 2.2 \times 800 \text{ DGSF} = 1,760 \text{ DGSF}$$

While the projection indicates 3 rooms could be needed, because of the limited history with this service, the **Medical Center is only seeking to have 2 rooms and will use 1,574 DGSF**, well below the standard.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

Pre-Surgical Care is considered by HFSRB rules to be an Ambulatory Care Service and the standards apply.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Clinical List Designation C-1

Mammography, Dedicated Needle Localization

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not replace any deteriorated Mammography equipment.

2. Necessary Expansion

Advocate Illinois Masonic Medical Center's plan for the proposed Center for Advance Care has focused on providing service to outpatients, the growing segment of healthcare. There are three destination services at the heart of the program: Digestive Health, Cancer, and Ambulatory Surgery. The proposed addition of a mammography unit is specifically to address the needs of the patients who have been diagnosed with possible breast disease and are coming to have a surgical procedure on their breast.

As breast cancer screening with mammography increases, many impalpable breast lesions are being detected. These lesions are then usually diagnosed by using image-guided needle biopsy. After needle biopsy, some of these lesions may require diagnostic or therapeutic surgical biopsy. If a malignant or indefinite diagnosis is obtained, surgical excision is indicated. This, in turn, requires accurate localization of the lesion, which is required to ensure correct and adequate removal of the lesions and to minimize the degree of cosmetic disfigurement. Although a number of techniques are used to localize non-palpable breast lesions, needle localization is the most common.

Using mammography to view the breast, a needle or wire is inserted into the location in question. The patient is then taken into surgery where the surgeon can follow the needle to the area in question and excise the tissue with precision.

The current mammography service is located in the Women's Health Center, in the Medical Office Center, a significant distance from the proposed new ambulatory surgery. It is not feasible to move the patient any distance with a wire in the breast because it might move or become dislodged and ultimately complicate the surgery. Furthermore, the prospect of being transported through a public hallway with a needle in the breast is unacceptable to most patients and their physicians. With accuracy and sensitivity to the patient in mind, the physicians in the Surgical Department have requested that a mammography unit be placed in the Center for Advanced Care, near the proposed ambulatory surgery, for the sole purpose of positioning the needles or guide wires in a patient's breast.

The demand for the service is growing as shown in the historic utilization below:

Breast Surgery Needle Localizations

	Historic Utilization					Projected Utilization						
	2010	2011	5 months of 2012	Projected for 2012	% change 2010-2012	Annual Increase Projected	2012	2013	2014	2015	2016	2017
Breast Surgery with Needle Localization	64	75	37	89	39%	20%	106	127	152	182	217	260

Source: AIMMC

A major goal of health reform is to assure patients have access to early diagnosis to prevent major illnesses, hospitalizations, and death. Advocate Illinois Masonic Medical Center has recruited Dr. Heidi Memmel, a well-known breast surgeon. She will strengthen the breast program and is expected to see increased volumes of breast cancer patients who will require needle localizations.

Currently, 1 in 8 women will have breast cancer in their lifetime, and a small but increasing number of men develop breast cancer. Having a full array of surgical services for breast patients is an important element in improving that ratio.

3. Utilization**A) Major Medical Equipment**

N/A. There is no mammography equipment in this Project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

The need for this service is specifically related to the new location of the ambulatory surgery department. The current mammography service will remain in the medical office building, as a component of the Women's Health Center. The Department does the screening and diagnostic breast studies using four units. The utilization trends show that the four existing units will continue to be needed when the new Center for Advanced Care has been open for two years.

Mammography Screening and Diagnostic Historical Utilization

Department	Historical Utilization						Annual Increase Projected
	2007	2008	2009	2010	2011	change 2007-2011	
Mammography visits	13,366	14,994	15,760	14,593	14,618	9.37%	2.34%

Source: AIMMC

Mammography Screening and Diagnostic Projected Utilization

CAGR Projected Utilization						
Annual Increase Projected	2012	2013	2014	2015	2016	2017
2.34%	14,960	15,311	15,669	16,036	16,412	16,796

Source: AIMMC data

The State Standard for utilization of mammography is 5,000 visits per unit. By looking out to 2017, the volume of work and number of mammography screening and diagnostic units needed is expected to be:

$$16,796 \div 5,000 = 3.4 \text{ or } 4 \text{ units}$$

Maintaining the use of the four units in the existing medical office building is warranted for the screening and diagnostic studies are performed. The full complement of mammography technologists and educational systems are in place there.

Therefore, this supports the need to leave the existing units in place and **add a mammography unit for the specific, dedicated purpose of doing the needle localizations** on patients going to surgery in the Center for Advanced Care. Radiology staff will meet the patient in the Center for Advanced Care immediately prior to the surgery, to position the needle, and then take the patient directly to the operating suite via a private corridor.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

A State Standard exists that shows the current units are needed in their present location. Therefore, the addition of a dedicated mammography unit to support surgery in the proposed Center for Advanced Care is warranted.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Linear Accelerator

Clinical List Designation D-1

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not replace radiation therapy rooms or equipment that has deteriorated.

2. Necessary Expansion

In 2009, as part of its strategic commitment to establishing destination programs in several areas, Advocate Illinois Masonic Medical Center set a goal of building the existing Creticos Cancer Center into a cancer Center of Excellence. The Medical Center is proud to be accredited by the American College of Surgeons' Commission on Cancer (COC). Participation in clinical trials sponsored by the National Cancer Institute is providing access to therapies and treatments before they become widely available. A cancer registry collects data throughout the continuum of care and the Cancer Committee evaluates that data to assure the Medical Center is performing per national benchmarks. Significant progress has been made in physician staff development, planned technology enhancements, and strengthening referral relationships. As a result of this progress, it has become evident that further development is hampered by physical space limitations.

Over the last two years, the cancer program has deepened and broadened its clinical capabilities in the following areas:

1. The base of high-quality cancer specialists has been expanded:

- A dedicated Memorial Sloan-Kettering-trained surgical oncologist, Dr. Ajay Maker, has been recruited to complement the current cancer team. He is developing a hepatobiliary practice, and has introduced isolated limb infusion treatment (ILI) for melanoma and sarcoma. Advocate Illinois Masonic is one of only two Chicago hospitals to offer ILI to patients.
- Colorectal surgeon, Dr. Joaquin Estrada, was recruited to address digestive system cancer.
- Dr. Heidi Memmel joined the breast surgery team in July 2012.
- The neuro-oncology program is developing rapidly under the partnership of Dr. Santoch Yajnik and Dr. Kenji Muro.
- Two additional medical oncologists, Drs. Mebea Akfili and Denise Levitan, will join the medical staff in 2012, bringing the total number to five.

2. Referral channels have been established routing Advocate Medical Group and Union Health patients to the Creticos Cancer Center. The impact of this will be an increase in all cancer services.
3. Advocate Illinois Masonic Medical Center is building multidisciplinary teams to assure that the right team of sub-specialists are partnering with oncology specialists to provide comprehensive care for high volume tumor sites.

The significant expansion of cancer services has resulted in a similar growth of the number of linear accelerator treatments provided each year. The pattern of growth for the past 5 years is as follows:

2007	2008	2009	2010	2011	% change 2007- 2011	Annual Increase Projected
4920	5577	5,819	6,466	8,084	64.31%	16.08%

Source: AIMMC

The State Standard for utilization is 7,500 treatments per unit; therefore, the department has already exceeded that threshold in 2011. With the projected utilization, the demand is clear for a second unit but there is no space available in the current site. Furthermore, there are significant issues being remote from the hospital that make staying in the current location unacceptable for the future.

The Advisory Board Roundtable on Oncology has predicted a 21 percent increase in demand for cancer care in general during the next decade. The existing Creticos Cancer Center is too small to accommodate that growth. The facility has become outdated and unable to offer the environment, convenience, or physical capacity for the increased patient volume and treatment modalities required to achieve Center of Excellence status.

In "*Redesigning Cancer Care for the Era of Accountability*", March 29, 2012, Advisory Council Oncology Roundtable, the authors emphasize patients are indicating their preference for more convenience, privacy, and comfort in what are often long periods of care. In the current setting these expectations are not being met. At the Medical Center, the changing rooms are not adjacent to the treatment room, so gowned patients must move through the hallway. Patients with modesty concerns often complain about this lack of privacy. This is especially problematic for patients with religious or cultural influences that necessitate modesty. Furthermore, an outside door is nearby, causing temperature fluctuations during the winter.

Most important is the fact that the current Creticos Cancer Center site requires transporting patients across Wellington Avenue to get to the main hospital. Patients are moved by ambulance, by wheelchair, or on foot. While the ambulance costs are covered by the Creticos Cancer Center, the patients experience the transfer as added inconvenience and the appearance of discontinuity to the patient experience.

The site initially opened in 1990 with a view to accommodating patient needs and regulatory environment at the time of construction. However, this transportation issue is a clear barrier to achievement of the constellation of "comfort/convenience/privacy" that patients are expecting along with outstanding clinical quality and state-of-the-art technology.

Advocate Illinois Masonic Medical Center has one linear accelerator with significant reliability issues and is also at maximum capacity. In the recent past, the unit was taken out of service for eight weeks to add Image-Guided Radiation Therapy (IGRT) capabilities. Image-Guided Radiation Therapy is a procedure that uses a computer to create a picture of a tumor to help guide the radiation beam during radiation therapy.

With only one unit, it was necessary for patients needing a course of treatment to go to Advocate Lutheran General Hospital, in Park Ridge, for that period. In other times, when there is unscheduled downtime of the one unit, the patients wait, are sent home, or their treatment is canceled which disrupts their care. The history of patients canceled is as follows:

Linear Accelerator History of Patients Canceled

	2007	2008	2009	2010	2011
Patients canceled due to unscheduled downtime on a single machine	52	64	33	72	178

Source: AIMMC

The Medical Center proposes to relocate the existing linear accelerator and add one new multifunctional unit. The new unit would accommodate neuro-oncology procedures and more complex treatments, while maintaining an optimal level of throughput.

With the addition of a second linear accelerator, the Medical Center can expand the number of patients served in radiation oncology and preserve continuity of service during times when one unit is out of service for maintenance or upgrades. With a second treatment unit, the Medical Center will also be able to expand treatment options for patients who need radiation therapy by using leading edge delivery systems including stereotactic body radiation therapy (SBRT).

Among the specific technological needs to be addressed are:

1. Advances in Radiation Oncology require specialized treatment and procedure rooms for modalities such as High Dose Rate Brachytherapy (HDR), Stereotactic Body Radiotherapy (SBRT) and proton beam therapy. Small-scale proton beam therapy (not part of this Project but a consideration for the future) will require a special vault, which can not be accommodated in the current physical space.
2. Specialized treatment modalities currently in use that require transportation across the street or from floor-to-floor include High Dose Rate (HDR) Brachytherapy treatment for prostate cancer, which requires ambulance transportation from the main hospital's surgical suites to the Cancer Center, across Wellington Avenue. (See Clinical Service Area D.3 for more detail on Brachytherapy.)

Relocation of the Creticos Cancer Center program to an area adjacent to the Ambulatory Surgery Center and Center for Digestive Health allows for the integration of care and interdisciplinary focus desired by both practitioners and patients. It will enable medical, surgical and radiation oncology to provide team consultations and coordinated treatment for patients, while also consulting with gastroenterologists, head and neck surgeons, and other surgical modalities. It also provides patients easier access to services that range from screening, diagnostic, treatment, and survivorship.

To achieve Center of Excellence status, the provision of appropriate space becomes the next challenge. The proposed space must serve the growing volume requirements of this rapidly developing program, while potentially paving the way for newer technology such as proton therapy.

The current physical spaces within the Creticos Cancer Center also do not accommodate families and support systems so needed by its patients. Cancer is well known to be a family experience. Patients need their support systems physically with them during their appointments and the current physical space does not accommodate that need.

Advocate Illinois Masonic Medical Center concluded that the lack of physical connection to the hospital prevents easy access by patients and physicians, and creates a barrier for the integration of clinical services across the various disciplines. As a result, medical and radiation oncology specialists are not well connected with surgical oncologists and gastroenterologists. These findings have led to a proposed integrated Project that has numerous clinical and service benefits.

3. Utilization

A) Major Medical Equipment

N/A. There is no radiation therapy equipment in this Project that meets or exceeds the capital expenditure threshold.

B) Service or Facility

As defined in Subsection (c) (2) Necessary Expansion, the current level of use has exceeded the threshold for a second unit.

Current Utilization**Linear Accelerator Historical Utilization**

	Historical Utilization						Annual Increase Projected
	2007	2008	2009	2010	2011	change 2007-2011	
LINAC Treatments	4,920	5,577	5,819	6,466	8,084	64.31%	16.08%

Source: AIMMC

$$8,084 \text{ treatments} \div 7,500 \text{ treatments/unit} = 1.1 \text{ or } 2 \text{ units}$$

Projected Utilization

To project the future demand, utilization trends were prepared using the past 5 year's utilization. The trend was then projected to 2017 using the CAGR trend lines. That resulted in the following:

Linear Accelerator Projected Utilization

Annual Increase Projected	CAGR Projected Utilization					
	2012	2013	2014	2015	2016	2017
16.08%	9,384	10,892	12,644	14,676	17,036	19,775

Source: AIMMC

$$19,775 \text{ treatments in } 2017 \div 7,500 \text{ treatments/unit} = 2.65 = 3 \text{ units}$$

While the numbers suggest 3 units will be needed, the **Medical Center is only requesting two units in the proposed Project** and expects to be fully utilizing them in the second year of operation.

Future Programming

Prostate cancer is the third most commonly diagnosed cancer at the Medical Center. Program development is underway to create a multi-specialty prostate program through partnerships with medical oncology, radiation oncology and urology. Dr. Mebea Aklilu, medical oncologist, has clinical expertise in genitourinary cancers. Dr. Santosh Yajnik, radiation oncologist, did extensive work at Memorial Sloan-Kettering focused on prostate cancer. There is a growing demand to build a high risk prostate cancer program for men who may have certain risk factors and fall into the "watchful waiting" category.

The Medical Center also considered a 15 percent growth factor to recognize the impact of national health care reform. This factor could further increase the projected utilization to be 22,741 treatments or the need for 3 rooms in 2017.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

N/A. There is a State Standard for Radiation Therapy. The projections show the Medical Center's volume will meet that by the second full year of operation.

Clinical Service Area
CT Simulator

Clinical List Designation D-2

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. No deteriorated equipment or facilities are addressed in this service.

2. Necessary Expansion

In Section D.1 Linear Accelerator, the need for therapeutic radiology was established. The CT Simulator is a piece of equipment that must be used with the Linear Accelerator to establish the parameters of the anatomy that is to be treated. Clinicians must plan the target volume precisely in three dimensions. To do that it is necessary to visualize anatomy in three dimensions to enable planning to conform the dose around the target in order to irradiate the tumor with as high a dose as possible, while saving the nearby normal tissues.

In order to establish the parameters of the anatomy, the CT Simulator provides:

- Identification of critical structures using advanced anatomical and functional imaging methods.
- Visualization of treatment targets with respect to other structures in three dimensions.
- Efficient and accurate outlining of a tumor using contouring tools.
- Addition of symmetrical or asymmetrical volumetric margins.
- Shaping fields around the target and adding beams together.
- Dose volume histogram generation.
- Export of the plan to linear accelerator.

3. Utilization

A) Major Medical Equipment

This unit will be relocated from the current Creticos Cancer Center.

B) Service or Facility

The **proposed one CT Simulator** is sufficient to provide the planning for the two proposed linear accelerators. There is no utilization standard for the simulator. The only standard is for the space required which is addressed under the section on Size. The space required includes a room for the CT Simulator, patient dressing areas, patient toilet, and a control room.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

One CT Simulator will be required to develop the treatment plans for all patients receiving radiation therapy. The incidence of disease that requires the therapy is supported by the historic utilization as defined in section D.1 Linear Accelerator.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area

Clinical List Designation: D.3

Brachytherapy

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. No deteriorated equipment or facilities are addressed in this service

2. Necessary Expansion

Brachytherapy is a type of radiation treatment for cancer in which the source of the radiation is applied directly to the surface of the body or within the body. The method involves the placement of radioactive materials—iridium-192, radium-226, and other radioisotopes, sealed in needles, seeds, wires, or catheters, in direct contact with certain carcinomas to deliver locally intense ionizing radiation—for example, as needed in invasive cancer of the uterine cervix.

The tumor tissues are treated for a specific period. Sources of the radiation can be temporary or permanent. The rationale for this treatment is to provide a highly absorbed dose of radiation in the tumor tissues and a very limited absorbed low dose in the surrounding normal tissues. Traditional Brachytherapy implants deliver low doses of radiation; the newest variations deliver higher doses. Brachytherapy is sometimes used as a palliative therapy, a therapy done to relieve symptoms such as bleeding or to open airways.

Advocate Illinois Masonic Medical Center has been offering Brachytherapy as one of the radiation treatment modalities since 1990. The equipment to provide this procedure is leased and brought into the hospital on an as needed basis. Currently, the unit is brought into the Linear Accelerator room and set up there for the scheduled procedure. When a Brachytherapy case is scheduled, it takes the linear accelerator out of use for patients needing that form of treatment.

3. Utilization

A) Major Medical Equipment

N/A. No major medical equipment will be purchased for this service. Advocate Illinois Masonic Medical Center intends to continue leasing the equipment at this time. The proposed Brachytherapy room will be located near an outside service entrance to facilitate bringing in the equipment.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

Current Need

Presently, when a brachytherapy procedure is ordered, it must be done in the linear accelerator room, which is already over capacity. Knowing this, in the past some physicians have been cautious about ordering this procedure. Today, the demand for high dose rate (HDR) Brachytherapy is developing, especially for early stage prostate and breast cancers. The growth in the past year is reflective of the newer physicians who are using this to address internal tumors. The range of tumors treated include (but are not limited to) breast, prostate, gynecologic, and lung.

Brachytherapy Historical Utilization

	2009	2010	2011	Change 2009- 2011	Annual Increase Projected
Brachytherapy Treatments	16	14	38	137.50%	68.75%

Source: Annual Hospital Questionnaire

Projected Utilization

A CAGR projection was used to project the trend in growth:

Brachytherapy Historical Utilization

Annual Increase Projected	2012	2013	2014	2015	2016	2017
68.75%	64	108	183	308	520	877

Source: Annual Hospital Questionnaire

The volume continues to indicate that one unit would be sufficient to provide the much higher level of utilization. However, that is subject to reconsideration in years to come if the applications continue to increase.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

There are no state utilization standards for Brachytherapy. The use is dictated by the newer methodologies and the incidence of tumors that respond to this treatment. High Dose Rate (HDR) Brachytherapy is a treatment option for several types of cancer. At the Creticos Cancer Center, this technology is utilized for breast, prostate and gynecologic cancers. The appropriateness of this treatment modality relies on the stage of the cancer.

The Medical Center has recruited a breast surgeon, who joined the team in July 2012. It is expected that her service will increase the utilization of Brachytherapy, as it continues

to show positive clinical outcomes and patient experiences related to reduced disfigurement and pain.

The Medical Center has expanded the genitourinary cancer service line with the addition of Dr. Mebea Aklilu. Prostate cancer cases utilize HDR Brachytherapy where the patient begins the process in surgery in the hospital. Currently, the patient is then transported by ambulance to the Creticos Cancer Center first floor to have a CT simulation. Next the patient is transported to the third floor to an infusion bed to rest while the radiation therapy team creates the treatment plan. The patient is finally transported to the first floor for treatment. The convoluted process can be a deterrent to patients agreeing to this treatment in the current arrangement. By having surgery and cancer care in close proximity within the same building, HDR Brachytherapy will be situated to maximize its potential as a treatment modality.

Because of the current use and expected demand, space for one unit is all that is being included in the proposed Center for Advanced Care.

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service – Review Criteria

Clinical Service Area
Pharmacy, Satellite

Clinical List Designation: E

c) Service Modernization

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

1. Deteriorated Equipment or Facilities

N/A. The proposed Project will not replace Pharmacy facilities or equipment that have deteriorated.

2. Necessary Expansion

Since the opening of the Creticos Cancer Center on the Medical Center campus in 1990, there has been a satellite pharmacy located within the Infusion Therapy Department. This is an essential service that provides the oncology drugs that must be prepared immediately before infusion. Skilled pharmacy technicians, under the supervision of board certified oncology pharmacists, provide this service using secure, temperature controlled storage, and special exhaust hoods.

The proposed satellite pharmacy will be located within the Infusion Therapy Department on the first floor of the Center for Advanced Care. The chemotherapy drugs cannot be prepared in the main hospital pharmacy and transported to the Infusion Therapy Department because they could cause a safety hazard if they were to be spilled, and they must be made right before infusing so need to be close to the Infusion team.

By being in the Center for Advanced Care, the pharmacists are available for consultation with the oncologists and will also oversee the management of the drugs used in the proposed Ambulatory Surgery. The pharmacists will also provide consultation to patients regarding medication dosages, drug interactions, and potential side effects.

3. Utilization

A) Major Medical Equipment

N/A. There is no pharmacy equipment in this Project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

There are no State Standards for Pharmacy utilization.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

The need for a satellite pharmacy is linked to the need for an Infusion Therapy Department. Infusion is a key component in cancer centers and the growth of that service

is discussed in the section of this application that addresses Infusion. The following table shows the projected infusion utilization.

Infusion Therapy Historical/Projected Utilization

	Historical Utilization				Projected Utilization						
	2009	2010	2011	% change 2009-2011	Annual Increase Projected	2012	2013	2014	2015	2016	2017
Infusion Visits	4,157	4,489	4,605	10.78%	5.39%	4,853	5,115	5,390	5,681	5,987	6,309

Source: AIMMC

Because of the importance of having the pharmacy located near the Infusion Therapy Department, and the essential element of infusion in the care of cancer patients, Advocate Illinois Masonic Medical Center has demonstrated the demand for this service.

Non-Clinical Service Areas

While this information is not required, it is included to provide a better understanding of the non clinical areas in the project

F. Physicians and Multidisciplinary Team Offices

Central to the services planned in Advocate Illinois Masonic Medical Center's (Medical Center) proposed new Center for Advanced Care are physicians and other professionals to provide diagnosis and treatment. Physicians' offices are presently in multiple locations throughout the hospital, in the Creticos Cancer Center, or in locations remote from the hospital. Patients must find the physician and then find the diagnostic services and places where treatments can be given.

Through this Project, multi-specialty physicians will be located near the key diagnostic services and therapies essential to their programs of care. Physicians seeing patients in the proposed Center for Advanced Care will be from among more than 880 active physicians on staff representing 43 medical specialties. Additionally, there will be representatives from 200 residents and 500 medical students trained at the Medical Center each year. The patients will have access to their physician and hospital services, all in one location. By operating timeshare offices, the model of care is more efficient for the patient and for all people providing their care.

The gastroenterologists and colorectal surgeon at the Medical Center offer a full spectrum digestive health program, which is becoming a regional destination service that includes preventive, diagnostic, interventional, and surgical services. They will be located on the first floor, close to the Surgical Procedure Suite where gastrointestinal endoscopy and other diagnostic procedures will be offered.

Digestive health is a growing field. Adding to the general demand from the public, the Medical Center is located in one of the largest communities of lesbian, gay, bisexual, and transgender (LGBT) people in the nation. The LGBT patients have a higher than usual amount of digestive health issues. Getting proper care is often hindered by the LGBT patients' hesitance to talk with their physicians about their illnesses and the physicians' hesitance about asking questions that would identify them at risk.

The Human Rights Campaign (HRC) Foundation named Advocate Illinois Masonic Medical Center as one of only three hospitals in Illinois in 2012 as a leader in the organization's Healthcare Equality Index (HEI). Illinois Masonic earned top marks for its treatment of lesbian, gay, bisexual and transgender patients and staff.

As noted earlier in this document, the demand for Digestive Health is also increasing in the Hispanic community. Having programming for this population is especially important considering 41% of the population of the Medical Center's service area is Hispanic.

The Creticos Cancer Center at the Medical Center provides the most advanced diagnostic and treatment options for the full range of routine or complex cancers. The oncologists and other oncology specialists, along with their multidisciplinary team of professionals, will be in a portion of the ground floor near radiation therapy and right below the clinical services of Infusion

Therapy and a Satellite Pharmacy. The team will also have easy access to the research and education components.

The Medical Center is proud of being accredited by the American College of Surgeons' Commission on Cancer (COC). Participation in clinical trials sponsored by the National Cancer Institute is providing access to therapies and treatments before they become widely available. There is a strong commitment to preventing cancer before it even begins, with dedicated programs for cancer screening and educational programs.

The reasons to combine digestive health, cancer services and ambulatory surgery in one setting include:

- Physician collaboration/ opportunities for multi-specialty care
- Ease for patients needing endoscopic procedure, ambulatory surgery and/or cancer treatment
- Better coordination of care and resources for patients seeking these services

The unique approach to the Center for Advanced Care allows one location to combine several important and inter-connected outpatient services: ambulatory surgery, cancer treatment, and digestive health services. These specialties tend to work very closely and in a multidisciplinary fashion. For example, digestive health services provide preventative health as well as endoscopic screening and staging for cancer. The function of the endoscopic procedures is diagnostic and preventative in nature. In other cases, oncologists will order a colonoscopy or endoscopic ultrasound to have better visualization of the GI tract or stage a tumor before surgical intervention or oncologic treatment care plan is developed. The ability to have these physicians under one roof with multidisciplinary spaces to treat patients and work with families allows for the optimal coordination of care for patients with digestive diseases or esophageal, colon, rectal, prostate, or pancreatic cancers. The proposed Project allows for physicians to work more closely, as well as patients to find all services they need in one location.

G. Patient Education, Resource Center, Conference Rooms

Patient Education rooms will be where frequent programs can be offered to patients and family members dealing with specific health conditions. The proposed Resource Center will be a location where patients, family members, and the general public can find materials related to health and life style, a health library of sorts.

Conference rooms will be used by physicians, staff, medical researchers, medical students and family meetings. As mentioned in the rest of this application, the Medical Center is a teaching hospital with 200 residents and 500 medicals students. The need for meeting space is critical for those programs. There are numerous clinical trials underway, which are managed by government agencies, educational institutions, private corporations, and pharmaceutical companies to evaluate the effectiveness of new therapies and medications. The need for meeting space for these programs has been growing.

H. Public Lobby, Waiting, Toilets, Stairs, Elevators, Corridors

These locations in the Center for Advanced Care make it easier for patients and those accompanying them to enter and find accommodations. This category of space includes comfortable waiting areas and nearby toilets. Sections of the building are passageways that help move people through the Center for Advanced Care to get to various departments. The stairs are part of the circulation area. A connection from the Center for Advanced Care to the existing hospital will permit unimpeded movement of patients, physicians, and other clinical support staff between the two sites. A pneumatic tube system is an essential mover of paper and small items, saving the staff untold hours of walking to make a delivery several floors away.

I. Corridors, Modernized Connectors

At the point where connector corridors enter the existing hospital, there will be some modernization work done to open up passageways on each floor and leave the area with good traffic flow.

J. Mechanical, Electrical, and Plumbing

The mechanical support for the whole building will come from areas designated as mechanical. That includes the heating, ventilation, and cooling systems as well as vacuum. The electrical and plumbing fixtures are also located in various sites throughout the building. The efficiency of operating the building is linked to the quality of mechanical, electrical, and plumbing systems including how they are installed, operated and maintained.

K. Crawl Area

This is the unfinished, gravel floored, unconditioned, and inaccessible area under the south part of the first floor. The foundations that support the elevator shafts are located there.

L. Penthouse

This is the area on the rooftop where air handlers, chillers, pumps, and additional mechanical equipment are located.

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)

VIII. - 1120.120 - Availability of Funds

This section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, and by Moody's as Aa2 which qualifies the applicants for the waiver. Documentation of the DCEO grant follows the bond ratings

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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 anticipated pledges showing anticipated receipts and discounted value, estimated time table 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 time table of receipts;
	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment, 5) For any option to lease, a copy of the option, including all terms and conditions.
	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

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

FitchRatings

Tagging Info

Fitch Affirms Advocate Health Care's (IL) at 'AA/F1+'; Outlook Stable Ratings Endorsement Policy
19 Jul 2012 5:52 PM (EDT)

Fitch Ratings-Chicago-19 July 2012: Fitch Ratings has affirmed the 'AA' rating on approximately \$1.14 billion in revenue bonds issued by the Illinois Health Facilities Authority and the Illinois Finance Authority on behalf of Advocate Health Care, and its 'F1+' short-term ratings on the following Illinois Finance Authority bonds based upon self-liquidity provided by Advocate:

- \$51.9 million put bonds, series 2008A&C;
- \$137.2 million put bonds, series 2008A-1, 2 &3;
- \$21.9 million put bonds, series 2008C-3B;
- \$70 million put bonds, series 2011B.

The Rating Outlook is Stable

SECURITY

The bonds are unsecured obligations of the obligated group. They are not secured by a pledge of, mortgage on, or security interest in any obligated group assets.

KEY RATING DRIVERS

STRONG PROFITABILITY AND LIQUIDITY: Advocate's strong operating cash flow generation has led to substantial balance sheet strength, with liquidity indicators that well exceed Fitch's 'AA' category median ratios.

ROBUST DEBT SERVICE COVERAGE: Advocate's light debt burden combined with strong profitability has resulted in robust coverage of maximum annual debt service (MADS) by EBITDA of 9.6x and 10.6x in 2011 and 2010, respectively, which exceed the Fitch 'AA' category median metrics.

LEADING MARKET SHARE POSITION: Advocate is the largest healthcare provider in the State of Illinois and maintains a leading market share that is more than double its nearest competitor in the highly competitive six-county Chicago metropolitan area.

INTEGRATED DELIVERY PLATFORM: Advocate's integrated delivery approach facilitates increased physician alignment, efficient coordination of care and effective contracting and positions the organization for the expected implementation of healthcare reform.

CREDIT PROFILE

The 'AA' rating reflects Advocate's strong liquidity and profitability, robust debt service coverage, leading market share position in the Chicago land area and its integrated physician model. Advocate's historical profitability has been very strong. From 2008 through 2011, Advocate has generated operating margins between 4.9% and 7.4% and operating EBITDA margins ranging from 9.5% to 12.1%. In fiscal 2011, the system generated operating and operating EBITDA margins of 6.5% and 11.1%, respectively, which exceed the respective 'AA' medians of 4.3% and 10.6%. As a result of the system's strong cash flow generation and modest capital spending, Advocate's liquidity metrics are among the strongest in Fitch's not for profit portfolio. At March 31, 2012, Advocate's unrestricted cash and investments totaled \$3.2 billion which translates into 280.9 days cash on hand (DCOH), cushion ratio of 49x and 262.1% cash and investments to long-term debt; all of which exceed Fitch's respective 'AA' category medians of 240 DCOH, 22.4x cushion ratio and 159%.

Advocate's debt burden is light as indicated by MADS equating to just 1.4% of 2011 total revenues and debt to 2011 EBITDA of 1.9x. Advocate's strong profitability coupled with its light debt burden results in robust coverage of MADS by

http://beta.fitchratings.com/creditdesk/press_releases/detail.cfm?print=1&pr_id=755562

7/19/2012

EBITDA of 9.6x and 10.6x in fiscal 2011 and 2010, respectively, which is favorable to Fitch's 'AA' category median of 5.0x.

A key rating consideration continues to be Advocate's strong market position and coverage in the fragmented Chicago metropolitan market. Advocate remains the market share leader in the six-county Chicago metropolitan area with a 15.7% market share through Dec. 30, 2011 compared with its closest competitor, Presence Health Care (fka Resurrection Health Care, revenues rated 'BBB+' with a Stable Outlook by Fitch) with a 10.6% market share. Fitch believes Advocate benefits from its wide geographic coverage across the metropolitan area with 11 hospitals and over 200 separate sites including outpatient clinics, imaging centers, physician offices and urgent care centers. Furthermore, Advocate has a highly aligned medical staff with over 700 employed physician full-time employees (FTEs) in the Advocate Medical Group and its 4,100-member physician-hospital organization (PHO). While not without risk, Fitch views Advocate's recent initiatives in 'value based' reimbursement favorably as its better positions the organization towards the expected full implementation of the PPACA in 2014.

The 'F1+' rating reflects the strength of Advocate's cash and investment position to pay the cost of a mandatory tender on the series 2011B, 2003A, 2003C, 2008A-1, 2008A-2, 2008A-3 and 2008C-3B put bonds. At June 30, 2012, Advocate's eligible cash and investment position available for same-day settlement (see Fitch's report 'Criteria for Assigning Short-Term Ratings Based on Internal Liquidity' dated June 15, 2012) would cover the cost of the maximum mandatory put on any given date in excess of Fitch's criteria of 1.25x. Advocate has provided Fitch with an internal procedures letter outlining the procedures to meet any un-remarketed puts. In addition, Advocate provides monthly liquidity reports to Fitch to monitor the sufficiency of Advocate's cash and investment position relative to its mandatory put exposure.

At March 31, 2012 Advocate had total long-term debt of \$1.2 billion, of which \$321 million are weekly variable rate demand bonds (VRDBs), \$70 million are Windows VRDBs, and \$211 million are put bonds. The debt mix is 40% traditional fixed rate, 27% VRDBs, and 27% are in various put modes. Advocate is counter-party to three floating-to fixed-rate swaps with a total notional value of \$326.3 million. The mark-to-market on the swaps at June 30, 2011 was approximately negative \$72.4 million with no collateral posting required.

MADS is measured at \$65.8 million as provided by the underwriter. Through March 31, 2012, MADS as percentage of revenues was a low 1.4% and long-term debt equated to 2x EBITDA; both of which are lighter than the 'AA' category medians of 2.6% and 3x, respectively. Further, long-term debt to capitalization was a low 25.2% against Fitch's 'AA' category median of 34%.

The Stable Outlook reflects the strong financial profile of the system which provides strong financial cushion for the uncertainties that will impact the sector with further implementation of PPACA. Fitch believes Advocate's experienced management team and effective management practices should ensure strong relative performance over the longer term.

Advocate is an integrated health care system composed of 10 acute care hospitals, two integrated children's hospitals, a home health agency, and over 200 sites located throughout the Chicago metropolitan area and in Bloomington, IL. Total revenues in audited fiscal 2011 were \$4.65 billion (reflects Fitch's reclassification of bad debt to an expense).

Advocate's disclosure is outstanding and includes annual audited financial statements as well as quarterly unaudited balance sheet, income statement, cash flow statement, an extensive MD&A, and utilization statistics. The information is posted to the Municipal Securities Rulemaking Board's EMMA system. In addition, management holds quarterly calls with rating agencies and annual calls with investors. Fitch considers Advocate's disclosure standards to be best practice.

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Additional information is available at www.fitchratings.com. The ratings above were solicited by, or on behalf of, the issuer, and therefore, Fitch has been compensated for the provision of the ratings.

In addition to the sources of information identified in Fitch's Revenue Supported Rating Criteria, this action was informed by information from Citigroup as Underwriter.

Applicable Criteria and Related Research:
--'Revenue-Supported Rating Criteria', dated June 20, 2011;
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Aug. 12, 2011;
--'Criteria for Assigning Short-Term Ratings Based on Internal Liquidity' dated June 20, 2011

For information on Build America Bonds, visit www.fitchratings.com/BABs.

Applicable Criteria and Related Research:
Criteria for Assigning Short-Term Ratings Based on Internal Liquidity
Nonprofit Hospitals and Health Systems Rating Criteria
Revenue-Supported Rating Criteria

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MOODY'S INVESTORS SERVICE

Rating Update: Moody's affirms Aa2, Aa2/VMIG 1, and Aa2/P-1 ratings on Advocate Health Care Network's outstanding bonds; Outlook is stable

Global Credit Research - 19 Jul 2012

Rating actions affect approximately \$1.1 billion of outstanding debt

ILLINOIS FINANCE AUTHORITY
Hospitals & Health Service Providers
IL

Opinion

NEW YORK, July 19, 2012 --Moody's Investors Service has affirmed the Aa2, Aa2/VMIG 1 and Aa2/P-1 ratings on Advocate Health Care Network's (Advocate) outstanding bonds. The rating outlook is stable. The affirmation of the Aa2 long-term rating applies to all outstanding rated bonds. The Aa2/VMIG 1 ratings apply to the Series 2003A, Series 2003C, Series 2009A, and Series 2009C-3B variable rate annual and multi-annual put bonds, all of which are supported by self-liquidity. The Aa2/P-1 rating applies to the Series 2011B Windows variable rate bonds, as discussed below.

Moody's Investors Service, at Advocate's request, has reviewed the documents submitted to us in connection with the substitution of the current Standby Bond Purchase Agreements (SBPAs or liquidity facilities) provided by JPMorgan Chase Bank, N.A. for Series 2009C-1 and Series 2009C-2B, The Northern Trust Company for Series 2009C-2A and Bank of America, N.A. for Series 2009C-3A with new SBPAs for each Series. The new SBPAs will be provided by JPMorgan Chase Bank, N.A. for Series 2009C-1 and Series 2009C-2B, Wells Fargo Bank, National Association for Series 2009C-2A and The Northern Trust Company for Series 2009C-3A. The long-term and short-term rather senior obligation ratings of JPMorgan Chase Bank, N.A., Wells Fargo Bank, National Association and The Northern Trust Company are each Aa3/P-1.

Upon the substitution, the short-term rating for each Series will be based on the short-term rating of the applicable bank providing the liquidity facility, the long-term rating of the Bonds, and Moody's assessment of the likelihood of an early termination of a liquidity facility without a mandatory tender. Events which could lead to the immediate termination of a liquidity facility without a mandatory tender are directly related to the credit quality of Advocate. Accordingly, the likelihood of any such events occurring is reflected in the long-term rating assigned to the bonds which is currently Aa2.

Upon the effective date of the substitute liquidity facilities, which is currently scheduled for August 1, 2012, Moody's expects to upgrade to VMIG 1 from VMIG 2 the current rating assigned to the Series 2009C-3As as well as affirm the current short-term rating, VMIG 1, assigned to the Series 2009C-1, Series 2009C-2B and Series 2009C-2A bonds.

SUMMARY RATINGS RATIONALE:

The Aa2 long-term rating is based on Advocate's status as the largest healthcare system in the greater Chicago area with good geographic diversity and well positioned individual hospitals, sustained improvement in operating margins, moderate debt levels driving exceptional debt measures, a strong and growing investment portfolio, and well funded pension plan. The system's challenges include an increasingly competitive and consolidating healthcare market, moderate margins compared with similarly-rated peers, and expected increases in capital spending.

STRENGTHS:

*Leading market position in greater Chicagoland with good geographic coverage and individual hospitals that maintain leading or prominent market shares in their local markets; geographic reach and diversification expanding with strategy to extend further statewide

*Consistent margins over the last several years with operating cashflow margins in the 9-10% range; in 2011, most

hospitals improved or were relatively stable compared with the prior year

*Conservative and balanced approach to financing capital needs; proforma debt measures based on fiscal year 2011 are strong with a low 27% debt-to-operating revenue, exceptional Moody's adjusted peak debt service coverage of over 10 times and favorably low Moody's adjusted debt-to-cashflow of 1.9 times

*Strong and growing liquidity position with 261 days of cash on hand as of March 31, 2012, providing a strong 259% coverage of proforma debt

*Pension plan is well funded, even with recent increase in obligation, with a 86% pension funded ratio relative to a projected benefit obligation (PBO) of \$762 million at fiscal yearend (FYE) 2011

*Debt structure risks are manageable relative to liquidity with over 400% cash-to-demand debt and over 300% monthly cash-to-demand debt based on fiscal yearend 2011

*Strong management capabilities evidenced by the organization's historical ability to absorb operating challenges and continue to generate consistently solid absolute operating cashflow levels, meet or exceed operating budgets, effectively execute strategies including integrating newly acquired hospitals, and a commitment to very good disclosure practices

CHALLENGES

*Operating income and operating cashflow margins are below similarly-rated peers, in part due to the system's close integration with a large number of physicians

*An increasingly competitive market for a number of Advocate's hospitals, with competitors expanding facilities, growing consolidation with several large mergers or new entrants into the market and increasing competition for physicians

*Capital spending is anticipated to increase, although capital needs can be funded with cashflow and bond proceeds from issuances last year and a moderate amount of debt later this year; the system has a history of closely managing capital spending relative to cashflow and adjusting to operating shortfalls if necessary

*Changes in investment strategy with an increased allocation to alternative investments, resulting in a less liquid portfolio relative to historically conservative practices (74% of unrestricted investments can be liquidated within a month, compared with 79% median for the Aa2 rating category)

*Comprehensive debt (including pension and operating lease obligations) is almost 50% higher than direct debt, primarily as a result of sizable operating leases; however, cash-to-comprehensive debt for fiscal year 2011 is still good at 172%, compared with a median of 162% for the Aa2 category

DETAILED CREDIT DISCUSSION

LEGAL SECURITY: Obligated group includes the Advocate Health Care Network (system parent), Advocate Health and Hospitals Corporation (operates most of the system's hospitals), Advocate North Side Health Network, and Advocate Condell Medical Center. Security is a general, unsecured obligation of the obligated group. No additional indebtedness tests.

INTEREST RATE DERIVATIVES: Advocate has interest rate swaps associated with the Series 2008C bonds. There is a total of \$326 million of swaps associated with the Series 2008C bonds for which Advocate pays a fixed rate of 3.6% and receives 61.7% of LIBOR plus 26 basis points. The swaps mature in 2038 and the counterparties are Wells Fargo and PNC. As of March 31, 2012 the mark-to-market on the swaps was a negative \$72 million and no collateral was posted.

RECENT DEVELOPMENTS/RESULTS

Advocate has pursued an effective strategy to develop an integrated and full service system that has resulted in broad geographic coverage. The system controls ten acute care facilities, a large home health care operation and is closely aligned with approximately 1,000 physicians through either employment contracts or long-term contractual arrangements as well as another approximate 3,000 physicians through hospital-physician organizations. According to management, Advocate as a system maintains a leading market position in the greater Chicagoland area with a

15.7% share in 2011, compared with Presence Health at 10.3% and Northwestern Memorial Hospital at 5.7%. While most of Advocate's hospitals face local competition, the system's hospitals are large and very prominent providers with five of the nine generating over 15,000 admissions annually and the largest (Advocate Christ Medical Center) generating more than 40,000 admissions.

Despite good regional and local market positions, Advocate's hospitals face increasing competition. While Chicagoland had remained relatively fragmented, over the last two years there have been several large mergers or acquisitions, including some by large systems outside of the market. The largest of these transactions include Resurrection Healthcare and Provena Health System to form Presence Health, Ascension Health and Alexian Brothers, and Trinity Health and Loyola University Health System. Several community hospitals are in discussions with larger systems as well. Additionally, there has been increasing physician alignment and acquisition activity.

Advocate's growth strategies include expanding its geographic reach through mergers or affiliations with hospitals in a broader geographic region across Illinois as well as growing its physician affiliations or employment. Advocate's expansion beyond the greater Chicagoland region is a relatively new strategy, which we believe carries some risk as the system integrates hospitals in farther locations while aiming to maintain or improve operating performance at the existing hospitals. We believe that Advocate has a good track record in implementing similar strategies and, if executed successfully, its growth strategy would add diversification and market leverage. BroMenn Medical Center was the last acquisition in January 2010.

In addition to mergers and acquisitions, a major strategy of the system relates to partnerships with payers and transitioning to managing populations under value-based strategies, shifting from fee-for-service models. Advocate has a large contract with Blue Cross under this new model and has received approval for the Medicare shared savings model. Combined, these arrangements will represent over 500,000 lives and require the system to manage under these risk-based models. However, compared with other healthcare systems, we do believe that Advocate is relatively better positioned to manage this risk given the system's advanced strategies related to physician alignment and integration, information systems, historical experience with managing under capitated contracts, and strong financial resources.

Volume trends for the system were down moderately in fiscal year 2011 with a 2% decline in system-wide admissions and a 0.5% decline when including observation cases. The decline is reportedly due to the economy and benefit plan design changes, as well as the system's strategies to reduce hospital utilization under its new contractual arrangements; volumes in the region were generally down the end of 2011 and the beginning of 2012. This is evidenced in part by the slight uptick in Advocate's market share in 2011 compared to 2010.

Advocate's operating performance in fiscal year 2011 was below the prior year but margins remained relatively consistent with historical levels and significantly exceeded the budget. The system generated \$243 million (5.3%) of operating income in 2011 (excluding investment income on self-insurance funds, which are substantial), compared with \$272 million (6.1%) of operating income in 2010. Operating cashflow was \$460 million (10.0%) in fiscal year 2011, compared with \$484 million (10.9%) in 2010. Revenue growth was moderate at 3%, reflecting volumes and an increase in self-pay patients. The system absorbed a large increase in insurance expense in 2011, following unusually low costs in 2010. Advocate is implementing a major cost reduction program with a target of \$350 million by 2016. This program follows careful cost management in the last several years as revenue growth has slowed; costs per adjusted discharge have been flat.

Unrestricted investments grew significantly in fiscal year 2011, by \$230 million, to a very strong \$3.1 billion (269 days); investments as of March 31, 2012 are generally stable. Cash growth was due to good operating margins and the use of bond proceeds to partially fund capital. Based on data provided by management, Advocate's investment allocation has shifted to include a higher allocation to alternative investments (17% hedge funds and 9% private equity), more typical of systems with Advocate's size and resources. As a result, overall assets are less liquid but still provide adequate support for debt structure risks.

Capital spending is projected to increase in 2012 to over \$500 million and will be funded with debt proceeds (from the 2011 issuances), cashflow and a possibly a moderate amount of new debt later this year. The largest projects include a new ambulatory pavilion at Christ to alleviate space constraints and improve access and an ambulatory surgery center, and expanded cancer care capabilities at Illinois Masonic.

Advocate's debt structure includes variable rate bonds with mandatory tenders within the next twelve months; if these bonds are not remarketed, the system will use its own liquidity to pay the tenders, which supports the Aa2/MIG 1 ratings on these bonds. As of June 30, 2012, the Series 2008A-1 (\$51 million), Series 2008A-2 (\$43

million) and Series 2003C (\$26 million) have mandatory tenders within twelve months. Given the modest size of these staggered obligations, infrequent and known tender dates, and Advocate's experienced treasury management, the system has flexibility to use its large investment portfolio to fund any tenders on short notice if needed. The system has over \$300 million of assets that can be liquidated on a daily basis and another \$1.8 billion that can be liquidated within a week. Additionally, the system has the Series 2011B bonds (\$70 million), which bear interest at the Windows interest rate mode. This structure allows flexibility in planning for an unremarketed tender since it requires a 7-month advance put and, if not remarketed, 6 months to plan for a mandatory tender. Assignment of the P-1 rating to the Windows mode bonds is based on Moody's market access approach to self-liquidity on longer-term variable rate instruments and reflects our estimation of Advocate's ability to timely pay mandatory tenders at the close of the "Mandatory Tender Window". Please see Moody's report dated September 1, 2011 for more details.

SHORT-TERM RATINGS ON BANK SUPPORTED VARIABLE RATE DEBT BASED ON SBPA PROVISIONS AND BANK RATING

Each bank's obligations under the respective SBPA can be immediately terminated or suspended as a result of the occurrence of any of the following events: (i) the principal of or interest on any of the bonds, including bank bonds, is not paid when due; (ii) the SBPA, the bonds, the Bond Indenture, the Loan Agreement or the Master Indenture or any provision thereof requiring the Obligated Group or any Material Member thereof to make principal or interest payments with respect to the bonds (including the bank bonds) or relating to the security granted pursuant to the Master Indenture shall at any time for any reason cease to be valid and binding on the Obligated Group or such Material Member or shall be declared to be null and void, or the validity or enforceability thereof shall be contested by the Obligated Group or by an authorized officer of a Material Member; (iii) any governmental authority having jurisdiction shall find or rule that the SBPA, the bonds, the Bond Indenture, the Loan Agreement or the Master Indenture or any provision thereof requiring the Obligated Group or any Material Member thereof to make principal or interest payments with respect to the bonds (including the bank bonds) or relating to the security granted pursuant to the Master Indenture is not valid or binding on the Obligated Group or any Material Member; (iv) an authorized officer of a Material Member shall deny that it has any or further liability or obligation to make principal or interest payments with respect to the bonds (including the bank bonds) under any such document; (v) the bankruptcy or insolvency of the Obligated Group or any Material Member; (vi) the Obligated Group or any Material Member shall default in any payment of principal of or interest on any debt which is senior to or on parity with the bonds; (vii) a final, non-appealable judgment for the payment of money in excess of \$25,000,000 shall have been rendered against the Obligated Group or any Material Member and such judgment or order shall not have been satisfied, stayed or bonded pending appeal within a period of sixty (60) days from the date on which it was first so rendered; or (viii) each rating agency then rating the bonds shall downgrade the long-term unenhanced credit rating of the bonds or any parity bonds to below investment grade, or each rating agency shall suspend or withdraw such rating of the bonds or any parity bonds for credit related reasons. Material Member shall mean a member of the Obligated Group, or a combination of members of the Obligated Group whose: (a) total net assets are 50% or more of the combined or consolidated net assets of the Obligated Group; or (b) total net revenues are 50% or more of the combined or consolidated net revenues of the Obligated Group, in each case as shown on the financial statements for the most recently completed fiscal year.

The bonds while in the daily rate mode will pay interest on the fifth business day of each month and while in the weekly rate pay interest on the first business day of each month. Each series of bonds are convertible, in whole by series, to the daily rate, weekly rate, bond interest term rate, long term rate, auction rate or fixed rate mode. Upon conversion, the bonds of such series shall be subject to mandatory tender. Each SBPA supports the bonds while they bear interest in the weekly and daily rate modes only. Moody's short term rating only applies to the bonds bearing interest in the daily and weekly rate.

Bondholders may tender their bonds during a weekly rate mode on any business day with at least seven days prior written notice to the trustee, tender agent and remarketing agent. During the daily mode, a holder may exercise such tender option by delivering written notice to the trustee, tender agent and remarketing agent by 11:00 a.m. (New York City time) on any business day. Bonds which are purchased by a liquidity facility provider due to a failed remarketing may not be released by the tender agent until the applicable SBPA has been reinstated.

The bonds of each Series are subject to mandatory tender as follows: (i) on any interest rate conversion date for such series of bonds being converted to a different interest rate mode; (ii) at the end of each bond interest term rate; (iii) on the fifth (5th) business day preceding the expiration date of the SBPA; (iv) on the fifth (5th) business day prior to termination of the SBPA, including voluntary termination by Advocate; (v) on the substitution date of any liquidity facility; and (vi) on the fifth (5th) business day preceding the notice termination date of the liquidity facility specified

in such notice of termination delivered by such liquidity facility provider to the tender agent due to the occurrence of an event of default under the liquidity facility.

Each bank's commitment under the standby bond purchase agreement is sized for the full principal of the applicable series of bonds, plus 37 days interest at 12%, the maximum rate for such bonds. The SBPAs will secure payments of purchase price while the bonds bear interest in the daily and weekly rate modes.

Each SBPA is to be drawn on to make timely payment of purchase price to the extent remarketing proceeds are insufficient. Under the terms of each SBPA, conforming draws received by the bank by 12:00 p.m. (New York time) on a mandatory or optional tender date will be honored by 2:30 p.m. (New York time) on the same day.

Each bank's commitment under the SBPA will terminate, with respect to the applicable series of bonds, upon the earliest to occur: (i) the stated expiration date of the SBPA; (ii) the date on which no bonds remain outstanding; (iii) the close of business on the substitution date of the liquidity facility, provided the bank has honored all draws in connection with such substitution; (iv) the business day immediately following conversion of the bonds to a rate mode other than the weekly rate or daily rate; (v) the close of business on the 30th day following receipt by the tender agent of a notice of termination from the bank as a result of the occurrence of an event of default under the SBPA; (vi) the close of business on the date on which the available commitment has been reduced to zero; or (vii) upon an automatic termination event under the liquidity facility.

Each liquidity provider may be substituted and the corresponding series of bonds shall be subject to mandatory tender on the substitution date. The tender agent shall draw on the existing applicable liquidity facility and not cancel such facility until all draws have been honored.

Outlook

The stable outlook is based on the expectation that the system will continue to maintain solid operating performance and a strong market position and balance future capital spending and debt with cash flow and liquidity strength.

WHAT COULD MAKE THE LONG-TERM RATING GO UP

Sustained improvement in operating margins, further strengthening of liquidity, and growth in the system's size to provide significantly greater geographic diversity.

WHAT COULD MAKE THE LONG-TERM RATING GO DOWN

Significant greater than expected increase in debt or unexpected and prolonged decline in operating performance; material weakening of liquidity

WHAT COULD MAKE THE SHORT TERM RATING GO DOWN

The short-term rating on the bonds would be downgraded if the short-term rating on the Bank was downgraded, or could be downgraded if the long-term rating on the bonds was downgraded.

KEY INDICATORS

Assumptions & Adjustments:

-Based on financial statements of Advocate Health Care Network and Subsidiaries

-First number reflects audit year ended December 31, 2010

-Second number reflects audit year ended December 31, 2011

-Investment returns smoothed at 6% unless otherwise noted

*Inpatient admissions: 170,254; 166,756

*Total operating revenues: \$4.4 billion; \$4.6 billion

*Moody's-adjusted net revenue available for debt service: \$711 million; \$693 million

- *Total debt outstanding: \$1,041 million; \$1,221 million
- *Total comprehensive debt (including operating leases and pension obligations): \$1,593 million; \$1,793 million
- *Maximum annual debt service (MADS): \$52 million; \$66 million
- *Moody's-adjusted MADS Coverage with normalized Investment Income: 13.6 times; 8.9 times
- *Debt-to-cash flow: 1.6 times; 1.9 times
- *Days cash on hand: 263 days; 269 days
- *Cash-to-debt: 278%; 252%
- *Cash-to-comprehensive debt: 181%; 172%
- *Operating margin: 6.1%; 5.3%
- *Operating cash flow margin: 10.9%; 10.0%

RATED DEBT (as of December 31, 2011)

- Series 1993C (\$24 million), Series 2008D (\$164 million), Series 2010A (\$37 million), Series 2010B (\$52 million), Series 2010C (\$26 million), Series 2010D (\$122 million), Series 2011A (\$44 million) fixed rate bonds: Aa2
- Series 2003A (\$26 million), Series 2003C (\$26 million), Series 2008A (\$145 million), Series 2008C-3B (\$22 million) variable rate annual and multi-annual put bonds, supported by self-liquidity: Aa2/MMIG 1
- Series 2008C-1 (\$128 million), Series 2008C-2B (\$58 million) variable rate bonds supported with SBPAs from JPMorgan Chase (expires August 20, 2013; to be replaced with new SBPAs expiring August 1, 2017): Aa2/MMIG 1
- Series 2008C-3A (\$87 million) variable rate bonds supported by SBPAs from Bank of America (expires August 20, 2013) (to be replaced by Northern Trust Company, expiring August 1, 2017): Aa2/MMIG 2
- Series 2008C-2A (\$49 million) variable rate bonds supported by SBPA from The Northern Trust Company (expires August 20, 2013) (to be replaced by Wells Fargo Bank, expiring August 1, 2015): Aa2/MMIG 1
- Series 2011B Windows variable rate bonds (\$70 million): Aa2/P-1

CONTACTS

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- Financial Advisor: Jim Blake, Managing Partner, Kaufman, Hall & Associates, (847) 441-8780
- Underwriter: Ryan Freel, Director, Citi, Health Care Group, (312) 876-3564

PRINCIPAL METHODOLOGY USED

The principal methodology used in rating the bonds was Variable Rate Instruments Supported by Third-Party Liquidity Providers, published on November 3, 2006. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in March 2012. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

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Information sources used to prepare the rating are the following: parties involved in the ratings, public information, confidential and proprietary Moody's Investors Service's information, and confidential and proprietary Moody's Analytics' information.

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Please see ratings tab on the Issue/entity page on www.moodys.com for the last rating action and the rating history.

The date on which some ratings were first released goes back to a time before Moody's ratings were fully digitized and accurate data may not be available. Consequently, Moody's provides a date that it believes is the most reliable and accurate based on the information that is available to it. Please see the ratings disclosure page on our website www.moodys.com for further information.

Please see www.moodys.com for any updates on changes to the lead rating analyst and to the Moody's legal entity that has issued the rating.

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Grant Management Program 01

Grant No. 11-203303

for the

Advocate Northside Health Network

Illinois Department of Commerce and Economic Opportunity
500 E. Monroe St.
Springfield, IL 62701

Page 1

Grant Number 11-203303

**STATE OF ILLINOIS
DEPARTMENT OF COMMERCE AND ECONOMIC OPPORTUNITY**

Notice of Grant Award No. 11-203303

This Grant Agreement (hereinafter referred to as the "Agreement") is entered into between the Illinois Department of Commerce and Economic Opportunity (hereinafter referred to as the "Department" or "DCEO") and Advocate Northside Health Network (hereinafter referred to as the "Grantee"). Subject to terms and conditions of this Agreement, the Department agrees to provide a Grant in an amount not to exceed \$2,500,000.00 to the Grantee.

Subject to the execution of this Agreement by both parties, the Grantee is hereby authorized to incur costs against this Agreement from the beginning date of 04/01/2011 through the ending date of 03/31/2013, unless otherwise established within Part II Scope of Work. The Grantee hereby agrees to use the Grant Funds provided under the Agreement for the purposes set forth herein and agrees to comply with all terms of this Agreement.

This Agreement includes the following sections, all of which are incorporated into and made part of this Agreement:

Parts:

- I. Budget
- II. Scope of Work
- III. Grant Fund Control Requirements
- IV. Terms and Conditions
- V. General Provisions
- VI. Certifications

This grant is state funded.

Under penalties of perjury, the undersigned certifies that the name, taxpayer information number and legal status listed below are correct.

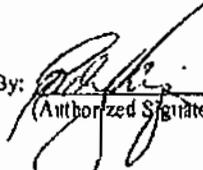
Name: Advocate Northside Health Network

Taxpayer Identification Number:
SSN/FEIN: 363196629

- Legal Status:
- Individual (01)
 - Sole Proprietor (02)
 - Partnership/Legal Corporation (03)
 - Corporation (04)
 - Not For Profit Corporation (04)
 - Medical Corporation (06)
 - Governmental (08)
 - Estate or Trust (10)
 - Pharmacy-Noncorporate (11)
 - Nonresident Alien (13)
 - Pharmacy/Funeral Home/Cemetery Corp (15)
 - Tax Exempt (16)
 - Limited Liability Company (select applicable tax classification)
 - C - Corporation
 - P - Partnership

GRANTEE:
Advocate Northside Health Network

Grantee's execution of this Agreement shall serve as its certification under oath that Grantee has read, understands and agrees to all provisions of this Agreement and that the information contained in the Agreement is true and correct to the best of his/her knowledge, information and belief and that the Grantee shall be bound by the same. Grantee acknowledges that the individual executing this Agreement is authorized to act on the Grantee's behalf. Grantee further acknowledges that the award of Grant Funds under this Agreement is conditioned upon the above certification.

By:  Date: 8-30-11
 (Authorized Signatory) _____
Randy Varju, Interim President
 Name and Title _____

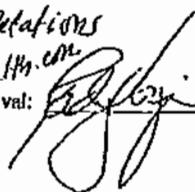
STATE OF ILLINOIS DEPARTMENT OF COMMERCE AND ECONOMIC OPPORTUNITY

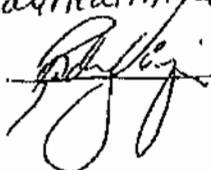
By:  ¹⁰ By: 
 Warren Ribley, Director Anita D. Patel
 Chief Financial Officer Date: 9/6/11

Grantee Address: Please indicate any address changes below
 836 W WELLINGTON AVE
 Chilongo, IL 60657-5147

In processing this grant and related documentation, the Department will only accept materials signed by the Authorized Signatory or Designee of this Agreement, as designated or prescribed herein. If the Authorized Signatory chooses to assign a designee to sign or submit materials required by this Agreement to the Department, the Authorized Signatory must either send written notice to the Department indicating the name of the designee or provide notice as set forth immediately following this paragraph. Without such notice, the Department will reject any materials signed or submitted on the Grantee's behalf by anyone other than the Authorized Signatory. The Authorized Signatory must approve each Authorized Designee separately by signing as indicated below. If an Authorized Designee(s) appears below, please verify the information and indicate any changes as necessary.

The following are designated as Authorized Designee(s) for the Grantee:

Authorized Designee: Beth Blacksin
 Authorized Designee Title: Director of Government Relations
 Authorized Designee Phone: 847-384-3423
 Authorized Designee Email: Beth.Blacksin@advocatehealth.com
 Authorized Signatory Approval:  8-30-11

SUSAN Toler
 Manager of Sponsored Programs
 630-990-5192
 susan.toler@advocatehealth.com
 8-30-11

PART I
BUDGET

Cost Category Description	Cost Cat	DCEO Budget Amount	Variance %	Variance Limit
DESIGN/ENGINEERING	1205	250,000.00	10.00	0.00
WIRING/ELECTRICAL	1215	284,000.00	10.00	0.00
EQUIPMENT/MATERIAL/LABOR	1217	312,000.00	10.00	0.00
PAVING/CONCRETE/MASONRY	1219	244,000.00	10.00	0.00
CONSTRUCTION MGMT & OVERSIGHT	1221	250,000.00	10.00	0.00
MECHANICAL SYSTEMS	1223	480,000.00	10.00	0.00
EXCAVATION/SITE PREP/DEMO	1225	306,000.00	10.00	0.00
PLUMBING	1229	124,000.00	10.00	0.00
OTHER CONSTRUCTION EXPENSES	1233	250,000.00	10.00	0.00
Total		\$2,500,000.00		

BUDGET LINE ITEM DEFINITIONS

The definitions listed below will help to identify allowable costs for each of the budgeted lines in this Agreement. Any costs not specifically named below should be verified to be allowable by the DCEO grant manager prior to incurring the cost.

DESIGN/ENGINEERING	costs associated with creation of the project's architectural drawings; engineering studies and/or fees; etc., including costs of plans & specs and/or printing costs if specifically identified as such within the Part II Scope of Work.
WIRING/ELECTRICAL	purchase of materials necessary for completion of the project scope such as: electrical wiring; conduit; outlets; switches; etc. including associated labor/installation costs, as identified within the Part II Scope of Work.
EQUIPMENT/MATERIAL/LABOR	purchase of materials and/or purchase/lease of equipment, to use or install for the project, such as: steel; drywall; lumber; wiring; doors; windows; roofing; rock; etc. including labor/installation costs, as identified within Part II Scope of Work.
PAVING/CONCRETE/MASONRY	purchase of materials necessary for completion of the project scope such as bituminous pavement; concrete; rock; bricks; blocks; mortar; tuckpointing; etc. including associated labor/installation costs, as identified within the Part II Scope of Work.
CONSTRUCTION MGMT & OVERSIGHT	costs associated with managing the construction activities and/or overseeing all aspects of the construction project, either by contractor personnel or Grantee personnel, but limited to verifiable time working on this project.
MECHANICAL SYSTEMS	purchase of materials necessary for completion of the project scope such as: HVAC; elevators; fire alarm, sprinkler, or ventilation systems; etc. including associated labor/installation costs, as identified within the Part

II Scope of Work.

EXCAVATION/SITE PREP/DEMO	costs associated with demolition of existing structures on the project site and/or preparation of the project site including excavation, etc. ahead of actual new construction/renovation activities.
PLUMBING	purchase of materials necessary for completion of the project scope such as: internal or external pipes for water, gas, and/or sewage; fixtures; etc. including associated labor/installation costs, as identified within the Part II Scope of Work.
OTHER CONSTRUCTION EXPENSES	costs that can't be easily broken out to or covered by other individual/specific Budgetary line items such as: landscaping; hauling; equipment rental; insurance; environmental fees; loan payments; etc. as identified within the Part II Scope of Work.

Pass-Through Entity or Subgrantor Responsibilities. If Grantee provides any portion of this funding to another entity through a grant agreement or contract, Grantee is considered to be a pass-through entity or subgrantor. Per Section 5.10(M) of the Agreement, Grantee must obtain written approval before it provides any portion of this funding to another entity through a grant agreement or contract. If the Department provides written approval, the Grantee must adhere to the following for any awards or contracts entered into using the Grant Funds listed above:

- (1) Ensure that all subgrant or contractual awards of Grant Funds are made in conformance with the terms of this Agreement specifically including, but not limited to, Sections 3.4 and 3.6 of this Agreement; and
- (2) Ensure subgrantees are aware of the terms and conditions of this grant and abide by them.

PART II

SCOPE OF WORK

In consideration for the Grant Funds to be provided by the Department, the Grantee agrees to perform the Project described in Part II (Scope of Work) hereof, in accordance with the provisions of Part I (Budget) hereof.

Section 1. Public Benefit

The Grantee is a not for profit organization that serves the health needs of individuals, families, and communities through a holistic philosophy. Patients are identified by referring physicians, family members, advocates, partner agencies, physician office visits/hospitalizations and diagnostic testing. The Grantee utilizes a sliding scale program for patients who qualify. However, the Grantee has a charity care policy in place and no patient is ever turned away because of inability to pay. Any patients regardless of income, age, religion, or employment status, who meet qualifying conditions, are eligible.

Grant funds will be used for a portion of the cost to construct a building addition to the existing Grantee owned Creticos Cancer Center located at 904 West Wellington, Chicago, Illinois on the overall campus of Advocate Illinois Masonic Medical Center. Specifically, Grant funds will be used for:

- **Design/Engineering** - to include the completion of the project's architectural/engineering drawings and specification documents, including fees, regulatory submissions, reimbursables, and printing costs.
- **Wiring/Electrical** - to include all associated materials and installation costs for electrical wiring, conduits, outlets, switches, site utilities, and low voltage wiring/outlets, including associated labor costs.
- **Equipment/Material/Labor** - to include all associated materials and installation of exterior super structure and walls, foundations, metal studs, drywall, lumber, doors & frames, door hardware, windows, roofing, and insulation, including associated labor costs.
- **Paving/Concrete/Masonry** - to include all associated materials and installation of concrete, bricks, mortar, and pavement, including associated labor costs.
- **Construction Management/Oversight** - all costs associated with managing the construction activities and/or overseeing all aspects of the construction project, either by contractor personnel or Grantee Personnel.
- **Mechanical System** - to include all associated materials and installation of the HVAC, fire alarm, sprinkler systems, exhaust systems, and site utilities, including associated labor costs.
- **Excavation/Site Prep/Demolition** - all costs associated with demolition of an existing structure and preparation of the project site including excavation and backfilling prior to the construction of the new structure.
- **Plumbing** - to include all associated materials and installation of interior/exterior piping for water, gas, sewage, and vents, including associated labor costs.
- **Other Construction Expenses** - to include all associated materials and installation of landscaping, equipment rental, surveys, miscellaneous carpentry, hauling, and contractor insurance including associated labor costs.

The Grant funded project will benefit the public by providing a state of the art cancer care to a larger number of patients and families.

Section 2. Grant Tasks

- 2.1 The Grantee shall use Grant funds as detailed in Part I, BUDGET. Expenditure of Grant funds will comply with applicable bond guidelines.
- 2.2 The Grantee shall utilize property acquired, constructed or improved with funds provided under this Agreement solely to provide the programs and services specified in Section 1, above, for at least the term of the Grant Agreement. Any sale, transfer, assignment or other conveyance of property acquired, constructed or improved shall provide that the property must continue to be used to accomplish or facilitate the public purpose described in Section 1, above.

- 2.3 The Grantee agrees to comply with the following:
- (a) The Grantee shall utilize grant funds in accordance with Part I (Budget) to complete the activities/performance described in Section 1, above. The Grantee shall provide any additional funds, or secure commitments therefore, which are necessary to complete the specified activities/performance during the grant term set forth in the Notice of Grant Award.
 - (b) The Grantee shall execute all agreements necessary to complete the activities/performance described in Section 1, above, including, but not limited to, purchase/sales contracts for real and/or personal property, leases, easements, loans, financing agreements, grant agreements, operating agreements, etc., during the grant term specified in the Notice of Grant Award.
 - (c) The Grantee shall obtain all authorization necessary to complete the activities/performance described in Section 1, above, including, but not limited to, municipal ordinances, permits, variances, other approvals, etc., during the grant term specified in the Notice of Grant Award.
 - (d) The Grantee shall notify the Departmental grant manager in writing no later than 10 days after it becomes aware of any events/circumstances that will result in substantial delays or may substantially impair the Grantee's ability to complete the activities/performance described in Section 1, above, during the grant term specified in the Notice of Grant Award.
 - (e) The Grantee shall provide to the Department additional information relative to its compliance with the provisions set forth in subsections (a) through (d), above, pursuant to Part III, Section 3.2C, "Additional Information."
 - (f) In addition to the requirements of Part III, Section 3.7, the Grantee shall maintain in its file, and make available to the Department upon request therefore, copies of documentation, correspondence, agreements, etc., evidencing compliance with the requirements of subsections (a) through (d), above.
- 2.4 Any equipment purchased with Grant funds provided hereunder shall only be used for the purposes set forth above for the term of the grant.
- 2.5 The Grantee agrees and affirms that its programs are available to any person interested in participating, regardless of that person's financial situation, religious affiliation (or lack thereof), ethnicity, or national origin.
- 2.6 The Grantee shall continue to provide the programs and services specified in Section 1 and 2, above, for the term of the Grant Agreement. The Grantee acknowledges that it shall not utilize Grant funds to perform or further the performance of sectarian activities.

IX. 1120.130 - Financial Viability

This section is not applicable. Advocate Health Care Network bonds have been rated by Moody's as Aa2, and Fitch AA, which qualifies the applicants for the waiver.

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

Financial Viability Waiver

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

- 5. All of the projects capital expenditures are completely funded through internal sources
- 6. 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
- 7. 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-40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (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.

2. 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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120. **Part A of this section is not applicable. Advocate Health Care Network bonds have been rated by Fitch as AA, and by Moody's as Aa2 which qualifies the applicants for the waiver.**

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 of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

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

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

C. Reasonableness of Project and Related Costs
 Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

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

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

A letter attesting to the conditions of debt financing follows as Attachment 42, Exhibit 1:



Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

July 16, 2012

Mr. Dale Galassie, Chairman
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Mr. Galassie:

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

Sincerely,

Susan Nordstrom Lopez
President

Subscribed and sworn before me this 16TH day of July 2012.

Notary Public

Cost & Gross Square Feet by Department or Service																	
Dept. / Area	A		B		C		D		E		F		G		H		Total Cost
	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. \$		Mod. \$		Total Cost						
	New	Mod	New	Circ	Mod.	Circ.	A x C	B x E	G + H								
CLINICAL																	
Surgery																	
Surgery Operating Rooms	\$ 518.43		19,742	15%								\$ 10,234,890					\$ 10,234,890
Surgery Procedure Rooms	\$ 432.03		6,559	15%								\$ 2,833,664					\$ 2,833,664
Phase II Recovery (Prep/recovery)	\$ 432.03		16,169	15%								\$ 6,985,443					\$ 6,985,443
Ambulatory Care Serv																	
Infusion Therapy	\$ 367.22		5,721	15%								\$ 2,100,882					\$ 2,100,882
Pre-Surgical Care	\$ 367.22		1,574	15%								\$ 578,009					\$ 578,009
Diag and Interv Rad.																	
Mammography, Needle Loc Only	\$ 475.23		338	15%								\$ 160,628					\$ 160,628
Therapeutic Radiology																	
Linear Accelerator	\$ 518.43		4,752	15%								\$ 2,463,590					\$ 2,463,590
CT Simulator	\$ 518.43		1,663	15%								\$ 862,153					\$ 862,153
Brachytherapy	\$ 518.43		2,046	15%								\$ 1,060,712					\$ 1,060,712
Pharmacy																	
Pharmacy, Satellite	\$ 367.22		665	15%								\$ 244,203					\$ 244,203
Total Clinical			59,229									\$ 27,524,175					\$ 27,524,175
Clin Contingency																	\$ 2,135,733
Total Clin Const + Contingency																	\$ 29,659,908
Clinical Const. + Contingency/DGSIF																	\$ 500.77

Source: AIMMC

Cost & Gross Square Feet by Department or Service											
Dept. / Area	A	B	C		D	E		F	G	H	Total Cost G + H
	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. \$	Mod. \$	A x C	B x E	
	New	Mod	New	Circ	Mod.	Circ.					
NON CLINICAL											
Physicians & Multidisciplinary Team Offices (Time Share, Exam, Consultation)	\$ 367.22		17,184	15%					\$ 6,310,358		\$ 6,310,358
Patient Ed/Resource Center/Conf	\$ 367.22		2,373	15%					\$ 871,420		\$ 871,420
Public Lobby, Waiting, Toilets, Stairs, Elevators, Corridors	\$ 302.42		25,852	35%					\$ 7,818,132		\$ 7,818,132
Corridors (Modernized Connectors)		\$219.73	0			4,300	100%			\$944,832	\$ 944,832
Mechanical/Electrical/Plumbing	\$ 302.42		6,411	0%					\$ 1,938,807		\$ 1,938,807
Crawl Area	\$ 194.41		11,086	0%					\$ 2,155,253		\$ 2,155,253
Penthouse, Air Handlers	\$ 302.42		17,656	0%					\$ 5,339,507		\$ 5,339,507
Total Non Clinical			80,562			4,300			\$ 24,433,476	\$944,832	\$ 25,378,308
Non Clin Contingency											\$ 3,060,032
Total Non Clin Const + Contingency											\$ 28,438,339
Non Clin Const. + Conting/DGSF											\$335.11
									\$		
Total Construction Cost									\$ 51,957,650	\$944,832	\$ 52,902,482
Total DGSF											144,091
Contingency											\$ 5,195,765
Total Construction + Contingency											\$ 58,098,247
Total Const. + Contingency/DGSF											\$403.21

Source: AIMMC

It is significant to note that there is extra cost in construction beyond the usual expectations for an outpatient center. See the list on the following pages that defines the pre-investment and premiums in the construction expense, which total \$10,032,000.

Any development of additional floors would likely be considered with a certificate of need application.

PRE-INVESTMENT AND PREMIUM COSTS

This Project has several items that are unusual for a typical outpatient center and have added significantly over the expected cost.

Included is the pre-investment costs to prepare the structure for up to six more floors to be added in the future by assuring the facility was sized, shaped, and of the right strength to accommodate that weight and use. There is no more vacant land around the Medical Center so it is essential that the proposed structure be able to meet that need, if and when the next modernization occurs.

Elements of the plan were affected by that forward thinking, including the following:

Pre-Investing Construction Costs	Cost
The new Center for Advanced Care foundation requires over 90 drilled piers (caissons) to be install versus spread footings, due to the existing soil classification as identified by GEI Consultants. These foundations are required to be oversized to accept the future Phase 2 patient tower.	\$ 350,000
The superstructure will also need to be oversized in order to support the Phase 2 patient bed tower (vertical expansion). The steel columns, girders and beams need to accommodate the future building.	\$ 1,500,000
Elevators shaft space will accommodate (6) six future elevators needed in Phase 2	\$ 120,000
The mechanical and electrical piping enclosed in building shafts to the new penthouse will be oversized to accommodate the future patient bed tower. This Project will have a penthouse where air handling units and water cooled chillers will be housed and this penthouse will provide a floor of separation for Phase 2 and utilize optimal air intake for the new facility.	\$ 350,000
The new Center for Advanced Care (Phase 1) is pre-investing in a 3 story Atrium entrance designed to integrate with the future Phase 2 patient bed tower expansion, which would be built above and to the west of Phase 1. The lobby space will connect with the existing hospital Stone Building on the 1 st and 3 rd levels.	\$ 400,000
Pre-Investment Costs	\$ 2,720,000

There are several other factors affecting the construction cost that take it above the usual and customary construction project.

Project Premiums	Cost
As the piers are drilled (see above) extra cost will be incurred due to the existing soil classification. Environmental company GSG Consultants, Inc issued a report dated May 30, 2012, that confirmed the soils are contaminated and will not be able to be disposed of in a typical Chicagoland landfill. The existing soils will need to be disposed of at a permitted Subtitle D landfill facility in accordance with all applicable	\$ 2,400,000

local, state and federal regulations. In order to construct a lower level to match the existing Stone Building, a sub-floor will be installed. To cut off the area from the high water table during the excavation and construction of the sub-floor, steel sheeting will be driven around the entire perimeter.	
Because this site is surrounded by residential property, there will be significantly more landscaping than usual for an outpatient center, in keeping with the expectations of the neighbors. (See the site plan drawing following the Narrative.)	\$ 550,000
There is a new City of Chicago requirement that 50 percent of roof area will be green. This requires constructing a roof that is fully insulated with waterproofing, drainage mat, protection soil sheet, specialized light weight soil along with plantings.	\$ 350,000
To match the existing hospital, additional floor-to-floor heights are required, which means the exterior wall is higher. Costs involved in supporting the exterior wall heights and the materials involved are incorporated into the cost of the Project.	\$ 450,000
The work required to connect the new Building to the existing hospital involves sawcutting and penetrating the exterior wall, frame-in exterior wall openings (lintels & expansion joints), re route existing air intake, relocate mechanical, electrical, plumbing, and fire protection utilities and build out the new corridor to the existing main corridors. This involves various steps to implement phasing and control of interim life safety measures and infection control.	\$ 900,000
Low voltage wiring is typically done by the owner, however it is included with construction cost in this Project because the project is being constructed as an Integrated Project Delivery (IPD). The IPD approach is to eliminate waste and incorporate the LEAN principles in constructing the new Building. It is more cost effective to have one electrician manage the low voltage system then three to four subcontractors working directly under the owner.	\$ 950,000
New to hospital construction costs is the Chicago permit cost. At the end of 2012 the City of Chicago CDOT waiver for permits will expire and not be renewed.	\$ 500,000
Construction within a residential neighborhood requires later starting and earlier stopping times, which in turn can limit the efficiency of the process. The noise ordinance prohibits major noise before 8 am. There is a premium to the cost when the worker can not start early in the day as they do in some other parts of the City.	\$ 350,000
Two linear accelerator concrete vaults added significantly to the cost over the usual construction cost of the most complex departments.	\$ 640,000
LEED administrative costs	\$ 222,000
Project Premium Costs	\$ 7,312,000
Total Pre-Investment and Premium Costs	\$ 10,032,000

Projected Operating Costs

	2017	Cost Per Equivalent Patient Day
Operating Cost	\$ 25,184,201	\$ 171.72

Impact of Project on Capital Costs

	2017	Cost Per Equivalent Patient Day
Capital Costs	\$ 9,856,967	\$ 67.21

Source: AIMMC

XI. Safety Net Impact Statement

While the following Safety Net Impact information is NOT required of non-substantive projects, it has been included to give the reader a better understanding of the hospital and the many ways it serves its community.

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Advocate Health and Hospitals Corporation, as a system, has a history of providing quality care to over a million patients annually. In addition, Advocate provides essential community services and programs to patients, families, and communities. In 2011, the Advocate system provided more than \$571 million in charitable care and services.

It is significant to note that in 2011 Advocate Illinois Masonic Medical Center (Medical Center) served 4,178 Medicaid inpatients and 33,784 Medicaid outpatients. Because of the high volume of Medicaid patients served, the Medical Center is a Disproportionate Share Hospital.

The Community Benefits provided by Advocate Illinois Masonic Medical Center in 2011 were as follows:

From 2011 Community Benefit Report Filing

Advocate Illinois Masonic Medical Center	Benefits Provided
Cost of charity Care	\$ 13,717,605
Cost of uncollectible accounts	\$ 4,962,836
Cost of government sponsored indigent health care	\$ 4,888,764
Total Education cost	\$ 16,843,291
Other Government-sponsored program services	\$ 80,281
Total Subsidized Health Services	\$ 3,841,496
Total donations	\$ 791,220
Total Volunteer services	\$ 377,680
Language Assistance Services	\$ 704,738
Total community benefits	\$ 46,207,909

Source: AIMMC Note the Cost of Charity Care has been recalculated with the most recent cost to charges ratio so differs from the number reported in the Annual Hospital Questionnaire.

The proposed Center for Advanced Care will have a positive impact on safety net services by expanding capacity and thus making more accessible the services it has historically provided to the region, including a growing number of patients with financial barriers to healthcare, special needs, or other limitations.

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.

Advocate Illinois Masonic Medical Center's development of a Center for Advanced Care should not affect any other facilities' ability to cross-subsidize other safety net services. The patients expected to use the services in the Center for Advanced Care, historically, have been served by Advocate Illinois Masonic Medical Center.

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

Not applicable.

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

- 1. For the three 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.

Advocate Illinois Masonic Medical Center certifies that the following charity care and community benefits information is accurate and complete and in accordance with the Illinois Community Benefits Act, and certifies the amount of care provided to Medicaid patients is consistent with the information published in the Annual Hospital Profile.

Safety Net Information per PA 96-0031

CHARITY CARE			
Charity (# of patients)	Year 2009	Year 2010	Year 2011
Inpatient	852	1,066	939
Outpatient	1,994	2,471	2,532
Total	2,846	3,537	3,471
Charity (cost in dollars)			
Inpatient	\$ 7,170,800	\$ 7,722,800	\$ 10,147,928 *
Outpatient	\$ 1,636,200	\$ 1,423,000	\$ 3,569,677 *
Total	\$ 8,807,000	\$ 9,145,800	\$ 13,717,605*
MEDICAID			
Medicaid (# of patients)	Year 2009	Year 2010	Year 2011
Inpatient	4,861	4,574	4,178
Outpatient	33,535	34,181	33,784
Total	38,396	38,755	37,962
Medicaid (revenue)			
Inpatient	\$ 36,862,754	\$ 29,696,470	\$ 31,264,925
Outpatient	\$ 2,050,610	\$ 4,259,220	\$ 3,591,168
Total	\$ 38,913,364	\$ 33,955,690	\$ 34,856,093

Source: AIMMC as reported with the 2011 Annual Hospital Questionnaire

*These Charity Care numbers are the updated value for the 2011 Annual Hospital Questionnaire (AHQ) as sent to IHFSRB. When the 2011 AHQ was originally submitted in April, the 2011 Medicare Cost Report with the 2011 Cost to Charges ratio was not yet available so the calculation was based on the 2010 Cost to Charges ratio.

By the time the Community Benefits report was due on June 30, the 2011 Cost to Charges ratio was known and used to restate the Charity Care.

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

Advocate Illinois Masonic Medical Center (Medical Center) has a long history of serving the North Side of Chicago. It takes great pride in the relationship it has had with many families, communities, organizations and agencies it serves. The following give a glimpse into some of the ways the Medical Center is addressing the needs of the people.

Advocate Illinois Masonic Medical Center has a strong relationship with the Hispanic community. As Chicago's Hispanic population has grown over the past decades, the Medical Center has stayed current with the community's health needs with Hispanocare. The program brings culturally tailored services and health education to Latino families. Community health fairs offer preventive screenings for conditions such as diabetes, high cholesterol, HIV and osteoporosis — all free of charge. Free symposiums and community seminars arm the community with information to reduce disease risk and stay healthy. Through a program for seniors, La Edad do Oro (The Golden Age), seniors benefit from a discount of up to 30 percent on optometry, podiatry, and dental services when they use a Hispanocare provider. The initiative also aims to usher more Hispanic students into health care professions through the use of scholarships.

The Medical Center is located in one of the largest lesbian, gay, bisexual, and transgender (LGBT) communities in the nation. In 2012, Advocate Illinois Masonic Medical Center was named a Leader in LGBT Healthcare Equality in the Human Rights Campaign Foundation's *Health Care Equality Index (HEI)* report for a fourth consecutive year.

Advocate Illinois Masonic Medical Center earned top marks for its policies and practices related to LGBT patients and their families. The Medical Center was one of only three facilities in Illinois to have been recognized as a Leader, demonstrating protection of LGBT patients and employees from discrimination, ensuring equal visitation access for same-sex couples and same-sex parents through explicitly inclusive policies and providing training for all personnel on LGBT cultural competency.

The benefit of the proposed Project to the LGBT community is the catering to the community's higher incidence of digestive disease issues. Digestive Health Services in the proposed Center for Advanced Care will help meet the needs of this growing demand.

Health care experts have predicted a shortage of physicians over the next 5 years. Advocate Illinois Masonic Medical Center is doing its part to make sure that prediction does not impact Chicago's North Side. Through strong ties with three universities, the medical center operates a robust residency program to train physicians in a variety of medical specialties, including family medicine, cardiology, obstetrics and gynecology, podiatry, and surgery. Residents engage in research and advanced care for patients from diverse cultural and economic backgrounds. The medical center also offers the only nurse residency program available in Chicago which provides new nurses the skills and confidence they need to thrive throughout their careers.

Quality medical care is important for children's futures. Advocate's Pediatric Developmental Center, the state's largest provider of medical diagnostic team evaluations for infants, offers home-based interventions. At Heartland Pediatric Center, children are able to receive care at all

stages of development, from birth through adolescence. The Center is located on the Advocate Illinois Masonic Medical Center campus and operated by Heartland International Health Center. Heartland's medical team offers well-child exams, school physicals and immunizations, chronic disease management and urgent care service for children, regardless of the family's insurance status. Most of the pediatric patients receive Medicaid benefits or are covered by the Illinois' All Kids Program. Families with uninsured children also are able to access care through an affordable sliding-fee scale.

Advocate Physicians Partners has established a Clinical Integration Program with new initiatives to address diabetes, asthma, coronary artery disease and congestive heart failure. This model, which includes training for small independent practices and their practice managers, is gaining support. The community continues to benefit from more coordinated care, and improved outcomes.

The Medical Center's Medication Assistance Program helps patients unable to afford medication who often forego treatment and their conditions worsen, resulting in higher health care costs. Advocate Illinois Masonic Medical Center's Pharmacy Department envisioned a program to help patients secure prescriptions they were unable to afford. The Medication Assistance Program, which began in 2009, helped more than 920 patients in 2011 access \$712,000 worth of medication, including \$43,000 worth of co-payment grants. In addition, the program prevented more than 10 patients from costly hospital admissions by providing medication assistance directly in the hospital's Emergency Department.

The goal of the program is to match Advocate Illinois Masonic patients who cannot afford much-needed medications with pharmaceutical programs that provide free and discounted prescription drugs to fulfill their doctor's orders. In 2012, it is anticipated that this program will enable patients to access more than \$1 million in prescription drugs, helping them stay healthy and avoid admission.

For more than 35 years, the Special Care Dentistry Program at Advocate Illinois Masonic Medical Center has gone to great strides to provide quality oral health care for patients with mental or physical disabilities. A patient with developmental disabilities may not understand the need for dental care, or why a dentist wants to probe inside his or her mouth. A patient with seizure disorder, cerebral palsy, muscular dystrophy or other challenging condition may find it nearly impossible to sit in a dental chair for an examination. And these special needs patients and their families may overlook essential dental care in the face of more pressing health problems. In addition, many dentists lack the training or equipment needed to help such patients. As a result, many people with disabilities lack access to even the most basic dental care. It is estimated that one out of two persons with a significant disability cannot find a professional resource to provide appropriate and necessary dental care.

The Special Care Dentistry Program provides routine dental care to adults and children with developmental disabilities, including Down syndrome, mental retardation and cerebral palsy. Since its inception, the program has served more than 68,000 special needs patients, now seeing more than 2,000 patients annually. The patients seen through the program are a diverse group, with varying limitations, capabilities and resources. Some are minimally challenged and can be

treated in a dentist's chair without any problem. Others are more difficult to care for as outpatients due to the challenge to cooperate with the dentist. There are also patients with severe handicaps, who must be hospitalized so that their dental treatment can be performed under general anesthesia in the operating room.

In addition to the clinical services it performs, the Special Care Dentistry Program also provides educational outreach and screening services within the community. The program's dental hygienist travels to schools, workshops and residential facilities for the disabled and provides on-site oral hygiene instruction.

Advocate Illinois Masonic Medical Center conducted a Community Health Needs Assessment in 2011 that identified the health needs of low income, underserved and uninsured communities and then helped identify programming to meet those needs with measurable impact. One of the confirmed needs was to address childhood obesity in the service area.

Jahn Elementary School Childhood Obesity Program was developed to help stem the tide of childhood obesity, which is no easy task, taking patience and effort. The work underway over the past year in a partnership between the Medical Center and Jahn Elementary School on Chicago's North Side is showing promising results. During the first year of the partnership, 60 of the 123, or 49.8 percent, of students whose body mass index (BMI) was measured more than once have either decreased or remained the same.

This is an educational process for the students, focusing on long-term changes. Three Body Mass Index clinics were performed at the school and the students were provided pedometers by the hospital. In addition, Advocate Illinois Masonic nutritionists worked with the Jahn staff and, by extension, Chicago Public Schools, to create a healthier lunch menu—including a salad bar—that provides more vegetable and fruit choices.

Nationally, experts estimate that about 25 to 28 percent of grade-school-age children are clinically obese or overweight. In Chicago, that number is estimated to be more than 30 percent. The Jahn School program takes a multi-prong approach to the obesity battle, with educational components now for students and school staff, and programs to be added for parents in the future. The pilot program, a result of the hospital's 2011 community health needs assessment, began with a weigh-in before the summer break. Students will weigh in a few times a year, with programs to support their efforts being added, as needed.

Other community outreach programs of significance include:

- Behavioral Health Center, which is noted for substance abuse, crisis intervention and multilingual psychiatric services.
- The Pediatric Development Center offers the Puentes ("bridges" in Spanish) Autism Program for young children with autism.
- Asthma Learning Center provides adults and children with free education to help regulate their asthma.
- Diabetes Care Program is long recognized for its comprehensive, bilingual educational services.
- Mobile Dentistry Program brings much-needed dental services to underserved populations of Chicago.

- In addition to Spanish and Polish interpreters, the Medical Center has a full-time American Sign Language (ASL) interpreter for the deaf and hard-of-hearing patients and guests. The Spanish and Polish interpreters are employed by the Medical Center. Other interpreter services are provided, either by phone or in person, and encompass over 35 difference languages.
- Hispanocare and the Creticos Cancer Center have historically partnered on several cancer prevention and screening programs. Specifically, bilingual programs have been held to educate the community about breast and prostate health. Other offerings have included physical exams, free PSA blood draws, and community referrals for free mammograms.
- Dr. Marek Rudnicki, a surgeon at the Medical Center, leads an annual Polish American Breast Cancer program, which is a valued resource in Chicago, as Chicago has the largest Polish population outside of Warsaw. This event is partially funded by a Susan Komen Foundation grant.
- The Medical Center partners with the Howard Brown Health Center to connect underserved women in the community with the Illinois Breast and Cervical Cancer Program.
- The Creticos Cancer Center offers free psychosocial services to patients and their families. The literature indicates that psychosocial distress must be addressed for cancer patients and is correlated with healing and coping. Services include individual and family counseling, smoking cessation counseling, biofeedback and connection to community resources. These programs are partly funded by philanthropic funds and are offered to patients and their families free of charge.
- The Medical Center also provides transportation services to patients who cannot afford such services to and from their appointments. This becomes especially important for patients with diagnoses such as cancer who may not have family members to transport them for daily treatments and who may otherwise have to depend on public transportation in their physically compromised state.
- The Medical Center's Emergency Department is currently seeing many community members with behavioral health issues, who have been displaced by the closing of several mental health facilities in the Uptown area. As a result of the patient focused approach to caring for this population, the Emergency Department was identified as a "best practice" during the last survey by the Joint Commission.

Advocate Illinois Masonic Medical Center is the lead hospital for the city of Chicago in the event of a disaster. It is one of only 11 hospitals in Illinois to be responsible for coordinating disaster medical response upon the activation of the Emergency Medical Disaster Plan. To achieve this assignment the Medical Center is the designated resource hospital, designated Level I Trauma Center, and leads coordination of disaster response activities with its resource, associate and participating hospitals and EMS providers. This requires the Medical Center to maintain an established two-way communication system to participating and associate hospitals.

The Medical Center was recognized by the Chicago Fire Department for its preparation and action during a recent blizzard that closed down Lake Shore Drive. Another recent example of this excellent system at work was during the NATO Summit in Chicago in May 2012.

In summary, the impact of the Medical Center has both depth and breadth. Many of the programs have been in place for years and the community has come to rely on them to meet

various special needs. At the same time, the associates at the Medical Center have been atuned to the changing times and have been developing new partnerships and new services to support the health and wellness of all they serve.

Press Release

July 9, 2012

Contact:
Stephanie S. Johnson
Director, Public Affairs

Midwest's Largest Health System Reports \$571 Million in Community Benefits

Oak Brook, Ill. — Oak Brook based Advocate Health Care, recognized as one of the nation's top health systems announced today that it provided \$571 million in charitable care and services in 2011. The contribution represents more than one-million lives touched in the communities Advocate serves throughout Chicagoland and central Illinois.

"We are proud to have provided charitable care and services that touched more than one million lives last year," said Jim Skogsbergh, president and CEO of Advocate Health Care. "We continually challenge ourselves to extend our services beyond our hospital walls."

Advocate provided \$95.3 million in free and discounted charity care for the uninsured and underinsured, and supplied more than \$295 million in care without full reimbursement from Medicare, Medicaid or other government-sponsored programs. In 2011, these benefits alone totaled \$390 million in health care service costs.

In addition to free and subsidized health care, Advocate also offers programs and services that respond to communities' unique needs. These include health and wellness screenings, behavioral health services, and school-based health care. Advocate also made significant investments in language-assistance programs, which offer our patients access to interpreters and other non-English patient education materials.

Contributions to other not-for-profit community organizations, as well as equipment, supplies and clinic space donations totaled \$4.6 million. Advocate also increased its provision of medical education and training in 2011 by more than \$9 million. As part of its annual Community Benefits Report, a detailed breakdown of Advocate's contributions was recently filed with the State.

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About Advocate Health Care

Advocate Health Care, one of the nation's top health systems based on clinical performance, is the largest health system in Illinois and one of the largest health care providers in the Midwest. Advocate operates more than 250 sites of care, including 10 acute care hospitals, two integrated children's hospitals, five Level I trauma centers (the state's highest designation in trauma care) and two Level II trauma centers, one of the area's largest home health care companies and one of the region's largest medical groups. Advocate Health Care trains more than 2,000 residents, medical students and fellows at its three major teaching hospitals. As a not-for-profit, mission-based health system affiliated with the Evangelical Lutheran Church in America and the United Church of Christ, Advocate contributed \$571 million in charitable care and services to communities across Chicagoland and central Illinois in 2011.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

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 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

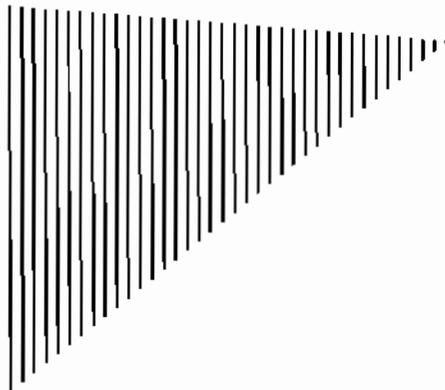
Charity Care History

	Year 2009	Year 2010	Year 2011
Net Patient Revenue	\$348,898,149	\$361,327,709	\$356,402,216
Amount of Charity Care (charges)	\$ 40,612,361	\$ 30,231,287	\$ 43,124,690
Cost of Charity Care	\$ 8,807,000	\$ 9,145,800	\$ 13,717,605*
Charity Care as percent of total net patient revenue	2.5%	2.5%	3.8%

Source: AIMMC as reported with the 2011 Annual Hospital Questionnaire

*This Charity Care number is the updated value for the 2011 Annual Hospital Questionnaire (AHQ) as sent to IHFSRB. When the 2011 AHQ was originally submitted in April, the 2011 Medicare Cost Report with the 2011 Cost to Charges ratio was not yet available so the calculation was based on the 2010 Cost to Charges ratio.

By the time the Community Benefits report was due on June 30, the 2011 Cost to Charges ratio was known and used to restate the Charity Care.



CONSOLIDATED FINANCIAL STATEMENTS

Advocate Health Care Network and Subsidiaries
Years Ended December 31, 2011 and 2010
With Report of Independent Auditors

Ernst & Young LLP



Advocate Health Care Network and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2011 and 2010

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Report of Independent Auditors

The Board of Directors
Advocate Health Care Network

We have audited the accompanying consolidated balance sheets of Advocate Health Care Network and subsidiaries (collectively, the System) as of December 31, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the System's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the System's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Advocate Health Care Network and subsidiaries at December 31, 2011 and 2010, and the consolidated results of their operations and changes in net assets and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, in 2011 the System adopted authoritative guidance issued by the Financial Accounting Standards Board related to presentation and disclosures of patient service revenue, provisions for bad debts, and the allowance for doubtful accounts.

March 9, 2012

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A member firm of Ernst & Young Global Limited

Advocate Health Care Network and Subsidiaries

Consolidated Balance Sheets
(Dollars in Thousands)

	December 31	
	2011	2010
Assets		
Current assets:		
Cash and cash equivalents	\$ 302,796	\$ 542,002
Short-term investments	20,372	25,464
Assets limited as to use	75,710	69,604
Patient accounts receivable, less allowances for uncollectible accounts of \$132,507 in 2011 and \$129,209 in 2010	511,302	400,855
Amounts due from primary third-party payors	6,357	4,056
Prepaid expenses, inventories, and other current assets	258,971	220,093
Collateral proceeds received under securities lending program	19,135	218,777
Total current assets	1,194,643	1,480,851
Assets limited as to use:		
Internally and externally designated investments limited as to use	3,636,696	2,998,858
Investments under securities lending program	19,067	213,830
	3,655,763	3,212,688
Other noncurrent assets	110,445	109,766
Interest in health care and related entities	129,955	132,324
Reinsurance receivable	177,207	164,074
Deferred costs and intangible assets, less allowances for amortization	36,708	22,175
	4,110,078	3,641,027
Property and equipment – at cost:		
Land and land improvements	180,834	170,705
Buildings	2,098,612	1,971,568
Movable equipment	1,204,236	1,111,226
Construction-in-progress	112,855	132,544
	3,596,537	3,386,043
Less allowances for depreciation	1,922,395	1,786,886
	1,674,142	1,599,157
	\$ 6,978,863	\$ 6,721,035

	December 31	
	2011	2010
Liabilities, net assets and shareholders' equity		
Current liabilities:		
Current portion of long-term debt	\$ 22,711	\$ 17,418
Long-term debt subject to short-term remarketing arrangements	197,870	122,060
Accounts payable	201,800	166,442
Accrued salaries and employee benefits	335,044	305,421
Accrued expenses	196,584	206,874
Amounts due to primary third-party payors	214,637	237,731
Current portion of accrued insurance and claims costs	98,152	91,807
Obligations to return collateral under securities lending program	19,410	219,052
Total current liabilities	<u>1,286,208</u>	<u>1,366,805</u>
Noncurrent liabilities:		
Long-term debt, less current portion	1,000,521	901,091
Pension plan liability	108,372	34,296
Accrued insurance and claims cost, less current portion	648,885	679,317
Accrued losses subject to reinsurance recovery	177,207	164,074
Obligations under swap agreements, net of collateral posted	89,092	16,111
Other noncurrent liabilities	109,073	91,323
	<u>2,133,150</u>	<u>1,886,212</u>
Total liabilities	<u>3,419,358</u>	<u>3,253,017</u>
Net assets/shareholders' equity:		
Unrestricted	3,444,745	3,363,405
Temporarily restricted	75,331	74,786
Permanently restricted	38,463	28,794
	<u>3,558,539</u>	<u>3,466,985</u>
Non-controlling interest	966	1,033
Total net assets/shareholders' equity	<u>3,559,505</u>	<u>3,468,018</u>
	<u>\$ 6,978,863</u>	<u>\$ 6,721,035</u>

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Operations and
Changes in Net Assets
(Dollars in Thousands)

	Year Ended December 31	
	2011	2010
Unrestricted revenues, gains, and other support		
Net patient service revenue	\$ 3,982,373	\$ 3,885,322
Provision for uncollectible accounts	(211,507)	(212,536)
	<u>3,770,866</u>	<u>3,672,786</u>
Capitation revenue	397,485	392,854
Other revenue	272,113	227,464
	<u>4,440,464</u>	<u>4,293,104</u>
Expenses		
Salaries, wages, and employee benefits	2,221,793	2,137,097
Purchased services and operating supplies	1,085,228	1,053,932
Contracted medical services	180,130	180,921
Insurance and claims costs	89,091	46,422
Other	346,385	329,340
Depreciation and amortization	171,884	164,984
Interest	45,141	45,205
	<u>4,139,652</u>	<u>3,957,901</u>
Operating income	300,812	335,203
Nonoperating (loss) income		
Investment (loss) income	(92,062)	285,560
Change in fair value of interest rate swaps	(45,011)	(14,335)
Fair value of net assets acquired	-	225,541
Loss on refinancing of debt	(32)	(453)
Other nonoperating items, net	(15,354)	(17,447)
	<u>(152,459)</u>	<u>478,866</u>
Revenues in excess of expenses	<u>\$ 148,353</u>	<u>\$ 814,069</u>

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Operations and
Changes in Net Assets (continued)

(Dollars in Thousands)

	Year Ended December 31	
	2011	2010
Unrestricted net assets		
Revenues in excess of expenses	\$ 148,353	\$ 814,069
Net assets released from restrictions and used for capital purchases	4,767	8,716
Postretirement benefit plan adjustments	(71,780)	25,137
Increase in unrestricted net assets	81,340	847,922
Temporarily restricted net assets		
Contributions for medical education programs, capital purchases, and other purposes	\$ 12,979	\$ 11,789
Realized gains on investments	2,197	1,199
Unrealized (losses) gains on investments	(2,122)	3,524
Contribution of net assets of BroMenn Healthcare System and subsidiaries	-	9,814
Net assets released from restrictions and used for operations, medical education programs, capital purchases, and other purposes	(12,509)	(16,254)
Increase in temporarily restricted net assets	545	10,072
Permanently restricted net assets		
Contributions for medical education programs, capital purchases, and other purposes	9,669	998
Contribution of net assets of BroMenn Healthcare System and subsidiaries	-	10,223
Increase in permanently restricted net assets	9,669	11,221
Increase in net assets	91,554	869,215
Change in non-controlling interest	(67)	(204)
Net assets/shareholders' equity at beginning of year	3,468,018	2,599,007
Net assets/shareholders' equity at end of year	\$ 3,559,505	\$ 3,468,018

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended December 31	
	2011	2010
Operating activities		
Increase in net assets	\$ 91,487	\$ 869,011
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation, amortization, and accretion	173,040	166,077
Provision for uncollectible accounts	211,507	212,536
Credit for deferred income taxes	3,013	16,303
Losses (gains) on disposal of property and equipment	2,726	(1,989)
Loss on refinancing of debt	32	453
Change in fair value of interest rate swaps	45,011	14,335
Postretirement benefit plan adjustments	71,780	(25,138)
Contribution of certain net assets of BroMenn Healthcare System and subsidiaries, net of \$4,918 cash received	-	(245,578)
Restricted contributions and gains on investments, net of assets released from restrictions used for operations	(7,742)	(7,538)
Changes in operating assets and liabilities:		
Trading securities	(459,448)	(759,060)
Patient accounts receivable	(319,061)	(246,997)
Amounts due to/from primary third-party payors	(25,395)	47,926
Accounts payable, accrued salaries and employee benefits, accrued expenses, and other noncurrent liabilities	59,081	149,285
Other assets	(29,688)	(54,340)
Accrued insurance and claims cost	(74,230)	(39,384)
Net cash (used in) provided by operating activities	(207,887)	95,902
Investing activities		
Purchases of property and equipment	(250,582)	(178,656)
Proceeds from sale of property and equipment	3,685	6,929
Cash acquired in the acquisition of BroMenn Healthcare System and subsidiaries	-	4,918
Purchases of investments designated as non-trading	(253,913)	(96,976)
Sales of investments designated as non-trading	254,291	130,414
Other	(16,401)	(6,089)
Net cash used in investing activities	(262,920)	(139,460)
Financing activities		
Proceeds from issuance of debt	214,228	243,746
Payments of long-term debt	(33,319)	(173,456)
Collateral returned under swap agreements	27,969	3,930
Proceeds from restricted contributions and gains on investments	22,723	17,510
Net cash provided by financing activities	231,601	91,730
(Decrease) increase in cash and cash equivalents	(239,206)	48,172
Cash and cash equivalents at beginning of year	542,002	493,830
Cash and cash equivalents at end of year	\$ 302,796	\$ 542,002

See accompanying notes to consolidated financial statements.

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Advocate Health Care Network and Subsidiaries**Notes to Consolidated Financial Statements**
(Dollars in Thousands)

December 31, 2011

1. Organization and Summary of Significant Accounting Policies**Organization**

Advocate Health Care Network (the System) is a nonprofit, faith-based health care organization dedicated to providing comprehensive health care services, including inpatient acute and nonacute care, primary and specialty physician services and various outpatient services to communities in Northern and Central Illinois. Additionally, through a long-term academic and teaching affiliation, the System trains resident physicians. The System is affiliated with the United Church of Christ and Evangelical Lutheran Church of America. Substantially all expenses of the System are related to providing health care services.

Effective January 6, 2010, the net assets of BroMenn Healthcare System and subsidiaries (collectively, BroMenn) were merged into the System. BroMenn, a not-for-profit organization, is located in the greater Bloomington-Normal and Eureka, Illinois, areas. The transaction was accounted for as an acquisition in accordance with the authoritative guidance on not-for-profit mergers and acquisitions and is described in Note 13.

Mission and Community Benefit

As a faith-based health care organization, the mission, values and philosophy of the System form the foundation for its strategic priorities. The System's mission is to serve the health care needs of individuals, families and communities through a holistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. The System's core values of compassion, equality, excellence, partnership and stewardship guide its actions to provide health care services to its communities. Consistent with the values of compassion and stewardship, the System makes a major commitment to patients in need, regardless of their ability to pay. This care is provided to patients who meet the criteria established under the System's charity care policy. Patients eligible for consideration can earn up to 600% of the federal poverty level. Qualifying patients can receive up to 100% discounts from charges and extended payment plans. In 2011 and 2010, \$276,993 and \$234,295, respectively, of patient charges were foregone under this policy. The System's cost of providing charity care in 2011 and 2010 was \$76,367 and \$64,595, respectively. The cost of providing charity care is calculated using the 2010 Medicare cost to charge ratio.

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Advocate Health Care Network and Subsidiaries**Notes to Consolidated Financial Statements (continued)***(Dollars in Thousands)***1. Organization and Summary of Significant Accounting Policies (continued)**

The System is also involved in other numerous wide-ranging community benefit activities that include providing health education, immunizations for children, support groups, health screenings, health fairs, pastoral care, home-delivered meals, transportation services, seminars and speakers, crisis lines, publication of health magazines, medical residency and internships, research and language assistance and other subsidized health services. These activities are provided free of charge or at a fee that is below the cost of providing them. The cost of these activities and the costs of uncompensated care for 2011 will be included in a community benefit report that will be filed with the Office of the Attorney General for the State of Illinois in June 2012.

Principles of Consolidation

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

Use of Estimates

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

Cash Equivalents

The System considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

Advocate Health Care Network and Subsidiaries**Notes to Consolidated Financial Statements (continued)**
*(Dollars in Thousands)***1. Organization and Summary of Significant Accounting Policies (continued)****Investments**

The System has designated substantially all of its investments as trading. Certain debt-related investments are designated as non-trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices. The non-trading portfolio consists mainly of cash equivalents, money market, and commercial paper. Investments in limited partnerships that invest in marketable securities and derivative products (hedge funds) are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships are recorded using the cost method of accounting, as the System's ownership percentage is less than 5% and the System has no significant influence over the partnerships. Investment income or loss (including realized gains and losses, interest, dividends, changes in equity of limited partnerships and unrealized gains and losses) is included in investment income unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue. Unrealized gains and losses that are restricted by donor or law are reported as a change in temporarily restricted net assets.

Assets Limited as to Use

Assets limited as to use consist of investments set aside by the Board of Directors for future capital improvements and certain medical education and health care programs. The Board of Directors retains control of these investments and may, at its discretion, subsequently use them for other purposes. Additionally, assets limited as to use include investments held by trustees under debt agreements and self-insurance trusts.

Patient Service Revenue and Accounts Receivable

Patient accounts receivable are stated at net realizable value. The System evaluates the collectibility of its accounts receivable based on the length of time the receivable is outstanding, major payor sources of revenue, historical collection experience and trends in health care insurance programs to estimate the appropriate allowance for uncollectible accounts and provision for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for uncollectible accounts. For receivables associated with self-pay patients, the System records a significant provision for

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**1. Organization and Summary of Significant Accounting Policies (continued)**

uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods. Accounts receivable are charged to the allowance for uncollectible accounts when they are deemed uncollectible.

The allowance for uncollectible accounts as a percentage of accounts receivable decreased from 24% in 2010 to 21% in 2011 primarily due to an increase in Medicaid accounts receivable due to a slow down by the State of Illinois in processing claims and an increase in the number of self-pay patients qualifying for charity care. The System's combined allowance for uncollectible accounts receivable, uninsured discounts and charity care covered 100% of self-pay accounts receivable at December 31, 2011 and 2010, respectively.

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. For uninsured patients that do not qualify for charity care, the System recognizes revenue on the basis of its standard rates for services provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for uncollectible accounts), is reported at the estimated net realizable amounts from patients, third-party payors and others for service rendered, including estimated adjustments under reimbursement agreements with third-party payors, certain of which are subject to audit by administering agencies. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods. Patient service revenue, net of contractual allowances and discounts (but before the provision for uncollectible accounts), recognized in the period from these major payor sources, is as follows for the year ended December 31, 2011:

	<u>Third-Party Payors</u>	<u>Self-Pay</u>	<u>Total All Payors</u>
Patient service revenue (net of contractual allowances and discounts)	\$ 3,646,278	\$ 336,095	\$ 3,982,373

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market value.

Reinsurance Receivable

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Deferred Costs

Deferred costs consist primarily of noncurrent deferred tax assets and deferred bond issuance costs. Deferred bond issuance costs are amortized over the life of the bonds using the effective interest method.

Asset Impairment

The System considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs, except for those related to investments, are recognized in operating income at the time the impairment is identified.

Property and Equipment

Provisions for depreciation of property and equipment are based on the estimated useful lives of the assets ranging from 3 to 80 years using both accelerated and straight-line methods.

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Asset Retirement Obligations

The System recognizes its legal obligations associated with the retirement of long-lived assets that result from the acquisition, construction, development or the normal operations of long-lived assets when these obligations are incurred. The obligations are recorded as a noncurrent liability and are accreted to present value at the end of each period. When the obligation is incurred, an amount equal to the present value of the liability is added to the cost of the related asset and is depreciated over the life of the related asset. The obligations at December 31, 2011 and 2010, were \$19,031 and \$19,320, respectively.

Derivative Financial Instruments

The System has entered into derivative transactions to manage its interest rate risk. Derivative instruments are recorded as either assets or liabilities at fair value. Subsequent changes in a derivative's fair value are recognized in nonoperating income (loss).

General and Professional Liability Risks

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

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

Assets released from restriction to fund purchases of property and equipment are reported in the consolidated statements of operations and changes in net assets as increases to unrestricted net assets. Those assets released from restriction for operating purposes are reported in the consolidated statements of operations and changes in net assets as other revenue. When restricted, earnings are recorded as temporarily restricted net assets until amounts are expended in accordance with the donor's specifications.

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

Capitation Revenue

The System has agreements with various managed care organizations under which the System provides or arranges for medical care to members of the organizations in return for a monthly payment per member. Revenue is earned each month as a result of agreeing to provide or arrange for their medical care.

Other Nonoperating Items, Net

Other nonoperating items, net primarily consist of provisions for environmental remediation, contributions to charitable organizations and income taxes.

Revenues in Excess of Expenses and Changes in Net Assets

The consolidated statements of operations and changes in net assets include revenues in excess of expenses as the performance indicator. Changes in unrestricted net assets, which are excluded from revenues in excess of expenses, primarily include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets) and postretirement benefit adjustments.

Grants

Grant revenue is recognized in the period it is earned based on when the applicable project expenses are incurred and project milestones are achieved. Grant payments received in advance of related project expenses are recorded as deferred revenue until the expenditure has been incurred. The System records grant revenue in other revenue in the consolidated statements of operations and changes in net assets.

Under certain provisions of the American Recovery and Reinvestment Act of 2009, federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt certified electronic health record (EHR) technology or become "meaningful users" of EHRs in ways that demonstrate improved quality, safety and effectiveness of care. These incentive payments are being accounted for in the same manner as grant revenue.

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

1. Organization and Summary of Significant Accounting Policies (continued)

New Accounting Pronouncements

In July 2011, the System adopted the authoritative guidance issued by the Financial Accounting Standards Board (FASB) requiring the reclassification of the provision for uncollectible accounts associated with patient revenue from an operating expense to a deduction from patient service revenue. Additionally the guidance requires enhanced disclosure about policies for recognizing revenue, assessing uncollectible accounts and qualitative and quantitative information about changes in the allowance for uncollectible accounts. The System early adopted this guidance in 2011.

On January 1, 2011, the System adopted the authoritative guidance issued by the FASB to clarify for health care entities that estimated insurance recoveries should not be netted against related claim liabilities. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. As the System was already following this guidance prior to 2011, there was no impact on the System's financial statements.

On January 1, 2011, the System adopted the authoritative guidance issued by the FASB requiring that cost be used as the measurement basis for charity care disclosure purposes. The method used to identify the direct and indirect costs of providing the charity care must be disclosed. Other than requiring additional disclosures, adoption of this new guidance did not have a material impact on the System's consolidated financial statements.

Recent Accounting Guidance Not Yet Adopted

In May 2011, the FASB issued guidance to amend disclosure requirements related to fair value measurement. The guidance expands disclosures for Level 3 fair value measurements, addresses nonfinancial assets' highest and best use and permits fair value adjustments for assets and liabilities with offsetting risks. The guidance is effective for the System with the reporting period beginning January 1, 2012. Other than requiring additional disclosures, adoption of this new guidance will not have a material impact on the System's consolidated financial statements.

Reclassifications in the Consolidated Financial Statements

Certain reclassifications were made to the 2010 consolidated financial statements to conform to the classifications used in 2011.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**2. Contractual Arrangements With Third-Party Payors**

The System provides care to certain patients under payment arrangements with Medicare, Medicaid, Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois (Blue Cross) and various other health maintenance and preferred provider organizations. Services provided under these arrangements are paid at predetermined rates and/or reimbursable costs, as defined. Reported costs and/or services provided under certain of the arrangements are subject to audit by the administering agencies. Changes in Medicare and Medicaid programs and reduction of funding levels could have a material adverse effect on the future amounts recognized as patient service revenue.

Amounts received under the above payment arrangements accounted for 92% and 91% of the System's net patient service revenue in 2011 and 2010, respectively. For the years ended December 31, 2011 and 2010, 30% of net patient service revenue was under contracts with Blue Cross, 10% was earned from the Medicaid program, and 26% was earned from the Medicare program. Provision has been made in the consolidated financial statements for contractual adjustments, representing the difference between the established charges for services and actual or estimated payment. The extreme complexity of laws and regulations governing the Medicare and Medicaid programs renders at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Changes in the estimates that relate to prior years' third-party payment arrangements resulted in increases in net patient service revenue of \$26,322 and \$17,758 for the years ended December 31, 2011 and 2010, respectively.

The System's concentration of credit risk related to accounts receivable is limited due to the diversity of patients and payors. The System grants credit, without collateral, to its patients, most of whom are local residents and insured under third-party payor arrangements. The System has established guidelines for placing patient balances with collection agencies, subject to terms of certain restrictions on collection efforts as determined by the System. Amounts due to/from primary third-party payors in the consolidated balance sheets primarily relate to the Blue Cross, Medicare or Medicaid programs. At both December 31, 2011 and 2010, 18% of patient accounts receivable were due under contracts with Blue Cross and 13% were due from the Medicaid program. Patients accounts receivable due from Medicare program were 10% and 12% at December 31, 2011 and 2010, respectively.

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Contractual Arrangements With Third-Party Payors (continued)

The System has entered into various capitated physician provider agreements, including Humana Health Plan, Inc. and Humana Insurance Company and their affiliates (collectively, Humana, Healthspring Inc. and Wellcare Health Plans, Inc). Capitation revenues received under the agreements with Humana amounted to 38% and 37% of the System's capitation revenue for the years ended December 31, 2011 and 2010, respectively. Capitation revenues received under Healthspring Inc, Inc. and Wellcare Health Plans, Inc. agreements amounted to 25% and 27% of the System's capitation revenue for the years ended 2011 and 2010, respectively.

Provision has been made in the consolidated financial statements for the estimated cost of providing certain medical services under capitated arrangements with managed care organizations. The System accrues a liability for reported, as well as an estimate for incurred but not recorded (IBNR), contracted medical services. The liability represents the expected ultimate cost of all reported and unreported claims unpaid at year-end. The System uses the services of a consulting actuary to determine the estimated cost of the IBNR claims. Adjustments to the estimates are reflected in current year operations. At December 31, 2011 and 2010, the liabilities for unpaid medical claims amounted to \$22,388 and \$23,552, respectively, and are included in accrued expenses in the consolidated balance sheets.

The System participates in the State of Illinois' Hospital Assessment Program, in which the System recognized \$147,779 and \$147,781 of Illinois hospital assessment revenue in net patient service revenue and \$106,190 and \$106,274 of expense in other expense in 2011 and 2010, respectively.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use)**

Investments (including assets limited as to use) and other financial instruments at December 31 are summarized as follows:

	<u>2011</u>	<u>2010</u>
Assets limited as to use:		
Designated for self-insurance programs	\$ 804,174	\$ 888,753
Internally and externally designated for capital improvements, medical education and health care programs	2,773,301	2,139,891
Externally designated under debt agreements	134,931	39,818
Investments under securities lending program	19,067	213,830
	<u>3,731,473</u>	<u>3,282,292</u>
Other financial instruments:		
Cash and cash equivalents and short-term investments	323,168	567,466
	<u>\$ 4,054,641</u>	<u>\$ 3,849,758</u>

Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices. Investments in limited partnerships that invest in marketable securities and derivative products (hedge funds) are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships are reported using the cost method of accounting. The composition and carrying value of assets limited as to use, short-term investments and cash and cash equivalents at December 31 is set forth in the following table:

	<u>2011</u>	<u>2010</u>
Cash and short-term investments	\$ 538,223	\$ 709,469
Corporate bonds and other debt securities	224,843	160,117
United States government obligations	201,740	115,720
Government mutual funds	535,663	119,446
Bond and other debt security mutual funds	549,142	912,584
Commodity mutual funds	3,205	3,770
Hedge funds	521,552	294,002
Private equity limited partnership funds	267,968	163,376
Equity securities	746,764	948,189
Equity mutual funds	465,541	423,085
	<u>\$ 4,054,641</u>	<u>\$ 3,849,758</u>

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

**3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use)
(continued)**

The System regularly compares the net asset value (NAV), which is a proxy for the fair value of its private equity investments, to the recorded cost for potential other-than-temporary impairment. In 2011, the System identified and recorded \$1,500 of impairment losses that is included in investment (loss) income in the consolidated statements of operations and changes in net assets. In 2010, no impairment losses were identified. The NAV of these investments based on estimates determined by the investments' management was \$284,987 and \$173,496 at December 31, 2011 and 2010, respectively.

At December 31, 2011 and 2010, the System has commitments to fund an additional \$298,118 and \$122,184, respectively. The unfunded commitments at December 31, 2011, are expected to be funded over the next seven years.

Investment returns for assets limited as to use, cash and cash equivalents and short-term investments comprise the following for the years ended December 31:

	2011	2010
Interest and dividend income	\$ 55,984	\$ 79,511
Net realized gains	70,088	89,063
Net unrealized (losses) gains	(159,770)	182,750
	<u>\$ (33,698)</u>	<u>\$ 351,324</u>

Investment returns are included in the consolidated statements of operations and changes in net assets for the years ended December 31 as follows:

	2011	2010
Other revenue	\$ 58,289	\$ 61,041
Investment (loss) income	(92,062)	285,560
Realized and unrealized gains on investments – temporarily restricted net assets	75	4,723
	<u>\$ (33,698)</u>	<u>\$ 351,324</u>

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use)
(continued)**

As part of the management of the investment portfolio, the System has entered into an arrangement whereby securities owned by the System are loaned primarily to brokers and investment bankers. The loans are arranged through a bank. Borrowers are required to post collateral in the form of United States Treasury securities for securities borrowed equal to approximately 102% of the value of the security on a daily basis at a minimum. The bank is responsible for reviewing the creditworthiness of the borrowers. The System has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At December 31, 2011 and 2010, the System loaned \$19,067 and \$213,830, respectively, in securities and accepted collateral for these loans in the amount of \$19,410 and \$219,052, respectively, of which \$19,135 and \$218,777, respectively, represents cash collateral and is included in current assets and current liabilities in the accompanying consolidated balance sheets.

4. Fair Value Measurements

The System accounts for certain assets and liabilities at fair value. The hierarchy below lists three levels of fair value based on the extent to which inputs used in measuring fair value are observable in active markets. The System categorizes each of its fair value measurements in one of the three levels based on the highest-level input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices in active markets for identified assets or liabilities.

Level 2: Inputs, other than the quoted process in active markets, that are observable either directly or indirectly.

Level 3: Unobservable inputs in which there is little or no market data, which then requires the reporting entity to develop its own assumptions about what market participants would use in pricing the asset or liability.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**4. Fair Value Measurements (continued)**

The following section describes the valuation methodologies the System uses to measure financial assets and liabilities at fair value. In general, where applicable, the System uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments such as domestic and international equities, United States Treasuries, exchange-traded mutual funds and agency securities. If quoted prices in active markets for identical assets and liabilities are not available to determine fair value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, commercial paper and certain agency securities. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include fair value adjustments related to the System's credit risk.

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

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

4. Fair Value Measurements (continued)

The following are assets and liabilities measured at fair value on a recurring basis at December 31, 2011 and 2010:

Description	2011	Fair Value Measurements at Reporting Date Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	\$ 538,223	\$ 474,318	\$ 63,905	\$ -
Corporate bonds and other debt securities	224,843	-	224,843	-
United States government obligations	201,740	-	201,740	-
Government mutual funds	535,663	-	535,663	-
Bond and other debt security mutual funds	549,142	-	549,142	-
Commodity mutual funds	3,205	-	3,205	-
Equity securities	746,764	746,764	-	-
Equity mutual funds	465,541	385,504	80,037	-
Investments at fair value	3,265,121	\$ 1,606,586	\$ 1,658,535	\$ -
Investments not at fair value	789,520			
Total investments	<u>\$ 4,054,641</u>			
Collateral proceeds received under securities lending program	\$ 19,135		\$ 19,135	
Liabilities				
Obligations under swap agreements	\$ (89,092)		\$ (89,092)	
Liability under swap agreements	<u>\$ (89,092)</u>		<u>\$ (89,092)</u>	
Obligations to return collateral under securities lending program	\$ (19,410)		\$ (19,410)	

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

4. Fair Value Measurements (continued)

Description	2010	Fair Value Measurements at Reporting Date Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	\$ 709,469	\$ 607,254	\$ 102,215	\$ -
Corporate bonds and other debt securities	160,117	-	160,117	-
United States government obligations	115,720	-	115,720	-
Government mutual funds	119,446	-	119,446	-
Bond and other debt security mutual funds	912,584	2,079	910,505	-
Commodity mutual funds	3,770	-	3,770	-
Equity securities	948,189	948,189	-	-
Equity mutual funds	423,085	367,212	55,873	-
Investments at fair value	3,392,380	\$ 1,924,734	\$ 1,467,646	\$ -
Investments not at fair value	457,378			
Total investments	<u>\$ 3,849,758</u>			
Collateral proceeds received under securities lending program	\$ 218,777		\$ 218,777	
Liabilities				
Obligations under swap agreements	\$ (44,081)		\$ (44,081)	
Collateral under swap agreements	27,970		27,970	
Liability under swap agreements	<u>\$ (16,111)</u>		<u>\$ (16,111)</u>	
Obligations to return collateral under securities lending program	\$ (219,052)		\$ (219,052)	

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**4. Fair Value Measurements (continued)**

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

The estimated fair value of long-term debt based on quoted market prices for the same or similar issues was \$1,252,830 and \$1,060,842 at December 31, 2011 and 2010, respectively, which included a consideration of third-party credit enhancements, of which there was no impact.

5. Interest in Health Care and Related Entities

During 2000, in connection with the acquisition of a medical center, the System acquired an interest in the net assets of the Masonic Family Health Foundation (the Foundation), an independent organization, under the terms of an asset purchase agreement (the Agreement). The use of substantially all of the Foundation's net assets is designated to support the operations and/or capital needs of one of the System's medical facilities. Additionally, 90% of the Foundation's investment yield, net of expenses, on substantially all of the Foundation's investments is designated for the support of one of the System's medical facilities. The Foundation must pay the System, annually, 90% of the investment yield or an agreed-upon percentage of the beginning of the year net assets.

The interest in the net assets of this organization amounted to \$78,450 and \$82,927 as of December 31, 2011 and 2010, respectively, and is reflected in interest in health care and related entities in the accompanying consolidated balance sheets. The System's interest in the investment yield is reflected in the accompanying consolidated statements of operations and changes in net assets and amounted to \$(548) and \$8,460 for the years ended December 31, 2011 and 2010, respectively. Cash distributions received by the System from the Foundation under terms of the Agreement amounted to \$3,169 and \$2,691 during the years ended December 31, 2011 and 2010, respectively. In addition to the amounts distributed under the Agreement, the Foundation contributed \$411 and \$376 to the System for program support of one of its medical facilities during the years ended December 31, 2011 and 2010, respectively.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**5. Interest in Health Care and Related Entities (continued)**

The System has a 50% membership and governance interest in Advocate Health Partners (d/b/a Advocate Physician Partners) (APP), which has been accounted for on an equity basis. The System's carrying value in this interest was \$0 at December 31, 2011 and 2010. Financial information relating to this interest is as follows:

	2011	2010
Assets	\$ 143,337	\$ 130,785
Liabilities	141,261	129,394
Revenues in excess of expenses	-	-

The System contracts with APP for certain operational and administrative services. Total expenses incurred for these services were \$22,219 and \$16,010 in 2011 and 2010, respectively. At December 31, 2011 and 2010, the System had an accrued liability to APP for those services for \$1,562 and \$836, respectively.

APP purchased claims processing and certain management services from the System in the amounts of \$8,827 and \$8,071 in 2011 and 2010, respectively. Under terms of an agreement with the System, APP reimburses the System for salaries, benefits and other expenses that are incurred by the System on APP's behalf. The amount billed for these services in 2011 and 2010 was \$16,809 and \$13,948, respectively. The System had a receivable from APP at December 31, 2011 and 2010, for claims processing and management services of \$5,363 and \$3,139, respectively.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**6. Long-Term Debt**

Long-term debt, net of unamortized original issue discount or premium consisted of the following at December 31:

	2011	2010
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series:		
1993C, 6.0% to 7.0%, principal payable in varying annual installments through April 2018	\$ 24,592	\$ 24,805
1998A, 5.20%, principal payable in varying annual installments through August 2022; refunded in full during 2011	-	4,667
1998B, 4.60% to 5.25%, principal payable in varying annual installments through August 2018; refunded in full during 2011	-	11,821
2003A (weighted-average rate of 4.38% during 2011 and 2010), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	26,290	28,405
2003C (weighted-average rate of 0.44% and 0.46% during 2011 and 2010, respectively), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	25,585	27,695
2008A (weighted-average rate of 1.92% and 1.61% during 2011 and 2010, respectively), principal payable in varying annual installments through November 2030; interest based on prevailing market conditions at time of remarketing	145,510	145,510

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

6. Long-Term Debt (continued)

	2011	2010
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series (continued):		
2008C (weighted-average rate of 0.44% and 0.51% during 2011 and 2010, respectively), principal payable in varying annual installments through November 2038; interest based on prevailing market conditions at time of remarketing	\$ 343,270	\$ 343,270
2008D, 4.25% to 6.50%, principal payable in varying annual installments through November 2038	163,985	167,755
2010A, 5.50%, principal payable in varying annual installments through April 2044	37,297	37,307
2010B, 5.38%, principal payable in varying annual installments through April 2044	52,180	52,173
2010C, 5.38%, principal payable in varying annual installments through April 2044	25,529	25,526
2010D, 3.00% to 5.25%, principal payable in varying annual installments through April 2038	122,415	128,143
2011A, 2.00% to 5.00%, principal payable in varying annual installments through April 2041	44,183	-
2011B, (weighted average rate of 0.25% during 2011), principal payable in varying annual installments through April 2051, subject to a put provision that provides for a cumulative seven-month notice and remarketing period, interest tied to a market index plus a spread	70,000	-
2011C, (weighted average rate of 0.88% during 2011), principal payable in varying annual installments through April 2049, interest tied to a market index plus a spread	50,000	-
2011D, (weighted average rate of 0.98% during 2011), principal payable in varying annual installments through April 2049, interest tied to a market index plus a spread	50,000	-
Capital lease obligations	31,407	31,552
Other	8,859	11,940
	<u>1,221,102</u>	<u>1,040,569</u>
Less current portion of long-term debt	22,711	17,418
Less long-term debt subject to short-term remarketing arrangements	197,870	122,060
	<u>\$ 1,000,521</u>	<u>\$ 901,091</u>

Maturities of long-term debt, capital leases and sinking fund requirements, assuming remarketing of the variable rate demand revenue refunding bonds, for the five years ending December 31, 2016, are as follows: 2012 - \$22,711; 2013 - \$18,856; 2014 - \$18,582; 2015 - \$20,760; and 2016 - \$20,223.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**6. Long-Term Debt (continued)**

The System's unsecured variable rate revenue bonds, Series 2003C of \$25,585; Series 2008 (A-1 and A-3) of \$102,285 and Series 2011B of \$70,000, while subject to a long-term amortization period, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within a maximum of 12 months after December 31, 2011, the principal amount of such bonds has been classified as a current obligation in the accompanying consolidated balance sheets. To address the possibility that a material amount of these bonds would be put back to the System, steps have been taken to provide various sources of liquidity in such event, including maintaining unrestricted assets as a source of self-liquidity. Management believes the likelihood of a material amount of bonds being put to the System is remote. However, to address this possibility, the System has taken steps to provide various sources of liquidity, including entering into standby bond purchase agreements and assessing alternate sources of financing, including lines of credit and/or unrestricted assets as a source of self-liquidity.

All outstanding bonds were issued pursuant to a Master Trust Indenture dated as of December 1, 1996 (the Master Indenture), as subsequently amended, between the System and Bank of New York Mellon as master trustee. Under the terms of the Master Indenture and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The Master Indenture and other debt agreements, including a bank credit agreement, also place restrictions on the System and require the System to maintain certain financial ratios.

Interest paid, net of capitalized interest, amounted to \$41,485 and \$38,591 in 2011 and 2010, respectively. The System capitalized interest of approximately \$2,928 and \$2,340 in 2011 and 2010, respectively.

On September 21, 2011, the Illinois Finance Authority, on behalf of the System, issued its Revenue Bonds, Series 2011A-D, in the amount of \$213,730. The proceeds of the Series 2011 Bonds were used, together with other funds available to the System, to finance, refinance, or reimburse the System for a portion of the costs related to the acquisition, construction, renovation, and equipping of certain capital projects; to refund prior bonds (Series 1998A and Series 1998B); and pay certain costs of issuing the Series 2011 Bonds.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**6. Long-Term Debt (continued)**

On January 6, 2010, the Illinois Finance Authority, on behalf of the System, issued its Revenue Bonds, Series 2010A-D, in the amount of \$238,255. The proceeds of the Series 2010 Bonds were used, together with other funds available to the System, to pay the costs related to the merger with BroMenn and the construction and equipping of a new patient tower; to pay or reimburse the System for the payment of certain costs of acquiring, constructing, renovating and equipping certain capital projects; to refund prior bonds (Series 2008B); and to pay certain costs of issuing the Series 2010 Bonds and refunding the prior bonds.

On April 29, 2008, the Illinois Finance Authority, on behalf of the System, completed the issuance of uninsured variable rate bonds, Series 2008A, B and C in the amount of \$624,180. The proceeds were used to refund the Series 2005 and Series 2007 insured auction rate securities in the amount of \$623,225. In connection with the issuance of the Series 2008C bonds, the System transferred floating-to-fixed interest rate swap agreements, which were previously attached to the Series 2007B bonds, effectively converting the variable rate demand bonds to a fixed rate of 3.605%. Effective March 10, 2010, the notional amount of the Series 2008C interest rate swap was reduced by \$21,975. The System maintains an interest rate swap program on certain of its variable rate debt as described in Note 7.

At December 31, 2011 the System had lines of credit with banks aggregating to \$203,000. These lines of credit provide for various interest rates and payment terms and expire as follows: \$25,000 in March 2012, \$3,000 in November 2012, \$50,000 in December 2012, \$75,000 in March 2013 and \$50,000 in November 2013. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures or for general working capital purposes. At December 31, 2011, there was \$2,974 outstanding that bears interest of prime (3.25% at December 31, 2011). At December 31, 2010, no amounts were outstanding on these lines of credit.

In 2012, \$25,000 of the lines of credit was extended to March 2013.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**7. Derivatives**

The System has interest rate related derivative instruments to manage its exposure on its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management purposes. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The System also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

At December 31, 2011, the System maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose the System to variability in interest payments due to changes in interest rates. The System believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, the System entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps limit the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in various outstanding bond series. The following is a summary of the outstanding positions under these interest rate swap agreements at December 31, 2011:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	\$ 129,900	November 1, 2038	61.7% of LIBOR + 26 bps	3.60%
2008C-2	\$ 108,425	November 1, 2038	61.7% of LIBOR + 26 bps	3.60%
2008C-3	\$ 88,000	November 1, 2038	61.7% of LIBOR + 26 bps	3.60%

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

7. Derivatives (continued)

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

The fair value of derivative instruments is as follows:

	December 31	
	2011	2010
Consolidated balance sheet location		
Obligations under swap agreements	\$ (89,092)	\$ (44,081)
Collateral posted under swap agreements	-	27,970
Obligations under swap agreements, net	<u>\$ (89,092)</u>	<u>\$ (16,111)</u>

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

	Year Ended December 31	
	2011	2010
Consolidated statement of operations and changes in net assets location		
Net cash payments on interest rate swap agreements (interest expense)	<u>\$ 10,400</u>	<u>\$ 10,429</u>
Change in the fair value of interest rate swaps (nonoperating)	<u>\$ (45,011)</u>	<u>\$ (14,335)</u>

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**7. Derivatives (continued)**

The aggregate fair value of all swap instruments with credit risk-related contingent features that are in a liability position was \$89,092 and \$44,081 at December 31, 2011 and 2010, respectively, for which the System has posted collateral of \$0 and \$27,970 at December 31, 2011 and 2010, respectively, in the normal course of business. The swap instruments contain provisions that require the System's debt to maintain an investment grade credit rating from certain major credit rating agencies. If the System's debt were to fall below investment grade on the valuation date, it would be in violation of these provisions, and the counterparty to the derivative instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on derivative instruments in net liability positions.

8. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods at December 31:

	<u>2011</u>	<u>2010</u>
Net assets currently available for:		
Purchases of property and equipment	\$ 5,598	\$ 5,542
Medical education and other health care programs	57,394	57,876
Net assets available for future periods:		
Purchases of property and equipment	3,952	3,031
Medical education and other health care programs	8,387	8,337
	<u>\$ 75,331</u>	<u>\$ 74,786</u>

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

8. Restricted Net Assets (continued)

Permanently restricted net assets generate investment income, which is used to benefit the following purposes or periods at December 31:

	<u>2011</u>	<u>2010</u>
Net assets currently producing investment income:		
Purchases of property and equipment	\$ 1,000	\$ 1,000
Medical education and other health care programs	21,559	21,047
Net assets available to produce investment income in future periods:		
Medical education and other health care programs	15,904	6,747
	<u>\$ 38,463</u>	<u>\$ 28,794</u>

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**9. Retirement Plans**

The System maintains defined-benefit pension plans that cover a majority of its employees (associates).

A summary of changes in the plan assets, projected benefit obligation and the resulting funded status of the System's defined-benefit pension plans is as follows:

	<u>2011</u>	<u>2010</u>
Change in plan assets:		
Plan assets at fair value at beginning of year	\$ 672,769	\$ 606,558
Actual return on plan assets	(7,294)	78,296
Employer contributions	22,300	22,560
Benefits paid	(34,257)	(34,645)
Plan assets at fair value at end of year	<u>\$ 653,518</u>	<u>\$ 672,769</u>
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	\$ 707,064	\$ 666,903
Service cost	38,285	37,104
Interest cost	39,012	38,106
Actuarial gain (loss)	11,786	(404)
Benefits paid	(34,257)	(34,645)
Projected benefit obligation at end of year	<u>\$ 761,890</u>	<u>\$ 707,064</u>
Plan assets less than projected benefit obligation	<u>\$ (108,372)</u>	<u>\$ (34,296)</u>
Accumulated benefit obligation at end of year	<u>\$ 699,330</u>	<u>\$ 650,664</u>

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)

*(Dollars in Thousands)***9. Retirement Plans (continued)**

The Condell Retirement Plan paid lump sums totaling \$3,896 and \$4,250 in 2011 and 2010, respectively. These amounts are greater than the sum of the plan's service cost and interest cost for 2011 and 2010. As a result, the System recognized a settlement charge in the amount of \$1,199 and \$767 in 2011 and 2010, respectively.

	<u>2011</u>	<u>2010</u>
Net periodic pension expense consists of the following for the years ended December 31:		
Service cost	\$ 38,285	\$ 37,104
Interest cost	39,013	38,106
Expected return on plan assets	(56,290)	(54,340)
Amortization of:		
Prior service credit	(4,823)	(4,910)
Recognized actuarial loss	7,392	5,100
Settlement/curtailment	1,199	767
Net pension expense	<u>\$ 24,776</u>	<u>\$ 21,827</u>

The amount of actuarial loss and prior service cost (credit) included in other changes in unrestricted net assets expected to be recognized in net periodic pension cost during the fiscal year ending December 31, 2012, is \$12,496 and \$4,823, respectively.

For the defined benefit plans previously described, changes in plan assets and benefit obligations recognized in unrestricted net assets during 2011 and 2010 include actuarial losses of \$66,779 and \$30,227 and net prior service costs of \$4,823 and \$4,910, respectively.

Included in unrestricted net assets are the following amounts that have not yet been recognized in net periodic pension cost:

	<u>2011</u>	<u>2010</u>
Unrecognized prior credit	\$ (33,063)	\$ (37,886)
Unrecognized actuarial loss	247,416	180,638
	<u>\$ 214,353</u>	<u>\$ 142,752</u>

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**9. Retirement Plans (continued)**

Employer contributions were paid from employer assets for both years presented. No plan assets are expected to be returned to the employer. All benefits paid under the defined-benefit pension plan were paid from the plan's assets. The System anticipates making \$28,550 in contributions to the plan's assets during 2012. Expected associate benefit payments are \$51,220 in 2012, \$52,840 in 2013, \$55,040 in 2014, \$58,870 in 2015, \$61,670 in 2016, and \$340,410 in 2017 through 2021.

The pension plan's asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors and manager style to minimize the risk of loss. The System uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. The System regularly monitors manager performance and compliance with investment guidelines.

The System's target and actual pension asset allocations are as follows:

Asset Category	Target	Actual Asset Allocation	
		2011	2010
Domestic and international equity securities	42.5%	46.5%	50.7%
Private equity limited partnerships and hedge funds	17.5	15.8	12.5
Fixed income securities	30.0	28.7	29.7
Real estate	10.0	9.0	7.1
	100.0%	100.0%	100.0%

Within the domestic and international equity portfolio, investments are diversified among large and mid-capitalizations (20%), non-large capitalizations (7%) and international and emerging markets (20%).

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
*(Dollars in Thousands)***9. Retirement Plans (continued)**

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 4. Fair value for Level 3 represents the plan's ownership interests in the NAVs of the respective private equity partnerships, hedge funds and real estate commingled funds for which active markets do not exist (alternative investments). The System opted to use the NAV per share, or its equivalent, as a practical expedient for fair value of the Plan's interest in hedge funds and private equity funds. The alternative investment assets consist of marketable securities as well as securities and other assets that do not have readily determinable fair values. The fair values of the alternative investments that do not have readily determinable fair values are determined by the general partner or fund manager taking into consideration, among other things, the cost of the securities or other investments, prices of recent significant transfers of like assets and subsequent developments concerning the companies or other assets to which the alternative investments relate. There is inherent uncertainty in such valuations, and the estimated fair values may differ from the values that would have been used had a ready market for these investments existed. Private equity partnerships and real estate commingled funds typically have finite lives ranging from 5 to 10 years, at the end of which all invested capital is returned. For hedge funds, the typical lock-up period is one year, after which invested capital can be redeemed on a quarterly basis with at least 30 days' but no more than 90 days' notice. The Plan's investment assets are exposed to the same kinds and levels of risk as described in Note 4.

At December 31, 2011 and 2010, the System, on behalf of the Plan, has commitments to fund an additional \$38,699 and \$34,273, respectively. The unfunded commitments at December 31, 2011, are expected to be funded over the next seven years.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)

*(Dollars in Thousands)***9. Retirement Plans (continued)**

The following are the plan's financial instruments at December 31, 2011, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

Description	Fair Value Measurements at Reporting Date Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	\$ 2,864	\$ -	\$ 2,864	\$ -
Equity securities:				
Small cap	2,909	-	2,909	-
Large cap	53,827	43,033	10,794	-
Value equity	41,173	38,645	2,528	-
Growth equity	56,122	54,593	1,529	-
U.S. equity	20,993	19,954	1,039	-
International equity	94,906	31,691	63,215	-
International equity - emerging	38,533	34,327	4,206	-
Fixed income securities:				
Core plus bonds	177,007	-	177,007	-
Long duration bonds	12,314	-	12,314	-
Other types of investments:				
Hedge funds	43,083	-	-	43,083
Private equity funds	53,737	-	-	53,737
Real estate	56,050	-	39,920	16,130
Total	\$ 653,518	\$ 222,243	\$ 318,325	\$ 112,950

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)

(Dollars in Thousands)

9. Retirement Plans (continued)

The table below sets forth a summary of changes in the fair value of the plan's Level 3 assets for 2011:

	Hedge Funds	Private Equity	Real Estate
Fair value at January 1, 2011	\$ 30,414	\$ 46,290	\$ 11,194
Net purchases and sales	14,774	5,010	1,489
Realized gains and losses	-	1,053	137
Unrealized gains and losses	(2,105)	1,384	3,310
Fair value at December 31, 2011	\$ 43,083	\$ 53,737	\$ 16,130

The following are the plan's financial instruments at December 31, 2010, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

Description	Fair Value	Fair Value Measurements at Reporting Date Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	\$ 7,457	\$ 97	\$ 7,360	\$ -
Equity securities:				
Small cap	3,265	3,125	140	-
Large cap	58,593	58,559	34	-
Value equity	37,756	35,346	2,410	-
Growth equity	86,304	85,217	1,087	-
U.S. equity	41,593	38,816	2,777	-
International equity	96,891	96,370	521	-
International equity -- emerging	22,810	21,841	969	-
Fixed income securities:				
Core plus bonds	196,836	95,072	101,764	-
Other types of investments:				
Hedge funds	30,414	-	-	30,414
Private equity funds	46,290	-	-	46,290
Real estate	44,560	-	33,366	11,194
Total	\$ 672,769	\$ 434,443	\$ 150,428	\$ 87,898

Advocate Health Care Network and Subsidiaries
Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

9. Retirement Plans (continued)

The table below sets forth a summary of changes in the fair value of the plan's Level 3 assets for 2010:

	<u>Hedge Funds</u>	<u>Private Equity</u>	<u>Real Estate</u>
Fair value at January 1, 2010	\$ 27,860	\$ 28,109	\$ 6,333
Net purchases and sales	3,464	14,631	1,910
Realized gains and losses	-	882	-
Unrealized gains and losses	(910)	2,668	2,951
Fair value at December 31, 2010	<u>\$ 30,414</u>	<u>\$ 46,290</u>	<u>\$ 11,194</u>

Assumptions used to determine benefit obligations at the measurement date are as follows:

	<u>2011</u>	<u>2010</u>
Discount rate	4.75%	5.40%
Assumed rate of return on assets	7.75	8.00
Weighted-average rate of increase in future compensation (age-based table)	4.80	4.80

Assumptions used to determine net pension expense for the fiscal years are as follows:

	<u>2011</u>	<u>2010</u>
Discount rate	5.40%	5.65%
Assumed rate of return on assets	8.00	8.00
Weighted-average rate of increase in future compensation (age-based table)	4.80	4.80

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**9. Retirement Plans (continued)**

The assumed rate of return on plan assets is based on historical and projected rates of return for asset classes in which the portfolio is invested. The expected return for each asset class was then weighted based on the target asset allocation to develop the overall expected rate of return on assets for the portfolio. This resulted in the selection of the 7.75% and 8.00% assumption for 2011 and 2010, respectively.

In addition to the defined-benefit pension plan, the System sponsors various defined-contribution plans. Amounts contributed by the System approximated \$32,752 and \$35,042 in 2011 and 2010, respectively, and are included in salaries, wages and employee benefits expense in the consolidated statements of operations and changes in net assets.

10. General and Professional Liability Risks

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

The estimated cost of claims is actuarially determined based on past experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance liabilities and contributions to the revocable trust were determined using a discount rate of 4.00% for 2011 and 2010. Accrued insurance liabilities for the System's captive insurance company were determined using a discount rate of 3.00% for 2011 and 2010. Total accrued insurance liabilities would have been approximately \$64,775 and \$62,786 greater at December 31, 2011 and 2010, respectively, had these liabilities not been discounted.

The System is a defendant in certain litigation related to professional and general liability risks. Although the outcome of the litigation cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of this litigation will not have any material adverse effect on the System's operations or financial condition.

Advocate Health Care Network and Subsidiaries**Notes to Consolidated Financial Statements (continued)**
*(Dollars in Thousands)***11. Legal, Regulatory, and Other Contingencies and Commitments**

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. During the last few years, as a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, exclusion from the Medicare and Medicaid programs, and revocation of federal or state tax-exempt status. Moreover, the System expects that the level of review and audit to which it and other health care providers are subject will increase.

Various federal and state agencies have initiated investigations, which are in various stages of discovery, relating to reimbursement, billing practices and other matters of the System. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have on the System. As a result, there is a reasonable possibility that recorded amounts will change by a material amount in the near term. To foster compliance with applicable laws and regulations, the System maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

The System is committed to constructing additions and renovations to its medical facilities and implementing information technology projects, which are expected to be completed in future years. The estimated cost of these commitments is \$251,564, of which \$199,444 has been incurred as of December 31, 2011.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**11. Legal, Regulatory, and Other Contingencies and Commitments (continued)**

Future minimum rental commitments at December 31, 2011, for all noncancelable leases with original terms of more than one year are \$43,434, \$31,715, \$25,925, \$23,400 and \$20,039 for the years ending December 31, 2012 through 2016, respectively, and \$40,502 thereafter.

Rent expense, which is included in other expenses, amounted to approximately \$77,170 and \$83,702 in 2011 and 2010, respectively.

12. Income Taxes and Tax Status

Certain subsidiaries of the System are for-profit corporations. Significant components of the for-profit subsidiaries' deferred tax assets (liabilities) are as follows at December 31:

	2011	2010
Deferred tax assets		
Allowance for uncollectible accounts	\$ 4,523	\$ 3,363
Other accrued expenses	39	487
Reserves for incurred but not reported claims	364	384
Accrued insurance	7,732	6,351
Accrued compensation and employee benefits	4,023	3,279
Third-party settlements	848	802
Prepaid and other assets	373	373
Net operating losses	25,809	13,941
Total deferred tax assets	43,711	28,980
Less valuation allowance	25,809	13,941
Net deferred tax assets, included in deferred costs and intangible assets and prepaid expenses, inventories, and other assets	\$ 17,902	\$ 15,039
Deferred tax liabilities		
Property and equipment	\$ (7,149)	\$ (3,110)
Other accrued expenses	(272)	-
Deferred gain on BroMenn acquisition	(6,228)	(5,064)
Total deferred tax liabilities, included in other noncurrent liabilities	\$ (13,649)	\$ (8,174)

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)**12. Income Taxes and Tax Status (continued)**

Significant components of the provision (credit) for income taxes are as follows for the years ended December 31:

	<u>2011</u>	<u>2010</u>
Current:		
Federal	\$ 4,629	\$ (5,505)
State	1,413	(1,239)
Deferred	2,612	16,626
	<u>\$ 8,654</u>	<u>\$ 9,882</u>

Federal and state income taxes paid relating to the System's for-profit corporations were \$1,102 and \$1,697 in 2011 and 2010, respectively.

The System and all other controlled or wholly owned subsidiaries are exempt from income taxes under Internal Revenue Code Section 501(c)(3). They do, however, operate certain programs that generate unrelated business income. The current tax provision recorded on this income was \$390 and \$685 for the years ended December 31, 2011 and 2010, respectively. Federal, state, and local governments are increasingly scrutinizing the tax status of not-for-profit hospitals and health care systems.

13. Acquisition

On January 6, 2010, the System merged with BroMenn, which was accounted for as an acquisition in accordance with the authoritative guidance on not-for-profit mergers and acquisitions. The BroMenn system, which is located in the greater Bloomington-Normal and Eureka, Illinois, areas, includes a 224-bed acute care hospital, a 34-bed acute care hospital and approximately 60 employed physicians in one medical group.

Advocate Health Care Network and Subsidiaries

Notes to Consolidated Financial Statements (continued)

*(Dollars in Thousands)***13. Acquisition (continued)**

For accounting purposes, this transaction was accounted for under the purchase accounting rules, and a contribution of \$225,541 was recorded in the accompanying consolidated statements of operations and changes in net assets for the year ended December 31, 2010. This contribution reflected the fair value of the unrestricted net assets of BroMenn on the date of the merger. The total increase in net assets attributable to the merger, which included the fair value of temporarily and permanently restricted net assets contributed, was \$245,578. No goodwill was recorded as a result of this transaction. In valuing these assets and liabilities, fair values were based on, but not limited to, professional appraisals, discounted cash flows, replacement costs and actuarially determined values.

The fair value of assets and liabilities of BroMenn contributed at January 6, 2010, consists of the following:

Cash and cash equivalents	\$ 10,998
Other current assets	61,836
Property and equipment	160,788
Other long-term assets	47,759
Total assets	<u>281,381</u>
Current liabilities	26,354
Other long-term liabilities	9,449
Total liabilities	<u>35,803</u>
Increase in net assets	<u>\$ 245,578</u>

14. Subsequent Events

The System evaluated events occurring between January 1, 2012 and March 9, 2012, which is the date when the consolidated financial statements were issued.