

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

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

JUL 31 2012

This Section must be completed for all projects.

HEALTH FACILITIES &  
SERVICES REVIEW BOARD**Facility/Project Identification**

Facility Name: Advocate Christ Medical Center – Patient Tower			
Street Address: 4440 West 95 <sup>th</sup> Street			
City and Zip Code: Oak Lawn		60453-2699	
County: Suburban Cook	Health Service Area	7	Health Planning Area: A-04

**Applicant /Co-Applicant Identification**

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center	
Address: 4440 West 95 <sup>th</sup> Street, Oak Lawn, IL 60453-2699	
Name of Registered Agent: Gail D. Hasbrouck	
Name of President: Kenneth Lukhard, President Advocate Christ Medical Center	
President Address: 4440 West 95 <sup>th</sup> Street, Oak Lawn, IL 60453-2699	
Telephone Number: (708) 684-5010	

**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: Robert Harrison
Title: Market Vice President, Business Development
Company Name: Advocate Christ Medical Center
Address: 4440 West 95 <sup>th</sup> Street, Oak Lawn, IL 60453
Telephone Number: (708) 684-4274
E-mail Address: Robert.Harrison@advocatehealth.com
Fax Number: (708) 684-5012

**Additional Contact**

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

Name: Jeffrey So
Title: Director, Business Development/Community Relations
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5763
E-mail Address: Jeffrey.So@advocatehealth.com
Fax Number: (708) 684-5707

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

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County: Suburban Cook	Health Service Area	7	Health Planning Area: A-04

**Applicant /Co-Applicant Identification**

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

Exact Legal Name: Advocate Health Care Network	
Address: 4440 West 95 <sup>th</sup> Street, Oak Lawn, IL 60453-2699	
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**.
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**Primary Contact**

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

Name: Robert Harrison
Title: Market Vice President, Business Development
Company Name: Advocate Christ Medical Center
Address: 4440 West 95 <sup>th</sup> Street, Oak Lawn, IL 60453
Telephone Number: (708) 684-4274
E-mail Address: Robert.Harrison@advocatehealth.com
Fax Number: (708) 684-5012

**Additional Contact**

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

Name: Jeffrey So
Title: Director, Business Development/Community Relations
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5763
E-mail Address: Jeffrey.So@advocatehealth.com
Fax Number: (708) 684-5707

**Additional Contact**

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

Name: Wendy Mulvihill
Title: Planning Manager
Company Name: Advocate Christ Medical Center
Address: 9401 S. Pulaski, Suite 201, Evergreen Park, IL 60805
Telephone Number: (708) 684-5765
E-mail Address: Wendy.Mulvihill@advocatehealth.com
Fax Number: (708) 684-5707

**Additional Contact**

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

Name: Janet Scheuerman
Title: Senior Consultant
Company Name: PRISM Healthcare Consulting
Address: 1808 Woodmere Drive, Valparaiso, IN 46383
Telephone Number: (219) 464-0027
E-mail Address: jscheuerman@consultprism.com
Fax Number: (219) 464-0027

**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

**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: Albert Manshum
Title: Vice President, Facilities and Construction
Company Name: Advocate Health Care
Address: 2025 Windsor Drive, Oak Brook, IL 60523
Telephone Number: (630) 990-5546
E-mail Address: Albert.Manshum@advocatehealth.com
Fax Number: (630) 990-4798

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation
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 Health and Hospitals Corporation d/b/a Advocate Christ Medical Center
Address: 4440 W. 95 <sup>th</sup> Street, Oak Lawn, IL 60453
<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
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>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.</li> <li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>
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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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)]

Part 1110 Classification:

- Substantive  
 Non-substantive

Part 1120 Applicability or Classification:  
[Check one only.]

- Part 1120 Not Applicable  
 Category A Project  
 Category B Project  
 DHS or DVA Project

## 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 and Advocate Health and Hospital Corporation d/b/a Advocate Christ Medical Center is proposing to construct a 9-level Patient Tower to accommodate increasing volume of high acuity adult and neonatal services.

In the July 17, 2012 issue of U.S News and World Report's, "Best Hospitals 2012-2013," Advocate Christ Medical Center was recognized as being among the top hospitals in the nation for cardiology and heart surgery and for geriatric medicine. The Medical Center was also ranked fourth among all hospitals in the Chicago metropolitan area and the State of Illinois as a "high performer" in 10 other clinical areas: cancer; diabetes and endocrinology; treatment of ear nose and throat disorders; gastroenterology, gynecology, nephrology, neurology and neurosurgery; orthopedics; pulmonology; and urology. This announcement came only a few weeks after the Medical Center was named one of the Top 100 Hospitals® in the United States by Thomson Reuters in the Major Teaching Hospitals category. Thomson Reuters evaluated performance in 10 areas including morality; medical complications; patient safety; average patient stay; expenses, profitability; patient satisfaction; adherence to clinical standards of care; post discharge morality; and readmission rates for acute myocardial infarction, heart failure, and pneumonia.

The proposed project has three major components, all of which are necessary to serve critically ill patients from the broad geographic area served by Advocate Christ Medical Center (ACMC, the Medical Center). The project will be accomplished by constructing and modernizing space for these very high acuity services. First, the Medical Center proposes to increase the number of adult intensive care beds by 86. To achieve this increase, 108 new intensive care beds will be constructed and 22 existing intensive care beds constructed in the 1980's will be vacated. Next, the Medical Center proposes to increase by 17, or from 39 to 56, the number of obstetric beds for high risk antepartum, postpartum and gynecology patients. All of the proposed obstetric beds, as well as labor/delivery/recovery, surgical delivery rooms (C-Section rooms), and related Phase I recovery areas will be relocated to new construction. Finally, the Medical Center will modernize the space vacated by the obstetric services for 64 neonatal intensive care beds, (or 27 more than are currently authorized) and an enlarged OB Triage Area.

The proposed patient tower will have the following functions in new construction:

Roof	Elevator Machine Room
Penthouse	Mechanical
Level 10	MICCU Intensive Care Beds and Non Clinical Space
Level 9	Cardiac/Thoracic and Transplant Intensive Care Beds and Non Clinical Space
Level 8	Neuro Intensive Care Beds and Non Clinical Space
Level 7	Postpartum Beds, Newborn Nursery, and Non Clinical Space
Level 6	GYN Postpartum/Obstetric Beds, Newborn Nursery, Non Clinical Space and Shelled Space
Level 5	There is no Level 5*
Level 4	There is no Level 4*
Level 3	Mechanical Space
Level 2	Antepartum Obstetric Beds/Labor/Delivery/Recovery, Surgical Delivery Suite, Phase I Recovery, and other Non Clinical Space
Level 1	Public Space, Café, and other Non Clinical Space
Ground Level	Kitchen, Morgue, and other Non Clinical Space

\*Note: There is no level 4 or 5 due to the matching of floor levels with existing building levels.

Connector	A connector between the existing tower and the new patient tower will provide direct linkage between the two towers at Ground and Level 1 through Level 9.
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The space vacated by the obstetric service in the existing tower will house the following functions in modernized space:

Level 2	Level IIIC Neonatal Intensive Care Unit, OB Triage, and Non Clinical Space
---------	--

A site plan showing the location of the new construction and modernization and a stacking diagram showing the location of the functions in new construction and modernization are appended as Narrative, Exhibits 1 and 2.

Today, the Medical Center is experiencing an acute shortage of obstetric, adult intensive care and neonatal intensive care beds and an overall critical shortage of space. According to Kurt Salmon and Associates, a nationally respected facility planning firm, the Medical Center has 1,260,000

BGSF of space when national standards for similar tertiary care/education/research facilities for similar facilities suggest that it should have from 1,750,000 to 2,100,000 BGSF. This is a deficit from 490,000 BGSF to 840,000 BGSF. As an initial campus redevelopment process, the Medical Center added 324,675 BGSF of space in a new Ambulatory/Outpatient Pavilion that is currently under construction (Permit #11-019 approved on August 16, 2011). Even with this initiative, the Medical Center continues to have a deficit of from 165,325 BGSF to 515,325 BGSF. The proposed Project will add 388,871 BGSF of space.

### Project Size

The amount of total physical space programmed for the proposed project is necessary and conservative compared to State Standards. The only apparent exception is Phase I recovery rooms – these exceed the State Standard.

Project Size Compared to State Standards

Department/Service	Number of Key Rooms	Proposed BGSF/GSF	State Standard	Met Standard?
OB Triage	12	451	NA	NA
Labor/Delivery/Recovery	15	923	1,200 to 1,600 per room	YES
Surgical Delivery/ C-section Rooms	4	881	2,075 per OR	YES
Phase I Recovery	4	405	180 per room	NO
Obstetric Beds	56	652	500 to 660 per room	YES
Newborn Nursery	24	75	106 per bed	YES
Neonatal Intensive Care	64	338	443 to 560 per bed	YES
Intensive Care Beds	108	618	600 to 685 per bed	YES
Medical Surgical Beds	378 <sup>1</sup>	248 <sup>1</sup>	500 to 600 per bed	YES
Morgue	1	2,597	NA	NA

<sup>1</sup> The Medical Surgical bed complement does not include the “20-bed rule” addition or its related square footage.

The size of the Phase I recovery rooms is justified based on their being two patients and large equipment in the room.

### Project Utilization

The utilization of all the project departments/areas will exceed State Standard Target Occupancy by the second full year of utilization.

## Project Utilization Compared to State Standards

Department/Service	Projected Utilization 2 <sup>nd</sup> Full Year	State Standard	Proposed Rooms	Met Standard?
OB Triage	7,770 Visits	NA	12	NA
Labor/Delivery/Recovery	17,913 hours	400 procedures per room	15	YES
Surgical Delivery/ C-section Rooms	1,734 surgeries	800 procedures	4	YES
	5,142 hours	1,500 hours/room	4	
Guidelines do not include one necessary room for emergency surgery.				
Phase I Recovery	NA	None	4	NA
Obstetric Beds	86.3 percent	78.0 percent	56	YES
Newborn Nursery	NA	NA	24	NA
Neonatal Intensive Care	92.3 percent	75.0 percent	64	YES
Intensive Care Beds	73.3 percent	60.0 percent	189	YES
Medical Surgical Beds	87.4 percent	88.0 percent	386 staffed	YES
Morgue	NA	NA	1	NA

The Medical Center is striving for gold certification according to Leadership in Energy and Environmental Design (LEED) standards for sustainability.

The project has received strong community support; letters of support are included as Narrative, Exhibit 3.

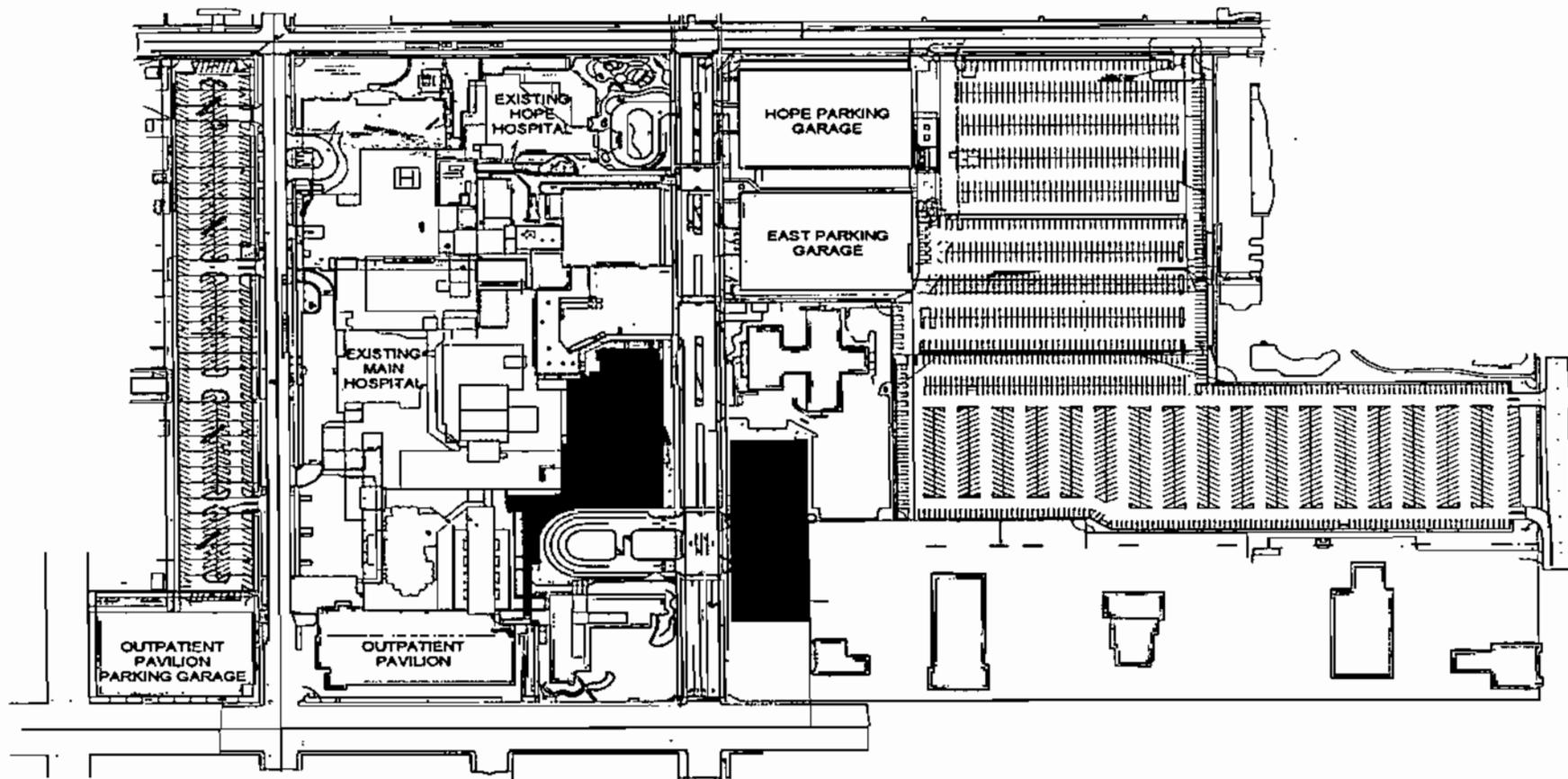
This project will be completed in two major phases. The proposed Patient Tower is expected to be completed in October 2016. At the completion of the Patient Tower, the intensive care beds, the obstetric beds and related services and the morgue will be relocated to the Tower. Next, the vacated obstetric space and the existing neonatal intensive care unit will be modernized for the expanded neonatal intensive care unit and the OB Triage area. These modernization projects are expected to be completed by April 2017. The completion of non clinical construction and modernization will be completed in phases with the entire project by July 31, 2019.

Of the total square footage, 338,871 GSF will be in new construction; 83,985 GSF will be in modernization.

Total project cost is expected to be \$345,756,980. The project will be funded with cash and securities and debt.

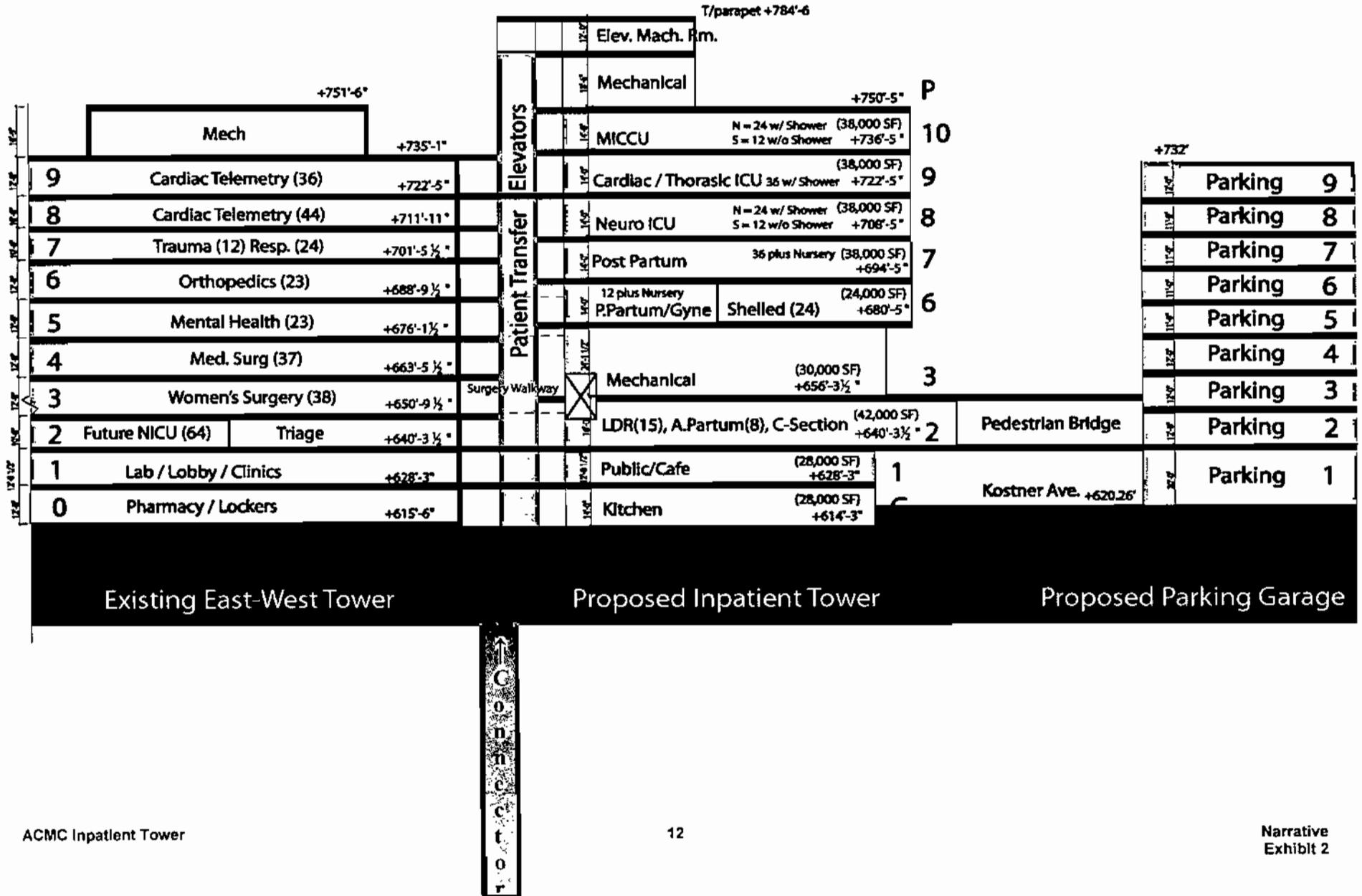
In accordance with the Illinois Administrative Code, Chapter II, Section 1110.40 (b), the project is classified as substantive because the project is neither emergency nor non substantive; further total project cost exceeds the HFSRB threshold.

Advocate Christ Medical Center  
Proposed Site Plan



Advocate Christ Medical Center

Proposed Stacking Diagram



## Letters of Support

### Public Officials

Rep. Kelly Burke, Illinois State Representative – 36<sup>th</sup> District  
Sen. Maggie Crotty, State Senator – 19<sup>th</sup> District  
Rep. Renee Kosel, Illinois State Representative  
Rep. Monique Davis, Illinois State Legislator  
Mayor Harry Klein, Mayor of the City of Burbank  
John Murphy, Supervisor, Worth Township  
Louis Viverito, Supervisor, Stickney Township

### Other Community

James Casey, Director, Oak Lawn Public Library  
William Villanova, Chief of Police, Oak Lawn  
Robert Pyznarski, Chief of Police, Chicago Ridge  
Dr John Byrne, Superintendent of Schools, Community HS District 218  
Daniel Riordan, Superintendent of Schools, Reavis HS District 220  
Ruth Faklis, Director, Prairie Trails Public Library District  
Dennis Duffy, Commissioner & Director, Evergreen Park Recreation Dept.  
James Buschbach, Chairman, Oak Lawn Business Development Commission  
Joan Buschbach, President, Oak Lawn Library Board  
Jane Quinlan, Village Clerk, Oak Lawn  
Helen Cuprisin, President, Evergreen Park Chamber of Commerce  
Karen Boll, President, Oak Lawn Chamber of Commerce  
Karen Miller, President Board of Trustees, Worth Public Library District

**Physicians**

Dr. James Weese, Medical Director, Cancer Institute

Dr. Daniel Girzadas, Jr., Program Director, Department of Emergency Medicine

Dr. Joseph Pavese, Chairman, Department of Obstetrics and Gynecology

Dr. Thomas Myers, Medical Director, Neonatal Intensive Care

Dr. Marc Silver, Clinical Professor and Chairman, Department of Medicine

Dr. Helen Kay, Department of Maternal Fetal Medicine

Dr. James Doherty, Director, Trauma & Critical Care Programs

Dr. Jae Kim, Urologist

Dr. Kevin Luke, Co-Chair, Bone & Joint Institute

Dr. Pat Pappas, Director, Cardiovascular Surgery – Medical Director, Heart & Vascular Institute

Dr. Antone Tatooles, Vice Chairman, Department of Surgery – Director, Mechanical Assist Device Program

Dr. Warren Robinson, Family Medicine

## ILLINOIS HOUSE OF REPRESENTATIVES



District Office  
5144 W. 95th Street  
Oak Lawn, IL 60453  
708.425.0571  
708.425.0642 fax

**Kelly Burke**  
State Representative  
36th District

Capitol Office  
266-S Stratton Office Building  
Springfield, IL 62706  
217.782.0515  
217.558.3741 fax

March 26, 2012

Ms. Courtney R. Avery  
Administrator  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761

Dear Ms. Avery:

I wholeheartedly support plans by Advocate Christ Medical Center to construct a patient bed tower. The medical center serves as the only comprehensive tertiary and quaternary care facility in the Southland, and the residents whom I represent depend on it remaining a top-level facility that is able to expand to meet the growing needs of communities in our region.

During 2011, many patients in need of health care were unable to gain admission to the hospital because of a lack of patient beds. The patient bed tower is an important component of an overall medical center modernization that will result in additional parking and an improved environment for patients, families, and visitors. In addition, health care services will be delivered in a more effective and patient-friendly environment.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that will meet the current and future needs of our area. I fully support the project, and I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for a patient bed tower.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Burke".

Kelly Burke  
State Representative - 36<sup>th</sup> District

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Capitol Office:  
123 State Capitol  
Springfield, Illinois 62706  
(217) 782-9395  
(217) 558-6006 Fax

District Office:  
5119 W. 139<sup>th</sup> St.  
1<sup>st</sup> Floor East  
Oak Forest, Illinois 60432  
(708) 687-9696  
(708) 687-9801 Fax



ILLINOIS STATE SENATE  
**MAGGIE CROTTY**  
STATE SENATOR • 19TH DISTRICT  
ASSISTANT MAJORITY LEADER

COMMITTEES:  
Joint Committee on  
Administrative Rules - Co-Chair  
Environment  
Executive  
Executive Appointments  
Higher Education  
State Government & Veterans Affairs

March 23, 2012

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

Dear Ms. Avery:

*I am writing this letter in strong support of Advocate Christ Medical Center/Advocate Hope Children's Hospital to construct a patient bed tower addition on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its capacity to meet the growing demands of communities in the region and to decompress its overcrowded emergency department.*

*The medical center is not only a Level I trauma center that treats the sickest and most severely injured patients in the Southland, it has developed into one of the Chicago area's largest tertiary and quaternary care providers, drawing patients from throughout the southern and southwestern portion of Chicago and surrounding suburbs.*

*With its current 690 patient beds, the medical center has been running at approximately 90 percent capacity. During 2011, many patients in need of health care were unable to gain admission to the hospital because of a lack of patient beds. The medical center was forced to go on bypass for 1,100 hours and divert patient to other area and out-of-area facilities.*

*In essence, the medical center has reached critical capacity, and, without relief, will be unable to meet the region's needs for a medical center that delivers the highest levels of care. First-rate facilities are keys to providing patients with the most advanced health care in contemporary, safe and efficient space that is designed for today's health-related needs. A new patient bed tower will increase patient safety, including infection control plus improve overall patient experience.*

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*I applaud Advocate's ongoing effort to meet the health care needs of the Southland, especially in the areas of trauma, emergency services, critical care and treatment of high-risk mothers and infants. For this reason, I urge the members of the Illinois Health Facilities and Services Review Board to approve the Certificate of Need application for the patient bed tower.*

*If you should have any further questions please do not hesitate to contact me at anytime. Thank you in advance for your time and consideration.*

*Sincerely,*



*M. Maggie Crotty  
Assistant Majority Leader  
State Senator ~ 19<sup>th</sup> District*

*mncfmm*



*Renee Kosel*  
State Representative  
Assistant Republican Leader

Springfield Office: Stratton Office Building Springfield, Illinois 62706 217.782.0424 217.557.7249 fax

June 2012

Ms. Courtney Avery, Administrator  
Illinois Health Facilities Planning Board  
525 W. Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761

Dear Ms. Avery:

In my capacity as an Illinois State Representative, I am writing in support of the Certificate of Need application of Advocate Christ Medical Center and Hope Children's Hospital to construct a patient bed tower on its Oak Lawn campus. Many of my constituents utilize the services which these facilities provide, and I and my family also utilize these facilities for many of our personal medical needs.

It is critically important to resolve the medical center's lack of capacity, its inability to admit all patients who require and seek care, as well as its need to upgrade facilities and create more intensive care unit space. Patient visits to the medical center ER exceeded 90,000 last year and the congestion impacted the center's ability to tend to those in need of care in a timely manner. This number is expected to grow due to the area's demographics, and implementation of national Health Care Reform legislation which will increase demand for hospital care.

Additionally, as the only tertiary and quaternary service provider in the Southland area of metropolitan Chicago, the medical center needs to upgrade its services in more contemporary efficient facilities to accommodate continuing advancements in medicine and technology, while providing care in space that ensures the highest quality care, enhances patient safety and protects patient privacy.

I respectfully request and strongly urge the Board to approve Advocate Christ Medical Center and Hope Children's Hospital's CON, which will ensure that patients have access to the life sustaining services they need. I encourage the Board to endorse this project and give its full support to the CON request.

Sincerely,

Renee Kosel  
State Representative  
Assistant Republican Leader

District Office: 19201 S. LaGrange Road, Suite 204B, Mokena, Illinois 60448 708.479.4200 708.479.7977 fax

ILLINOIS HOUSE OF REPRESENTATIVES

## COMMITTEES:

Chairperson,  
Insurance  
Vice-Chairperson,  
Financial Institutions  
Appropriations - General Services  
Appropriations - Higher Education  
Elementary & Secondary Education  
Juvenile Justice Reform  
Railroad Industry  
State Government Administration



**MONIQUE D. DAVIS**  
STATE REPRESENTATIVE  
27TH DISTRICT

District Office:  
1234 W. 95th St.  
Chicago, Illinois 60643  
773/445-9700  
Fax: 773/445-5755  
Legislative Aide  
Arnold Jordan

Capitol Office:  
241-E Stratton Building  
Springfield, Illinois 62706  
217/782-0010  
Fax: 217/782-1795

March 20, 2012

Courtney R. Avery  
Administrator  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761

Dear Ms. Avery:

As an Illinois State Legislator, I am pleased to give my full support and endorse Advocate Christ Medical Center and Hope Children's Hospital in the construction of a patient bed tower on its Oak Lawn campus.

As the major provider of health care in the Southland area of metropolitan Chicago, construction of the proposed patient bed tower is critical if the medical center is to maintain its role as a state and national leader in heart care and heart surgery, treatment of stroke, and other disorders that are increasing in prevalence due to an aging population.

The full implementation of national Health Care Reform legislation will increase the demand for hospital care. Therefore, the medical center will continue to attract outstanding health care professionals and become a resource for employment.

Sincerely,

A handwritten signature in cursive script that reads "Monique D. Davis".

Monique D. Davis  
State Representative

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**Office of the Mayor**  
6530 West 79th Street  
Burbank, IL 60459-1198  
(708) 599-5500

**Harry J. Klein**  
Mayor

March 21, 2012

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

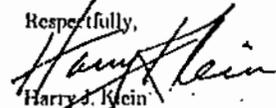
Dear Ms. Avery:

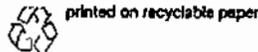
I write this letter as the Mayor of the City of Burbank which has a population of nearly 30,000 people. In this regard, I strongly support Advocate Christ Medical Center in the construction of a patient bed tower to serve the people of the southwest side and the south suburban area.

Specifically, Christ Hospital provides health care to over 90% of our population in the City of Burbank. Our residents depend on them every day!

Unfortunately, because of bed-space, they cannot effectively care for the thousands who knock at their doors, day after day. An increase in space will allow Advocate to perform their services as a professional health care provider for many years to come.

Allowing Advocate Christ Medical Center to provide additional space will guarantee better health care for not only the City of Burbank but for thousands of people in the Southland.

Respectfully,  
  
Harry J. Klein  
Mayor



**WORTH TOWNSHIP**

**John F. Murphy**  
*Supervisor*  
**Thomas "Bud" Gavin**  
*Clerk*  
**John Z. Toscas**  
*Assessor*  
**Steve Loulouis**  
*Highway Commissioner*



*Office of the Supervisor*  
**John F. Murphy**

*Trustees*  
**Roger Benson**  
**Michael Mahoney**  
**John "Jack" Lind**  
**Michael B. Stillman**

**David Walsh**  
*Collector*

March 20, 2012

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

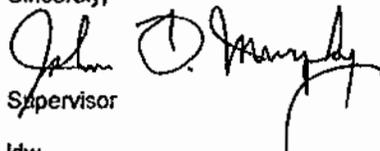
Dear Ms. Avery,

Worth Township would like to publically issue its support for the construction of a patient bed tower on the Oak Lawn campus of Advocate Christ Medical Center and Hope Children's Hospital. For several decades this facility has been the backbone of our community. Their successes have been widely publicized. Yet it is the day-to-day unheralded success stories which occur at the Medical Center and Hope Children's Hospital that convey the true need for this facility.

Advocate Christ Medical Center and Hope Children's Hospital is wholly located within Worth Township, whose population is 152,633. As this population grows older and new families move into our community, Advocate is poised to meet the needs of everyone.

Should you have any questions or if I can be of further service, please do not hesitate to call on me.

Sincerely,

  
Supervisor

ldw

11601 S. Pulaski Road ~ Alsip, IL 60803 ~ 708-371-2800 ~ Fax: 708-371-2144  
[www.worhtownship.com](http://www.worhtownship.com)

Main Office  
SOUTH  
708.424.9200  
5635 State Road  
Burbank, IL 60459

LOUIS S. VIVERITO  
SENIOR CENTER  
708.636.8950  
7745 S. Leamington  
Burbank, IL 60459

## TOWNSHIP OF STICKNEY



LOUIS S. VIVERITO  
Supervisor

NORTH  
708.788.9100  
6721 W. 40th Street  
Stickney, IL 60402

CENTRAL  
708.458.4126  
4949 S. Long  
Chicago, IL 60638

March 27, 2012

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

Dear Ms. Avery:

My name is Louis Viverito, President, Board of Health, Stickney Public Health District, and retired State Senator, 11<sup>th</sup> District. I am in writing this letter because I feel very strongly about the growth of Advocate Christ Medical Center and Hope Children's Hospital.

The medical center's record of high occupancy, among the highest in Illinois, reduces patient access to its exceptional services. Multiple patients had to be transported away from Advocate Christ Medical Center and taken to other facilities because they were on bypass for a record number of hours. A critical lack of capacity, including too few ICU and telemetry beds, was the prime reason for the extensive number of bypass hours.

With this and multiple other reasons, I am pleased to give my full support to the project.

Sincerely,

Louis S. Viverito, Supervisor  
President, Board of Health

LSV/dmr



## Oak Lawn Public Library

9427 S. Raymond Ave. | Oak Lawn, IL 60453 | 708-422-4990 | www.oaklawnlibrary.org

March 19, 2012

Courtney R. Avery,  
Administrator  
Illinois Health Facilities and Services Review Board  
525 W. Jefferson, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

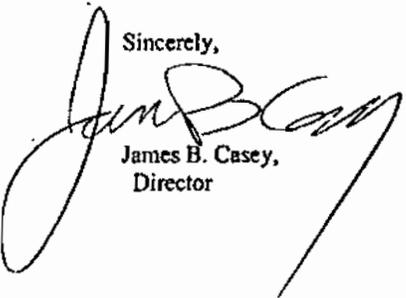
Dear Ms. Avery:

I am writing in support of plans by Advocate Christ Medical Center/ Advocate Hope Children's Hospital to construct a patient bed tower addition on its Oak Lawn Campus. This expansion plan is in response to the growing need for increased capacity for service to the many communities in the region.

The Advocate Christ Medical Center is the second busiest hospital in the Chicago metropolitan area and includes among the communities it services many thousands of underprivileged persons for whom that hospital facility is the only option after shootings, accidents or other life threatening events. There is also every indication that the pressing need for hospital facilities is likely to continue increasing as the annual patient admissions have risen and emergency room visits exceeded 90,000 last year.

As one who has been a resident of Oak Lawn and leader of the community's public library since 1992, I urge the members of the Illinois Health Facilities and Services Review Board to approve the Certificate of Need request for the patient bed tower proposed by the Advocate Christ Medical Center.

Sincerely,

  
James B. Casey,  
Director

JC/jn

**OAK LAWN POLICE DEPARTMENT**

9446 S. Raymond Avenue • Oak Lawn, Illinois 60453 • Phone (708) 422-8292

www.oaklawn-il.gov

**William Villanova**  
Chief of Police  
SPSC 136h**Roger Pawlowski**  
Division Chief Administrative  
SPSC 123h**Michael Kaufmann**  
Division Chief Investigations  
FBINA 212h**Michael Murray**  
Division Chief Patrol  
SPSC 267h

March 27, 2012

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

Dear Ms. Avery:

As Police Chief for the Village of Oak Lawn, I am acutely aware of the critical role Christ Medical Center plays as a POD hospital (disaster-coordinating hospital in region 7 of Illinois emergency medical services program) and as a Level 1 trauma center.

As a major provider of health care in the Southland area of Chicago, Advocate Christ Medical Center and Hope Children's Hospital meet a regional need for tertiary and quaternary services. Construction of the proposed patient bed tower is critical if the medical center is to continue growing the cancer, heart and vascular, neurosciences and bone and joint institutes, plus maintain its role as a state and national leader in heart care and heart surgery.

The medical center's record high occupancy-among the highest in Illinois-reduces patient access to its unique services. The medical center's emergency room treated more than 90,000 patient visits in calendar year 2011. The emergency center was constructed to accommodate significant fewer patients.

First-rate facilities are keys to providing patients with the most advanced health care in a contemporary, safe and efficient space that is designed for today's health related needs. A new bed tower will increase patient safety, including infection control, enhance patient privacy and improve the overall patient experience

I am pleased to give my full support to this project and respectfully ask that the Illinois Health Facilities and Services review Board approve this project.

Sincerely

William Villanova  
Chief of Police  
Oak Lawn Police Department

**VILLAGE OF CHICAGO RIDGE****POLICE DEPARTMENT**  
10425 S. RIDGELAND AVENUE  
CHICAGO RIDGE, ILLINOIS 60415EMERGENCY 911  
NON-EMERGENCY  
708-425-7831**CHIEF ROBERT D. PYZNARSKI**FAX  
708-857-4460

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

Ms. Avery,

Advocate Christ Medical Center and Hope Children's Hospital serve the Village of Chicago Ridge's residents as our local medical center. I care about the quality of services, and the ability for this organization to continue to attract first-class health care professionals, the education of resident physicians and other medical and nursing students, along with providing advanced technological medical facilities to our community.

I believe that increasing the center's patient capacity will make for a healthier, more secure environment for families and the patients being cared for at the hospital. The emergency department has outgrown the capacity to serve the community in an efficient manner and adding to the hospital's capacity to house patients will make that process much better for the people being served by Advocate Christ Medical Center and Hope's Children's Hospital.

I give full support to the expansion of the patient care facilities and request that the Illinois Health Facilities and Services Review Board approve the project that has been presented to them.

Sincerely,

A handwritten signature in black ink that reads "Robert D. Pyznarski".

Robert D. Pyznarski  
Chief of Police

RP/db

**COMMUNITY HIGH SCHOOL DISTRICT 218**

Dwight D. Eisenhower • Harold L. Richards • Alan B. Shepard • 218 ALT ED • Summit

**Office of the Superintendent**

Administrative Center  
10701 S. Kilpatrick Avenue  
Oak Lawn, Illinois 60453  
Phone: 708-424-2000  
Fax: 708-424-6389

*March 21, 2012*

*Public Affairs and Marketing  
Advocate Christ Medical Center  
4440 W. 95<sup>th</sup> Street  
Oak Lawn, IL 60453*

*Attn: Cindi Jaranowski**Dear Ms. Jaranowski,*

*I am writing this letter in support of the proposed bed tower project that Advocate Christ Medical Center and Hope Children's Hospital is planning to construct.*

*As the major provider of health care in the Southland area of metropolitan Chicago, Advocate Christ Medical Center and Hope Children's Hospital meet a regional need for tertiary and quaternary services. Construction of the proposed patient bed tower is critical if the medical center is to:*

- *Continue to provide quality healthcare to the 6,000 students who attend Harold L. Richards, Alan B. Shepard, Dwight D. Eisenhower, Delta, Summit High Schools and their families.*
- *Continue and expand the partnerships with schools that allow students to explore the many career options available in the health field.*
- *Continue to support emergency preparedness in the surrounding communities and schools.*
- *Grow the cancer, heart and vascular, neurosciences and bone and joint institutes.*
- *Maintain its role as a state and national leader in heart care and heart surgery, laparoscopic and minimally invasive surgery, treatment of stroke, and other disorders that are increasing in prevalence due to an aging population.*
- *Continue its mission of excellence in patient care clinical research and education of resident physicians and medical and nursing students.*
- *Keep pace with the ever-changing advancements in medicine and technology.*
- *Continue to attract outstanding health care professionals to work at the medical center.*

*As superintendent of a high school district located within the boundaries of Advocate Christ Medical Center, I feel strongly that these new facilities could bring training and educational opportunities to our students. In addition, these students may aspire to careers in the medical field by acquiring hands on knowledge of the inner workings of a health care system. The proposed project is the groundwork for meeting the future needs and growing demands of the community and will help the hospital to stay financially viable for the future. I support efforts to modernize this facility and to provide even better care than we already have in place.*

*Sincerely,*

*Dr. John Byrne  
Superintendent of Schools*

[www.chsd218.org](http://www.chsd218.org)

Providing Quality Education for Today - and Tomorrow

**ADMINISTRATION**  
**DANIEL J. RIORDAN, Ed.D.**  
*Superintendent*

**RAYMOND P. NEGRETE**  
*Assistant Superintendent  
 for Business & Finance*

**TIMOTHY J. SMITH**  
*Assistant Superintendent  
 for Facilities & Operations*

**PAIGE A. DAQUE, Ed.D.**  
*Principal*



**REAVIS HIGH SCHOOL**  
 District NO. 220

6034 West 77<sup>th</sup> Street • Burbank, Illinois 60459-3199  
 Phone: 708-599-7200 • Fax: 708-599-8751



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**JOHN F. SEPER**

March 29, 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 Superintendent of Reavis High School District #220 in Burbank, Illinois, I am requesting that the *Illinois Health Facilities and Services Review Board* give serious consideration to approving the bed tower project that Advocate Christ Medical Center is looking to undertake.

As the major provider of health care in the southland area, Advocate Christ Medical Center and Hope Children's Hospital meet a critical need of providing patients with the most advanced health care in contemporary, safe and efficient space designed for today's health-related needs. A new patient bed tower will increase patient safety, including Infection control, provide room for family support and improve the overall patient experience.

On behalf of the students, families and staff of Reavis High School, we thank you in advance for your support of the proposed project.

Sincerely,

Daniel J. Riordan, Ed.D.  
 Superintendent  
 Reavis High School District #220  
 708-599-7200 ext. 247  
[driordan@d220.org](mailto:driordan@d220.org)

---

PROMOTING A STUDENT-CENTERED ENVIRONMENT

## Prairie Trails Public Library District



**BOARD OF TRUSTEES**  
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Anita M. Byrne, *Vice President*  
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Ann M. Trovato  
Michael Valerio

April 2, 2012

**DIRECTOR**  
Ruth E. Faklis

Courtney R. Avery,  
Administrator  
Illinois Health Facilities and Services Review Board  
525 W. Jefferson, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

Dear Ms. Avery:

On behalf of the Board of Trustees and staff of the Prairie Trails Public Library District, I am writing this letter of support for the Advocate Christ Medical Center's plan to construct a patient bed tower on its Oak Lawn campus.

All of our Trustees and the property owners who fiscally support our library reside in the service area of the Advocate Christ Medical Center. Having served as Director of the library since 1990, I know first hand of the quality of service the hospital has provided, as endorsed by patron commentary and personal experience. The expansion project is a necessary response to the life-safety needs of the thousands of residents we serve.

We recognize that in the Chicagoland area Advocate Christ Medical Center is the second busiest hospital, and serves constituents of all ages and economic status. Again we highly support the critical importance of this project in serving the health care needs of the region.

Sincerely,

  
Ruth E. Faklis  
Director

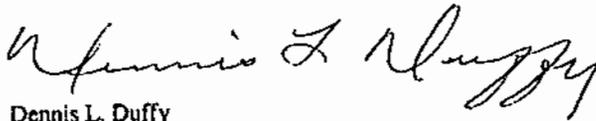
8449 S. MOODY AVE. • BURBANK, ILLINOIS 60459 • PHONE: (708) 430-3688 • FAX: (708) 430-5596  
EMAIL: pts@mnlslib.il.us • WEBSITE: prairietrailslibrary.org

Dennis L. Duffy  
9307 S St. Louis  
Evergreen Park, IL 60805

It is with the utmost urgency that I write this letter on behalf of Advocate Christ Medical Center and Hope Children's Hospital regarding their plan to construct a patient bed tower on their Oak Lawn campus. I am well aware of the importance of this hospital to the community. As a trauma center, it supports a vast area. Listen to the daily news reports to hear how often victims are transported to this hospital. Christ Hospital provides immediate critical care to patients from all over the Chicago area. In order to keep up with the demands, it is essential to improve and augment the existing facility.

If Christ Hospital is to uphold its reputation for excellence, it is imperative to make improvements such as building the patient bed tower. Change and discovery are a continuous part of the medical field; thus, hospitals must adapt and change facilities to meet these challenges. This new building will help provide better facilities for patients and their families, more privacy for the patient, and better technology to support patient care. It is important to look to the future and plan for the future. The community needs Advocate Christ Medical Center and Hope Children's Hospital for the multi-dimensional services they provide. I heartily support their endeavor to build a new patient bed tower.

Sincerely,



Dennis L. Duffy

Apr 05 2012 11:00AM World Travel Mart

7006364902

p. 3

**Buschbach****INSURANCE AGENCY, Inc.**

5615 W. 95th Street • Oak Lawn, Illinois 60453

Phone: 708-423-2350

Fax: 708-425-5077



e-mail: sales@buschbach.com

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

Dear Ms. Avery,

My family and I have lived in Oak Lawn for over 50 years. My wife and I are active on many boards, commissions and committees in the community. I am chairman of the Business Development Commission, past chairman of the Oak Lawn Chamber of the Chamber of Commerce, governing council at Advocate Christ Medical Center and several other community boards. My wife is currently the President of the Library Board, past president of the Chamber of Commerce and board member of the Children's Museum in Oak Lawn.

I feel that the proposed patient bed tower is extremely important to the Medical Center to help with the growth of the cancer, heart and vascular, neurosciences and bone and joint institutes. The growth of these institutes will continue to attract outstanding healthcare professionals so that they can keep pace with the ever changing advancements in medicine and technology.

The emergency department was constructed to accommodate about 45,000 visits a year, but they treated over 90,000 in 2011. They also had to turn away patients because the campus was on bypass for a record number of hours.

The new patient bed tower will result in more efficient healthcare services delivered in a more effective and patient friendly environment. I give my full support to this project and hope that the Illinois Health Facilities and Services Review Board will approve the project.

Thank you for your support,

James A. Buschbach  
J. Buschbach Insurance Agency

Apr 05 2012 11:08AM World Travel Mart

7086364902

p. 2

*World Travel Mart*5815 W. 85th Street - Oak Lawn, IL 60453  
(708) 638-7800  
(708) 636-4902 fax

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

Dear Ms Avery,

I am very active in the Oak Lawn Community and President of the Oak Lawn Library Board.

I support the proposed patient bed tower. The medical center's track record for excellence and it's location in the fastest growing region of the Chicago area have resulted in demand for services that far exceed the hospital's current capacity.

I hope that the Illinois Health Facilities and Services Review Board will approve this project.

Thank you for your support,

Joan Buschbach



THE VILLAGE OF  
**OAK LAWN**

9416 SOUTH RAYMOND AVENUE, OAK LAWN, ILLINOIS 60453  
TELEPHONE: (708) 636-4403 | FACSIMILE: (708) 636-8606 | WWW.OAKLAWN-IL.GOV

April 3, 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 this letter in support of Advocate Christ Medical Center and Hope Children's Hospital constructing a patient bed tower on its Oak Lawn campus. This proposed development would add inpatient beds, which is critical in resolving the medical center's lack of capacity for bed space.

With Advocate Christ Medical Center and Hope Children's Hospital being our largest employer in the Village of Oak Lawn, I do work closely with the hospital. We are proud to have them in our Village and I do see the day to day operations of the facility. I feel the patient bed tower is critical if Advocate wants to grow in various areas such as cancer and heart care, and to be able to accommodate the critical care patients that come in.

Advocate Christ Medical Center and Hope Children's Hospital is an asset to the Village of Oak Lawn in many aspects. From my own personal experiences at the hospital, I always know I am in good hands with their tremendous care.

Thank you for your time and if you have any questions, please feel free to contact me at [jquinlan@oaklawn-il.gov](mailto:jquinlan@oaklawn-il.gov).

Sincerely,

Jane M. Quinlan, CMC  
Oak Lawn Village Clerk

DAVE HEILMANN  
VILLAGE PRESIDENT

JANE M. QUINLAN, CMC  
VILLAGE CLERK

LARRY R. DEFTJEN  
VILLAGE MANAGER

VILLAGE TRUSTEES:  
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CAROL R. QUINLAN  
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CYNTHIA TRAUTSCH





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3960 W. 95th Street ▲ Third Floor ▲ Evergreen Park, IL 60805 ▲ 708.423.1118

April 2, 2012

Courtney R. Avery  
Administrator  
Illinois Health Facilities and Services Review Board  
Springfield, Illinois 62761

Over the years, I have had many family members well taken care of at Advocate Christ Medical Center. The hospital is now considering a proposed development of a patient bed tower to resolve the current lack of patient beds. Construction of the patient bed tower will allow Advocate Christ Medical Center and Hope Children's Hospital to continue to serve the area with the most advanced care delivered by outstanding health care professionals.

The Evergreen Park Chamber of Commerce endorses this project that is critical to the communities that will benefit from expanded medical care. Businesses, as well as residents, thrive when their neighborhoods provide a healthy, well-rounded environment.

I urge the Illinois Health Facilities and Services Review Board to approve the patient bed tower that Advocate Christ Medical Center and Hope Children's Hospital are planning to construct.

Sincerely,



Helen Cuprisin, President  
Evergreen Park Chamber of Commerce

---

[www.evergreenparkchamber.org](http://www.evergreenparkchamber.org)



April 3, 2012

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

Dear Ms. Avery:

I wholeheartedly support plans by Advocate Christ Medical Center/Advocate Hope Children's Hospital to construct an eight-story patient bed tower addition on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its capacity to meet the growing demands of communities in the region and to decompress its overcrowded emergency department.

The medical center is not only a Level I trauma center that treats the sickest and most severely injured patients in the Southland, it has developed into one of the Chicago area's largest tertiary and quaternary care providers, drawing patients from throughout the southern and southwestern portion of Chicago and surrounding suburbs. In fact, the latest hospital listing in *Crain's Chicago Business* indicates that Advocate Christ Medical Center is the second busiest hospital in the Chicago metropolitan region.

With its current 690 patient beds, the medical center has been running at approximately 90 percent capacity. In 2011, patients in need of health care were unable to gain admission to the hospital because a lack of patients beds. The campus was forced to go on bypass for some 1100 hours and divert patients to other area facilities. Meanwhile, patient congestion in the hospital's emergency department resulted in long waits last year and the loss of another 2,700 patients, who left the emergency waiting area to seek care elsewhere.

Meanwhile, the medical center's record of high occupancy – among the highest in Illinois which reduces patient access to its unique services. In essence, the medical center has reached critical capacity, and without relief, will be unable to meet the region's needs for a medical center that delivers the highest levels of care.

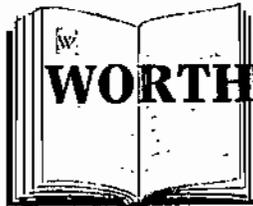
In addition to helping relieve capacity issues, the proposed project will enable Advocate Christ Medical Center/Advocate Hope Children's Hospital to expand the number of its critical care and telemetry beds, increase the number of beds dedicated to the care of children and enhance its health services to women and high-risk infants.

I applaud Advocate's ongoing efforts to meet the health care needs of the Southland, especially in the areas of trauma, emergency services, critical care and treatment of high-risk mothers and infants. For this reason, I am pleased to "give my full support to" the project. I urge the members of the Illinois Health Facilities Planning Board to approve the project.

Sincerely,

Karen Boll  
President  
Oak Lawn Chamber of Commerce





## WORTH PUBLIC LIBRARY DISTRICT

6917 West 111th Street  
Worth, IL 60482  
Phone (708) 448-2855  
Fax (708) 448-9174  
www.worthlibrary.com

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

April 3, 2012

Dear Ms. Avery,

Many happy memories have begun for my family at Advocate Christ Medical Center, and we have bid final farewell to loved ones there. Also, Christ Hospital has been there whenever we have needed their care whether for routine work-ups and surgeries; and for obstetric emergencies and end of life care whether in the emergency department or through home care services.

Christ Hospital has continued to lead the way for the southwest suburbs with major advancements in medicine, i.e. cardiology, pediatrics, oncology and emergency care. It is vital that Advocate Christ Medical Center be permitted to continue to provide the extraordinary medical and nursing care to the ever growing population of the southwest Chicago land area. To do this, construction of the next level of state of the art bed tower must be permitted. Every evening news report seems to include press coverage of a patient transferred to the very congested emergency department at Christ. This then requires subsequent admission for a high level of critical care services in the ICU with eventual transfer to the floor bed that may take days to receive due to non-existent openings on the floor.

More important than ever before, Advocate Christ has led the way with superb patient privacy and technology standards. They have supplied crucial family support at times when families may not have any alternatives. Advocate Christ Medical Center continues to attract the best and most skilled physicians as evidenced through the multiple listings in the "Best of Lists" throughout the country.

As a patient, a family member, a community member of the southwest suburbs of Chicago, and a registered professional nurse, I request that you give your fullest support and endorse their construction of a patient bed tower. I am convinced that Advocate Christ Medical Center will be a leader in patient care for many years to come, and this construction would enhance the personal experience of every one that is welcomed through their doors.

Sincerely,

Karen M. Miller  
President, Board of Trustees  
Worth Public Library District



Advocate  
Christ Medical Center  
Hope Children's Hospital

4400 West 95th St., Suite 107 POB || Oak Lawn, IL 60453 || T 708.684.8000 || [advocatehealth.com](http://advocatehealth.com)

Cancer Institute Inspiring medicine. Changing lives.

March 27, 2012

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

Dear Ms. Avery:

I strongly support plans by Advocate Christ Medical Center to construct a patient bed tower on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its bed capacity. The medical center serves as the only comprehensive tertiary and quaternary care facility in the Southland, and the residents of this region depend on it remaining a top-level facility that is able to expand to meet the growing needs of communities in our region.

As the full time Medical Director of the Cancer Institute, I feel the importance of providing multidisciplinary care to patients with cancer is critical. In keeping with our recent affiliation with the MD Anderson Physicians Network we expect our expanding patient volume to accelerate. The multidisciplinary disease oriented centers are bringing more complex patients into the institution as is our new Intraoperative radiation therapy program. The addition of new surgical, medical and radiation oncologists to our staff continues to increase the complexity of patients treated at ACMC and will be greatly facilitated by the addition of new intensive care beds.

Construction of the new patient bed tower will improve patient access to all services on Christ Medical Center's main campus, and position the medical center for meeting the area's future health care demands. As admissions from our emergency department increase this new facility will help us overcome the over 1100 hours our institution was on bypass in 2011 alone and allow us provide lifesaving care to patients from this region and beyond. Just as important, this new structure and our new outpatient pavilion will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

A multi-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center

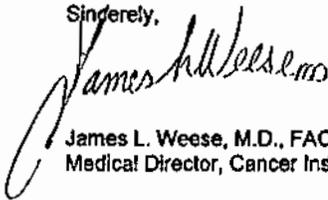


Ms. Courtney R. Avery

March 27, 2012  
Page - 2 -

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a new inpatient bed tower including many new intensive care beds. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the Institution's Certificate of Need request for an inpatient bed tower.

Sincerely,



James L. Weese, M.D., FACS  
Medical Director, Cancer Institute

JLW/rd

4440 West 95th Street  
Oak Lawn, Illinois 60453

 Advocate Christ Medical Center

March 30, 2012

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

Dear Ms. Avery:

I write this letter in the strongest possible support of the new patient bed tower at Advocate Christ Medical Center in Oak Lawn.

I have worked as an emergency medicine physician at Advocate Christ Medical Center since 1988. All through that time, I have felt that our medical center provided outstanding, state of the art, compassionate care to the people of the southwest side.

Over the last several years we have been faced with a growing space crisis here at Advocate Christ. The inpatient wards and intensive care units frequently have to function above capacity to manage our patient volumes. This high inpatient load translates to severe backlogs in the emergency department. Improvements in clinical efficiency and information technology have helped us manage the situation in a sub optimal fashion thus far. However, we have reached a point in which efficiency and technology will no longer assuage the problem. We now require more physical inpatient space to care for our patients.

I personally experience our institution's space constraints every day as they play out in the emergency department. I have seen heartbreaking examples of our patients (frequently senior citizens) lying for several hours in our emergency department waiting for a bed to open up in the hospital. As I walk by in the hall going to see another patient, they and their families ask when a bed will open up, why do they have to be in the hall, and can we get them some food and drink? The situation I described is repeated many, many times every day. It has lead to almost 2,700 patients leaving our emergency department prior to being seen by a physician. Hospital crowding

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has lead to hundreds of hours per year that our emergency department has gone on bypass. This causes ambulances to take many of our local patients to more distant hospitals or renders us unable to accept trauma patients.

Please allow Advocate Christ Medical Center to build a new patient bed tower. The added inpatient space will be vital to our ongoing efforts to provide outstanding, state of the art, compassionate medical care to our community. Thank you for your consideration.

Sincerely,



Daniel V. Girzadas Jr., MD, RBMS  
Program Director  
Department of Emergency Medicine  
Advocate Christ Medical Center

 Advocate Christ Medical Center4440 West 95th Street || Oak Lawn, IL 60463 || T 708.684.8000 || [advocatehealth.com](http://advocatehealth.com)

April 2, 2012

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

Dear Ms. Avery:

This letter is in support of the Certificate of Need (CON) application which will be submitted to the Illinois Health Facilities and Services Review Board for the bed tower project at Advocate Christ Medical Center in Oak Lawn, Illinois. As a Board Certified Obstetrician and Gynecologist who has been in practice in the Southland and Southwest Chicago Region for the last 28 years and also as the Chairman of Obstetrics and Gynecology at Advocate Christ Medical Center for the last 9 years, I am aware of the women's healthcare needs in this region. Advocate Christ Medical Center is the second largest delivery hospital in Illinois and is also the Southwest Regional Perinatal Center for the entire Chicago and Southwest Suburban area. As a Level IIIc Neonatal Intensive Care Facility we are responsible for the critical care needs of newborns throughout the region.

Advocate Christ Medical Center is one of the preeminent pediatric cardiac surgical programs in the country and as a result we have a large number of mothers and infants referred to our institution for advanced cardiac surgical care of the newborn.

With the nature of obstetrical practice we anticipate a growing need for high risk maternity services across the region and in order to achieve our goal of servicing our community we will need improvement of our current facilities and Neonatal Intensive Care Units. Currently we are struggling with capacity in our Neonatal Intensive Care Nursery with the demands of services with the high risk newborns. The bed shortage often creates bypass situations where babies in need of critical care may not be able to be transferred to Advocate Christ Medical Center. Given our large volume of obstetrical deliveries, our current obstetrical surgical facilities are overtaxed and this project will allow us to provide, going forward, state of the art maternity care in a patient safety dominated environment. We are very proud of our record at Advocate Christ Medical Center at being a leader in obstetrical care throughout the Midwest and we have reached top decile performance in national recognized standards for Women and Infants' care. This bed tower expansion is definitely needed to be able to continue to provide this care to our patients we serve.

Thank you for your consideration of this critical project for Advocate Christ Medical Center.

Sincerely,



Joseph M. Pavese MD  
Chairman, Department of Obstetrics and Gynecology  
Advocate Christ Medical Center

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Oak Lawn, IL 60453

May 25, 2012

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

RE: Letter of Support for the Certificate of Need (CON) Application of Advocate Christ Medical Center and Hope Children's Hospital proposed inpatient bed tower on its Oak Lawn campus

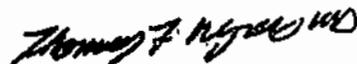
Dear Ms. Avery,

I am a medical staff leader at the above mentioned facility and have been the Medical Director of the Neonatal Intensive Care Unit since 1999. In the past, I have served on the Perinatal Advisory Committee which reports to the Illinois Department of Health regarding the Regionalized Perinatal System. I understand how complex and difficult your job is to oversee the development of medical facilities in the state of Illinois. I appreciate your service to the community. In bringing my knowledge and experience as a leader and provider of perinatal services to the southland community, I am writing to you to wholeheartedly support of the above mentioned project. I am confident that you will concur with me that the construction of this facility is an essential fiber in the fabric of health services in the Chicago southland.

Advocate Christ Medical Center and Hope Children's Hospital is the only tertiary and quaternary service provider located in the Southland. The medical center's emergency department is one of the busiest in the state; there is a constant stream of police and fire department vehicles into this department. The cardiac care and surgical program, stroke care program, and rehabilitation services are also among the busiest and the highest quality in the state. The maternity services program is among the busiest in the state and neonatal intensive care unit provides care to nearly 700 critical infants per year for almost 14,000 patient days per year in a facility that is 90% occupied. One needs only to walk the medical centers hallways to appreciate how over-utilized the facility is.

This medical center requires more private, contemporary, and efficient facilities to meet the needs of the southland community and to accommodate continuing advancements in medicine and technology, while enhancing patient safety and protecting patient privacy. The neonatal intensive care unit will be located in a completely redesigned area of the currently existing facility, while a new maternity service area will be constructed in the proposed inpatient tower. Both facilities will be fully occupied within days of opening. I know that after due consideration you will come to the same conclusion that I have.

Sincerely,



Thomas F. Myers, MD, MBA  
Medical Director, Neonatal Intensive Care  
Advocate Christ Medical Center and Hope Children's Hospital



**Advocate  
Christ Medical Center  
Hope Children's Hospital**

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.0000 || [advocatehealth.com](http://advocatehealth.com)

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April 3, 2012

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

**Re: Support for Advocate Christ Medical Center and Hope Children's Hospital  
Needed Patient Bed Tower**

Dear Ms. Avery:

I am writing to you based on my 14 years of being a member of the medical staff and serving as chairman of the largest department of primary care physicians on the campus. During that time, we have exceeded so many of my expectations in terms of growth and program development, bringing new and much needed healthcare to our community.

At the same time, however, we have been hindered in truly servicing our community by our lack of capacity and bed space.

On a personal level, I have been programmatically responsible for the development of our Advanced Heart Failure, LVAD and Transplant Programs, which have done so much to improve healthcare quality for our patients. Nonetheless, I personally have had to deprive patients care because of a lack of nothing more than beds within our medical center.

Also, as a care-deliverer for one of the nation's largest chronic disease states, I am aware that the trends towards trends for explosion of the need for care delivery within a hospital setting will continue in the decades ahead. Our hope is that we can provide ever-improving primary as well as advanced care for all of our community, which now extends well-beyond our Southland area.

I believe our expansion is long overdue, and I similarly believe that the plan that we have outlined has taken the community needs into consideration first and foremost. Additionally, the planning will not only deliver better care to our patients, but also minimize the burden on our local community so that additional parking and flow throughout the medical center will be enhanced.

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I appreciate your time and consideration, and wanted you to know my personal feelings and how much I do support and endorse this planned project. I look forward to your review and recommendation for approval. If there are questions, please do not hesitate to contact me directly.

Sincerely,



Marc A. Silver, MD  
Clinical Professor and Chairman  
Department of Medicine  
Advocate Christ Medical Center  
Director, Heart Failure Institute

MAS:vab



4400 W. 95th Street, Suite 207 || Oak Lawn, IL 60453 || T 708 684-5340 F 708-684-3045 || [advocatehealth.com](http://advocatehealth.com)

Women's Health Services

June 5, 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 a Maternal Fetal Medicine (MFM) subspecialist at Advocate Christ Medical Center and I am writing to support the application for a certificate of need for a new bed tower. MFM subspecialists provide care to pregnant women with many medical complications such as diabetes and cardiovascular disease, as well as those with fetal anomalies such as neural tube and cardiac defects. We see many primary patients who are referred to our practice and patients who are self-referred. We also work closely and collaboratively with primary Obstetrician Gynecologists to co-manage their patients. Due to our complex patients, we require the expertise of many subspecialists including adult and pediatric surgeons, cardiologists, and neurologists, to name a few. Patients are often admitted directly to the intensive care unit because of their acute complex needs. Currently, we struggle on a daily basis to find beds for patients when transported from other hospitals, from the emergency room and from referring physician offices. To expedite care, we need to be able to make a diagnosis as quickly as possible, and with other specialists when needed. We need the physical facilities to do so, to keep them as inpatients for close surveillance when required and to have the capability to perform cesarean sections emergently.

Several national organizations such as the American College of Obstetricians and Gynecologists, the Society of Maternal Fetal Medicine, the March of Dimes and the National Institutes of Health have established guidelines and nationwide initiatives to improve maternal health, to reduce the preterm delivery rate and to optimize long-term neonatal outcomes. We at Christ Hospital are dedicated to these missions but we need the proper space to do so. In addition to a new and larger delivery suite, we need a Neonatal Intensive Care Unit with appropriate space and functionality since they receive and care for the majority of our newborn infants.

Having worked in the Chicago area for several years, I am aware that Christ Hospital services many smaller community hospitals from the immediate and wide distant regions. Our MFM services are growing and we anticipate the volume to increase significantly.

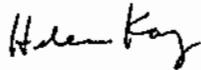
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-2-

with ongoing national Health Care Reform legislation. I cannot overemphasize the need for a new bed tower which will enable us to achieve the quality care we strive to provide to a growing number of complex obstetric patients.

Thank you for your consideration.

Sincerely,



Helen Kay, M.D.  
Perinatologist  
Maternal Fetal Medicine



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Illinois Health Facilities and Services Review Board

525 West Jefferson Street, Second Floor

Springfield, Illinois 62761

May 25, 2012

Dear Ms Avery and Members of the Review Board:

I am writing this letter to support the Certificate of need application of Advocate Christ Medical Center (ACMC) in Oak Lawn, Illinois regarding its planned construction of a new inpatient bed tower. As the busiest Trauma Center in the state, ACMC plays a crucial role in protecting the health of Illinois citizens. ACMC is the main trauma center for the Southside of Chicago as well as most of southern Cook County. Due to its rapid growth as a tertiary and quaternary care medical center, ACMC has been plagued by capacity issues for several years. The lack of a sufficient number of monitored inpatient beds on the existing medical center campus has forced ACMC to go on Emergency Department bypass status far too often. These bypass periods severely compromise the ability of ACMC to fulfill its mission of providing the highest level of trauma care to its community twenty four hours-a-day and 365 days-a-year.

The proposed development project would greatly expand the number of available critical care beds at ACMC, and hopefully, resolve the capacity issue. Addition of the new inpatient tower will allow ACMC to provide patient care in a safe and efficient space with access to the newest technologies available to optimize patient outcomes. As the Medical Director of Trauma at ACMC, I strongly endorse the proposed project, and I request that the Review Board deliberations result in its approval.

Sincerely,

A handwritten signature in cursive script that reads "James C. Doherty".

James C. Doherty, MD, MPH, FACS

Director of Trauma & Critical Care Programs, ACMC

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GENERAL UROLOGY  
RECONSTRUCTIVE AND FEMALE UROLOGY

HERBERT M. USER, M.D.  
UROLOGIC ENDOUROLOGY  
LAPAROSCOPY AND STONE DISEASE

AARON D. BEROER, M.D.  
UROLOGIC LAPAROSCOPY, ENDOUROLOGY  
ROBOTIC SURGERY AND STONE DISEASE

IKECHUKWU K. OGUEJIOFOR, M.D.  
UROLOGIC LAPAROSCOPY, ENDOUROLOGY  
ROBOTIC SURGERY AND MEDICALLY INVASIVE SURGERY

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NAPERVILLE, IL 60563  
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17680 S. KEDZIE AVE  
SUITE 201  
HAZEL CREST, IL 60429  
PHONE (708) 957-7611

2315 E. 93<sup>RD</sup> STREET  
SUITE 208  
CHICAGO, IL 60617  
PHONE (773) 768-7884  
FAX (708) 423-8659

Courtney R. Avery

Administrator

Illinois Health Facilities and Services Review Board

525 West Jefferson Street, Second Floor

Springfield, IL 62761

Dear Ms. Avery,

My name is Jae Kim, and I am a urologist practicing in the southwestern suburbs of Chicago. Over the past 14 years of my practice at Christ Hospital and Medical Center, I have witnessed amazing and exciting expansion of the hospital's service to the southwestern metropolitan Chicago area. With increasing medical staff membership as well as expansion of tertiary and quaternary services, the medical center truly has become a hub of advanced medical care that is not readily available in surrounding hospitals. In addition to being a level I trauma center, the medical center provides heart care and heart surgeries that are at the cutting edge of modern medicine. Surgical specialists provide latest treatment options, and Hope Children's Hospital has been providing much needed pediatric care for the region. Unfortunately, the medical center's service has been severely restricted by chronic shortage of the hospital beds, requiring many hours of hospital bypass due to critical lack of ICU and telemetry beds over the recent years.

This problem has also been the main cause of extreme congestion in the emergency department which provided more than 90,000 patient visits in the year 2011.

In order to increase patient safety, privacy, family support, and improved overall care of the patient, I strongly believe that a new patient bed tower is imperative to address the medical center's current challenges. I provide a full support to building a new patient tower at Christ Hospital and Medical Center and request the Illinois Health Facilities and Services Review Board to approve the project.

Thank you for your consideration.

Sincerely Yours,



Jae Kim, M.D.



## Parkview Musculoskeletal Institute

<b>James B. Beardslee, M.D., F.A.C.S.</b> Spine Surgery & Sports Medicine	<b>Kevin W. Luke, M.D., F.A.C.S.</b> Trauma & General Orthopaedics	<b>Paul F. Scythia, M.D.</b> Foot, Ankle & General Orthopaedics	<b>D. Duane Brazor, D.P.M.</b> Podiatric Surgery
<b>William J. Farrell, M.D.</b> General Orthopaedics	<b>William J. Dayle, D.O.</b> Hand Surgery & General Orthopaedics	<b>Anis Methall, M.D.</b> Spine Surgery	<b>Russell M. Ganss, M.D.</b> Neurological Consultant
<b>Scott P. Pines, M.D., F.A.C.S.</b> Sports Medicine & Arthroscopy	<b>Mark E. Moran, M.D., FRCR (C)</b> Podiatric Orthopaedics	<b>Henry J. Fuentes, M.D.</b> Sports Medicine & General Orthopaedics	
<b>Robert T. Famba, M.D., F.A.C.S.</b> Trauma & General Orthopaedics	<b>Steven R. Warden, M.D.</b> Adult Joint Reconstruction	<b>Stacy L. Perce, P.A.C.</b>	

June 1, 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 the Co-Medical Director of the Bone & Joint Institute at Advocate Christ Medical Center I would like to encourage, and support, the approval to construct a patient bed tower. The proposed development, which would add additional inpatient beds, is critically important to resolving the medical center's lack of capacity, its inability to admit all patients who require and seek care here, and its need to upgrade facilities and create more intensive care unit space. With its current 690 patient beds, the medical center has been running at around 90 percent capacity. During 2011, patients in need of health care were unable to gain admission to the hospital because of a lack of patient beds. The medical center was forced to go on bypass for some 1,100 hours in 2011 and diverted patients to other area and out of area facilities.

As the only Level 1 Trauma center in the Southland, it is critical that we proceed with increasing our current capacity to provide much needed access to those we serve. With the State's approval, we can increase access to our nationally recognized specialty programs for those in need.

Despite the hospital's improved efficiencies in coordinating the admission, testing and discharge of patients, the problems are only expected to grow due to the changing demographics of the area's population. At the same time, as the only tertiary and quaternary service provider in the Southland, the medical center will require more contemporary, efficient facilities to accommodate continuing advancements in medicine and technology, while providing care in space that ensures the highest quality care, enhances patient safety and protects patient privacy.

Sincerely,

*Kevin W. Luke, M.D.*

Kevin W. Luke, M.D.  
Co-Chair, Bone & Joint Institute

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Cardiovascular & Thoracic  
Surgey

Pat S. Pappas, M.D.  
Antone J. Thtoeles, M.D.  
George T. Hadakowski, M.D.  
Jack C. Roberts, M.D.  
Paul J. Gordon, M.D.  
Michael A. Brestlecker, M.D.  
Robert G. Kummerer, M.D.  
Timothy V. Votapka, M.D.  
Sammy I. Nawro, M.D.  
Keith D. Boverzon, M.D., PhD  
David A. DeBoer, M.D.  
William F. Polito, M.D.  
Jeffrey M. Silver, M.D.  
Stefano Schuan, M.D., PhD  
Elas E. Jwiced, M.D., PhD  
Anthony J. Ranson, M.D.  
Sini Sivadason, M.D.  
Chadrick A. Cross, M.D.  
James D. Hall, M.D.  
Kevin A. Richardson, M.D.

Peripheral Vascular Surgery

Dean M. Govostis, M.D.  
Marvin F. Ellenby, M.D.  
Robert G. Kummerer, M.D.  
Sanjeev K. Pradhan, M.D.  
Wade W. Kang, M.D.

Allied Health Professionals

Diana M. Evans, PA-C  
Alexandra Haraldsson, PA-C  
Susan E. Horregard, PA-C  
Annie A. Pauwaa, PA-C  
Rynn J. Hoessner, PA-C  
Janie A. Robisch, PA-C  
Dorothy A. Fedor, PA-C  
Danielle M. Amato, PA-C  
Ashley Echeverrin, PA-C  
Jacqueline R. Zdon, PA-C  
Chrystal Fankhanel, PA-C

Administrative Office

Christ Medical Center  
Physicians' Pavilion  
4400 W. 95th St., Suite 205  
Oak Lawn, IL 60453  
708-346-4030  
708-346-3287 Fax

## CARDIOTHORACIC & VASCULAR SURGICAL ASSOCIATES, S.C.

June 4, 2012

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

Dr. Ms. Avery:

I am writing to express my support for Christ Medical Center's proposed establishment of a new patient bed tower on its Oak Lawn campus. The continuing growth of the surrounding communities presents an inherent need for additional inpatient beds to fully accommodate all patients who seek care here.

As the only tertiary and quaternary service provider in this area, the community will benefit greatly from the addition of inpatient beds. The growing and aging population is entitled to a facility offering excellent patient care that has the ability to accept and treat all patients. Currently, we have a 22 bed ICU serving our cardiovascular patients, which, sadly, is not enough. We perform over 700 open heart procedures annually – one of the busiest programs in the state. We accept transfers from many hospitals for services such as transplant and left ventricular assist device therapy and we constantly struggle to make room for these very sick patients that no other hospital in the area is capable of treating. This expansion will provide us with the space necessary to continue to offer the highest level of care to the local community and the region.

I strongly support the construction of the additional patient bed tower that Christ Medical Center is proposing.

Thank you for your consideration of this important project.

Sincerely,

Pat S. Pappas, M.D.  
Director, Cardiovascular Surgery  
Medical Director, Heart & Vascular Institute  
Advocate Christ Medical Center

**Cardiovascular & Thoracic  
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Fat S. Pappas, M.D.  
 Antone J. Tatroles, M.D.  
 George T. Hodakowski, M.D.  
 Jack C. Roberts, M.D.  
 Paul J. Gordon, M.D.  
 Michael A. Berezicker, M.D.  
 Robert G. Kunimerer, M.D.  
 Timothy V. Votapka, M.D.  
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 Stefano Sghena, M.D., PhD  
 Elna E. Jwiled, M.D., PhD  
 Anthony J. Roussou, M.D.  
 Mihai Sivadann, M.D.  
 Chandrick A. Cross, M.D.  
 James D. Hall, M.D.  
 Kevin A. Richardson, M.D.

**Cardiothoracic Surgeon**

Dean M. Govash, M.D.  
 Martin I. Ellenby, M.D.  
 Robert G. Kunimerer, M.D.  
 Sanjeev K. Pradhan, M.D.  
 Wade W. Kang, M.D.

**Allied Health Professionals**

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 Alexandra Haraldsson, PA-C  
 Susan E. Borregard, PA-C  
 Anile A. Puvvas, PA-C  
 Ryan J. Housner, PA-C  
 Jamie A. Robisch, PA-C  
 Dorothy A. Fedor, PA-C  
 Danielle M. Asato, PA-C  
 Ashley Echeverria, PA-C  
 Jacqueline R. Zdon, PA-C  
 Choral Fankhamel, PA-C

**Administrative Office**

Christu Medical Center  
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 Oak Lawn, IL 60453  
 708-346-4040  
 708-346-3287 Fax

## CARDIOTHORACIC & VASCULAR SURGICAL ASSOCIATES, S.C.

June 4, 2012

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

Dear Ms. Avery:

This letter is in support of the proposed new ICU construction bed tower at Advocate Christ Medical Center. Over the years Advocate Christ Medical Center has developed into a tertiary institution for the care of critically ill patients. As a cardiac surgeon, many of the most critical patients present through our doors and require intensive care. Due to the changes in our population demographics, we are seeing a greater percentage of patients who require intensive care. Unfortunately, our current capacity is inadequate.

In attempts to improve the care to our community and offer patients the necessary services for improving the quantity and quality of their lives, an ICU bed tower is of vital importance to our institution. Therefore, I strongly support the institutions endeavors to proceed with construction on such an important addition to our region.

Thank you very much. Please do not hesitate with any questions regarding my thoughts for this project.

Sincerely,



Antone J. Tatroles, M.D.  
 Vice Chairman, Department of Surgery  
 Director, Mechanical Assist Device Program  
 Advocate Christ Medical Center

WARREN D. ROBINSON, MD  
4550 Southwest Hwy.  
Oak Lawn, IL 60453

(708) 425-8870

April 5, 2012

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

Dear Ms. Avery,

I am a privately practicing physician in Oak Lawn on the staff at Christ Medical Center and Hope Children's Hospital for the past 26 years. Christ Hospital has served my patients very well in their time of need and I would like to continue this excellent tradition.

Christ Hospital would like to improve their facilities and build a new patient tower. This would improve access and allow my patients to be able to use the newest and most advanced health care. My patients deserve and would appreciate this very fine addition at their hospital.

I strongly encourage you to move this project forward. This new addition would help Christ Hospital continue to be a major provider of healthcare in the Southland area of metropolitan Chicago. This new addition would also help Christ Hospital maintain their ability to keep and attract the most talented doctors to serve my patients.

I am pleased to give my full support to this project. I am requesting that the Illinois Health Facilities and Services Review Board approve this project.

Sincerely,

Warren D. Robinson, MD

**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)			
<b>TOTAL USES OF FUNDS</b>			
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			
<b>TOTAL SOURCES OF FUNDS</b>			
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Related Project Costs**

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

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

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

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

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

**Project Status and Completion Schedules**

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): July 31, 2019

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 **GSF** or the building/area **BGSF** and cost. The type of gross square footage either **GSF** 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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							

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 Christ Medical Center		CITY: Oak Lawn			
REPORTING PERIOD DATES: From: 12/31/10 to: 12/31/11					
Category of Service	Authorized Beds	Admissions	Patient Days <sup>1</sup> (including observation)	Bed Changes	Proposed Beds
Medical/Surgical	378	23,481 <sup>3</sup>	113,723 <sup>3</sup>	+ 16	378
Obstetrics	39	5,455 <sup>3</sup>	15,712 <sup>3</sup>	+ 17	56
Pediatrics	45	3,553	13,388	--	45
Intensive Care	103	5,260	32,937	+ 86	189
Comprehensive Physical Rehabilitation	37	911	12,536	--	37
Acute/Chronic Mental Illness	51	1,453	9,588	-12 <sup>4</sup>	39
Neonatal Intensive Care	37 <sup>2</sup>	654	10,910 <sup>2</sup>	+ 27	64
General Long Term Care	--	--	--	--	--
Specialized Long Term Care	--	--	--	--	--
Long Term Acute Care	--	--	--	--	--
Other ((identify))	--	--	--	--	--
<b>TOTALS:</b>	<b>690</b>	<b>40,767</b>	<b>208,794<sup>1</sup></b>	<b>134</b>	<b>824</b>

<sup>1</sup> Includes patient days and observation days in nursing units; excludes 2,163 observation days in 34 dedicated observation beds or stations.

<sup>2</sup> Includes only Level III neonatal days. Level II+ babies are also cared for in the neonatal intensive care beds per Permit #04-042. In 2011, there were 3,619 Level II+ inpatient days

<sup>3</sup> Medical surgical and obstetric utilization revised after the 2011 Annual Questionnaire was submitted based on a Declaratory Ruling approved by the HFSRB on June 5, 2012.

<sup>4</sup> The HFSRB approved bed adjustments at the July 23<sup>rd</sup> and July 24<sup>th</sup> Board meeting. By the action of the board, the Medical Center's authorized number of Acute/Chronic Mental Illness beds was reduced from 51 to 39 beds.

Facility Bed Capacity and Utilization, Exhibit 1 summarizes the Medical Center's bed changes between 2011 and the completion of the project in 2019.

### Advocate Christ Medical Center/Advocate Hope Children's Hospital - Detailed Bed Changes Pre- and Post-CON

Bed Modifications	Med/Surg			AMI			OB/GYN			Intensive Care			NICU			Rehabilitation			Pediatrics			Total		
	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve	Auth.	Staff	Reserve
Baseline - 2011 AHQ	378	376	2	51	35	16	39	39	0	103	103	0	37	37	0	37	37	0	45	45	0	690	672	18
IDPH Adjustment 7/23/2012				-12	0	-12																-12	0	-12
20 Bed Rule Approval 4/11/2011	16	17	-1																			16	17	-1
<b>Sub-total prior To CON</b>	<b>394</b>	<b>393</b>	<b>1</b>	<b>39</b>	<b>35</b>	<b>4</b>	<b>39</b>	<b>39</b>	<b>0</b>	<b>103</b>	<b>103</b>	<b>0</b>	<b>37</b>	<b>37</b>	<b>0</b>	<b>37</b>	<b>37</b>	<b>0</b>	<b>45</b>	<b>45</b>	<b>0</b>	<b>694</b>	<b>689</b>	<b>5</b>
<b>IP Bed Tower New Construction</b>																								
ICU Construction										108	108	0										108	108	0
MICCU Decommission										-22	-22	0										-22	-22	0
OB New Construction							56	56	0													56	56	0
OB Decommission							-39	-39	0													-39	-39	0
NICU													27	27	0							27	27	0
Med/Surg Displaced by Links	-17	-17	0																			-17	-17	0
Med Surg Additions	17	10	7																			17	10	7
<b>Sub-total CON Projects</b>	<b>0</b>	<b>-7</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17</b>	<b>17</b>	<b>0</b>	<b>86</b>	<b>86</b>	<b>0</b>	<b>27</b>	<b>27</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>130</b>	<b>123</b>	<b>7</b>
<b>Total After CON Projects</b>	<b>394</b>	<b>386</b>	<b>8</b>	<b>39</b>	<b>35</b>	<b>4</b>	<b>56</b>	<b>56</b>	<b>0</b>	<b>189</b>	<b>189</b>	<b>0</b>	<b>64</b>	<b>64</b>	<b>0</b>	<b>37</b>	<b>37</b>	<b>0</b>	<b>45</b>	<b>45</b>	<b>0</b>	<b>824</b>	<b>812</b>	<b>12</b>

Sources:

- 1) 2011 Annual Hospital Questionnaire as submitted to Illinois Department of Public Health
- 2) IDPH Bed Inventory Adjustment approved at the 7/23/2012 Illinois Health Facilities and Services Review Board
- 3) Request for an additional 16 Med/Surg beds with 20 Bed Rule approved on 4/11/2011
- 4) 1 AMI bed displaced by link/connector included in the 12 beds pulled of the bed inventory

**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 & Hospitals Corporation d/b/a Advocate Christ Medical Center in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application 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.**

Kenneth W. Lukhard  
SIGNATURE

Kenneth W. Lukhard  
PRINTED NAME

President  
PRINTED TITLE

William Santulli  
SIGNATURE

William Santulli  
PRINTED NAME

Executive Vice President, Chief Operating Officer  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 17 day of JULY

Dawn M. Getzloff  
Signature of Notary



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

Anna Zaborowski  
Signature of Notary



\*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 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.

JA Skogsbergh  
SIGNATURE

William Santulli  
SIGNATURE

James H. Skogsbergh  
PRINTED NAME

William Santulli  
PRINTED NAME

President and CEO  
PRINTED TITLE

Executive Vice President, Chief Operating Officer  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 23 day of July

Notarization:  
Subscribed and sworn to before me  
this 23 day of July

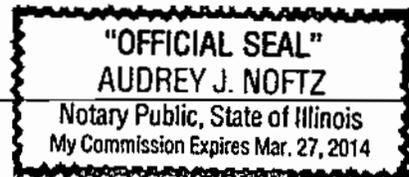
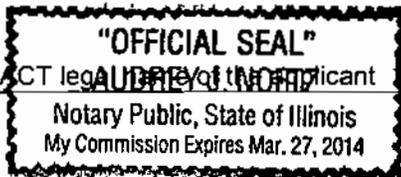
Audrey J. Noftz  
Signature of Notary

Audrey J. Noftz  
Signature of Notary

Seal

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.

**UNFINISHED OR SHELL SPACE:**

Provide the following information:

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

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

**ASSURANCES:**

Submit the following:

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

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

**SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA**

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

**A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care**

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

Category of Service	# Existing Beds	# Proposed Beds
<input type="checkbox"/> Medical/Surgical		
<input type="checkbox"/> Obstetric		
<input type="checkbox"/> Pediatric		
<input type="checkbox"/> Intensive Care		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) - Planning Area Need - Service Accessibility	X		
1110.530(c)(1) - Unnecessary Duplication of Services	X		
1110.530(c)(2) - Maldistribution	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		

<b>APPLICABLE REVIEW CRITERIA</b>	<b>Establish</b>	<b>Expand</b>	<b>Modernize</b>
1110.530(d)(1) - Deteriorated Facilities			X
1110.530(d)(2) - Documentation			X
1110.530(d)(3) - Documentation Related to Cited Problems			X
1110.530(d)(4) - Occupancy			X
1110.530(e) - Staffing Availability	X	X	
1110.530(f) - Performance Requirements	X	X	X
1110.530(g) - Assurances	X	X	X
<b>APPEND DOCUMENTATION AS <u>ATTACHMENT-20</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**C. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness**

1. Applicants proposing to establish, expand and/or modernize Acute Mental Illness and Chronic Mental Illness category of service must submit the following information:
2. Indicate bed capacity changes by Service:      Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
<input type="checkbox"/> Acute Mental Illness		
<input type="checkbox"/> Chronic Mental Illness		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) - Planning Area Need - Service Accessibility	X		
1110.730(c)(1) - Unnecessary Duplication of Services	X		
1110.730(c)(2) - Maldistribution	X		
1110.730(c)(3) - Impact of Project on Other Area Providers	X		
1110.730(d)(1) - Deteriorated Facilities			X
1110.730(d)(2) - Documentation			X
1110.730(d)(3) - Documentation Related to Cited Problems			X
1110.730(d)(4) - Occupancy			X
1110.730(e)(1) - Staffing Availability	X	X	
1110.730(f) - Performance Requirements	X	X	X
1110.730(g) - Assurances	X	X	X

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

**D. Criterion 1110.930 - Neonatal Intensive Care**

**This section is applicable to all projects proposing to add neonatal intensive care beds.**

**1. Criterion 1110.930(a), Staffing**

Read the criterion and for those positions described under this criterion provide the following information:

1. The name and qualifications of the person currently filling the job.
2. Letters of interest from potential employees.
3. Applications filed for each position.
4. Signed contracts with the required staff.
5. A detailed explanation of how you will fill the positions.

**2. Criterion 1110.930(b), Letter of Agreement**

Read the criterion and provide the required letter of agreement.

**3. Criterion 1110.930(c), Need for Additional Beds**

Read the criterion and provide the following information:

- a. The patient days and admissions for the affiliated center for each of the last two years;  
or
- b. An explanation as to why the existing providers of this service in the planning area cannot provide care to your projected caseload.

**4. Criterion 1110.930(d), Obstetric Service**

Read the criterion and provide a detailed assessment of the obstetric service capability.

**APPEND DOCUMENTATION AS ATTACHMENT-23, 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"/>		
<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
<b>APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>		

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:
	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:
	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.
	<b>TOTAL FUNDS AVAILABLE</b>

**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									
<b>TOTALS</b>									

\* 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			
<b>Total</b>			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			

Outpatient			
Total			
Medicald (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:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
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2	Site Ownership	80
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	85
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	88
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31	Kidney Transplantation	
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## ATTACHMENTS

;

### 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.

Certificates of Good Standing for Advocate Health and Hospital Corporation d/b/a Advocate Christ Medical Center and Advocate Health Care Network are appended as Attachment 1, Exhibits 1 and 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 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 18TH day of JANUARY A.D. 2012*



Authentication #: 1201800600  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE



*To all to whom these Presents Shall Come, Greeting:*

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

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 18TH day of JANUARY A.D. 2012 .*



Authentication #: 1201800524  
Authenticate at: <http://www.cyberdirillinois.com>

*Jesse White*

SECRETARY OF STATE

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation

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.

**COMMITMENT FOR TITLE INSURANCE**



**Chicago Title Insurance Company**

Providing Title Related Services Since 1847

CHICAGO TITLE INSURANCE COMPANY, a Missouri corporation, herein called the Company, for a valuable consideration, hereby commits to issue its policy or policies of title insurance, as identified in Schedule A (which policy or policies cover title risks and are subject to the Exclusions from Coverage and the Conditions and Stipulations as contained in said policy/ies) in favor of the proposed Insured named in Schedule A, as owner or mortgagee of the estate or interest in the land described or referred to in Schedule A, upon payment of the premiums and charges therefor, all subject to the provisions of Schedules A and B hereof and to the Commitment Conditions and Stipulations which are hereby incorporated by reference and made a part of the Commitment. A complete copy of the Commitment Conditions and Stipulations is available upon request and such include, but are not limited to, the proposed Insured's obligation to disclose, in writing, knowledge of any additional defects, liens, encumbrances, adverse claims or other matters which are not contained in the Commitment; provisions that the Company's liability shall in no event exceed the amount of the policy/ies as stated in Schedule A hereof, must be based on the terms of this Commitment, shall be only to the proposed Insured and shall be only for actual loss incurred in good faith reliance on this Commitment; and provisions relating to the General Exceptions, to which the policy/ies will be subject unless the same are disposed of to the satisfaction of the Company.

This Commitment shall be effective only when the identity of the proposed Insured and the amount of the policy or policies committed for have been inserted in Schedule A hereof by the Company, either at the time of the issuance of this Commitment or by issuance of a revised Commitment.

This Commitment is preliminary to the issuance of such policy or policies of title insurance and all liability and obligations hereunder shall cease and terminate six months after the effective date hereof or when the policy or policies committed for shall issue, whichever first occurs, provided that the failure to issue such policy or policies is not the fault of the Company.

This Commitment is based upon a search and examination of Company records and/or public records by the Company. Utilization of the information contained herein by an entity other than the Company or a member of the Chicago Title and Trust Family of Title Insurers for the purpose of issuing a title commitment or policy or policies shall be considered a violation of the proprietary rights of the Company of its search and examination work product.

This Commitment shall not be valid or binding until signed by an authorized signatory.

Issued By:

CHICAGO TITLE INSURANCE COMPANY  
P.O. BOX 827  
WHEATON, IL 60189-0827

Refer Inquiries To:

(630)871-3500



CHICAGO TITLE INSURANCE COMPANY

*Henry S. Gray*  
Authorized Signatory

Commitment No.: 1419 000284161 UL

CC00024161

JG3

07/01/05

CHICAGO TITLE INSURANCE COMPANY  
COMMITMENT FOR TITLE INSURANCE  
SCHEDULE A

YOUR REFERENCE: ADVOCATE CHRIST HOSPITAL MEDICAL CENTER ORDER NO.: 1410 008284161 UL

EFFECTIVE DATE: APRIL 27, 2005

1. POLICY OR POLICIES TO BE ISSUED:

LOAN POLICY: ALTA LOAN 1992  
AMOUNT: \$10,000.00  
PROPOSED INSURED: TO COME

2. THE ESTATE OR INTEREST IN THE LAND DESCRIBED OR REFERRED TO IN THIS COMMITMENT AND COVERED HEREIN IS A FEE SIMPLE UNLESS OTHERWISE NOTED.

3. TITLE TO SAID ESTATE OR INTEREST IN SAID LAND IS AT THE EFFECTIVE DATE VESTED IN:  
ADVOCATE HEALTH AND HOSPITALS CORPORATION

4. MORTGAGE OR TRUST DEED TO BE INSURED:

TO COME.

ENCLOSURE  
JG3

PAGE A1

07/01/05

10:13:20

CHICAGO TITLE INSURANCE COMPANY  
COMMITMENT FOR TITLE INSURANCE  
SCHEDULE A (CONTINUED)

ORDER NO.: 1410 008284161 UL

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

PARCEL ONE:

SOUTH 1/2 OF THE EAST 1/2 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 IN SECTION 3,  
TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN,

EXCEPT FROM ABOVE THE FOLLOWING DESCRIBED PROPERTY

THAT PART OF THE SOUTHWEST 1/4 OF SECTION 3, TOWNSHIP 37 NORTH, RANGE 13, EAST OF  
THE THIRD PRINCIPAL MERIDIAN, BOUNDED AND DESCRIBED AS FOLLOWS:

BEGINNING AT THE POINT OF INTERSECTION OF A LINE DRAWN 40.00 FEET WEST OF AND  
PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4 WITH A LINE DRAWN 60.00 FEET  
NORTH OF AND PARALLEL WITH THE SOUTH LINE OF SAID SOUTHWEST 1/4; THENCE WEST  
222.83 FEET ALONG A LINE 50.00 FEET NORTH OF AND PARALLEL WITH THE SOUTH LINE OF  
SAID SOUTHWEST 1/4, BEING ALSO THE NORTH LINE OF WEST 95TH STREET IN ACCORDANCE  
WITH PLAT OF DEDICATION RECORDED MAY 27, 1958 AS DOCUMENT NO. 77219540; THENCE  
NORTH 177.05 FEET ALONG A LINE FORMING AN ANGLE OF 89 DEGREES 54 MINUTES 37  
SECONDS AS MEASURED FROM EAST TO NORTH WITH SAID NORTH LINE OF WEST 95TH STREET;  
THENCE EAST 24.70 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET; THENCE  
NORTH 72.34 FEET PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4; THENCE EAST  
197.28 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET TO THE WEST LINE OF  
SOUTH KOSTNER AVENUE, BEING A LINE 40.00 FEET WEST OF THE EAST LINE OF SAID  
SOUTHWEST 1/4, IN ACCORDANCE WITH THE AFORESAID PLAT OF DEDICATION; THENCE SOUTH  
249.39 FEET ALONG THE WEST LINE OF SOUTH KOSTNER AVENUE TO THE HEREINABOVE  
DESCRIBED POINT OF BEGINNING, ALL IN COOK COUNTY, ILLINOIS.

PARCEL TWO:

THE EAST 3/4 OF THE SOUTHWEST 1/4 OF THE SOUTHEAST 1/4 OF SECTION 3, TOWNSHIP 37  
NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN,

(EXCEPT THE SOUTH 375 FEET THEREOF;

ALSO EXCEPT THAT PART LYING WITHIN THE SOUTH 400 FEET OF THE WEST 262.50 FEET OF  
SAID EAST 3/4 OF SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3;

ALSO EXCEPT THE EAST 33 FEET AND THE NORTH 33 FEET THEREOF; AND

ALSO EXCEPT THAT PART LYING WITHIN THE NORTH 669 FEET OF THE EAST 525 FEET OF  
SAID SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3), IN COOK COUNTY, ILLINOIS.

PARCEL THREE:

THE EAST 33 FEET OF THE NORTH 423 FEET OF THE SOUTH 823 FEET OF THE WEST 1/4 OF  
SAID SOUTHWEST 1/4 OF SOUTHEAST 1/4 OF SECTION 3, TOWNSHIP 37 NORTH, RANGE 13,  
EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL FOUR:

WJG/JAL  
JG3

PAGE A2

07/01/05

10:13:20

CHICAGO TITLE INSURANCE COMPANY  
COMMITMENT FOR TITLE INSURANCE  
SCHEDULE A (CONTINUED)

ORDER NO.: 1410 008284161 UL

LOT 3 IN SUBDIVISION OF ALL OF LOT 3 AND LOT 2 (EXCEPT THE EASTERLY 1/2 OF SAID LOT 2 MEASURED FROM THE CENTER OF THE NORTH LINE OF SAID OF SAID LOT 2 TO A POINT IN THE CENTER OF THE SOUTHEASTERLY LINE OF SAID LOT 2) IN THE RESUBDIVISION OF CALENDONIA PARK, BEING A SUBDIVISION OF THAT PART OF THE FRACTIONAL EAST 1/2 OF THE SOUTHEAST 1/4 OF SECTION 30, TOWNSHIP 41 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING NORTH OF THE CALENDONIA ROAD (EXCEPT THE NORTH 30 ACRES THEREOF), IN COOK COUNTY, ILLINOIS.

HCSCM

PAGE A 3

10:13:21

**Operating Identity/Licensee**

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center

Address: 4440 W. 95<sup>th</sup> Street, Oak Lawn, IL 60453

- |                                     |                           |                          |                     |                                |
|-------------------------------------|---------------------------|--------------------------|---------------------|--------------------------------|
| <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.
- 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.**

Certificates of Good Standing for Advocate Health and Hospital Corporation d/b/a Advocate Christ Medical Center and Advocate Health Care Network are appended as Attachment 3, Exhibits 1 and 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 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 #: 1201800500  
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 18TH day of JANUARY A.D. 2012 .*

*Jesse White*

SECRETARY OF STATE



*To all to whom these Presents Shall Come, Greeting:*

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

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



Authentication #: 1201300624  
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 18TH day of JANUARY A.D. 2012 .*

*Jesse White*

SECRETARY OF STATE

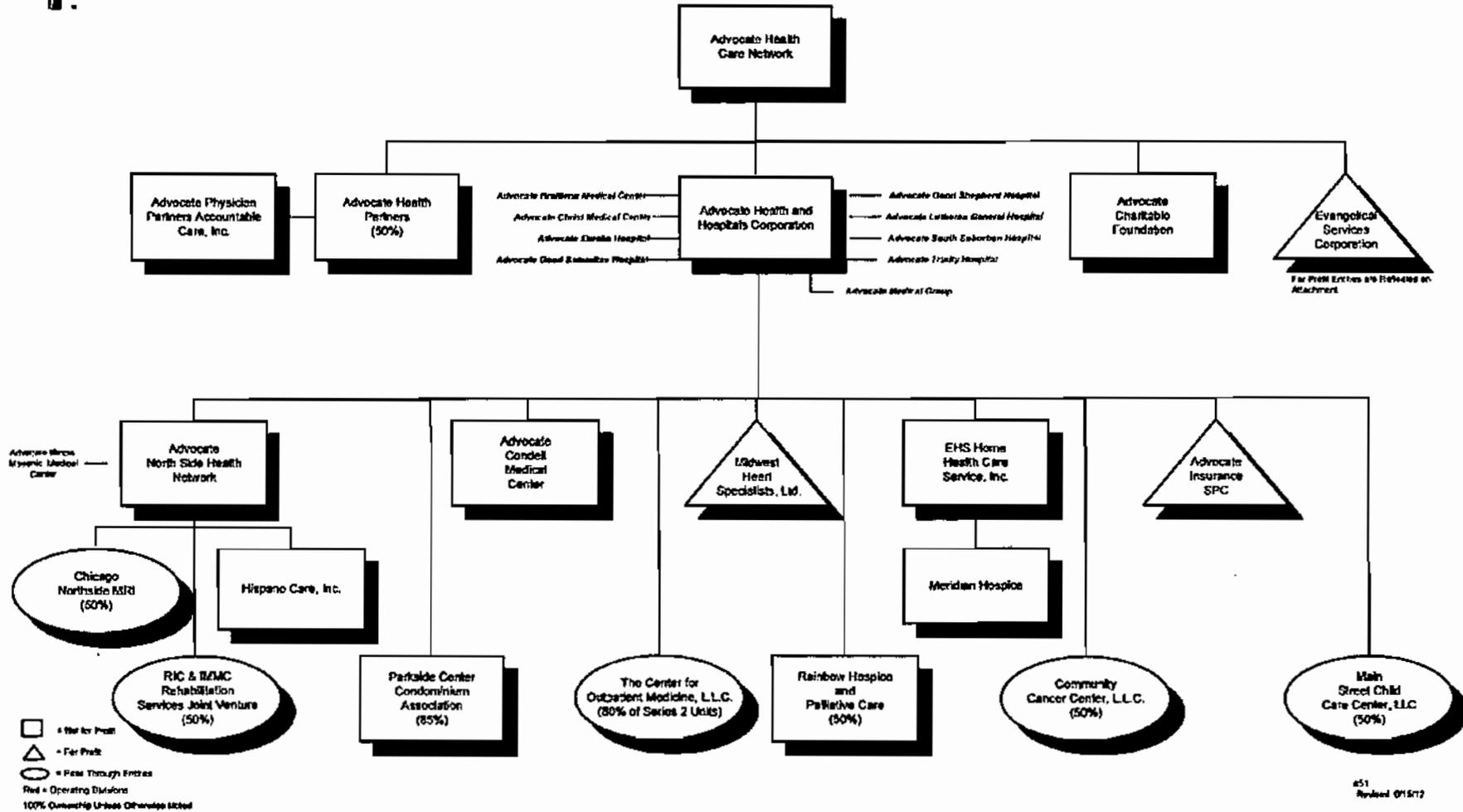
**Organizational Relationships**

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 and Hospitals Corporation and shows all of the relevant organizations including Advocate Health Care Network, Advocate Health and Hospitals Corporation and Advocate Christ Medical Center.

# Advocate Health and Hospitals Corporation Organizational Structure



## 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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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.

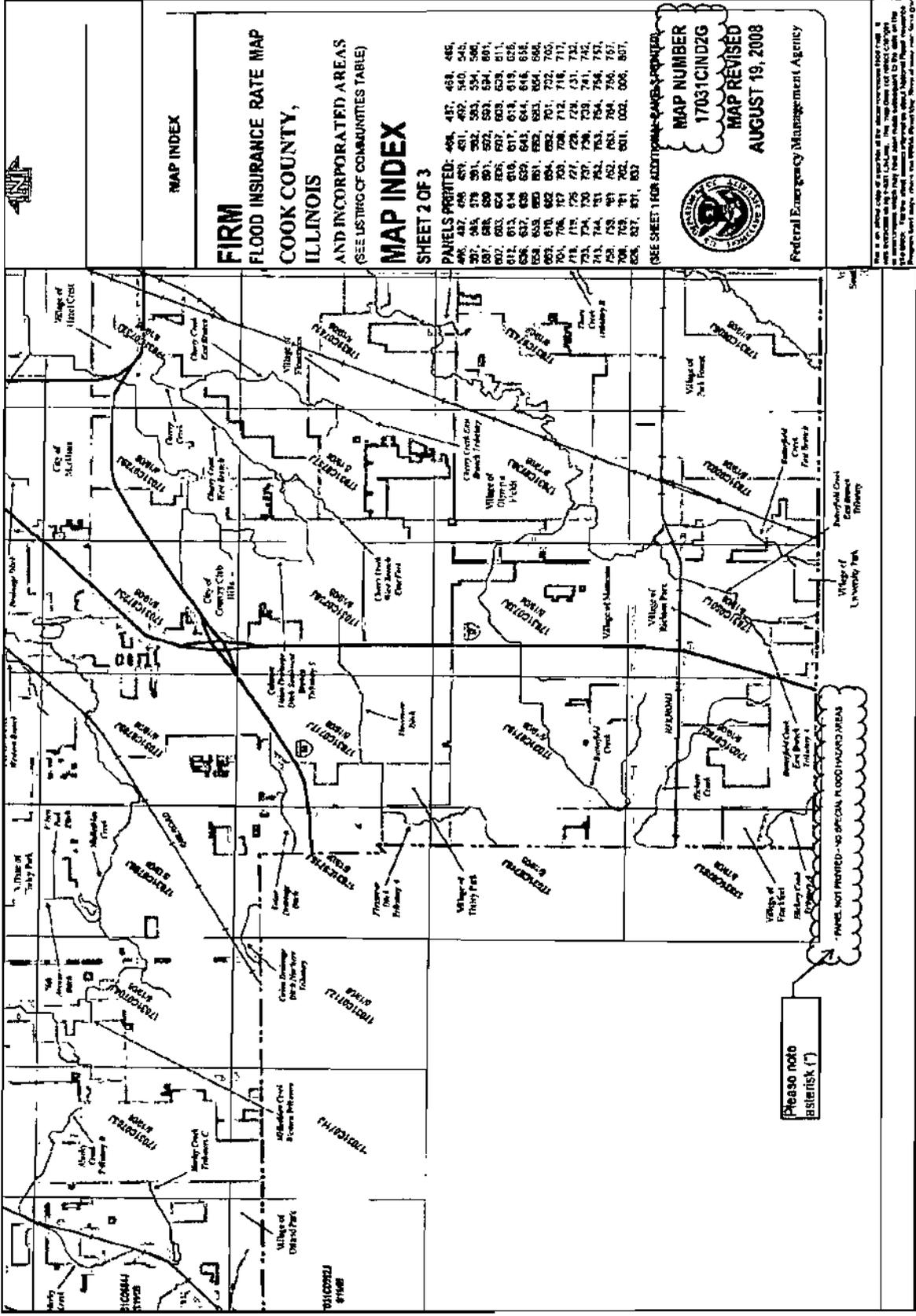
According to a phone conversation between Russell Warren, Project designer from Farnsworth Group, Inc., Bloomington, IL and Ken Hinderlong, Branch Chief, Risk Analysis, FEMA, Region V, Mr. Hinderlong said "FEMA does not always publish map panels for areas which do not contain Special Flood Hazard Areas". According to Mr. Hinderlong, there is no other document FEMA publishes which supplements or expounds on this statement of lack of potential flood condition.

In the case of Advocate Christ Medical Center, there is no published flood map, thus the lack of documentation is the proof that this site is nowhere near a Special Flood Hazard Area.

Exhibit 1, PDF (FM17031CIND2G-3.pdf) shows the Map Panel number within a red 'cloud'. This Panel Number is preceded by an asterisk. Exhibit 2 shows the meaning of the asterisk located elsewhere on the same document.

The asterisk footnote is the official statement given by FEMA indicating that no Special Flood Hazard Areas are contained within the boundaries of the stated Map Panel.

Attached is the most current flood plain documentation Advocate Christ Medical Center has on file. See attached Attachment 5, Exhibits 3 and 4.



MAP INDEX

**FIRM FLOOD INSURANCE RATE MAP  
COOK COUNTY,  
ILLINOIS  
AND INCORPORATED AREAS  
(SEE LISTING OF COMMUNITIES TABLE)**

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MAP NUMBER  
17031CINDZG  
MAP REVISED  
AUGUST 19, 2008

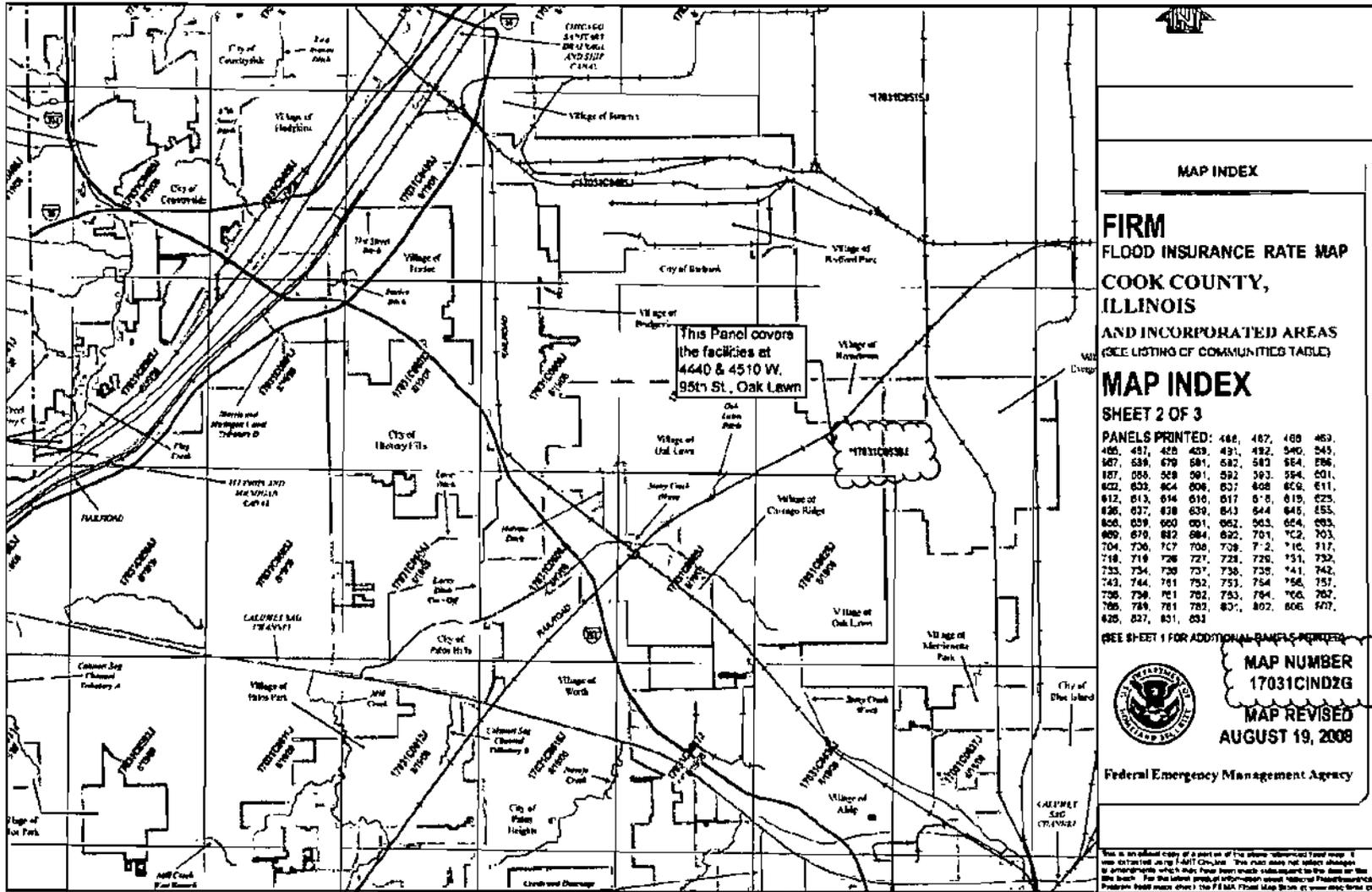


Federal Emergency Management Agency

Please note asterisk (\*)

PANEL NOT PRINTED - NO SPECIAL FLOOD HAZARD AREAS

This is a public map of the County of Cook, Illinois, prepared by the County Clerk of Cook County, Illinois, under the authority of the County Board of Cook County, Illinois. The map is not intended to be used for any purpose other than that for which it was prepared. The County Clerk of Cook County, Illinois, is not responsible for any errors or omissions in this map. The County Clerk of Cook County, Illinois, is not responsible for any damages or losses resulting from the use of this map. The County Clerk of Cook County, Illinois, is not responsible for any claims or liabilities resulting from the use of this map. The County Clerk of Cook County, Illinois, is not responsible for any claims or liabilities resulting from the use of this map.



MAP INDEX

**FIRM**  
**FLOOD INSURANCE RATE MAP**  
**COOK COUNTY,**  
**ILLINOIS**  
**AND INCORPORATED AREAS**  
 (SEE LISTING OF COMMUNITIES TABLE)

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(SEE SHEET 1 FOR ADDITIONAL PANELS PRINTED)



**MAP NUMBER**  
**17031CINDZG**  
**MAP REVISED**  
**AUGUST 19, 2008**

Federal Emergency Management Agency

This is an official copy of a part of the above referenced Flood Map. It was extracted using FIRM Explorer. This map does not reflect changes in assignments which have been made subsequent to the date on the title block. For the latest print, information and National Flood Insurance Program data, please visit the FEMA Flood Map Store at www.fema.gov.

UNIVERSITY OF ILLINOIS  
AT URBANA-CHAMPAIGN

Institute of Natural Resource Sustainability  
Illinois State Water Survey

2204 Griffith Drive, MC-674  
Champaign, Illinois 61820-7463



Special Flood Hazard Area Determination  
pursuant to Governor's Executive Order 5 (2006)  
(supersedes Governor's Executive Order 4 (1979))

Requester: Wendy Mulvihill, Planning Manager Business Development  
Address: Advocate Christ Medical Center, POB #408, 4440 W. 95th St.  
City, state, zip: Oak Lawn, IL 60453 Telephone: (708) 684-5765

Site description of determination:

Site address: Advocate Christ Medical Center (incl. Physician's Pavilion) & Hope Children's Hospital, 4440 W. 95th St.  
City, state, zip: Oak Lawn, IL 60453  
County: Cook Sec/4: SE 1/4 of SW 1/4 Section: 3 T. 37 N. R. 13 E. PM: 3rd  
Subject area: Parcels 24-03-318-016-0000 & -017-0000, which comprise the area bounded by S. Kilbourn Ave. on the west, S. Kostner Ave. on the east, W. 95th St. on the south, and W. 93rd St. on the north.

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.  
Floodway mapped: N/A Floodway on property: No  
Sources used: FEMA Flood Insurance Rate Map Index 17031CIND2G; www.cookcountyassessor.com; advocatehealth.com  
Community name: Village of Oak Lawn, IL Community number: 170137  
Panel/map number: 17031C0630 J\* Effective Date: August 19, 2008  
Flood zone: X [unshaded]\* Base flood elevation: N/A ft NGVD 1929

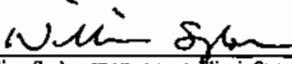
- N/A a. The community does not currently participate in the National Flood Insurance Program (NFIP). NFIP flood insurance is not available; certain State and Federal assistance may not be available.  
\*X b. Panel not printed: no Special Flood Hazard Area on the panel (panel designated all Zone C or unshaded X).  
N/A c. No map panels printed: no Special Flood Hazard Areas within the community (NSFHA).

The primary structure on the property:

- N/A d. Is located in a Special Flood Hazard Area. Any activity on the property must meet State, Federal, and local floodplain development regulations. Federal law requires that a flood insurance policy be obtained as a condition of a federally-backed mortgage or loan that is secured by the building.  
N/A e. Is located in shaded Zone X or B (500-yr floodplain). Conditions may apply for local permits or Federal funding.  
X f. Is not located in a Special Flood Hazard Area or 500-year floodplain area shown on the effective FEMA map.  
N/A g. A determination of the building's exact location cannot be made on the current FEMA flood hazard map.  
N/A h. Exact structure location is not available or was not provided for this determination.

Note: This determination is based on the effective Federal Emergency Management Agency (FEMA) flood hazard reference for the subject area. This letter does not imply that the referenced property will be free from water damage. Property not in a Special Flood Hazard Area may be damaged by a flood greater than that illustrated on the FEMA map, by local drainage problems or runoff not illustrated on the source map, or by failure of flood control structures. This letter does not create liability on the part of the Illinois State Water Survey or employee thereof for any damage that results from reliance on this determination. This letter does not exempt the project from local stormwater management regulations.

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 5 (2006), or State floodplain regulations, may be directed to John Lentz (847/608-3100 x2022) at the Illinois Department of Natural Resources' Office of Water Resources.

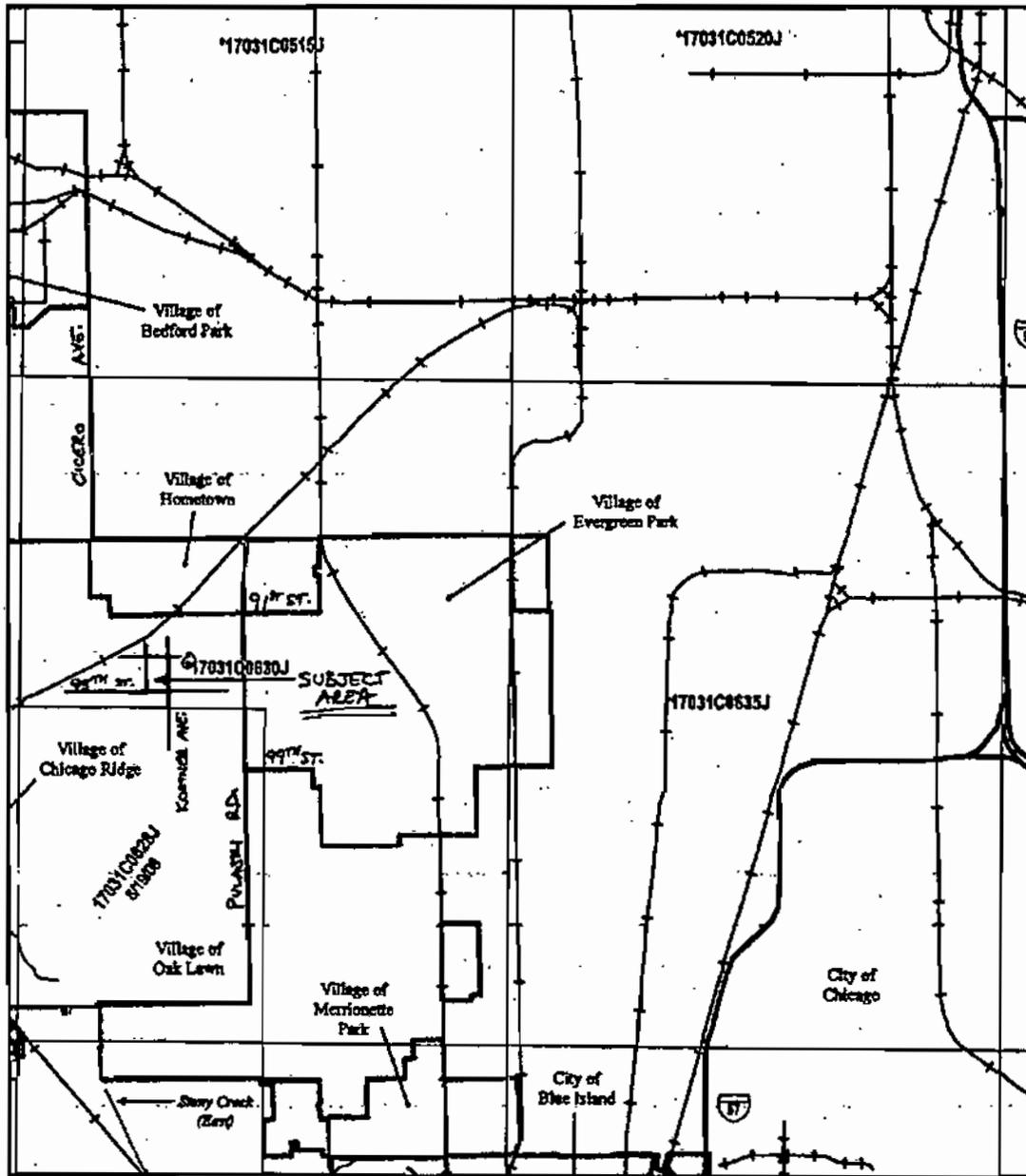
  
William Saylor, CFM IL-02-00107, Illinois State Water Survey

Title: ISWS Floodplain Information Specialist

Date: 8/19/2008

telephone 217-244-5459 • fax 217-333-4983 • www.sws.uiuc.edu

Form rev. -7/31/2008



Ⓞ PANEL NOT PRINTED - NO SPECIAL FLOOD HAZARD AREAS

MAP INDEX

**FIRM**  
**FLOOD INSURANCE RATE MAP**  
**COOK COUNTY,**  
**ILLINOIS**  
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 (SEE LISTING OF COMMUNITIES TABLE)

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(SEE SHEET 1 FOR ADDITIONAL PANELS PRINTED)



**MAP NUMBER**  
**1703TCIND2G**  
**MAP REVISED**  
**AUGUST 19, 2008**

Federal Emergency Management Agency

This is an official copy of a portion of the above referenced flood map. It was extracted using F-MIT On-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For the latest product information about National Flood Insurance Program flood maps check the FEMA Flood Map Store at [www.fema.gov](http://www.fema.gov)

-w3/15/08 8/19/2008

### **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 Historic Resources Preservation Agency which documents that no historic, architectural, or archaeological sites exist within the project area.

APR 12 2011



**Illinois Historic  
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • [www.illinois-history.gov](http://www.illinois-history.gov)

Cook County

Oak Lawn

New Construction of Ambulatory Pavilion  
4440 W. 95th St.  
IHPA Log #004031611

April 8, 2011

Janet Hood  
Advocate BroMann 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*  
Anne E. Haaker  
Deputy State Historic  
Preservation Officer

A teleprinter for the speech/hearing impaired is available at 217-524-7128. It is not a voice or fax line.

## 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)			
<b>TOTAL USES OF FUNDS</b>			
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			
<b>TOTAL SOURCES OF FUNDS</b>			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Project costs and sources of funds and detailed project costs are appended as Attachment 7, Exhibits 1 and 2.

### 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	\$ 1,240,265	\$ 3,130,235	\$ 4,370,500
Site Survey and Soil Investigation	\$ 86,140	\$ 177,260	\$ 263,400
Site Preparation	\$ 640,200	\$ 1,299,800	\$ 1,940,000
Off Site Work	\$ 1,578,390	\$ 3,204,610	\$ 4,783,000
New Construction Contracts	\$ 57,951,836	\$ 113,083,575	\$ 171,035,411
Modernization Contracts	\$ 12,778,103	\$ 17,910,151	\$ 30,688,254
Contingencies	\$ 7,676,534	\$ 13,929,384	\$ 21,605,918
Architectural/Engineering Fees	\$ 4,091,824	\$ 8,359,482	\$ 12,451,306
Consulting and Other Fees	\$ 2,882,880	\$ 5,853,120	\$ 8,736,000
Movable or Other Equipment	\$ 42,335,000	\$ 6,840,000	\$ 49,175,000
Bond Issuance Expense (project)	\$ 724,704	\$ 1,471,369	\$ 2,196,073
Net Interest Expense During	\$ 4,311,159	\$ 8,752,959	\$ 13,064,118
Fair Market Value of Leased	\$ -	\$ -	-
Other Costs To Be Capitalized	\$ 13,117,590	\$ 12,330,410	\$ 25,448,000
Acquisition of Building or Other	\$ -	\$ -	\$ -
<b>TOTAL USES OF FUNDS</b>	<b>\$ 149,414,625</b>	<b>\$ 196,342,355</b>	<b>\$ 345,756,980</b>
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$ 138,709,655
Pledges			
Gifts and Bequests			
Bond Issues (project related)			\$ 207,047,325
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>			<b>\$ 345,756,980</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**ACMC - Patient Tower + NICU  
PROJECT COSTS**

Cost Items	TOTAL
<b>Pre-Planning</b>	\$ 4,370,500
Site and Facility Planning	\$ 3,130,235
Programming thru SD	\$ 1,240,265
<b>Site survey</b>	\$ 263,400
Soils Investigation	\$ 80,400
Site Survey & Title	\$ 65,000
Traffic studies	\$ 118,000
<b>Site Preparation</b>	\$ 1,940,000
Prep Work (Demo, clearing, grading, shoring)	\$ 1,260,000
Earthwork, drainage, stone, foundation prep	\$ 480,000
Misc excavation, all backfill areas	\$ 200,000
<b>OFF-Site Work</b>	\$ 4,783,000
Site Work: Grading, Caissons, Concrete, ect	\$ 1,530,000
Main Entry Plaza reconfigure + landscape	\$ 1,653,000
MWRD - retention	\$ 530,000
ComEd - power extension from Kostner	\$ 890,000
Kostner Associate curb cut / drop-off	\$ 180,000
<b>Architect/Eng Fees</b>	\$ 12,451,306
Architect / Engineering Fees New 5.20%	\$ 9,902,338
Architect / Engineering Fees Mod 8.60%	\$ 2,548,968
<b>Consulting and Other Fees</b>	\$ 8,736,000
Building Civil Eng /misc	\$ 130,000
CON Consultant + CON Legal	\$ 310,000
CON Architect/Engineer Assistance	\$ 68,000
Permit/ Local Government review fees	\$ 250,000
Operational Consultants / Misc analysis	\$ 485,000
Interior Design	\$ 265,000
Equipment Planner	\$ 495,000
MEP /Envelop Commissioning	\$ 425,000
IPD - ETIPS	\$ 2,650,000
LEED Certification / Commissioning	\$ 360,000
Parking Consultant	\$ 55,000
Contract project managers	\$ 698,000
Zoning / Local Government Representation	\$ 110,000
Wayfinding Consultant / Material Mgmt	\$ 200,000
Technology Integration consultant	\$ 95,000
A/E CA (Const Admin) & Misc Consultants	\$ 1,390,000
Reimbursables/ Renderings / Misc support	\$ 425,000
OL Const Consultant / P-Tube / Elevator	\$ 325,000
<b>Movable / Equipment</b>	\$ 49,175,000
Kitchen Equipment / Misc	\$ 6,840,000
Head walls / Infant abduction	\$ 1,100,000
Medical / Misc	\$ 31,900,000
Misc	\$ 1,985,000
NICU	\$ 7,350,000

<b>Other Costs to be Capitalized</b>	<b>\$</b>	<b>25,448,000</b>
Nurse stations	\$	450,000
Utilities / Taps	\$	1,600,000
Exterior Signage	\$	1,171,410
Interior Signage	\$	863,590
Telecom Infrastructure	\$	650,000
Telecom Switch	\$	480,000
Data Infrastructure + wireless PT & NICU	\$	2,100,000
Misc - Software - Cerner PT & NICU	\$	2,750,000
Building Construction Permit	\$	685,000
Infrastructure - Generator / switch gear	\$	3,760,000
Security System / Access control	\$	480,000
City, County & Municipal fees	\$	500,000
CON Audit Consultant	\$	25,000
MWRD Fee	\$	78,000
Pac Stations / Equipment	\$	2,500,000
Testing consultant	\$	230,000
Expand Security / Equipment	\$	600,000
CON Fee	\$	100,000
IDPH Fee	\$	125,000
NICU Misc	\$	3,500,000
Pneumatic Tube System	\$	2,800,000

## 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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							
APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Cost Space Requirements are appended as 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	New Const.	Remodeled	As Is	Vacated Space
<b>CLINICAL</b>							
<b>OB Triage</b>	4,957,507	2,795	5,409		5,409		
<b>Labor/Delivery/Recovery</b>	12,745,068	9,444	13,853	13,853			
<b>C-Section Suite</b>	3,242,297	1,970	3,525	3,525			
<b>Phase I Recovery</b>	1,494,146	7,866	8,884	1,618		7,266	
<i>Existing C-Section Recovery</i>		600		1,618			
<i>Hospital Surgical Recovery</i>		2,796				2,796	
<i>Ambulatory</i>		4,470				4,470	
<b>Obstetric Beds</b>	30,092,105	18,410	36,506	32,702		3,804	8,873
<i>Antepartum beds</i>			3,824	3,824			
<i>Postpartum beds</i>			28,878	28,878		3,804	8,873
<i>2W</i>		5,761					5,761
<i>2E</i>		5,733					
<i>3W</i>		6,916				3,804	3,112
<b>Newborn nursery bassinets</b>	1,658,502	1275	1,799	1,799			1,275
<b>Neonatal Intensive Care Beds</b>	29,419,740	6,848	31,968		31,968		
<b>Intensive Care Beds</b>	61,379,529	40,356	98,308	66,698		31,610	8,746
<i>SINI</i>		9,464				9,464	
<i>MICCU</i>		8,746					8,746
<i>PICU/PSHU</i>		8,518				8,518	
<i>ASHU</i>		9,806				9,806	
<i>SVTU/AHU</i>		3,822				3,822	
<b>Medical Surgical Beds</b>	2,017,097	96,090	93,840		2,191	91,649	
<b>Morgue</b>	2,390,634	979	2,597	2,597			979
Clinical to Non Clinical	0	-2,574					
<b>TOTAL CLINICAL</b>	149,414,625	183,459	296,689	122,792	39,568	134,329	19,873

Source: ACMC records.

\*Note: Existing and proposed space included in the table above is only for areas in the project and do not represented total campus square footage.

Cost Space Requirements							
Dept. / Area	Total Costs	Department Gross Square Feet		Amount of Proposed Total Department Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Remodeled	As Is	Vacated Space
<b>NON-CLINICAL</b>							
Administrative	23,082,007	13,846	36,503	27,343	9,160		
Non Clinical Storage, Processing and Distribution	41,850,373	11,316	66,181	56,719	9,462		
Public Amenities	71,772,948	19,479	113,501	95,426	18,075		
Building Components	49,843,470	10,103	78,821	71,103	7,718		
Shell Space	9,793,557		15,488	15,488			
<b>TOTAL NON-CLINICAL</b>	<b>196,342,355</b>	<b>54,744</b>	<b>310,494</b>	<b>266,079</b>	<b>44,415</b>	<b>0</b>	<b>0</b>
<b>TOTAL PROJECT</b>	<b>345,756,980</b>	<b>238,203</b>	<b>607,183</b>	<b>388,871</b>	<b>83,983</b>	<b>134,329</b>	<b>19,873</b>

\*Note: Existing and proposed space included in the table above is only for areas in the project and do not represented total campus square footage.

### **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.**

Documents relating to licensing and certifications are appended in Attachment 11, Exhibits 1, 2 and 3.

**1. Health Care Facilities Owned and Operated by Advocate Health and Hospitals Corporation**

The licensing, certification and accreditation numbers of each of the organizations 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 Christ Medical Center	4440 W. 95 <sup>th</sup> St. Oak Lawn, IL	1899693	7397

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 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 Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	1895997	4068
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 <sup>rd</sup> St. Chicago, IL	1927349	7311

\*Advocate BroMenn and Advocate Eureka are accredited by the Joint Commission under the same number.

1. The license for Advocate Christ Medical Center (Medical Center) is included as Attachment 11, Exhibit 1.

The most recent Joint Commission accreditation certificates for the Medical Center and Behavioral Health Care are included as Attachment 11, Exhibits 2 and 3. The Medical Center and Behavioral Health Care were surveyed in July 2010. Advocate Christ Medical Center participates in Medicaid and Medicare.

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

By the signatures on this application, Advocate Health and Hospitals Corporation attests there have been no adverse actions against any facility owned and/or operated by Advocate Health and Hospitals Corporation by any regulatory agency which would affect its ability to operate as a licensed entity during the three years prior to the filing of this application.

3. Authorization Permitting HFSRB and IDPH to Access Necessary Documentation

By the signatures on this application, Advocate Health and Hospitals Corporation and Advocate Health Care Network hereby authorize the Health Facilities and Services Review Board and the Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

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

Not applicable. This is the first certificate of need filed by Advocate Christ Medical Center in 2012.

**State of Illinois 2065036**  
**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.

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

**CRAIG CONOVER, M.D.**  
**ACTING DIRECTOR**

EXPIRES FOR STATE	CATEGORY	ISS. NUMBER
12/31/12	0662	0000315

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 01/01/12**

**BUSINESS ADDRESS**

**CHRIST HOSPITAL AND MEDICAL CENTER**  
**4440 N. 55TH STREET**  
**CHICAGO, ILL 60645**

The face of this license has a colored background. Printed by Authority of the State of Illinois - 457 -

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

**REMOVE THIS CARD TO CARRY AS AN  
IDENTIFICATION**

↓

**State of Illinois 2065036**  
**Department of Public Health**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**  
**CHRIST HOSPITAL AND MEDICAL CENTER**

EXPIRES FOR STATE	CATEGORY	ISS. NUMBER
12/31/12	0662	0000315

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 01/01/12**

**11/08/11**

**CHRIST HOSPITAL AND MEDICAL CENTER**  
**4440 N. 55TH STREET**  
**CHICAGO ILL 60645**

**FEE RECEIPT NO.**

# Advocate Christ Medical Center Oak Lawn, 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

July 31, 2010

Accreditation is customarily valid for up to 39 months.

*David L. Nahrwold*

David L. Nahrwold, M.D.  
Chairman of the Board

Organization ID #7397  
Print/Reprint Date: 11/18/10

*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](http://www.jointcommission.org).



AMA  
AMERICAN  
MEDICAL  
ASSOCIATION



Advocate Christ Medical Center  
Oak Lawn, IL

has been Accredited by

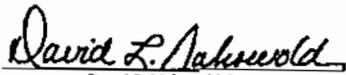


**The Joint Commission**

Which has surveyed this organization and found it to meet the requirements for the  
Behavioral Health Care Accreditation Program

**July 27, 2010**

Accreditation is customarily valid for up to 39 months.

  
David L. Nahrwold, M.D.  
Chairman of the Board

Organization ID #7397  
Print/Reprint Date: 11/18/10

  
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](http://www.jointcommission.org).



**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:

<p><b>PURPOSE OF PROJECT</b></p> <ol style="list-style-type: none"><li>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.</li><li>2. Define the planning area or market area, or other, per the applicant's definition.</li><li>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.]</li><li>4. Cite the sources of the information provided as documentation.</li><li>5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.</li><li>6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.</li></ol> <p>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.</p>
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**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. Document that the project will provide health care services that improved the health care or well-being of the market area population to be served.*

The fundamental purpose of this project is to provide better access to care, save lives and improve clinical outcomes of care.

The proposed project has three major components, all of which are necessary to serve critically ill patients from the broad geographic area served by Advocate Christ Medical Center (ACMC, Medical Center). The project will be accomplished by constructing and modernizing space for these very high acuity services. First, the Medical Center proposes to increase the number of adult intensive care beds by 86. To achieve this increase, 108 new intensive care beds will be constructed and 22 existing intensive care beds constructed in the 1980's will be vacated. Next, the Medical Center proposes to increase by 17, or from 39 to 56, the number of obstetric beds for high risk antepartum, postpartum and gynecology patients. All of the proposed obstetric beds, as well as labor/delivery/recovery, surgical delivery rooms (C-Section rooms), and related Phase I Recovery will be relocated to the new Patient Tower. Finally, as part of this project, the Medical Center will modernize the existing neonatal unit and the space vacated by the obstetric services

for 64 neonatal intensive care beds, (or 27 more than are currently authorized) and an enlarged OB Triage area.

These new high acuity beds and services are needed:

- To address the shortage of 51 intensive care beds in the Medical Center's planning area (A-04)
- To address the aging of the population – both the total adult population and women in the older childbearing age cohorts
- To meet the needs of current patients that cannot be admitted because of the Medical Center's extremely high census
- To allow new life-saving procedures and techniques to be implemented, and
- To treat other patients who have historically been too sick for many procedures and techniques

A connector between the existing tower and the new patient tower will provide a direct connection between the two towers at Ground and Level 1 through Level 9. These are especially important at Level 2 to connect the elements of the obstetric service and the neonatal intensive care unit and on Level 9 to link the cardiac-related floors.

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

Advocate Christ Medical Center's service area has two components. The first component is the local market, or the primary and secondary service areas. The Medical Center defines the primary service area as 75 percent and secondary service area as 10 percent of the where its inpatient population resides. The second component is the regional market. Patients in the service area seek care at the Medical Center for primary and secondary care as well as high acuity services, typically defined as tertiary and quaternary care. Patients from the broader regional service area seek the advanced clinical services and subspecialist physicians at the Medical Center that are not available in their community hospitals. The regional market extends throughout the south and southwest suburbs of Chicago to Peoria on the southwest (157 miles) and Kankakee to south (50 miles) from the Medical Center and beyond.

The following is a comparison of patient origin for key categories of patients that will benefit from the services that are in this project.

Comparison of Patient Origin by Category of Service, 2011  
Attachment 13, Table 1

Service Area	Total Percent	ICU Percent	OB/GYN Percent	NICU Percent	Medical Surgical Percent
Primary Service Area	68.8	61.7	63.6	43.7	74.4
Secondary Service Area	14.9	16.1	16.9	17.3	13.8
Subtotal	83.7	77.8	80.5	61.0	88.2
Other Illinois	14.6	18.6	18.2	32.3	10.3
Other States	1.8	3.6	1.3	6.7	1.5
Total	100.0	100.0	100.0	100.0	100.0

Source: APMC Internal Financial Records

As noted on the above table, 16.4 percent of total patients are from Other Illinois and Other States. In contrast, the percentage for medical surgical is 11.8, ICU is 22.2 percent, obstetrics/gynecology is 19.5 percent, and for neonatal intensive care is 39.0 percent. This in-migration of patients from across Illinois and Other States further describes the regional nature of the Medical Center's market. The primary and secondary service areas have a combined population of 1,567,551; although the population is relatively stable in number, it is aging.

Other Demographic Characteristics

Attachment 12, Tables 2 through 5 describe several key demographic characteristics of the Advocate Christ Medical Center/Advocate Hope Children's Hospital service area. Attachment 12, Table 2 is a comparison of the racial characteristics within APMC/AHCH's total service area (primary and secondary) to the State of Illinois and the Chicago Metropolitan Statistical Area (MSA). This table shows that the proportion of minority populations within APMC/AHCH's total service area is higher than the proportions in Illinois or the MSA. Approximately 50 percent of the population residing within APMC/AHCH's primary service area is minorities.

Attachment 12, Table 2  
2011 Comparison of Racial Composition of APMC/AHCH's  
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

Race	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Illinois	Percent MSA Area
White	50.6	27.0	40.5	63.8	53.2
Black	24.7	55.2	37.7	14.4	17.7
Hispanic	21.1	15.5	18.7	15.6	21.2
Asian & Pacific Island, Non Hispanic	1.6	0.8	1.3	4.4	5.9
All Others	2.0	1.5	1.8	1.9	2.1
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters)

There are multiple reasons why anticipated utilization from the populations the Medical Center serves will be higher than average utilization. According to the Centers for Disease Control

(CDC), deaths associated with coronary heart disease and strokes are greater among non-Hispanic blacks than non-Hispanic whites. Between 2000 and 2007, the reported infant mortality rate for non-Hispanic blacks was 2.4 times that for non-Hispanic whites. In 2006, a comparison of rates by race reveals that black women and men have much higher coronary heart disease (CHD) death rates in the 45 to 74 age cohorts than any other race. A higher percentage of black women (37.9 percent) than white women (19.4 percent) died before age 75 as a result of CHD, as did black men (61.5 percent) compared to white men (41.5 percent).

The same disparity was seen among women and men who died of stroke. A high percentage of black women (39.0 percent) died of stroke before age 75 compared with white women (17.3 percent), as did black men (60.7 percent) compared to white men (31.1 percent).

In addition, the CDC has well publicized morbidity statistics related to diabetes, hypertension and preterm births over the years. In 2008, marked disparities in age-standardized prevalence of diagnosed diabetes among U.S. adults were identified, with 11.0 percent of non-Hispanic blacks, 10.7 percent of Hispanics reporting the highest rates, compared to 8.2 percent for Asians and 7.0 percent of non-Hispanic whites. There is a significant population of undiagnosed diabetes that is expected to widen the actual diabetes disparities within the U.S. population.

The age-adjusted prevalence of hypertension among all U.S. adults 18+ was 29.9 percent from 2005 to 2008. Older adults, non-Hispanic blacks, U.S.-born adults, and adults with lower family income, lower education, public health insurance, diabetes, obesity, or a disability had a higher prevalence of hypertension than their counterparts. In 2007, approximately one out of every five infants born to non-Hispanic black mother in 2007 was born preterm, compared with one of every eight to non infants born to non-Hispanic white and Hispanic women. The rate was 59 percent higher in black mothers when compared to white mothers and 49 percent higher when compared to Hispanic mothers.

The average household income in the Medical Center's service area is compared to the State of Illinois and the Chicago Metropolitan Statistical Area (MSA) in Attachment 12, Table 3. The proportion of low income households, those typically with the most challenging access to health care is higher in the Medical Center's service area than in Illinois or the MSA. The proportion of very high income households is lower in the Medical Center's service area than in Illinois or the MSA.

Attachment 12, Table 3  
 Comparison of 2011 Household Income of ACMC/AHCH's  
 Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2011 Household Income	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Illinois	Percent MSA Area
< \$15K	11.0	18.6	14.2	11.5	10.4
\$15 - \$25K	9.6	11.2	10.3	9.6	8.2
\$25 - \$50K	25.5	26.2	25.8	25.3	23.1
\$50 - \$75K	21.0	17.3	19.5	20.2	19.8
\$75 - \$100K	14.0	11.1	12.8	13.1	13.9
Over \$100K	18.8	15.5	17.4	20.3	24.6
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters).

Healthy habits are strongly connected to physical health, and low-income Americans are less likely to practice healthy behaviors, underscoring the interconnectedness of different aspects of well-being. Low-income Americans are less likely to report healthy eating and frequent exercise compared with those with higher incomes. Smoking is nearly three times as common among low-income as among high-income Americans.

Attachment 12, Table 4 compares unemployment for the Medical Center's service area with the State of Illinois and with Chicago's MSA. The unemployment rate across the service area is higher than the State and MSA averages. Gallup-Healthways Well-Being Index data documents the severity of health disparities between low- and high-income Americans. Those making less than \$24,000 per year suffer from much lower emotional and physical health, have poorer health habits, and have significantly less access to medical care -- all of which combine to drag down their overall Well-Being Index score.

Attachment 12, Table 4  
 Comparison of 2011 Unemployment Percentages of ACMC/AHCH's  
 Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Illinois	Percent MSA Area
Percent of Unemployment	6.8	10.1	8.2	5.9	6.4

Source: Market Expert (Thomson Reuters)

According to the National Institutes of Health, there is reasonably good evidence that unemployment itself is detrimental to health and has an impact on health outcomes - increasing mortality rates, causing physical and mental ill-health and greater use of health services.

Attachment 12, Table 5 shows that the adult education level of the Medical Center's service area population is lower than that of Illinois or the MSA, with a higher proportion of the population

age 25+ with less than high school or some high school and lower proportions with a college bachelor's degree or greater.

Education is strongly linked to health and to determinants of health such as health behaviors, risky contexts and preventative service use. Those with more years of schooling tend to have better health and well-being and healthier behaviors. Education is an important mechanism for enhancing the health and well-being of individuals because it reduces the need for health care, the associated costs of dependence, lost earnings and human suffering. It also helps promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community well-being.

Source: Measuring the effects of education on health and civic engagement: proceedings of the Copenhagen symposium, 2006, [www.oecd.org/dataoecd/23/61/37437718.pdf](http://www.oecd.org/dataoecd/23/61/37437718.pdf)

Attachment 12, Table 5  
2011 Comparison of Adult Education Level of ACMC/AHCH's  
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2011 Adult Education Level	Percent Primary Service Area Age 25+	Percent Secondary Service Area Age 25+	Percent Total Service Area Age 25+	Percent Illinois Age 25+	Percent MSA Area Age 25+
Less than High School	7.9	7.4	7.7	6.2	7.1
Some High School	9.2	11.7	10.2	7.7	7.5
High School Degree	32.4	29.1	31.0	27.8	24.3
Some College/Assoc. Degree	28.9	31.7	30.1	28.1	26.3
Bachelor's Degree or Greater	21.6	20.2	21.0	30.2	34.7
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters).

Attachment 12, Tables 6, 7 and 8 summarize the payor mix of the Medical Center's adult and pediatric inpatient populations compared to Illinois.

Attachment 12, Table 6  
Inpatient Adult Payor Mix in ACMC/AHCH's Primary and Secondary Service Areas, 2011

Primary Service Area		
Insurance	Patients	Percent of Total
Medicaid	30,635	22.9
Self Pay	7,617	5.7
Managed Care	41,318	30.9
Medicare	48,949	36.6
Other	5,156	3.9
Total	133,675	100.0
Secondary Service Area		

Insurance	Patients	Percent of Total
Medicaid	32,913	31.2
Self Pay	7,770	7.4
Managed Care	24,517	23.3
Medicare	34,818	33.0
Other	5,413	5.1
Total	105,431	100.0

Source: IL CompData

Attachment 12, Table 7

Inpatient Pediatric Payor Mix in ACMC/AHCH's Primary and Secondary Service Areas, 2011

Primary Service Area		
Insurance	Patients	Percent of Total
Medicaid	13,232	60.5
Self Pay	829	3.8
Private Insurance/Managed Care	7,243	33.1
Medicare	18	0.1
Other	565	2.6
Total	21,887	100.0
Secondary Service Area		
Insurance	Patients	Percent of Total
Medicaid	5,253	48.6
Self Pay	259	2.4
Private Insurance/Managed Care	5,195	48.0
Medicare	-	0.0
Other	108	1.0
Total	10,815	100.0

Source: IL CompData

Attachment 12, Table 8

Illinois Inpatient Payor Mix, 2010

State of Illinois – Inpatient Payor Mix		
Insurance	Patients	Percent of Total
Medicaid	318,145	20.5
Self Pay	56,010	3.6
Private Insurance/Managed Care	474,649	30.5
Medicare	630,134	40.5
Other	75,552	4.9
Total	1,554,490	100.0

Source: IDPH 2010 IL Hospital State Summary

Medicaid patients account for a higher proportion of the Medical Center's payor mix than Illinois; private insurance is somewhat higher and inpatient Medicare is somewhat lower.

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.]*

Advocate Christ Medical Center is proposing a major capital investment in three categories of service – intensive care, obstetrics, and neonatology. Each of these areas has a severe deficit of beds and a serious shortage of space.

a. Intensive Care

The State Agency does not distinguish between adult and pediatric beds; the Medical Center currently has both dedicated pediatric and adult intensive beds.

Deficit of Beds

Together, there are 103 intensive care beds—79 adult beds and 24 pediatric beds at the Medical Center. In 2011, the total bed complement operated at 87.6 percent occupancy and the adult intensive care beds operated at 90.7 percent occupancy. These occupancy rates are considerably higher than the State Standard of 60 percent. At this current high occupancy, the Medical Center is often on bypass and cannot accept patients referred to its tertiary and quaternary programs.

The current total intensive care census is 96.0; this census justifies the need for 160 beds at the State Standard Target Occupancy of 60, or 57 more beds than currently available. This increase does not address other factors that are driving the need for additional intensive care beds at the Medical Center.

Shortage of Space

The existing intensive care beds at the Medical Center are located across 6 units; of these, 2 units are pediatric and the other 4 units are adult. Of the current 4 adult units, the 3 surgical intensive care units will remain as is; the fourth unit, the MICCU, will be replaced. The square footage of the current MICCU is 8,746 GSF or 398 GSF per bed. This is substantially lower than the State Standard for intensive care beds of 600 to 685 GSF per bed.

b. Obstetric Service

The Medical Center is a Level IIIC Perinatal Center. A Level IIIC Perinatal Center cares for very high risk pregnancies – both the mother and the baby. The Medical Center is the only Level IIIC Perinatal Center serving the south and southwest Chicago suburbs and far beyond; it is one of only six Level IIIC Centers in the State of Illinois.

Deficit of Obstetric Beds and Other Clinical Service Areas

The State Standard target occupancy for obstetric services with 26 or more beds is 78 percent. Antepartum (high risk before delivery), postpartum (high risk and normal after delivery), and gynecology patients are admitted to 39 authorized beds at the Medical Center. In 2011, the obstetric unit reported a total obstetrical and gynecology census of 42.7 or an occupancy rate of 109.6 percent. In the interest of patient safety, and in times of peak census, antepartum patients are admitted to labor/delivery/recovery rooms and gynecology patients are admitted to medical surgical beds in an adjacent unit. Concurrently patients scheduled for a C-section or an induction may be asked to remain at home; however, the obstetric team closely monitors them for any sign that they may need immediate admission. Utilization of the current obstetric beds is currently capped. In addition to the high census, the unit must keep beds available for emergency maternal transports, other high risk admissions received from other hospitals and antepartum patients whose condition deteriorates.

The current average daily census documents the need for 55 obstetric beds. This calculated bed number does not account for expected modest growth in the service.

The Obstetric Department also has 15 LDRs or enough to satisfy future need.

In addition to LDRs, the Medical Center has 3 surgical delivery rooms that are used for C-section deliveries as well as other obstetrical procedures. By 2017, the Medical Center is expected to have 1,734 procedures in the surgical delivery rooms. The State Standard for surgical delivery rooms is 800 procedures per room. Current volume justifies the need for 3 rooms; however a high risk perinatal center must have a surgical delivery room available at all times to immediately accommodate a high risk patient that is either in the antepartum unit, or is an incoming maternal transport, or a Trauma Center patient. With only 3 rooms, it is impossible to keep a room available. The Medical Center also has 3 Phase I recovery rooms; one room per each surgical delivery room is required by code. The Medical Center is requesting 4 surgical delivery rooms and 4 Phase I recovery rooms. Finally, the Medical Center has an OB Triage function. With 9 rooms, OB Triage is undersized. The Medical Center is requesting 12 OB Triage rooms. There is no State Standard for OB Triage volume.

#### Shortage of Space

The obstetrical unit and related clinical support services are located in a building that was constructed more than 50 years ago. Over the years the area has undergone modest renovations; today, however, it is outdated and congested. The design of the unit is dysfunctional. For example, the 15 labor/delivery/recovery rooms are in two pods – one with

9, the other with 6 rooms. The two pods are remote from each other and are very difficult to operate and staff efficiently; the smaller pod is not visible from the nursing station.

In addition to the functional limitations of the current obstetrical services, the department also has a serious shortage of square footage. The current and allowable square footage for the programmatic elements are as follows:

Comparison of Current and Allowable Square Footage

Attachment 12, Table 9

Program Element	Existing GSF	Allowable GSF
Obstetric Beds	18,410	28,000 to 36,960
Newborn Nursery Bassinets	1,275	6,240
Labor/Delivery/Recovery Rooms	9,444	16,800 to 24,000
Surgical Delivery/C-Section Room	1,970	6,225
Phase I Recovery Rooms	600	720
OB Triage	2,795	NA

The existing square footages of all the obstetric-related project elements are substantially below the State Standards with the exception of Phase I recovery rooms.

c. Neonatal Intensive Care Unit

Advocate Christ Medical Center is a Level IIIC Perinatal Center and one of only six in the State of Illinois. The smallest, the sickest, and the most compromised babies are cared for in this unit. It is the only neonatal intensive care unit in Planning Area A-04; 39.0 percent of the neonates are from beyond the Medical Center's defined service area.

Deficit of Beds

Consistent with current care model, neonatal care at the Medical Center includes caring for both Level 2+ infants and high risk infants in the 37-bed neonatal intensive care unit. In 2011, the Medical Center reported 10,910 neonatal days and 3,619 Level 2+ days or a total of 14,529 days, an average daily census of 39.8 and the potential for occupancy of 107.6 percent. To accommodate this volume, a small procedure room and an isolation room on the neonatal unit are sometimes used as patient rooms; if occupying these spaces does not satisfy demand, Level 2+ babies are admitted to the normal newborn nursery with special clinical support.

The current neonatal census supports the need for 53 neonatal beds. The Medical Center is requesting 64 beds.

### Shortage of Space

There is no space to expand the neonatal unit in its current location, as it has only 6,848 GSF or 185 DGFS per bed; this is only about 43 percent of the State Standard of 434 GSF to 567 GSF per bed.

In summary, the intensive care, obstetric and neonatal categories of service can document both a deficit of beds and shortage of space to meet the needs of the community and regional patients who look to the Medical Center for care.

#### d. Medical Surgical Beds

The currently proposed Patient Tower will be connected to the adjacent existing patient tower with a connector. To complete the connector the existing patient tower must be penetrated on each level. In that process, rooms housing 17 medical surgical beds will be taken out of service. To preserve these beds, the Medical Center will modernize 10 rooms in the medical surgical units in the existing patient tower and place the other 7 beds in reserve. At the completion of the project, the Medical Center the number of authorized medical surgical beds at the Medical Center will not change. In the most recent Annual Questionnaire, the Medical Center reported 378 beds; at the completion of the project, the Medical Center will continue to have 378 authorized medical surgical beds.

### Deficit of Beds

The Medical Center's beds operated at 82.4 percent occupancy in 2011. This is below the State Standard target medical surgical occupancy of 88.0 percent. However, only 67 percent of the Medical Center's medical surgical beds are in private rooms. Private rooms provide many benefits to patients, families and staff including safety, privacy, and comfort. In the future, the Medical Center plans to modernize vacated space and finish shell space to provide more private rooms. The modernization necessary to add more private rooms (but to maintain the existing authorized bed complement) is not part of this project.

### Shortage of Space

At project completion, the Medical Center's authorized beds will be located in 93,840 GSF of space or 249 GSF per bed. While this is below the State Standard of 500 to 660 GSF per bed, the proposed privatization of medical surgical beds at this point and time is a higher priority.

4. *Cite the sources of the information provided as documentation.*

The following sources of the information were used in the development of the responses in this application:

- Advocate Health and Hospitals Corporation and Advocate Christ Medical Center clinical, administrative, and financial data
- Advocate Christ Medical Center's Strategic Plan, Vision 2017
- Master Facility Plan
- KSA and Sg2 Studies
- Other studies performed by external planners, architects, and engineers
- National and State of Illinois demographic reports
- IDPH's Hospital Profiles
- HRSRB Rules
- HFSRB State Standards
- Technical Assistance from State Staff
- MapQuest
- Health care literature related to trends in intensive care, obstetric care, and neonatal care
- Health care literature related to the possible implications of State and National health care reform
- Illinois Department of Public Hospital Licensing Code, and
- Illinois and Oak Lawn building, mechanical, electrical, and accessibility codes.

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

Advocate Christ Medical Center has severe bed deficits and space shortfalls in three major categories of services and related clinical service areas – intensive care, obstetrics and neonatal intensive care. The proposed 9-level patient tower will be linked to existing patient care buildings either with direct connections or with bridges. With these connections, the new structure and the existing ones will function as a single inpatient entity.

1. Intensive Care Beds

Bed Deficit Resolved

At the completion of the project, the Medical Center will have 8 intensive care units. The two pediatric intensive care units as well as the three existing adult surgery-related units will

remain as-is. Three new 36-bed units will be developed in the new patient tower – one of which will replace the existing MICCU which will be decommissioned. The Medical Center will increase the total intensive care complement from 103 to 189 beds.

To be conservative, the Medical Center assumed that utilization of the pediatric intensive care beds would remain constant at the 2011 utilization level and projected need for adult intensive care beds based on a CAGR trend line and supporting justification.

Calculation of Future Intensive Care Bed Need, 2015 – 2019

Attachment 12, Table 10

	Projected Intensive Care Bed Need			
	2015	2017	2018	2019
Adult Intensive Care Patient Days	34,414	37,975	39,891	41,904
Pediatric Intensive Care Patient Days	6,787	6,787	6,787	6,787
Total Intensive Care Patient Days	41,201	44,762	46,678	48,691
ADC	112.9	122.6	127.9	133.4
Bed Need at 60 Percent	189	205	214	223
Proposed Beds	189	189	189	189

The proposed new intensive care beds will be occupied in October 2015; by the second full year of operation (2017) the total intensive care bed complement at the Medical Center is expected to be operating at 64.9 percent consistent with the State Standard of 60 percent. With the completion of the proposed project, people in the Medical Center’s community and regional service areas will have improved access to high acuity services, which in turn will improve their health status and well-being.

Shortage of Space Resolved

At the conclusion of the Patient Tower project, the 108 new intensive care beds will be located in 66,698 GSF or 618 GSF per bed or well within the State Standard of 600 to 685 GSF per bed. The total intensive care complement will be located in 98,308 GSF of space or 521 GSF per bed, somewhat below the State Standard, but adequate for safe patient care.

2. Obstetric Services

Bed Deficit Resolved

The Medical Center proposes to increase the obstetric bed complement from 39 to 56 beds at project completion.

Calculation of Future Obstetric Bed Need, 2015 – 2019

Attachment 12, Table 11

	Projected Obstetric Beds			
	2015	2017	2018	2019
Obstetric Patient Days	16,964	17,636	17,983	18,339
ADC	46.5	48.3	49.3	50.2
Bed Need at 78 Percent	60	62	64	65
Proposed Beds	56	56	56	56

Source: Attachment 20, Obstetric Beds

The Medical Center based future obstetric bed need on a CAGR trend line projection and supporting documentation. The need for the other related obstetric clinical service areas is consistent with the State Standards.

The obstetric unit will be relocated in new space that will be available for occupancy in October 2015. By 2017, the second full year of operation, the obstetric beds at the Medical Center will be operating at 86.3 percent and consistent with the State Standard Target Occupancy of 78 percent. With the completion of the proposed project, mothers, infants, and indeed families in the Medical Center’s community and regional service areas will have improved access to high acuity obstetric services, which, in turn, will improve their health status and well-being.

Shortage of Space Resolved

Comparison of Proposed and Allowable Square Footage

Attachment 12, Table 12

Program Element	Allowable GSF	Proposed GSF	Met Standard?
Obstetric Beds	28,000 to 36,960	36,506	YES
Newborn Nursery	6,240	1,799	YES
Labor/Delivery/Recovery	16,800 to 24,000	13,853	YES
Surgical Delivery C-Section Rooms	6,225	3,525	YES
Phase I Recovery Rooms	720	1,618	NO
OB Triage	NA	5,409	NA

The proposed square footages of all the obstetric-related project elements are well within the State Standards, except for Phase I recovery.

### 3. Medical Surgical

There will be no space added to the medical surgical bed complement; however proposed privatization of medical surgical beds is a priority for APMC. The Medical Center is adding an additional 16 beds by invoking the 20-bed rule in autumn of 2012.

### 4. Neonatal Intensive Care

#### Bed Deficit Resolved

The enlarged and remodeled neonatal intensive care unit (NICU) will be located in space vacated by the existing obstetric department. The Medical Center is proposing to increase the number of neonatal intensive care beds from 37 to 64 to safely accommodate all Level 2+ and neonatal intensive care patients, consistent with the model of care.

#### Calculation of Future Neonatal Bed Need, 2015 – 2019

Attachment 12, Table 13

	Projected Neonatal Intensive Care Bed Need			
	2015	2017	2018	2019
Neonatal and Level 2+ Patient Days	17,838	19,765	20,805	21,900
ADC	48.9	54.2	57.0	60.0
Bed Need at 75 Percent	66	73	76	80
Proposed Beds	64	64	64	64

Source: Attachment 23, Neonatal Intensive Care Beds

Because the neonatal unit is being developed in space being vacated by the obstetric department, the new unit will not be available for occupancy until April 2017; 2019 will be the second full year of utilization. By 2019, it is expected that the neonatal unit will be operating at 93.8 percent occupancy or higher than the State Standard of 75 percent. With the completion of the proposed neonatal intensive care unit, very high risk infants will have access to services that will improve their chances for survival and their quality of life.

#### Shortage of Space Resolved

The current 37 neonatal intensive care beds are located in 6,848 GSF of space or 185 GSF per bed. In the remodeled area, the NICU will have 21,657 GSF of space or 339 GSF per bed, almost twice as much space more per bed than in the existing unit.

Comparison of Proposed and Allowable Square Footage  
Attachment 12, Table 14

Program Element	Allowable GSF	Proposed GSF
Neonatal Intensive Care Beds	27,775 to 36,352	21,657

At the conclusion of the project, the increased number of neonatal intensive care beds and the greater square footage will alleviate the issues associated with the exceedingly high occupancy and the extremely limited quarters in which the new NICU will function.

In conclusion, the major issues of high utilization of the intensive care, obstetrics, and neonatal services will be greatly improved at the completion of the proposed project.

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

**Overriding Goal**

Advocate Christ Medical Center's overriding goal is to increase access to care, save lives and improve clinical outcomes of care in a patient-centric and clinically excellent manner to the residents of Chicago's south and southwest suburbs and beyond.

**Objective 1**

Expand adult intensive care services to 165 beds and total intensive care services to 189 beds in order to meet the current and projected need. In part the expansion of the intensive care bed complement is in anticipation of the future expansion of the Level I Trauma Center at the Medical Center. This service is among the busiest trauma services in the State and increased trauma capacity will have an immediate impact on intensive care volume. The further objective is to have the full complement of 165 adult intensive care beds operational in October 2015.

**Objective 2**

Expand obstetric services to 56 beds and relocate into new construction the obstetric services including labor/delivery/ recovery/ surgical delivery rooms, Phase I Recovery stations, obstetric beds for high risk antepartum, postpartum, and gynecology patients and to redevelop and expand OB Triage in modernized space. In order to meet the pressing need for these modern facilities, the objective is to have these new facilities available in October 2015, except for OB Triage which will be available in 2016.

### Objective 3

Modernize the neonatal intensive care unit to 64 beds within existing and renovated space, so that it can continue to provide exceptional care and improve outcomes for very high risk infants. Since the NICU will be relocating to space vacated by the existing obstetric service, the objective is to have the NICU relocated and fully functional during 2017.

### Objective 4

In addition to the clinical services, many non clinical services need to be expanded and upgraded to support the clinical functions and to ensure a safe and efficient environment. The completion of the non clinical construction and modernization will be completed in phases with the entire project complete by July 2019.

### Objective 5

Space vacated during this phase of the project will allow the Medical Center to plan for Phase III of its campus redevelopment plan – the expansion of trauma services, heart and cancer programs, diagnostics and other areas in need of expansion.

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

#### ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

**APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

#### Introduction

More than a decade ago, Advocate Health and Hospitals Corporation determined that the south and southwest Chicago area was one of the areas most in need of advanced clinical services and began the process of developing Advocate Christ Medical Center (ACMC, Medical Center) into what today is one of the major tertiary/quaternary referral hospitals in the Midwest. The Medical Center is a 678-bed facility, and according to *Crain's*, November 21, 2011, is the second largest hospital in Chicagoland (Cook, DuPage, Kane, Lake, McHenry, and Will counties) in terms of days of patient care.

Since Advocate recognized and focused on the need for a tertiary/quaternary facility in the south and southwest Chicago area, the Medical Center recruited medical and surgical physician specialists and subspecialists, retained highly skilled nurses and other professional staff, and expanded the availability of advanced clinical technology for the diagnosis and treatment of acutely ill and severely injured patients. Today, the Medical Center is continually developing new programs and services to better serve its patients. Much of this new development resides in the Heart and Vascular, Neuroscience, Bone and Joint, and Cancer Institutes.

In 1996, the Medical Center enhanced its services to the region by establishing Advocate Hope Children's Hospital; today, Hope is the only dedicated pediatric facility in Chicago's south and southwest suburbs and provides a full spectrum of clinical programs for children – including the Heart Institute for Children, the Keyser Family Pediatric Cancer Center, and the Cystic Fibrosis Center.

Because the Medical Center's programs and services responded to community and regional need and continued to grow, the original facility is no longer able to accommodate the increasing intensity of care and volume. In spite of its serious shortfall of space and high occupancy, Advocate Christ Medical Center in April 2012 was named one of the Top 100 Hospitals® in the United States by Thomson Reuters in the Major Teaching Hospitals category. Thomson Reuters evaluated performance in 10 areas including mortality; medical complications; patient safety; average patient stay; expenses; profitability; patient satisfaction, adherence to clinical standards of care; post discharge mortality; and readmission rates for acute myocardial infarction (heart attack), heart failure, and pneumonia.

In 2002 the leadership of Advocate Health and Hospitals and Advocate Christ Medical Center began a comprehensive process to identify and evaluate optional facility expansion strategies. The following is a discussion of the major alternatives that were considered and the rationale for these either being accepted or rejected.

#### 1) and 2) Identification and Documentation of Alternatives

Advocate Christ Medical Center considered several fundamental alternatives to the currently proposed project. They are:

Alternative 1 – Develop a New Hospital on the Advocate Southwest Medical Campus in Tinley Park/Orland Park

Alternative 2 – Utilize Other Health Care Resources or Joint Ventures with Others

Alternative 3 – Expand the Existing Campus with a New Patient Tower for Inpatient and Outpatient Services

Alternative 4 – Expand the Existing Campus with both Adult and Pediatric Inpatient Facility Expansion as Phase I

Alternative 5 – Expand the Existing Campus with Construction of both Adult and Pediatric Inpatient Services as Phase II

Alternative 6 – Focus the Phase II Project on New Construction and Modernization of Inpatient Facilities for Adult Intensive Care, Neonatal Intensive Care, and Obstetric Services

The following discussion describes the rationale for rejecting or accepting each of the alternatives.

Alternative 1 – Develop a New Hospital on the Advocate Southwest Medical Campus in Tinley Park/Orland Park

In December 2003, Advocate Health and Hospital Corporation filed a certificate of need application with the Illinois Health Facilities Planning Board (IHFPB), the predecessor of the Illinois Health Facilities and Services Review Board (IHFSRB), to obtain a permit to build a 144-bed new hospital on the Advocate Southwest Campus at the boundary of Tinley Park and Orland Park. The new hospital was to have 108 medical surgical beds, 16 intensive care beds, and 16 obstetric beds. All pediatric care was to remain at Advocate Hope Children's Hospital. The proposed new facility was designed as a community hospital to complement rather than compete with the high acuity services at the Medical Center. The ancillary services in the proposed hospital were sized based on the assumption that existing Advocate outpatient services already on the Southwest Campus would reduce the scope of the ancillary services that would be needed as part of the new hospital. Estimated total project cost for the proposed new hospital was \$226.26 million (in 2005 dollars).

In the State Agency Report (SAR), Advocate's Southwest Hospital proposal received negative findings on need because there were other similar community hospitals with the same services within the planning area and within 45 minutes travel time of the proposed new hospital, and many of these facilities were not at the target occupancy levels. Further, the SAR found that there were no limitations on government funded or charity patients or no restrictive admission policies at existing providers, there were no medical problems indicated, there were no

indications of high infant mortality, and there was no indication that this proposed service area was designated as a Health Manpower Shortage Area.

The IHFPB suggested that the Medical Center consider other alternatives, particularly, development on its existing campus. By developing on the campus, the Medical Center would reuse the existing capital investment on the site. Although this alternative appeared to have many merits, the IHFPB's decision removed it from further consideration.

The Medical Center accepted the IHFPB's direction and abandoned the plan to build a new hospital.

#### Alternative 2 – Utilize Other Health Care Resources or Joint Ventures with Others

Advocate Christ Medical Center and Advocate Hope Children's Hospital are major referral centers providing trauma, cardiovascular, neuroscience, cancer, orthopedic, women's, children's and surgical services, to name a few.

Because of these advanced clinical services and reputation for high quality and compassionate care, more and more physicians and hospitals referred complex cases to the Medical Center. More than 60 community hospitals and academic medical centers referred patients to the Medical Center between February 2011 and February 2012. The Medical Center seldom refers patients to other facilities for the reasons identified below.

The Medical Center rejected using other tertiary/quaternary hospitals in Chicago as well as using local community hospitals for the following reasons:

- The Medical Center rejected using other tertiary/quaternary hospitals in Chicago because of the long travel time for patients from the south and southwest suburbs. More importantly, referral to these centers disrupts continuity of care and introduces risk of poorly handled transitions.
- The Medical Center rejected using community hospitals because these nearby health care resources have neither the staff nor the technology to care for the Medical Center's acutely ill patients. Further referring patients to community hospitals separates them from their primary care physicians, family and community support network.
- The Medical Center and Hope support large graduate medical education programs. These students and the continuation of these programs depend on having patients with certain disease status present to meet the educational requirements of their respective specialties. If current and future patients were to be transferred to other facilities, the

extensive and needed educational programs at the Medical Center would be compromised.

- ACMC and AHCH support research in almost every clinical discipline. The Medical Center's patients would not have access to these clinical trials if they were referred to other facilities.

The Medical Center also rejected joint venturing with hospitals and other providers in Chicago; joint venturing was rejected for the following reason:

- The proposed modernized inpatient facilities will be operated as part of the premises licensed under The Illinois Hospital Licensing Act. Consequently, a joint venture would necessarily involve a joint venture of the entire hospital; this is not a feasible option.

Instead of using other health care resources or joint venturing with other organizations, the Medical Center is focused on a wide range of collaborative arrangements to enhance access, improve standards of care, and reduce cost.

A sampling of collaborative arrangements follows:

- The Cancer Institute at Advocate Christ Medical Center (ACMC, Medical Center) has emerged as a destination center for the treatment of patients with complex cancers. That role has been enhanced by the Medical Center's affiliation in 2011 with MD Anderson Physicians Network® – a subsidiary of The University of Texas MD Anderson Cancer Center, one of the world's most respected leaders in cancer care. ACMC is the only hospital in Illinois to establish an exclusive affiliation with MD Anderson Physicians Network®. Affiliation with MD Anderson Physicians Network® is provided selectively to hospitals and their medical staffs following a rigorous and extensive evaluation process, focused on evidence-based treatment guidelines and quality management.

ACMC has demonstrated a strong commitment to multidisciplinary evaluation and treatment of patients with cancer. That is why ACMC's search for an appropriate partner to help it enhance standards and quality of cancer care, and control costs led the Medical Center to its best possible choice – MD Anderson Physicians Network®. The MD Anderson Cancer Center has been ranked No. 1 in cancer care in the nation by *U.S. News & World Report's* "America's Best Hospitals" for eight of the past 10 years, including 2011. The relationship with MD Anderson Physicians Network® will allow patients in ACMC's regional service area to receive exceptional cancer care closer to home.

The campus' affiliation with MD Anderson Physicians Network® will enhance and offer new hope for cancer care in the community. To date, more than 30 ACMC physicians, representing a variety of medical and surgical specialties, including hematology oncology, radiation oncology, thoracic surgery, general surgery, surgical oncology, gynecologic oncology and urology, have met the criteria for the MD Anderson Physicians Network®.

- Collaborative arrangements are in place with other Advocate facilities and especially, as part of the Advocate South Market plan, with Advocate South Suburban Hospital for pediatric services and Advocate Trinity Hospital for stroke care.
- Collaborative arrangements with educational facilities. ACMC has educational arrangements with 13 colleges and universities for the training of physicians, nurses, and other health professionals.
- In early 2012, Advocate Christ Medical Center formed a collaborative arrangement with Carson Scholars Fund to provide funding for a reading room at Charles Gates Dawes Elementary School as well as grant money for more scholarships for local students through the Carson Scholar's Fund. In this special Reading Room, the students will have a comfortable area that hopefully will generate a newly found excitement for reading.
- Collaborative arrangements have been formed with community agencies; these include, for example, collaboration with Ronald McDonald House Charities® to operate the Ronald McDonald Care Mobile; with schools and school parish nurses; with anti-violence organizations; and with churches to support adoption programs, child and family services and aid to single mothers; as well as with community food pantries.
- The Medical Center has collaborative arrangements with the local community hospitals. The Medical Center provides a Level I Trauma Center and a Level IIIC Perinatal Center (the only centers in the south and southwest suburbs) that accepts acutely ill patients from the local hospitals and many others. In addition, the Medical Center provides neonatology coverage at local community hospitals.
- Collaborative arrangements with performance improvement organizations focused on cardiology, cardiovascular surgery, stroke, heart surgery, transplant, cancer including breast health; neonatal outcomes, and cystic fibrosis, to name a few. These collaborative arrangements support the Medical Center's ongoing outcomes and safety improvement initiatives.

There is no capital cost associated with these collaborative arrangements.

In summary, the Medical Center has rejected both the options of referring patients to other facilities and that of joint venturing. Other community hospitals do not have the same higher-end capabilities as the Medical Center and other tertiary/quaternary centers would require very sick patients to travel into downtown Chicago for care. Joint ventures for fundamental hospital services are not feasible. Instead, the Medical Center is focusing on cultivating and establishing a wide range of affiliations and collaborative arrangements.

### Alternative 3 – Expand the Existing Campus with a New Patient Tower for Inpatient and Outpatient Services

After the plans for a new hospital on the Advocate Southwest Medical Campus were abandoned and the options of referring patients to other facilities or developing joint ventures were also rejected, the Medical Center began to plan for expansion of the existing Oak Lawn campus. Initially, the Medical Center planned to develop an administrative building on the campus and use the vacated administrative space in the hospital to expand existing clinical services. This plan was immediately rejected because such a limited construction project would have been insufficient to address the far-reaching space needs on the campus. There was no doubt that either one or a series of major construction projects was the only feasible solution to the space shortage at the Medical Center.

In 2007, the Medical Center restarted a comprehensive planning process with the purpose of identifying the best response to the growing need for beds and services on the campus. The outcome of this process was *Vision 2017*, the Medical Center's strategic vision which centers on delivering outstanding clinical care in the most patient-centric settings. In action terms, the realization of this vision includes the growth of the Institutes (Heart & Vascular, Cancer, Bone and Joint, and Neurosciences) as well as the Level I Trauma Center and Women's Services; in turn, these required ongoing physician recruitment and expansion of facilities for adult intensive care, obstetrics, neonatal intensive care, and ambulatory services.

In the process of further defining how this vision would be implemented, the Medical Center initiated an architectural planning process to advance planning for the campus.

It was at that time that the nation's economy began to falter, and Advocate Health and Hospitals Corporation placed a capital freeze on all facility development across the system. The development of new construction on the Oak Lawn campus was indefinitely delayed.

With hints of an economic recovery in mid-2010, the Medical Center was given the green light to restart capital planning for the campus. To ensure that earlier plans were still appropriate, the

Medical Center engaged Sg2, a nationally recognized consulting group known for their expertise as clinical and health care strategic planners, to assess the current state of the campus. The result of this consulting engagement was reported to Medical Center administration in April of 2010. In the third quarter of 2010, the Medical Center commissioned Kurt Salmon and Associates (KSA), healthcare facility planning experts, to develop a Master Facility Plan for the campus.

Both firms agreed that there was an urgent need to increase both inpatient and outpatient capacity at the Medical Center. Instead of a single facility with co-mingled patients as was then being planned, they recommended that there should be two projects – one focused on the needs of outpatients and another focused on the needs of inpatients. The construction cost for Alternative 3 was \$143.8 million; project cost was \$202.0 million.

Based on the recommendations of both KSA and Sg2, the Medical Center rejected its plans for a single facility for both inpatients and outpatients.

#### Alternative 4 – Expand the Existing Campus with both Adult and Pediatric Inpatient Facility Expansion as Phase I

Because of the high occupancy of the inpatient beds, it appeared that a construction of inpatient adult and pediatric facilities should be the first phase of campus redevelopment. This alternative was rejected for the following reasons:

- KSA and Sg2 agreed that the best phasing of campus redevelopment first should include additional ambulatory/outpatient capacity and the additional inpatient capacity.
- The experts agreed that adding more beds to the already stressed facility before additional ancillary and clinic space was available would further exacerbate, rather than resolve, the severe operational and space issues related to the existing high inpatient volume, inadequate capacity, and co-mingling of patients.
- Since inpatient services could not be expanded until the needed ancillary and other outpatient service could be available, the Medical Center's leadership re-sequenced the original planning and moved forward with the development of an Ambulatory Pavilion (now called the Outpatient Pavilion) as Phase I. This project was approved by the Health Facilities and Services Review Board on August 16, 2011 as Permit #11-019. The ground breaking for the Outpatient Pavilion occurred in October 2011 and construction is moving forward on schedule and on budget.

The estimated construction cost for Alternative 4 was \$239.3 million; total project cost of adult and pediatric bed expansion was \$398.8 million.

### Alternative 5 – Expand the Existing Campus with Construction of both Adult and Pediatric Inpatient Services as Phase II

With the Outpatient Pavilion approved and under construction with a planned completion in December 2014, the Medical Center's leadership turned their attention to the next phase of campus redevelopment or the construction and expansion of the inpatient facilities – and especially adult and pediatric intensive care beds; general adult and pediatric medical surgical beds; neonatal intensive care beds; obstetric beds, labor/delivery/recovery rooms, surgical delivery rooms, Phase I recovery rooms, OB triage, and morgue. Of course, these services would also require related non clinical spaces. The initial concept was to concurrently develop an 11-level patient tower adjacent to the Medical Center's existing facility and to add as many as four levels to Advocate Hope Children's Hospital. However, soon after this planning was underway, APMC leadership determined rather than one project, two inpatient projects were warranted. The concurrent redevelopment and modernization of adult and pediatric inpatient and related services was rejected for the following reason:

- The planning for the pediatric inpatient services required more time than originally anticipated; to await the final results of the pediatric planning would have delayed the urgently needed development of the adult and neonatal intensive care, as well as obstetric services.

The estimated construction cost for Alternative 5 was \$239.3 million; total project cost of building both an adult inpatient tower and adding four levels to Hope was \$398.8 million.

### Alternative 6 – Focus Phase II of the Campus Redevelopment Process on the New Construction and Modernization of Inpatient Facilities for Adult Intensive Care, Neonatal Intensive Care, and Obstetric Services

Having concluded that phased new construction and modernization projects for adult and pediatric services would be the most prudent use of resources and result in the most timely completion of the services most in need of immediate expansion, the Medical Center's leadership moved forward with planning for adult intensive care and medical surgical beds, neonatal intensive care beds, and obstetric services. During the initial facility planning, the project was reduced by two levels – one level of intensive care beds and another of medical surgical beds.

The resulting plan is the alternative of choice for the following reasons:

- Alternative 6 provides for the next phase of the logical sequential development of the campus adding inpatient capacity and by freeing space for services that need to be

expanded and remodeled. Expansion and remodeling will occur in a future backfill phase.

- Alternative 6, the alternative selected, does not include any additional medical surgical beds. APMC's leadership believe that the future demand will not require additional beds due to new technology, new care models, and the reduction of average length of stay and of unnecessary admissions and readmissions. Therefore, additional medical surgical beds were eliminated from the project.
- This alternative does not include pediatric services. Because of a longer expected planning horizon for Advocate Hope Children's Hospital, expansion, the modernization of the inpatient project was bifurcated into Phase II and Phase III with filing of a certificate of need for Phase III pediatric services expected to be filed sometime after the approval of the current application.
- Bifurcating the adult and pediatric services will decrease construction-related traffic on the site and in the neighborhood. The Medical Center is located in an urban neighborhood. Although the Medical Center has been able to acquire property adjacent to the original campus for parking, the area will remain constrained. By moving forward with the adult project first, to be followed by pediatric and backfill projects, there will be less construction congestion in the neighborhood at any one time. This phasing addresses concerns of some of the neighboring communities.
- The Advocate system includes 13 hospitals as well as numerous outpatient centers. Each of these facilities has capital needs. By phasing the Medical Center's project, immediate capital demands at APMC will be reduced, thereby allowing other high priority projects across the System to move forward.
- The construction cost of this alternative is expected to be \$223,329,538. The total project cost is expected to be \$345,756,980.

For these reasons, Alternative 6 is the alternative of choice.

Summary of Alternatives			
Description	Construction Cost	Project Cost	Rationale
Alternative 1 – Develop a New Hospital on the Advocate Southwest Medical Campus in Tinley Park/Orland Park.	\$146.8 million	\$202.0 million (2003 dollars)	This alternative was rejected because the Illinois Health Facilities Planning Board declined the certificate of need application and suggested that ACMC/AHCH redevelop on the Oak Lawn campus.
Alternative 2 – Utilize Other Health Care Resources or Joint Venture with Others.	NA	NA	<p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>• Other local health care providers do not have the resources to support the needs of the acutely ill/severely injured patients cared for at ACMC.</li> <li>• Other regional providers with similar resources require patients to travel to Chicago. This is very difficult for acutely ill patients because it adds risk and precious time.</li> <li>• Utilizing other health care resources would compromise the Medical Center’s medical education and research initiatives.</li> <li>• A joint venture would have severe limitations because the new and modernized space will be operated under The Illinois Hospital Licensure Act. Instead of entering into joint ventures, the Medical Center is focused on the development of a wide range of collaborative arrangements to enhance access and standard of care while reducing cost.</li> </ul>

Summary of Alternatives			
Description	Construction Cost	Project Cost	Rationale
Alternative 3 – Expand the Existing Campus with a Single New Patient Tower for Inpatient and Outpatient Services	\$143.8 million	\$202.0 millions	This alternative was rejected because: <ul style="list-style-type: none"> <li>• A single new facility would continue to co-mingle inpatients and outpatients. With the ever-increasing volume of outpatients, this delivery model would be inefficient.</li> </ul>
Alternative 4 – Expand the Existing Campus with both Adult and Pediatric Inpatient Facility Expansion as Phase I	\$239.3 million	\$398.8 million	This alternative was rejected because: <ul style="list-style-type: none"> <li>• Adding more beds to the already stressed facility before additional ancillary and ambulatory space were available would further exacerbate, rather than resolve, the severe operational and space issues related to high inpatient volume.</li> <li>• Consequently, the Medical Center filed an application to develop an Outpatient Pavilion on the campus as Phase I. The application, Project # 11-019, was approved at the August 2011 meeting by the Health Facilities and Services Review Board. The Pavilion is currently under construction, on schedule and on budget.</li> </ul>
Alternative 5 – Expand the Existing Campus with Construction of both Adult and Pediatric Inpatient Services as Phase II	\$239.3 million	\$398.8 million	This alternative was rejected because: <ul style="list-style-type: none"> <li>• Planning for the pediatric inpatient services required more time than originally anticipated; it would not be prudent to delay the urgently needed adult and neonatal intensive care as well as obstetric services until the pediatric plan was complete.</li> </ul>

Summary of Alternatives			
Description	Construction Cost	Project Cost	Rationale
Alternative 6 – Focus the Phase II Project on New Construction and Modernization of Inpatient Facilities for Adult Intensive Care, Neonatal Intensive Care, and Obstetric Services	\$223.3 million	\$345.8 million	<p>Alternative 6 is alternative of choice because:</p> <ul style="list-style-type: none"> <li>• This alternative provides for next phase of the logical sequential development of the campus and addresses the most pressing needs on the Medical Center’s campus today.</li> <li>• This alternative does not include any pediatric beds or services.</li> <li>• This alternative does not include additional medical surgical beds, but rather meets the pressing need for adult and neonatal intensive care beds as well as obstetric services.</li> <li>• This alternative reduces construction traffic on site and in the neighboring communities.</li> </ul>

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

Advocate Health and Hospitals Corporation (AHHC) is committed to quality improvement and engages in a wide range of initiatives to ensure a high standard of quality at each of its provider sites.

This commitment is evident at Advocate Christ Medical Center (ACMC, Medical Center) and Advocate Hope Children's Hospital (AHCH, Hope). ACMC has been nationally recognized for quality outcomes. It has been named a top performing hospital (top 5 percent in the country) by the MIDAS+™ Platinum Award Program and is recognized by the American Heart Association and American Stroke Association for sustained "gold award" performance in treating coronary artery disease, heart failure, and stroke. Ninety-four of the Medical Center's physicians are Top Doctors in the January 2012 issue of Chicago Magazine. Hope is also nationally recognized for its high standards of care. Recently, AHCH received the coveted Fire Starter Award from the Quint Studer Group. This award is given to organizations that demonstrate outcomes excellence. In addition, for the second year in a row, AHCH has been listed among the nation's 50 top pediatric hospitals for cardiology and heart surgery (#34) and, for the first time, rated a national leader in neonatology (#25) in U.S. News & World Report's Best Children's Hospitals 2012-13 rankings.

On April 18, 2012, Thomson Reuters announced the Top 100 Hospitals® in the United States. Advocate Christ Medical Center was named in the Major Teaching Hospitals category along with Oshner Medical Center (New Orleans), Beth Israel Deaconess Medical Center (Boston), St. Joseph Mercy Medical Center (Ann Arbor), Geisinger Medical Center (Danville), Vanderbilt University Medical Center (Nashville), Baylor University Medical Center (Dallas), Scott and White Hospital (Temple), and The Methodist Hospital (Houston).

The Thomson Reuters Top 100 Hospitals® study evaluates performance in 10 areas – mortality; medical complications; patient safety; average patient stay; expenses; profitability; patient satisfaction; adherence to clinical standards of care; post-discharge mortality; and readmission rates for acute myocardial infarction (heart attack), heart failure and pneumonia.

Most recently, in July 2012 the Medical Center was recognized as being among the top hospitals in the nation for cardiology and heart surgery, and for geriatric medicine, according to the "Best Hospitals 2012-13" rankings released by U.S. News and World Report. Fewer than 150 of the

estimated 5,000 hospitals in the country achieved national ranking in at least one of 16 clinical specialties measured by the publication.

The medical center also was rated fourth overall among hospitals in the Chicago metropolitan area and the entire state of Illinois and cited as a “high performer” in 10 other clinical areas: cancer; diabetes and endocrinology; treatment of ear, nose and throat disorders; gastroenterology; gynecology; nephrology; neurology and neurosurgery; orthopedics; pulmonology; and urology.

Several quality outcome initiatives are described below – one is an Advocate Health and Hospital’s systemwide initiative and the others are Advocate Christ Medical Center initiatives to improve quality of care.

#### New Accountable Health Care Model

Advocate Health Care is taking aggressive steps to curb the use of unnecessary services and prevent patients from being inappropriately re-hospitalized in anticipation of the implementation of state and federal health care reform initiatives. An example of Advocate’s leadership in process improvement and quality outcomes relates to an innovative accountable health care model developed by the Advocate system and in place at both ACMC and AHCH. Advocate Health Partners d/b/a Advocate Physician Partners is the care management contracting venture between Advocate Health Care and selected physicians on the medical staffs of the Advocate hospitals, including Advocate Christ Medical Center and Advocate Hope Children’s Hospital.

Advocate Physician Partners is focused on improving health care quality and outcomes, while reducing overall cost of care – both in the inpatient and outpatient settings. This group’s award winning, clinically integrated approach to patient care utilizes the best practices in evidence-based medicine, advanced technology, and quality improvement techniques. Over the past 10 years, through its clinical integration program, Advocate has learned that coordinated health care translates to healthier patients. Based on their understanding, Advocate has been working to transform the way health care is delivered. In October 2010, Advocate announced that it was launching a benchmark care delivery system, AdvocateCare, which will further drive collaboration among physicians, hospitals, payors, and employers. The new approach is consistent with the Accountable Care Organization (ACO) model, sets higher clinical expectations, and puts reimbursement at risk for poor outcomes.

Accountable Care Organizations practice team-based care, an approach in which physicians, nurses, and other health care specialists work together to provide coordinated patient care. These

professionals come together and agree on ways to improve care outcomes. A strong emphasis is placed on proactive measures.

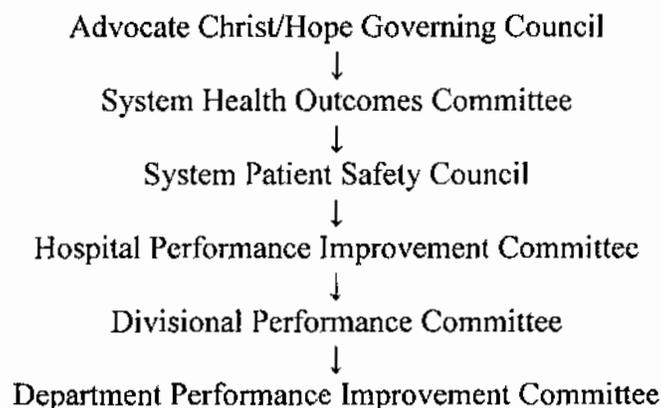
The current initiative is a partnership with Blue Cross Blue Shield of Illinois. Under this arrangement, Advocate, including ACMC and AHCH, intends to reduce overall utilization by providing the most appropriate care in the most appropriate setting. It is expected that many of today's short stay general medical and surgical patients will receive their care in the ambulatory setting at a lower cost rather than if they were admitted to an inpatient bed. However, acutely ill patients will still require intensive care services and, unlike general medical surgical utilization, high acuity services including intensive care will continue to grow because of the aging of the population as well as new technology and techniques.

It is expected that this will result in more ambulatory care, rather than general inpatient care, and that overall healthcare expenditures will decline. The goal of the program, called AdvocateCare, is to provide each patient with the right care at the right time in the most cost effective setting. The contract became effective January 1, 2011.

In September 2010, Washington administrative staff met with Advocate leaders to learn more about Advocate's clinical integration and how it can be used to craft ACO regulations and benefit millions of Medicare recipients nationwide. Earlier this year, Advocate testified before the Senate Finance Committee on its work in accountable care.

#### Established Performance Improvement Process

At ACMC and AHCH, as at all other Advocate hospitals, there is a comprehensive structure in place to continually enhance patient safety and improve quality of care. Each hospital uses this structure to implement its continually updated plan to improve performance, patient safety, and key process measures. The reporting structure is as follows:



Through this process, priorities are established in the following areas:

- Performance Improvement and Patient Safety
- Regulatory
- Magnet Indicators
- Root/Apparent Cause Analysis (RCA)
- Failure Mode Effect Analysis (FMEA)
- Key Result Area for the Organization, and
- Department Specific Indicators.

The metrics used in the performance improvement process include:

- Establish organizational definitions
  - Measures of success
  - Numerators/denominators used to measure success
  - Data sources
- Establish guidelines
- Research best practice, and
- Set target goals and monitor progress.

The Health Outcomes Committee's role is to:

- Monitor the effectiveness of performance improvement and patient safety initiatives
- Review reports on the status of performance improvement and patient safety measures conducted throughout the Medical Center, and evaluate throughout the year
- Supervise broader regulatory and accreditation compliance issues, monitoring performance against standards, and
- Review lessons learned from sentinel event RCA and FMEA teams.

The Hospital Performance Improvement Committee's role is to:

- Provide overall guidance for the quality structure for both clinical and non-clinical departments.
- Review/approve division/department performance improvement plans

- Monitor progress of the RCA/Continuous Quality Improvement multidivisional teams, and
- Facilitate continuous compliance with regulatory requirements.

The Divisional Performance Improvement Committee's role is to:

- Review all departmental performance improvement measures/plans quarterly
- Share action planning and best practice with the team, and
- Ensure compliance with regulatory requirements specific to the division.

The role of Department Performance is to:

- Monitor progress with performance improvement measures monthly
- Report results and action plans on the divisional plan, and
- Report performance improvement results at the Unit Council meetings.

#### Examples of ACMC Initiatives to Improve Outcomes

Information more specific to Advocate Christ Medical Center (ACMC, Medical Center) are described below.

#### Improved Intensive Care Outcomes

The following process changes in the intensive care units improved outcomes:

- A CLABSI (Central Line Acquired Blood Stream Infection) initiative resulted in a decrease of central line days and central line infections. According to the CDC, an estimated 41,000 central line associated blood stream infections occur in U.S. hospitals each year. These are usually serious infections typically causing prolonged hospital stays and increased cost as well as higher risk of mortality.
- Introduction of Spinal Cord Protocols resulted in a decrease in pressure ulcers in the spinal cord injury population with the use of order sets and protocols
- Pressure Ulcer Prevention Program introduced a process whereby sacral dressings are used as a preventative mechanism for pressure ulcers in identified high risk patients
- Several Mobility Research Studies involving early mobilization in the ICUs, including vented patients, have led to decreased average length of stay and improved outcomes for intensive care patients

- The ICU Mortality Committee developed processes and protocols including multidisciplinary rounds, vent weaning, glucose control monitors have led to a significantly lower intensive care unit mortality rating, and
- ICU Sepsis Mortality involved the use of sepsis order sets with eICU collaboration; this has led to significantly lower than expected research sepsis mortality.

#### Improved Documentation of Medical Indication, as well as, Reduction of Preterm Inductions and C-sections

Experts including those from the American College of Obstetricians and Gynecologists, the Joint Commission on Perinatal Measures, the US Department of Health and Human Resources, March of Dimes, the Leapfrog Group, and the American Hospital Association's Maternal and Child Health Section encourage efforts to ensure that inductions and C-section births are not performed before 39 weeks of gestation unless there is a medical indication.

According to the Center for Medicare and Medicaid Innovation, "Infants born prematurely are a growing public health problem with significant consequences for families and an estimated cost of at least \$26 billion each year. Each year, this is more than half a million infants in the United States, a number that has grown by 36 percent over the last 20 years. Infants born preterm (before 39 weeks) are at a greater risk for mortality and many endure a lifetime of developmental and health problems. In addition to enormous medical needs, these children often require early intervention services, special education, and have conditions that impact their productivity as adults." (<http://innovations.cms.gov/initiatives/strong-start/index.html>)

Advocate Christ Medical Center continues to reduce elective C-section and induced deliveries through the performance improvement process.

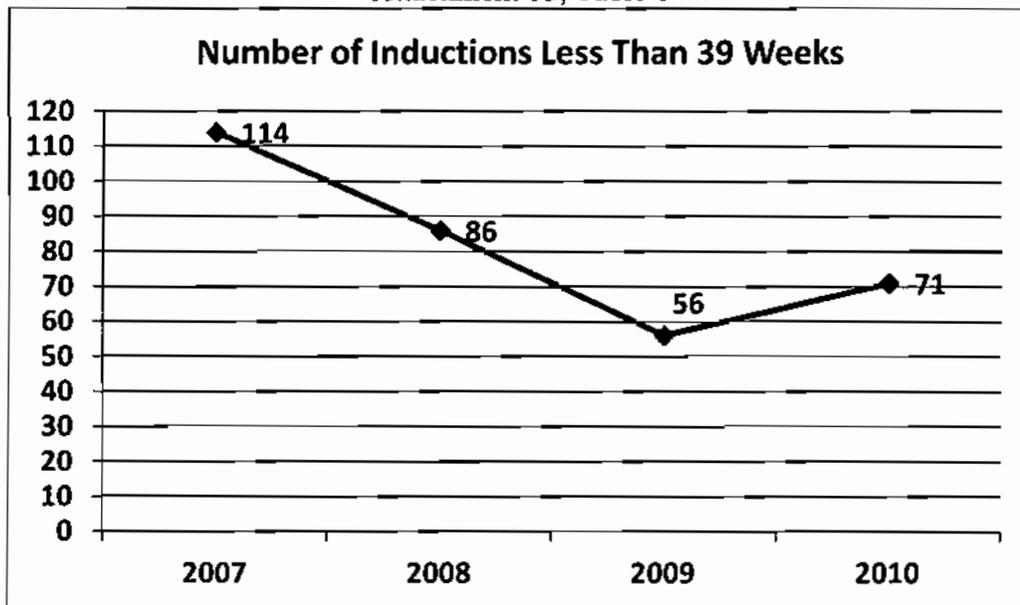
This performance improvement initiative at the Medical Center requires that all scheduled inductions less than 39 weeks must have a medical indication in the medical record.

To achieve this goal, the Medical Center undertook the following process to decrease elective deliveries less than 39 weeks without a medical indication.

- In 2008, the department began a prospective and retrospective review of scheduled inductions less than 39 weeks performed in 2007.
- Between 2007 and 2009, the records showed a steady decline in the number of scheduled inductions less than 39 weeks. In 2010, however, there was an increase in inductions less

than 39 weeks due to increasing high risk maternal transports and fetal and maternal acuity. (See Attachment 13, Table 1)

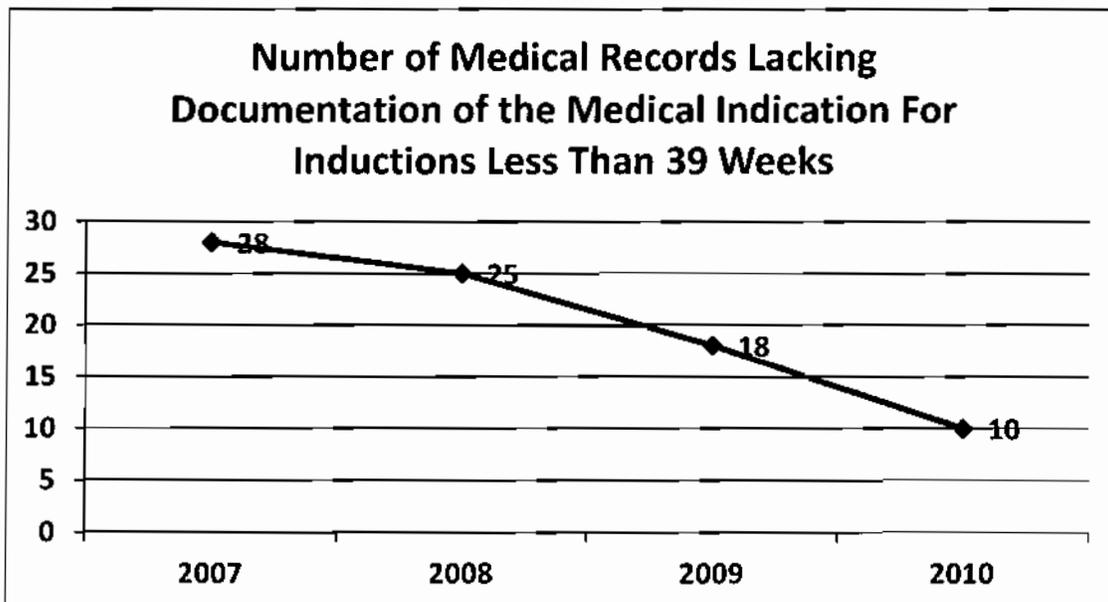
Number of Inductions Less than 39 Weeks  
Attachment 13, Table 1



Source: ACMC Records

- When reviewing medical records, the department found that beginning in 2007, there had been a steady decline in the number of medical records lacking documentation of a medical indication for the induction. Any medical record lacking documentation of medical indication is referred to and reviewed by the OB Performance Improvement Committee. (See Attachment 13, Table 2)

Decline in Medical Records Lacking Documentation  
Attachment 13, Table 2

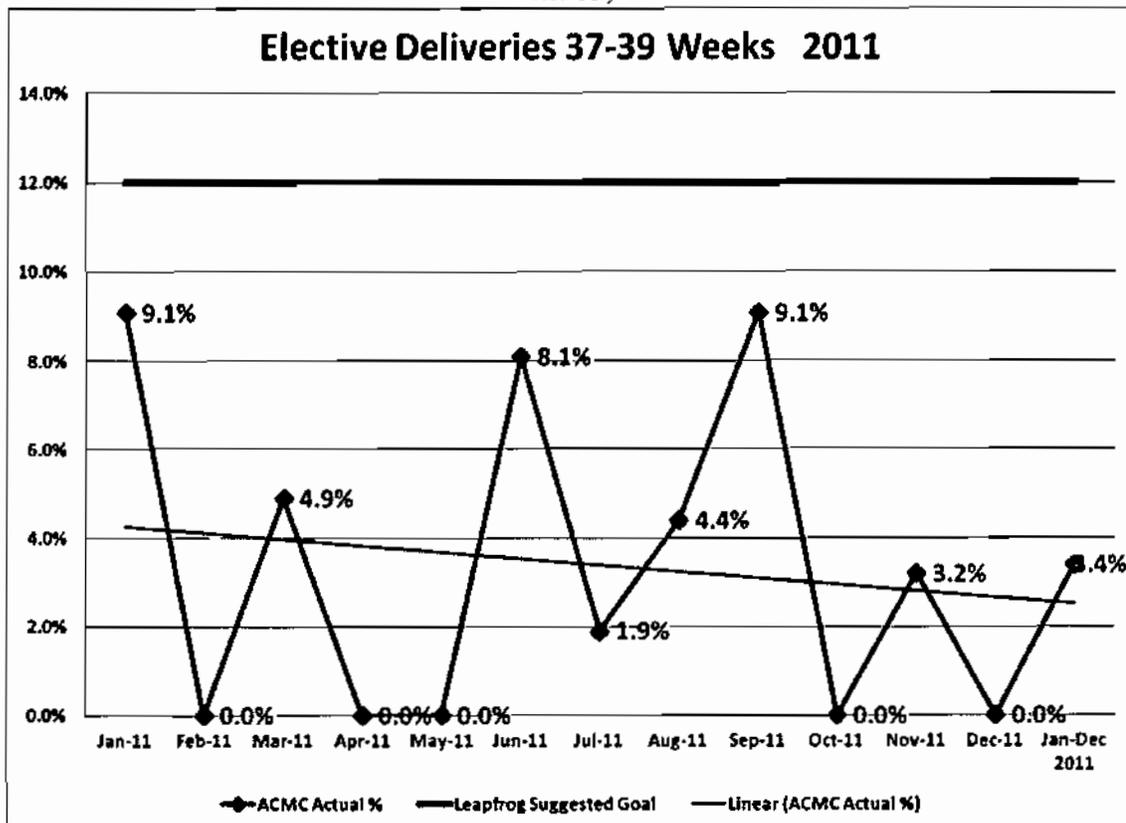


Source: ACMC Records

- In 2011, the performance improvement initiative changed to reflect the Leapfrog definitions. In these definitions the denominator includes all eligible cases where the mother delivered a newborn with less than 37 weeks of gestation and greater than 39 weeks of gestation during the reporting period; the numerator was the number of eligible cases included in the denominator that delivered their newborn electively. To further encourage compliance with the goal of decreasing elective deliveries less than 39 weeks, in 2011 a new form was implemented that was required from each scheduling physician for any Cesarean Section less than 39 weeks. This form requires the weeks of gestation at the time of surgery, the method that was used to determine the gestation, and the actual medical indication.

During 2011, the Leapfrog suggested goal was no more than 12.0 percent elective preterm deliveries. The Obstetric Department at ACMC achieved a linear average of 3.4 percent elective deliveries – or substantially better than the Leapfrog goal. (See Attachment 13, Table 3)

Elective Deliveries 37 – 39 Weeks 2011  
Attachment 13, Table 3



Source: ACMC Records

## Summary

Together these examples of Advocate's and Advocate Christ Medical Center's performance improvement, quality outcomes and safety initiatives demonstrate a very serious commitment to delivering outstanding patient care.

**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?
See Attachment 14, Exhibit 1				

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Size of Project**

The amount of total physical space programmed for the proposed project is necessary and conservative compared to the State Standards. The only apparent exception to the State Standard is Phase I recovery rooms; these exceed the State Standard. The surgical delivery rooms and the Phase I recovery rooms are co-located and share support space. When considered together (as shown in Attachment 14, Exhibit 1), the purposed square footage of the two departments is 3,877 GSF which is less than the allowable square footage.

The following narrative describes the purposed square footage of each department or area and compares it to the State Standard, where applicable.

Size of the Project						
Department/Service	Number of Key Rooms	Proposed BGSF/GSF	Proposed BGSF/GSF/Room	State Standard / Allowable	Difference	Met Standard?
OB Triage	12	5,409 GSF	451 GSF	NA	NA	NA
Labor/Delivery/Recovery	15	13,853 GSF	923 GSF	1,200-1,600 GSF/LDR Room	-277 to -677	Yes
Surgical Delivery/C-Section Rooms	4	3,525 GSF	881 GSF	2,075 GSF/OR	-1194	Yes
Phase I Recovery	4	1,618 GSF	405 GSF	180 GSF/Recovery Station	+225	No
Combined Surgical Delivery (C-Section) Rooms and Phase I Recovery	8	5,143 Total GSF		9,020 Total GSF	-3,877	Yes

<sup>1</sup> The surgical delivery rooms and the Phase I recovery rooms are co-located and share support spaces. When considered together, the proposed square footage of the two departments is less than the allowable square footage.

Allowable Square Footage

Number of surgical delivery rooms x State Standard square footage = allowable square footage

4 surgical delivery rooms x 2,075 allowable GSF per room = 8,300 allowable GSF

Number of Phase I recovery rooms x State Standard square footage = allowable square footage

4 Phase I recovery rooms x 180 allowable GSF per rooms = 720 allowable GSF

Proposed Square Footage

8,300 allowable surgical delivery GSF + 720 allowable Phase I recovery room GSF = 9,020 total combined allowable GSF

5,143 proposed GSF < 9,020 allowable GSF.

**Size of the Project**

Department/Service	Number of Key Rooms	Proposed BGSF/GSF	Proposed BGSF/GSF/Room	State Standard / Allowable	Difference	Met Standard?
OB Beds	56	36,506 GSF	652 GSF	500-660 GSF/Bed	+152 to -8	Yes
Newborn Nursery	24	1,799 GSF	75.0 GSF	106 GSF/OB Bed	-31	Yes
Combined Obstetric Beds and Newborn Bassinets	56	38,305 GSF		33,936 to 42,896 GSF / OB Bed	+14,369 to -4,591	Yes
Neonatal Intensive Care Beds	64	21,657 GSF	338 GSF	443-560 GSF/Bed or Bassinet	-105 to -222	Yes
Total Project	189	98,308 GSF	520 GSF	600-685 GSF/Bed	-80 to -165	Yes
Adult Intensive Care Beds	108	66,698 GSF	618 GSF	600-685 GSF/Bed	+18 to -67	Yes
Medical Surgical Beds	378	93,840 GSF	248 GSF	500-600 GSF/Bed	-252 to -352	Yes
Morgue	1	2,597 GSF	NA	NA	NA	Yes

<sup>2</sup> The Medical Center's obstetric program features family-centered care and all obstetric rooms will have rooming in capability. Hence in order to best determine the square footage of the obstetric rooms and the newborn nursery, the Medical Center assessed the total square footage for both functions.

**Allowable Square Footage**

Number of obstetric rooms x State Standard square footage = allowable square footage

56 obstetric rooms x 500 to 660 allowable GSF per room =  
28,000 GSF to 36,960 allowable GSF

Number of obstetric beds x State Standard square footage =  
allowable square footage for the newborn nursery

56 rooms x 106 allowable GSF per obstetric bed = 5,936 allowable GSF for the newborn nursery

28,000 GSF to 36,960 allowable obstetric bed GSF + 5,936 allowable newborn nursery GSF = from 33,936 to 42,896 allowable GSF

**Proposed Square Footage**

36,506 proposed obstetric room GSF + 1,799 proposed newborn nursery GSF =  
38,305 proposed GSF

38,305 proposed GSF < from 33,936 to 42,896 allowable GSF

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

Clinical

OB Triage

The OB Triage area will be located in remodeled space vacated by the postpartum beds on the second floor of the existing tower. The area will house 12 key rooms; of the key rooms, 3 will be used primarily for pre-op prep by C-section patients. The other rooms will be used primarily by patients who present with unexplained symptoms or are otherwise concerned about the progress of their pregnancy; these patients may not have a primary care physician or cannot see their physician. The 12 rooms will have dual capability so at times of higher census they will be able to accommodate either triage patients or scheduled C-Section patients.

There is no State Standard for OB Triage square footage.

Attachment 14, Table 1  
OB Triage

Department/Area	Existing GSF	Proposed GSF	State Agency Guideline	Allowable GSF	Met Standard?
OB Triage	2,795	5,409	NA	NA	NA

The amount of physical space proposed for OB Triage is necessary and not excessive.

Labor/Delivery/Recovery

As part of the Patient Tower project, the 15-room Labor/Delivery/Recovery (LDR) area will be relocated to Level 2 in new construction. Of the 15 LDR rooms, 13 will be standard and 2 will be isolation rooms and be ADA compliant. Clinical support for the area will include a team station and quiet workroom, physician charting, 2 consultation/education rooms, medi-prep areas, a nourishment station, clean supply, soiled holding, equipment storage, and a crash cart. In addition, there will be a staff lounge and lockers, an anesthesia on-call room as well as clinical and administrative offices. There will also be a family lounge.

Attachment 14, Table 2  
Labor/Delivery/Recovery

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Labor/Delivery/Recovery	9,444	15	1,120 to 1,600 GSF per Bed	16,800 to 24,000 GSF	13,853	YES

The amount of physical space proposed for Labor/Delivery/Recovery is less than the State Standard.

C-Section Suite/Surgical Delivery Rooms

The C-Section suite/surgical delivery area currently has 3 rooms. As part of the Patient Tower project, a 4-room C-Section suite/surgical delivery area is purposed to be developed on Level 2 in new construction. In addition to the operating rooms, the area will have scrub areas, sub sterile areas, sterile supply, transport incubator alcoves, an anesthesia med room, equipment storage, a nurse's station, as well as physician lounge and lockers.

Attachment 14, Table 3  
C-Section Suite/Surgical Delivery Area

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Surgical Delivery Area	1,970 GSF	4	2,075 GSF per Room	8,300 GSF	3,525 GSF	YES

The amount of physical space proposed for the surgical delivery area is less than the State Standard.

Phase I Recovery

As part of the Patient Tower project, the Phase I Recovery area will be relocated and expanded from 3 to 4 stations in new construction.

The proposed 4 Phase I recovery stations will be located in 1,618 or 405 GSF per room. As outlined in the documentation for the square footage later in the response, these recovery rooms are used differently than the general surgical recovery rooms. For example, the surgical delivery room Phase I Recovery rooms need space to support both the recovering mother and her

newborn infant, with associated additional staff and visitors. The Phase I recovery space will include 4 private recovery rooms, a nurses station, and a patient toilet.

Attachment 14, Table 4  
Phase I Recovery Area in the Delivery Suite

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Phase I Recovery Area	7,866 GSF	37	180 GSF per Station	6,660 GSF	8,884 GSF	NO

The amount of physical space proposed for all recovery rooms is more than the State Standard allows. However this space is necessary and not excessive.

See response 4. If the gross square footage exceeds BGSF/DGSF standards in Appendix B, justifies the discrepancies for further documentation of the need for the additional square footage.

#### Obstetric Beds

The proposed 56 obstetric beds will be located on Levels 2, 6 and 7 of the new Patient Tower. The 56 rooms can be used by any obstetric patient; however the 8 rooms on Level 2 will be primarily used by unstable antepartum patients since these rooms are in close proximity to the C-section delivery rooms, while the 36 rooms on Level 6 and the 12 rooms on Level 7 will be primarily used by stable antepartum patients, uncomplicated postpartum patients, and gynecology patients.

All rooms are sized to allow the mother to keep her baby in the room with her. There will be negative pressure isolation rooms and ADA compliant rooms. There will also be rooms to accommodate bariatric patients. Staff support on the unit will include a multipurpose workroom, consultation/conference rooms, a birth certificate office, staff lounge and lockers. There will also be a family waiting area.

Attachment 14, Table 5  
Obstetric Beds

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Obstetric Beds	18,410 GSF	56	500 to 600 GSF per Bed	28,000 to 36,960 GSF	36,506 GSF	YES

The amount of space proposed for the obstetric beds is less than the State Standard.

Normal Newborn Nursery

The obstetric care delivery model at the Medical Center encourages rooming in, or having the new baby in the room with the mother.

The Medical Center is proposing to provide 80 bassinets. These include 56 rooming-in bassinets as well as bassinets in two newborn nurseries – one on each level of primarily postpartum beds. Of these, there will be one nursery with 8 bassinets on Level 6 and another with 16 bassinets on Level 7. Only Level I babies will be cared for in these nurseries and rooming-in bassinets.

In addition to the main nursery there will be isolation rooms. The nurseries will also have exam/procedure rooms, an area for breastfeeding, equipment and other storage, clean supply, and nourishment.

Attachment 14, Table 6  
Newborn Nursery Bassinets

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Newborn Nursery Bassinets	1,275 GSF	Of the 80 total bassinets, only 24 will be in the nursery.	160 GSF per Obstetric Bed and LDRP	3,840 GSF	1,799 GSF	YES

The space for the newborn nurseries is less than the State Standard.

Neonatal Intensive Care Beds

The neonatal intensive care model at the Medical Center includes neonates as well as all Level 2+ babies on the unit. The enlarged, replacement neonatal unit will be on the second floor of the existing building with direct access between the obstetric services on Level 2 of the new tower and the neonatal intensive care unit. The new unit will have 64 beds.

The following cross walk shows the spaces in the existing building that will be used in the expansion of the current neonatal unit.

Attachment 14, Table 7  
Cross Walk of Existing Space at the Completion of the Patient Tower

Existing Space Allocation	New Space Allocation
Phase I Recovery – C-Section	Neonatal Intensive Care Beds
C-Section Suite	
LDR	
Neonatal Intensive Care Beds	
OB Postpartum – 2E	OB Triage

Source: APMC records.

The modernized neonatal space will be subdivided into 3 modules. There will be standard care spaces and negative isolation rooms. In addition there will be a procedure room, a respiratory therapy work room/blood gas lab/storage, a radiology viewing room, decentralized clinical support as well as shared support including a team station, clean and soiled utility, equipment storage, and a secured freezer room for breast milk. The area will have a resident workroom, staff lounge and lockers, a clinical conference room, on-call rooms and storage. Family support will include family gowning and lockers, family overnight rooms, a parent education room. In addition there will offices for the physicians as well as shared offices for social workers, dieticians, pharmacists, and nurse practitioners.

Attachment 14, Table 8  
Neonatal Intensive Care

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Neonatal Intensive Care Beds	6,848 GSF	64	434 to 568 GSF per Bed	27,776 GSF to 36,352 GSF	21,657 GSF	YES

The space for the neonatal intensive care beds is less than the State Standard.

Adult Intensive Care Beds

The Medical Center is a regional tertiary/quaternary referral center providing a wide range of very sophisticated medical and surgical services that require intensive care support. Today, the Medical Center has 4 adult and 2 pediatric intensive care units. Three of the existing adult units and the pediatric units will remain “as is.” The fourth adult unit will be vacated and replaced with a larger medical intensive critical care unit (MICCU) in the new Patient Tower. In addition to the new level of medical intensive critical care beds, there will be two other new 36-bed levels

that will also house intensive care beds. All of the new intensive care units will have negative and positive infection isolation rooms and rooms capable of supporting bariatric patients. Clinical support services will include nourishment, clean supply and soiled utility, medi-prep rooms, respiratory therapy storage, and a blood gas lab. Staff support will include team work stations, consultation/education and conference rooms, offices, physician on-call rooms, and staff lockers and lounge. In addition there will be family waiting and lounge.

Attachment 14, Table 9  
Intensive Care Beds

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Adult Intensive Care Beds	40,356 GSF	189 Beds	600 GSF to 685 GSF/ Bed	113,400 GSF to 129,465	98,308 GSF	YES

The amount of square footage proposed for the 189 intensive care beds is less than the allowable square footage.

$$98,308 \text{ proposed GSF} < 113,400 \text{ to } 129,465 \text{ allowable GSF}$$

The amount of square footage proposed for the 108 intensive care beds in the Patient Tower is also less than the allowable square footage.

$$66,698 \text{ proposed GSF for 108 intensive care beds in the Patient Tower} < \text{the } 64,800 \text{ to } 73,980 \text{ allowable GSF}$$

### Medical Surgical Beds

The proposed Patient Tower will be connected by passageways to the existing tower on all but Level 10. In the process of constructing these “connectors,” 17 medical surgical beds in the existing tower will be taken out of service. Ten of these beds will be redeveloped in existing medical surgical units and 7 will be placed on reserve status along with 2 other beds that are also on reserve status.

The existing 378 medical surgical beds are located in 96,090 GSF, or 254 GSF per bed. About one third of these rooms are double occupancy. At the conclusion of the Patient Tower construction project, the Medical Center will continue to have 378 beds.

Attachment 14, Table 10  
Medical Surgical Beds

Department/Area	Existing GSF	Proposed Key Rooms	State Agency Guideline	Allowable GSF	Proposed GSF	Met Standard?
Medical Surgical Beds	96,090 GSF	378 Beds	500 to 660 GSF per Bed	189,000 GSF to 240,480 GSF	96,090 GSF	YES

The space for the medical surgical beds is less than the State Standard.

As part of a separate modernization, approved by the HFSRB, the Medical Center will add 16 new medical surgical beds. The square footage for these beds has not been determined.

Morgue

The Medical Center is still using the morgue that was part of the original 191-bed hospital, constructed more than 50 years ago. Today the Medical Center has 678 beds and the size of the morgue has remained unchanged.

There is no current State Standard for morgue square footage.

According to the best practices in the design of health care facilities, the necessary square footage for a morgue ranges from 2.9 GSF per bed (an outdated HFPB guideline that has since been withdrawn) to 4.5 GSF per bed. Based on this range of square footages per bed, the Medical Center’s 678 beds can support from 1,966 GSF to 3,051 GSF of morgue space.

At the completion of the Patient Tower project, the Medical Center proposes to have 808 beds. This updated bed complement could support from 2,343 GSF to 3,636 GSF.

The new morgue will have a large cooler with capacity for 22 bodies and an organ harvesting room. The autopsy facilities will be larger and include an infectious control table. The design for the new morgue includes a family viewing area and needed storage space for slides, paraffin cassettes, and tissue samples as well as space to meet other storage needs.

Attachment 14, Table 11  
Morgue

Department/Area	Existing GSF	Proposed GSF	State Agency Guideline	Allowable GSF
Morgue	979 GSF	2,597 GSF	NA	NA

The amount of physical space proposed for the Morgue is necessary and not excessive.

## Non Clinical Departments/Areas – Proposed Patient Tower New Construction

In addition to the clinical square footage, there will also be non clinical square footage as part of the project. In reporting square footage, non clinical square footage has used the Health Facilities and Services Review Board definitions of Administration, Non Clinical Storage, Public Amenities or Building Components in the schematics. The following is a brief description of the non clinical space by floor in the new patient tower.

### All Levels

The proposed Patient Tower will have 8 occupied levels – Ground, 1, 2, 6, 7, 8, 9, and 10. There will also be a mechanical level, Level 3, as well as mechanical equipment on the roof (Level 11) and an elevator machine room (Penthouse) above.

There is neither a Level 4 nor a Level 5 in the building. This is a result of larger floor-to-floor heights on levels 2 and 3 to accommodate height requirements of the operating delivery rooms and mechanical equipment, as well as a desire to match floor numbers of the new tower to those of the existing campus.

A connector between the existing tower and the new patient tower will provide a direct connection between the two towers at Ground and Level 1 through Level 9. These are especially important at Level 2 to connect the elements of the obstetric service and the neonatal intensive care unit and on Level 9 to link the cardiac-related floors.

The building will have three elevator banks – one for patients and staff, the second for the public, and the third for material handling and back-of-house services. Each of the elevator banks will have an elevator lobby on each level. All levels of the building will be served by these three elevator banks. Only the patient/staff elevators have access (controlled) to the roof (Level 11).

Each floor will also have space assigned to information systems, electrical rooms, as well as mechanical and plumbing shafts. Each will also have storage and general circulation space.

### Ground Level

In addition to the elements described on all levels, the Ground Level will have all non clinical following functions. The kitchen is to be relocated to the Ground Level and will serve the entire campus. In addition, the Loading Dock will be renovated and expanded; it, too, will serve the entire campus.

- Kitchen

- Administrative space to support the kitchen
- Fresh, dry and frozen food storage
- Staff locker rooms and lounge
- Mechanical, electrical, information systems and plumbing support services including electrical switchgear and pump rooms, and
- Loading dock and associated bulk material storage.

### Level 1

Level 1 is a non clinical level and will have the following non-clinical functions:

- Lobby (with wheelchair storage, public toilets)
- Guest Services and Information Desk
- Valet office
- Volunteer rooms/orientation space
- A small kitchen supporting the servery
- A servery
- Public dining
- Chapel and related administrative space; other chapel-related administrative space will remain in the existing building
- A lactation suite for counseling, retail space, and pump rooms for nursing staff members
- Staff lockers and lounges, and
- Electrical backup generators.

### Level 2

Level 2 is primarily clinical space and includes antepartum rooms, the labor/delivery/recovery suite and the surgical delivery and Phase I recovery rooms. In addition to these clinical functions, this level will house the following non clinical functions:

- Public and Family Waiting
- On-call suite for physicians
- Staff lockers and lounge, and
- A bridge to the parking garage and associated Reception/ Information Desk.

### Level 3

Level 3 is essentially a mechanical level; even so, it will also house the following non clinical functions:

- Offices for the maintenance staff
- Bed storage, and

- Exit stair transfers.

As noted above, Level 4 and Level 5 will not exist.

#### Level 6

Level 6 will have a 12-bed obstetric unit and a small newborn nursery. The remainder of the floor will be non clinical space including:

- Public lounge on the unit
- Administrative conference room
- Conference/consulting rooms also to be used for education, and
- Shelled space connected to the service elevators by a corridor.

#### Level 7

Level 7 will have a 36-bed obstetric unit and a newborn nursery to support the obstetric beds. In addition, there will be the following non-clinical space:

- Public lounge on the unit
- Administrative conference room
- Staff lounge and lockers, and
- Conference/consulting rooms also to be used for education.

#### Levels 8, 9, and 10

Levels 8, 9, and 10 are all 36-bed intensive care units. The following non clinical functions support these patient care units:

- Public lounge on the unit
- Administrative conference room
- Staff lounge and lockers
- Conference/consulting rooms also to be used for education, and
- On-call room for physicians.

#### Non Clinical Departments / Areas – Existing Patient Tower Modernization

##### Non Clinical Space – OB Triage and NICU in Existing Patient Tower

The proposed plan includes relocating the obstetric beds to new space and modernizing the vacated space to house OB Triage and the Neonatal Intensive Care Unit. Both vacated departments are located the second floor in the existing hospital.

## Level 2 – Neonatal Intensive Care Unit

The non clinical areas in the neonatal intensive care unit include:

- Family support space including gowning, overnight room, education room, and parent lounge
- Conference rooms
- On-call room
- Resident and other workrooms
- Staff lockers and lounge
- Administrative offices
- Shared clinical offices
- Equipment and other storage

## Level 2 – OB Triage

The non clinical areas in the OB Triage area include:

- Physician on-call room
  - Staff lounge and lockers, and
  - Equipment storage and alcoves (crash cart, wheel chairs, stretchers, and portable ultrasound machines).
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 the services provided, justified by clinical or operational needs, as supported by published data or studies.*
  - b. *The existing facility's 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 an excess of square footage.*

Advocate Christ Medical Center currently has or proposes to have Phase I recovery stations in three locations – there are 19 stations adjacent to the main operating room in the hospital, there are 14 approved for the Outpatient Pavilion that is currently under construction, and there will be 4 located adjacent to the C-section rooms are being proposed for the Patient Tower.

Overall, the existing and approved Phase I recovery stations are located in 239 GSF per station. These 33 stations and their associated square footage have been approved in by the Health Facilities and Services Review Board (and its predecessor the Health Facilities Planning Board).

As part of the current Patient Tower project, the Medical Center proposes to increase the number of Phase I recovery stations related to the surgical delivery/C-section suite from the existing 3 to 4 rooms and relocate the service from the existing tower to Level 2 of the new Patient Tower. The increase of 1 operating room and 1 recovery station are addressed in Attachment 37. Code requires that there be one Phase I recovery station for each operating room.

Most of the patients who will use the new Phase I recovery stations will be either high risk patients or patients with multiple births. (The surgical delivery rooms are used for multiple births even when a C-section is not anticipated. This is for the safety of the babies. If the birth of the second (or third, etc.) infant becomes complicated, an emergency C-section can be readily performed).

The Phase I recovery rooms for the obstetric area will average 405 GSF. This is higher than the State Guideline of 180 GSF. There are many factors that support this additional space.

- Unlike adult surgical recovery stations (adjacent to the main operating room) that are cubicles, the surgical delivery recovery stations will be in rooms. Each room will be private; this will improve infection control. More important, private rooms will afford the new parents their privacy at this most momentous time in family formation. In the unfortunate case of a stillborn birth or a fetal demise, the parents can begin the grieving process with the obstetric bereavement counselor in the recovery area away from other mothers with healthy infants.
- Again, unlike surgical recovery stations, there is more than one patient in the room. There are at least two patients and maybe more – the mother and her baby(ies) – as well as the father. Research has shown that it is very important that newborns remain close to their mother immediately after birth. Skin-to-skin contact immediately after birth has many benefits for the mother's and the baby's health. Baby is warmer, cries less, breathes more easily and more rhythmically, and baby's heart rate is more normal. Skin-to-skin contact immediately after birth allows the baby to be colonized by the same bacteria as the mother. This is thought to prevent allergic diseases. This all adds up to a baby who is more stable. Providing the mother with the opportunity to hold her infant in skin-to-skin contact soon after birth can provide a sense of control and empowerment to the mother. In contrast, there is evidence that lack of early skin-to-skin contact may be harmful. Research has found that mother-infant separation during the first 2 hours after birth is associated with less infant self-regulation and decreased sensitivity and attachment that is not fully compensated for by rooming in.

- Many benefits to the infant have been associated with breastfeeding immediately after birth when the baby is likely to nurse sooner and longer. Benefits include lower risk of otitis media, gastrointestinal infection, necrotizing enter colitis, lower respiratory tract infection, sudden death syndrome, asthma, allergies, childhood leukemia, obesity and diabetes. At the Medical Center, 80 percent of the new mothers initiate breast feeding in the recovery room. The Medical Center's staff includes lactation specialists who can help new mothers. Longer bonding times and breastfeeding may increase the time the mother and baby stay in the recovery room.
- Under usual circumstances, in addition to the baby, mother and father, a maternal fetal medicine physician may be attending the mother with the support of the obstetric nurses. There may also be medical students and residents as well as EMT students to observe the recovery. The people add to the square footage needs of the Phase I Recovery area.
- In addition to the family and clinical staff in the room, there will also be at least one infant radiant warmer that measures 86 inches high, 47 inches deep, and 25 inches wide. This equipment and necessary circulation spaces also have to be accounted for in the recovery room square footage.

Several other factors contribute to the additional square footage of the Phase I recovery area:

- Illinois Department of Public Health (IDPH) requirements for support space in a recovery area are minimal. To promote staff efficiency and maximize the amount of time the staff spends with the patient, ACMC has added additional support space.
- IDPH does not address the need for hand washing space. To promote patient safety and infection control standards, the Medical Center is providing decentralized hand washing sinks and work areas within the recovery area.
- The nurse station will have central cardiac monitoring capability, medication and supply dispensers, and a pneumatic tube station. The obstetric recovery area has a multidisciplinary staff collaboration area that encourages comprehensive patient care with enhanced opportunity for communication among the physicians and other health professionals; these staff collaboration areas also enhance the Medical Center's teaching mission.
- Because of the configuration of the unit there will be 720 GSF of departmental corridors (or 180 GSF per room) linking the recovery rooms, the nurse station, and the supply alcoves.

In the total surgical delivery area and Phase I recovery area there are shared spaces that have been difficult to assign. As shown on Attachment 14, Exhibit 1, if the two areas are combined, together they have 3,877 less GSF than allowed by the State Guidelines.

In summary, Phase I Recovery care in the surgical delivery suite is far more complex than in most Phase I Recovery areas, especially in a center such as ACMC that cares for very high risk mothers and infants. The unique circumstances in the surgical delivery area do not seem to be anticipated in the current State Standard.

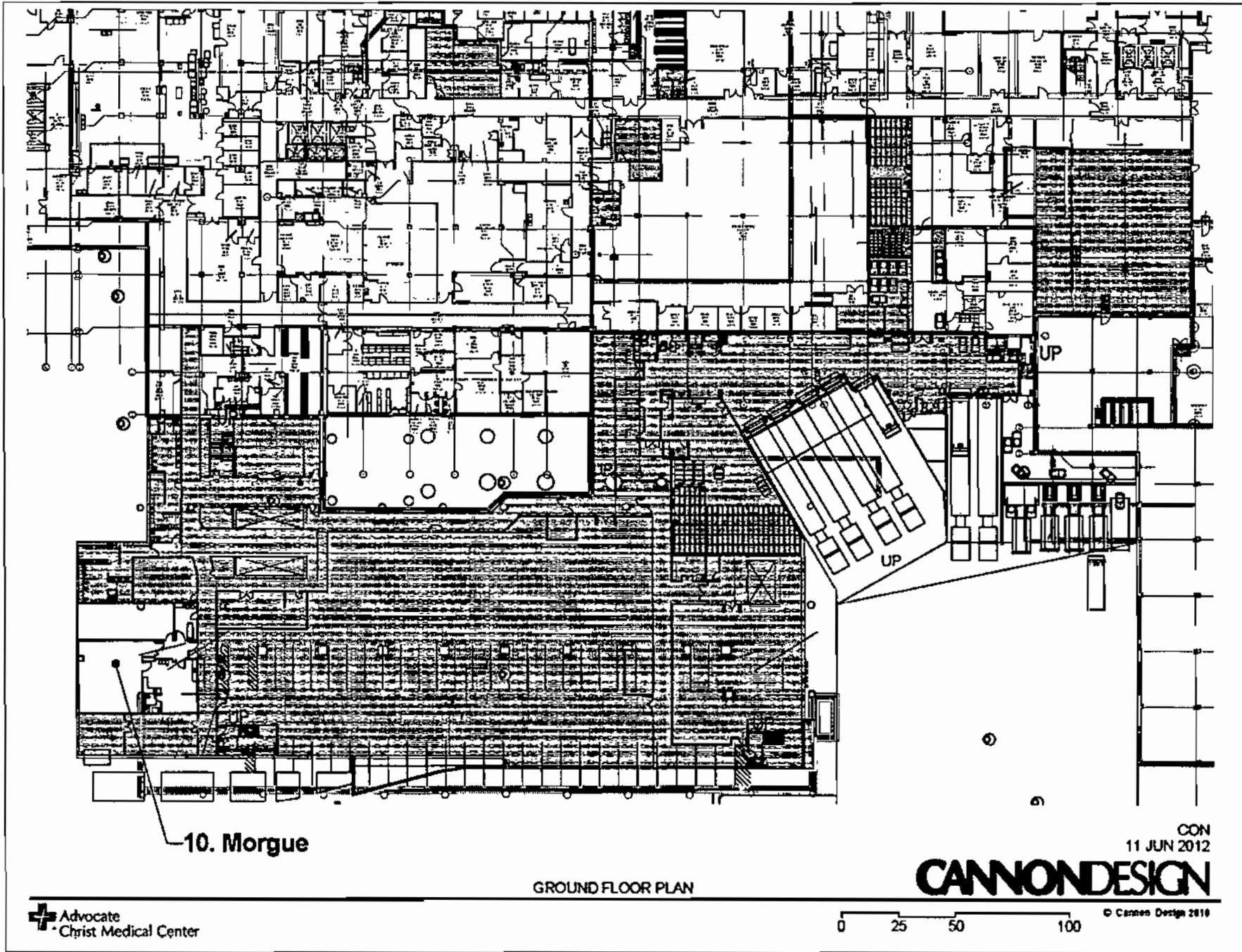
### Exhibits

The “Size of Project” exhibit described on the first page of this attachment is included as Attachment 14, Exhibit 1.

Attachment 14, Exhibit 2 includes architectural drawings of each floor of the proposed Patient Tower.

Attachment 14, Exhibit 3 is a letter prepared by Cannon Design and Power Construction Company LLC describing the design and construction impediments related to the project.

**Floor by Floor Drawings  
of the Proposed Patient Tower**

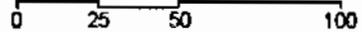


10. Morgue

CON  
11 JUN 2012

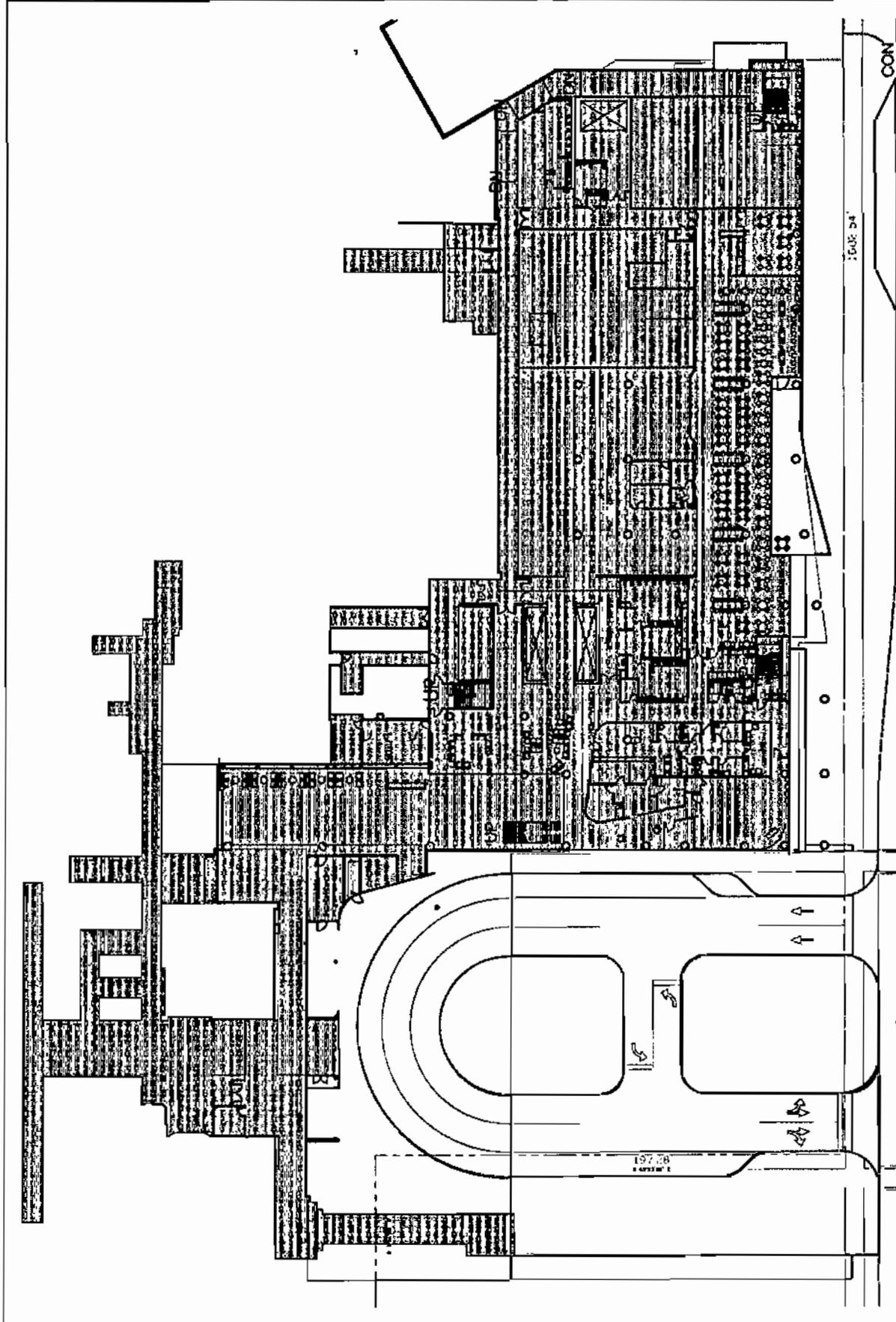
**CANNONDESIGN**

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GROUND FLOOR PLAN

Advocate  
Christ Medical Center



FIRST FLOOR PLAN

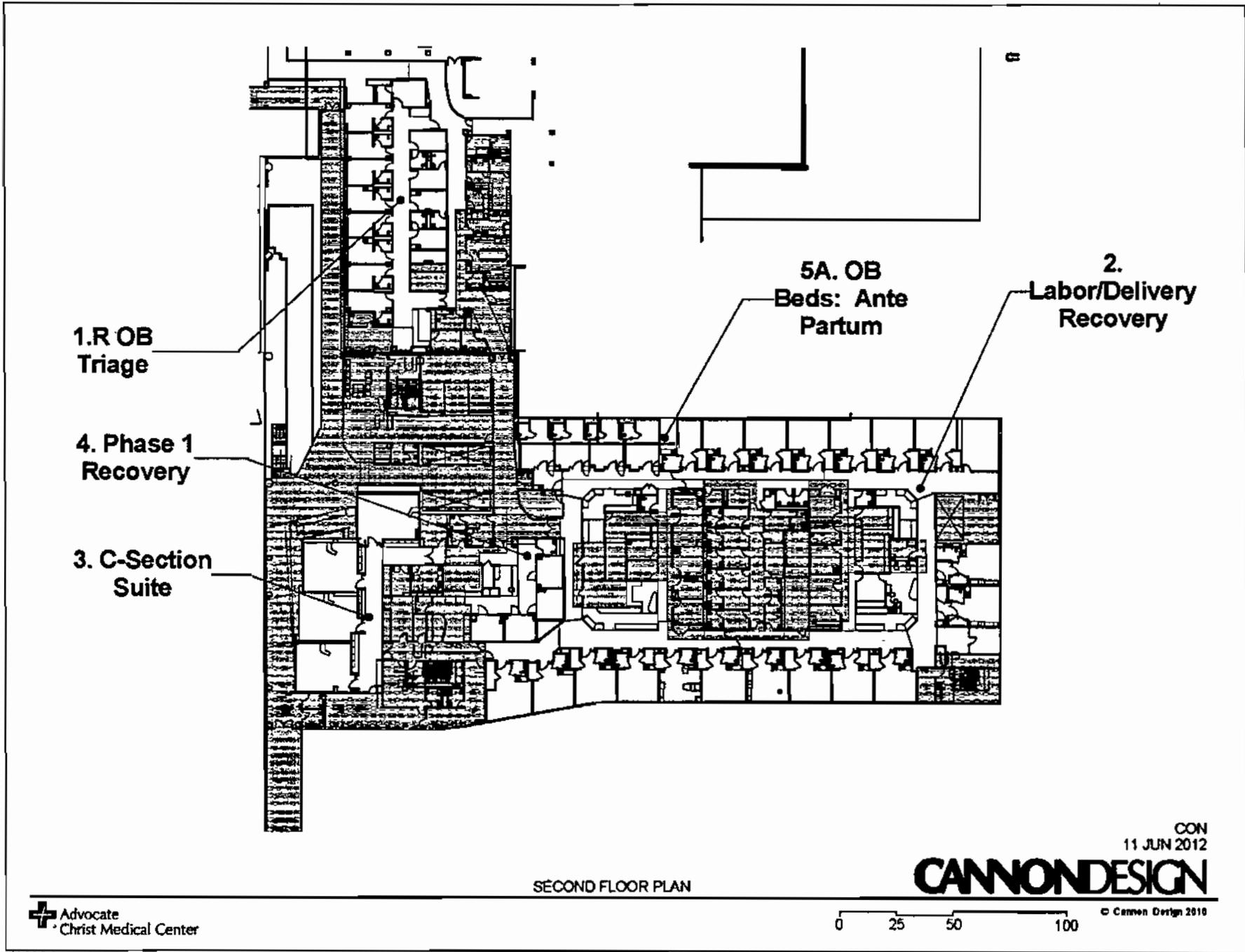
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Advocate  
Christ Medical Center

ACIMC Inpatient Tower



1.R OB  
Triage

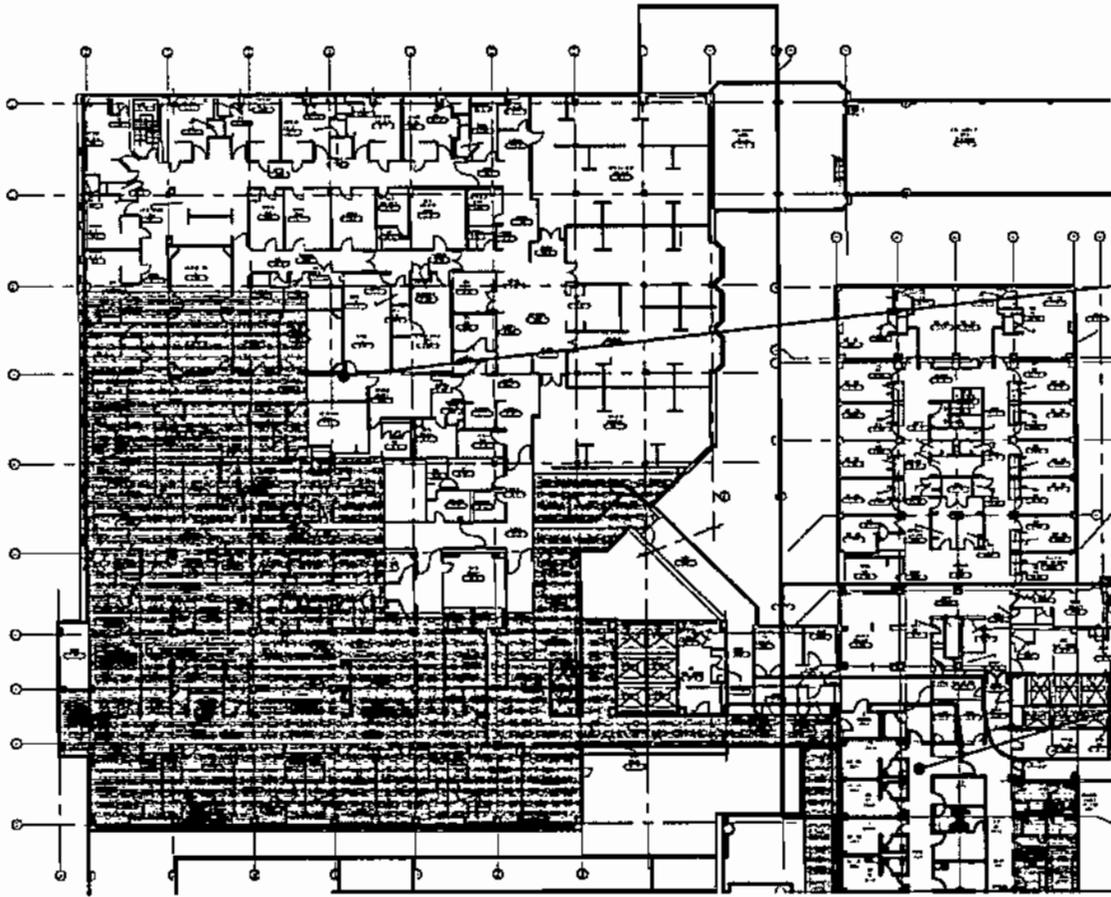
4. Phase 1  
Recovery

3. C-Section  
Suite

5A. OB  
Beds: Ante  
Partum

2.  
Labor/Delivery  
Recovery

SECOND FLOOR PLAN



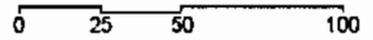
6. Neonatal Intensive Care Beds

1.R OB Triage

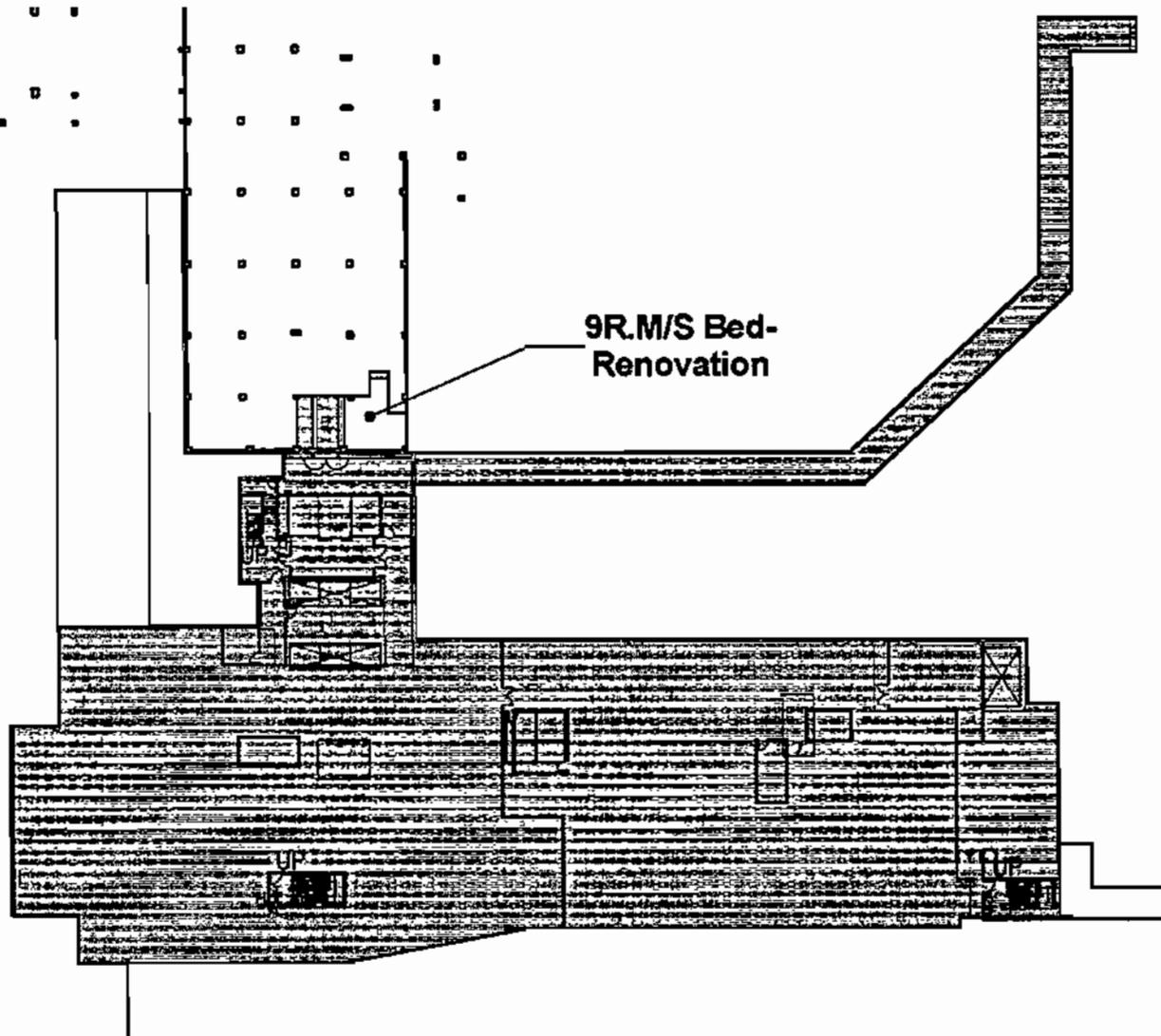
SECOND FLOOR NICU PLAN

CON  
11 JUN 2012  
**CANNONDESIGN**

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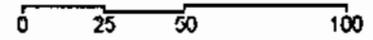
Advocate  
Christ Medical Center

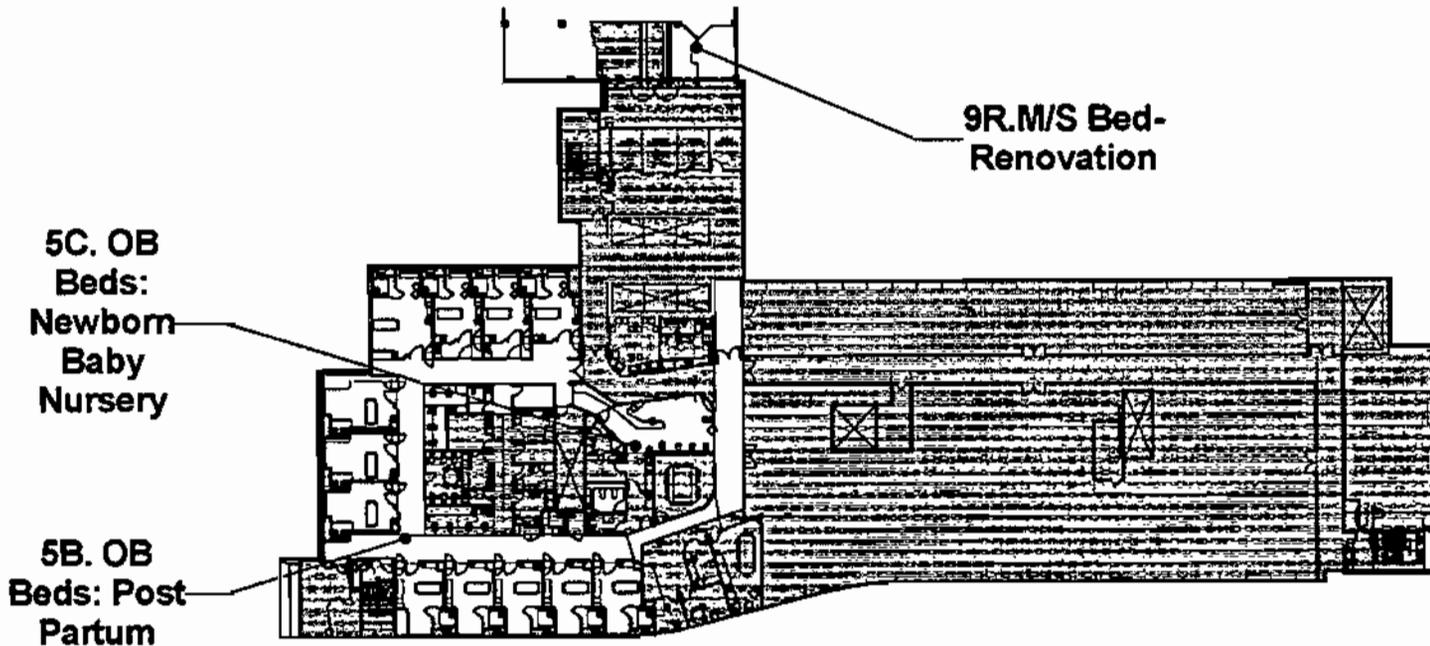


9R.M/S Bed-Renovation

THIRD FLOOR PLAN

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11 JUN 2012  
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5C. OB  
Beds:  
Newborn  
Baby  
Nursery

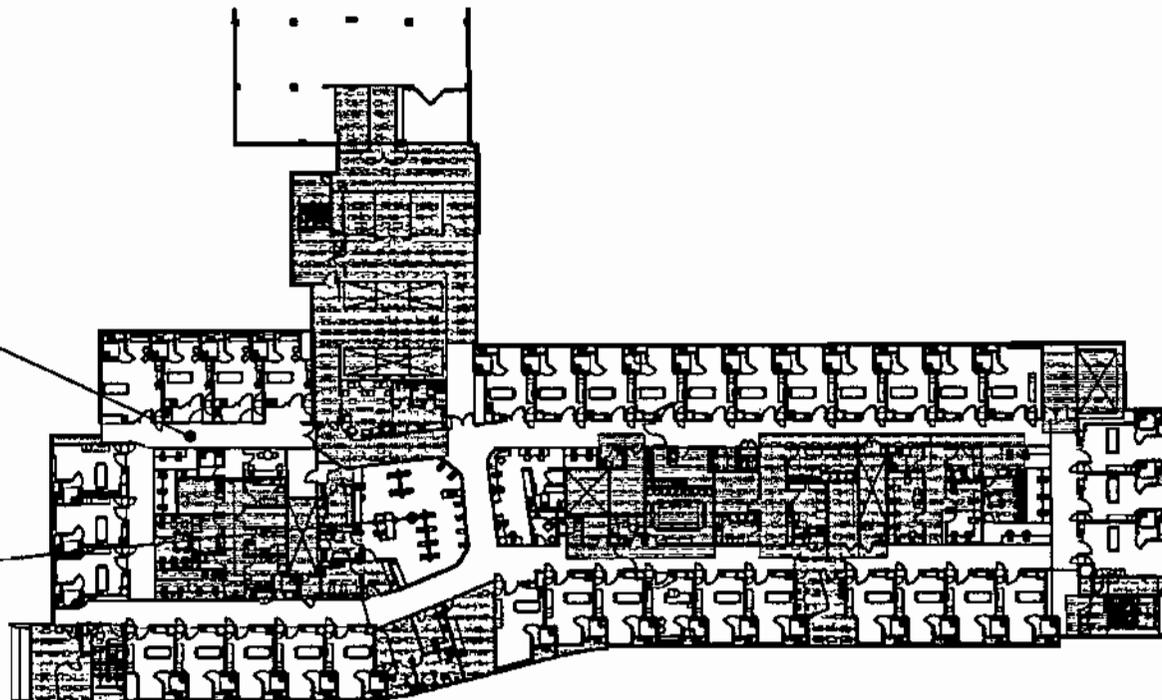
5B. OB  
Beds: Post  
Partum

9R.M/S Bed-  
Renovation

SIXTH FLOOR PLAN

5B. OB  
Beds: Post  
Partum

5C. OB  
Beds:  
Newborn  
Baby  
Nursery

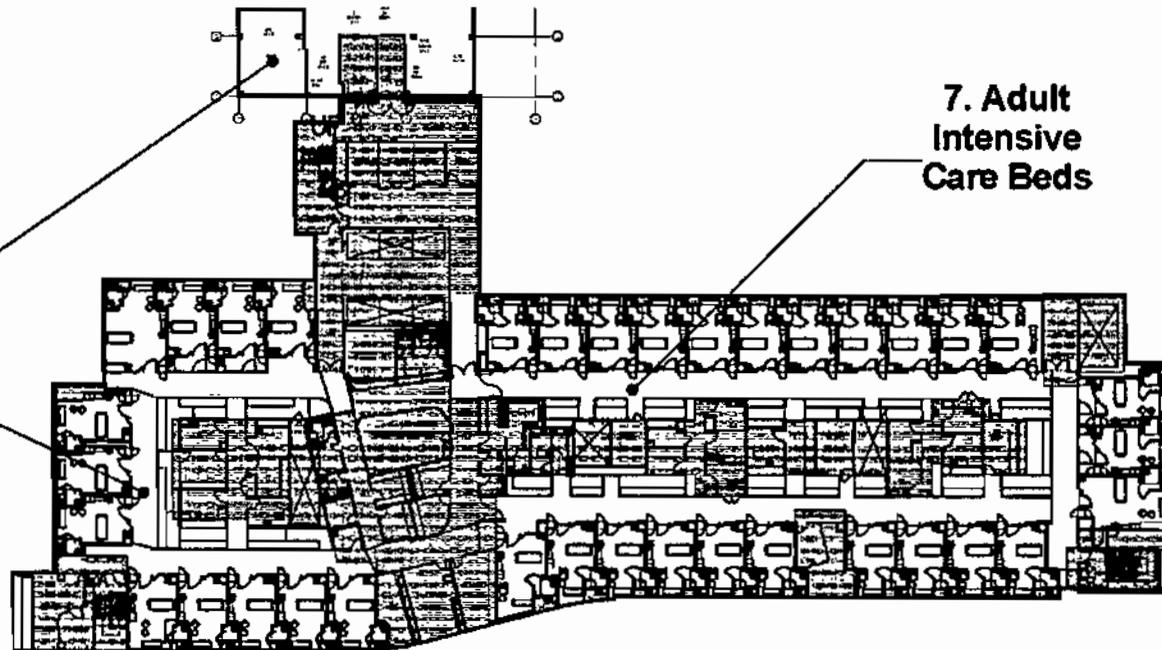


SEVENTH FLOOR PLAN

9R.M/S Bed-Renovation

7. Adult Intensive Care Beds

7. Adult Intensive Care Beds

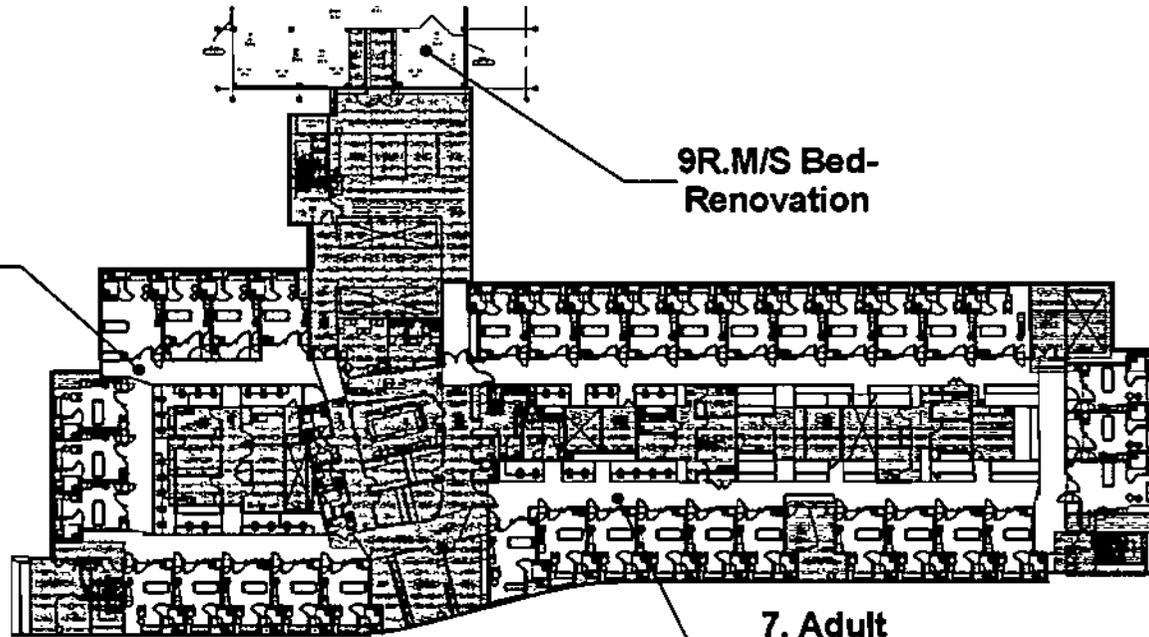


EIGHTH FLOOR PLAN

7. Adult Intensive Care Beds

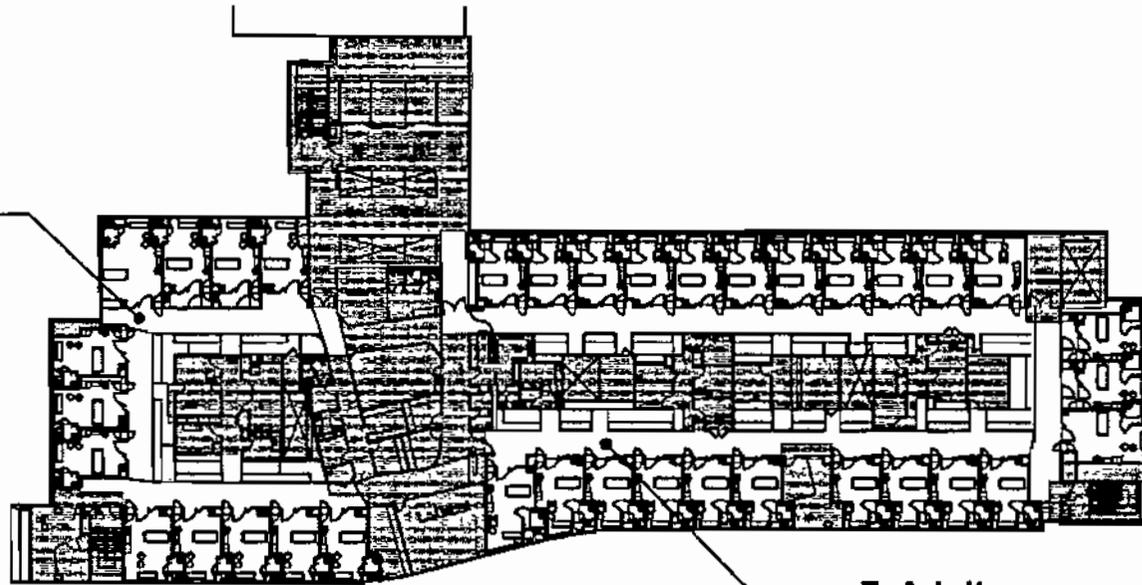
9R.M/S Bed-Renovation

7. Adult Intensive Care Beds



NINTH FLOOR PLAN

7. Adult Intensive Care Beds



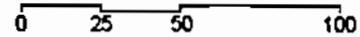
7. Adult Intensive Care Beds

CON  
11 JUN 2012

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TENTH FLOOR PLAN

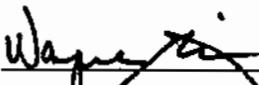


July 9, 2012

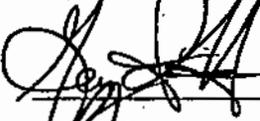
Courtney R. Avery, Administrator  
Health Facilities and Services Review Board  
525 West Jefferson Street, Second Floor  
Springfield, IL 62761  
Re: Christ Bed Tower

The following is a list of impediments that have impacted the cost of the Bed Tower:

1. Temporary demolition and rebuilding of the Adult Medicine clinic. This is necessary due to the clinic being constructed as slab on grade without a basement. A shoring/retention system is necessary to construct next to this area as well as providing a basement connection beneath this space to connect to the loading dock.
2. Tight, urban site. This requires sheeting and shoring to keep the adjacent areas operational. Premiums required for hoisting and logistics.
3. Working around the existing loading dock incurs premiums for logistics and retention.
4. Connecting to the existing East/West Tower requires structural gymnastics to align floors and adds double sided elevators with additional stops.
5. Working adjacent to the main hospital entry requires temporary measures to protect the public and create alternative ways for entry and egress.
6. The Skylink bridge to Surgery is provided due to the travel distance and turns (13) required through the existing hospital and the valuable added minutes in an emergency. This link minimizes that travel time.
7. Demolition of the West Garage. This is required due to the siting of the bed tower closest to the key clinical areas of the existing hospital.

 date 7/10/12

Wayne Ziemer, Project Executive, Power Construction Company LLC

 date 7/10/12

Greg Hoiser, Principal, Cannon Design

## 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:

#### 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.

Attachment 15, Exhibit 1, provides documentation that the services that are part of the Patient Tower project proposed by Advocate Christ Medical Center meet or exceed the utilization standards specified in 1110 Appendix B.

See Attachment 20 and Attachment 37 for a narrative of the rationale that supports the projections.

### Projected Services Utilization

Department/Service	Historical Utilization		Year		Projected Utilization	State Standard	Number		Met Standard?
	2010	2011	Complete	Second Year			Current	Proposed	
OB Triage			2016	2018	7,770	NA	9	12	NA
Labor/Delivery/Recovery			2015	2017	17,913 hours of use	400 births per room	15	15	Yes
Surgical Delivery Room/C-Section Suite	1,440 C-Sections	1,463 C-Sections plus surgeries	2015	2017	1,734 C-Section and other OB surgeries performed in delivery room  5,142 hours of surgery	800 procedures per room or 3 rooms  Alternative -1,500 hours of surgery per room or 4 rooms	3	4	Yes  Guidelines do not include necessary emergency operating room.
Phase I Recovery	NA	NA	2015	2017	NA	None	3	4	NA
Obstetric Beds	16,287 days Incl. observation	15,712 days Incl. observation	2015	2017	17,636 days 48.3 ADC 86.3 percent occupancy	78 percent occupancy	39	56	Yes
Newborn Nursery Bassinets	Level 1 8,767 days	Level 1 8,367 days	2015	2017	NA	None	44	24 + rooming in	NA
Neonatal Intensive Care	14,604	14,529	2017	2019	21,900 days 60.0 ADC 92.3	75 percent occupancy	37	64	Yes

**Projected Services Utilization**

Department/Service	Historical Utilization		Year		Projected Utilization	State Standard	Number		Met Standard?
	2010	2011	Complete	Second Year			Current	Proposed	
Intensive Care Beds	28,131 days Incl. bypass	28,262 days Incl. bypass	2015	2017	37,975 days 104.0 ADC 73.3 percent occupancy	60 percent occupancy	103	189	Yes
Medical Surgical Beds	124,118 days Incl. observation and bypass	124,723 days Incl. observation and by pass	2015	2017	123,128 days 337.3 ADC 87.4	88 percent occupancy	378	386 staffed	No
Morgue	1,495	1,425	2017	2019	NA	None	1	1	NA

Source: Attachment 20 and Attachment 37

**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:

**UNFINISHED OR SHELL SPACE:**

Provide the following information:

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

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

1. The Total Gross Square Footage of the Proposed Shell Space

The proposed Patient Tower of Advocate Christ Medical Center (ACMC, Medical Center) will include 15,488 GSF of shell space on Level 6.

In addition to the shell space, there will be a 19,873 total GSF of vacated space. The vacated space will be located in the following four areas.

**Attachment 16, Table 1  
Vacated Space at the Completion of the Patient Tower**

Area/ Department	Current Location	GSF Being Vacated
OB Postpartum	Second Floor – 2W	5,761
Newborn Nursery	Second Floor – 2W	1,275
OB Postpartum	Third Floor – 3W	3,112
MICCU	Fourth Floor – 4S	8,746
Morgue	Ground Floor	979

Source: ACMC records.

2. The Anticipated Use of the Shell and Vacated Space, specifying the Proposed GSF To Be Allocated to Each Department, Area or Function

At the present time, only 190 or 67 percent of the Medical Center's medical surgical rooms are private rooms. Today's standard of care is private patient rooms because they provide the following benefits:

- Improved infection control
- Reduced medication errors
- Reduced number of patient falls
- Fewer sleep disturbances
- Improved patient confidentiality and privacy
- Reduced noise
- Reduced patient stress
- Improved social support
- Improved communication between patients and physicians
- Fewer costly internal patient transfers, and
- Ability to operate at higher occupancies.

The Medical Center has not initiated the design of the shell space or the redesign of most of the vacated spaces. (The reuse of the Medical Intensive Critical Care Unit (MICCU) is the exception and is described below.) This modernization is expected to occur after the completion of the current project and at such time as additional capital funds become available. Ultimately, the Medical Center's goal is to increase the proportion of private medical surgical beds, while not changing the number of authorized beds.

The existing 22-bed MICCU will be replaced with a 36-bed MICCU on Level 10 of the proposed Patient Tower. The 22 beds in the vacated space will be decommissioned and the area will be left vacant as part of this project. In the future, the vacated MICCU space will be used as a staging area while units in the existing hospital undergo renovation and modernization. In this process, beds will be temporarily relocated to the vacated MICCU while modernizing the unit in which the beds are located. When the modernization of one unit is complete and the beds returned to the newly modernized unit, the beds from another unit will temporarily move to the MICCU until that unit is modernized – and so on. The interim use of the MICCU has not been allocated redevelopment funds. The final reuse of the MICCU will be determined depending on need at the time, although it too may be used for privatization of medical surgical beds.

The existing morgue space will be reused to expand one or more non-clinical functions on the Ground Level of the existing tower.

3. Evidence that the Shell Space Is Being Constructed due to:
  - a. Requirements of Governmental or Certification Agencies; or
  - b. Experienced Increases in the Historical Occupancy or Utilization of those Areas Proposed To Occupy the Shell Space

The development of shell space on Level 6 of the proposed patient tower is due to neither requirements of governmental or certification agencies or experienced increases in the historical occupancy or utilization of medical surgical beds. Rather the development of this space for future medical surgical rooms will reduce the current low proportion of single occupancy medical surgical rooms without increasing the number of authorized medical surgical beds at the Medical Center. This increase in the number of private rooms will enhance patient care and improve operational efficiency.

The footprint of the proposed patient tower was determined by the square footage requirements of the intensive care units. The Medical Center considered at least two options to Level 6 requiring less space than the footprint. The first option envisioned not building out the space. The second option considered shelling the space for a future use, more specifically to increase the proportion of private medical surgical beds at the Medical Center. The cost of shelling space was \$3.5 million. This cost is related to structural modifications and soffiting premiums required to stack floor plates of unequal area. The cost of shelling the space is \$6.6 million. The net cost of building the 15,500 GSF of shell space is \$3.1 million or \$200 per GSF. Since the Medical Center is located on a constrained site in an urban neighborhood and it is unclear if additional needed space could be built as economically in the future, ACMC determined that building shell space was the more farsighted and prudent option.

4. Provide:

- a. Historical utilization for the area for the latest 5-year period for which data are available; and
- b. Based on the average annual percentage increase for the period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

Shell Space

Over the last 5 years, the Medical Center has operated 378 medical surgical beds at occupancy rates of from 82.4 to 89.9 percent.

Attachment 16, Table 2  
Medical Surgical Utilization, 2007 to 2011

Year	Admissions	Patient Days	Average Daily Census	Authorized Beds	Percent Occupancy
2007	24,351	120,177	329.3	378	87.1
2008	24,534	124,010	339.8	378	89.9
2009	24,423	118,167	323.7	378	85.6
2010	23,486	115,753	317.1	378	83.9
2011	23,481	113,723	311.6	378	82.4

Sources: 2011 Annual Hospital Questionnaire, 2007-2010 *Hospital Profiles*; Declaratory Ruling approved by HFSRB on June 5, 2012.

These high occupancies do not account for blocked beds. The second bed in a double room may be blocked for several reasons including a patient's need to be isolated because of a contagious condition, compromised immunity, gender, or a behavior issue. Ventilator and hospice patients also require private rooms. In addition to patient needs, mechanical and maintenance issues may take one or both beds in a room out of operation. At any one time, 10 or more beds of the medical surgical complement may be blocked. For example, if 10 beds were not available, the actual occupancy of the medical surgical beds in 2011 was 84.7 percent.

Of the 378 medical surgical beds, 2 have been placed in reserve. As the result of both blocked and reserved beds, only 366 medical surgical beds would be available for service.

This determination of operating occupancy does not account for peaks in census during some seasons and by day of the week. The Medical Center operates at one of the highest occupancies of any hospital in Illinois.

In the conceptual planning for the new patient tower, the design included a floor of medical surgical beds. However, several factors mitigated the need for this additional level and it was deleted from the project. These reasons included:

- ACMC's leadership believes that the future demand for medical surgical beds will not require additional beds due to new technology, new care models, the continued reduction in average length of stay as well as the reduction of unnecessary admissions and readmissions. Therefore, additional medical surgical beds were eliminated from the project.
- Today, 33 percent of the medical surgical rooms at the Medical Center are double occupancy. This high percentage of two-bed rooms detracts from patient care, health outcomes, and operational efficiency. By reducing the number of medical surgical beds in double rooms and increasing the percentage of private rooms, the Medical Center will improve health outcomes and enhance patient care and operational efficiency.
- The current patient tower design has shell space on Level 6. This space could accommodate as many as 24 medical surgical beds, thereby reducing the number of double occupancy rooms without increasing the number of authorized beds.
- This space on Level 6 is more cost effectively constructed now than even deleting it from the project.
- In addition to the shell space, the Medical Center will have vacated space at the completion of the project. This space can also be used to increase the privatization of medical surgical beds.
- Current budget constraints do not allow the Medical Center finish these spaces at the present time.
- In a separate project and board actions, 16 additional medical surgical beds are being added to the Medical Center's bed complement, which is expected to be completed in autumn of 2012. This will result in a small net increase in medical surgical beds.

For these reasons, the Medical Center is proposing to shell the unassigned space on Level 6 for future use as medical surgical beds, more specifically to increase the proportion of private medical surgical beds at the facility.

**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:

**ASSURANCES:**

Submit the following:

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

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

The requested assurances letter is appended as Attachment 17, Exhibit 1.

July 17, 2012

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

Dear Ms. Avery:

The purpose of this letter is to assure the Health Facilities and Services Review Board (HFSRB) that Advocate Health Care Network and Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center will submit one or more certificate of need applications to build out the proposed shell space in the new patient tower, regardless of the capital thresholds in effect at the time or the categories of service involved.

The timing of the buildout of the shell space and the modernization of the vacated space will depend on capital approvals by Advocate Health and Hospitals Corporation. The anticipated date when the shell and vacated spaces will become operational also will depend on certificate of need approvals and construction duration.

We must plan for the highest and best use of all space and the most prudent use of scarce capital.

Sincerely,



Kenneth W. Lukhard, Market President  
Advocate Christ Medical Center and Trinity Hospital

CC: Mr. Mike Constantino, Supervisor of Project Review Section

A faith-based health system serving individuals, families and communities

Recipient of the Magnet Award for excellence in nursing services by the American Nurses Credentialing Center



## SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

### A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

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

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

Category of Service	# Existing Beds	# Proposed Beds
<input checked="" type="checkbox"/> Medical/Surgical	378	378
<input checked="" type="checkbox"/> Obstetric	39	56
<input type="checkbox"/> Pediatric	NA	NA
<input checked="" type="checkbox"/> Intensive Care	103	189

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) - Planning Area Need - Service Accessibility	X		
1110.530(c)(1) - Unnecessary Duplication of Services	X		
1110.530(c)(2) - Maldistribution	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X
1110.530(d)(2) - Documentation			X

<b>APPLICABLE REVIEW CRITERIA</b>	<b>Establish</b>	<b>Expand</b>	<b>Modernize</b>
1110.530(d)(3) - Documentation Related to Cited Problems			X
1110.530(d)(4) - Occupancy			X
1110.530(e) - Staffing Availability	X	X	
1110.530(f) - Performance Requirements	X	X	X
1110.530(g) - Assurances	X	X	X
<b>APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

## OBSTETRIC BED NEED

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

### b) 2) Planning Area Need – Service to Planning Area Residents

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

The Advocate Christ Medical Center (ACMC, Medical Center) obstetric category of service has two overlapping service areas. The defined primary and secondary service areas of the hospital represent the Medical Center's community. In addition, the Medical Center is a Level IIIC Perinatal Center; as a perinatal center, ACMC cares for women with high risk pregnancies involving the mother, the fetus, or both. Because these patients require unique medical expertise and technological support, only a few hospitals are designated as Level IIIC Perinatal Centers. In fact, the Medical Center, located in Chicago's south and southwest areas, is one of only six such centers in the State. The Medical Center's geographic reach is primarily to the south and southwest; the nearest Level IIIC Center is in Peoria, 157 miles away.

The purpose for this project will be to provide a comprehensive range of normal and high risk obstetric services to the Medical Center's community and to provide high risk services to the residents of a broader geographic area to the south and southwest of the Medical Center where these services are not available at the local community hospitals.

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

An obstetric service is a category of service pertaining to the medical and surgical care of maternity and newborn patients or medical surgical gynecologic cases that may be admitted to a postpartum unit. Advocate Christ Medical Center provides “Obstetric Gynecological Care,” a subcategory of obstetric services where medical care is also provided to clean gynecological, surgical, or medical cases which are admitted to the postpartum section of an obstetrics unit in accordance with the requirements of The Illinois Hospital Licensing Act.

The following is a summary of the Medical Center’s total patient origin as well as the patient origins for obstetric, gynecologic, and combined obstetric/gynecological patients.

Comparison of Total, Obstetric, GYN, and  
Obstetric/GYN Patient Origin, 2011  
Attachment 20, Table 1

Service Area	Total Percent	OB Percent	GYN Percent	OB/GYN Percent
Primary	68.8	65.2	55.5	63.6
Secondary	14.8	15.6	23.2	16.9
Total	83.7	80.9	78.7	80.5
Other Illinois	14.5	17.7	20.3	18.1
Other States	1.8	1.4	1.0	1.3
Grand Total	100.0	100.0	100.0	100.0

Source: APMC Internal Financial Data

This summary table shows that approximately 80 percent of the Medical Center’s obstetric and gynecology patients are from the local community. Even with an expected modest increase in the proportion of obstetric admissions that are from “Other Illinois” and “Other States,” at least 50 percent of the projected patient volume will be residents of the primary and secondary service area communities.

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

Attachment 20, Exhibits 1, 2, and 3 provide the complete zip code patient origin data for obstetric (antepartum and postpartum) patients, for gynecologic patients that are part of the obstetric category of service, and for all obstetric and gynecologic patients

b) 4) Service Demand – Expansion of Existing Category of Service

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

A) Historical Service Demand

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

In both 2010 and 2011, the latest two years. Advocate Christ Medical Center's obstetric utilization exceeded the State Standard Target Occupancy.

There are three subgroups of patients admitted to the obstetric beds at the Medical Center. First, there are mothers with an expectation that they will have uncomplicated deliveries. Neither these mothers nor their fetuses have displayed any high risk factors, although an apparently normal pregnancy can become a high risk pregnancy at any time. Second, there are high risk mothers or mothers with a high risk infant, or high risk mothers with a high risk infant. These are antepartum obstetric patients. They are admitted to the hospital to be monitored and treated to prevent a preterm delivery or to monitor abnormalities of the pregnancy. The third group is gynecologic patients, often called "clean GYN" patients. This mix of patients supports high utilization of the obstetric beds because:

The Medical Center's staff has determined that gynecologic admissions are highest on Monday and Tuesday, and these patients tend to be discharged by mid-week. Obstetric admissions are highest on Tuesday, Wednesday and Thursday and tend to be discharged before the end of the week. With this mix of patients it is possible to continually maintain a high census and operate the combined obstetric/gynecologic beds very efficiently.

The obstetric unit at the Medical Center has a severe shortage of beds, as demonstrated by the very high average occupancy during each of the last 2 years. At periods of elevated occupancy, antepartum patients may be admitted to labor/delivery/recovery rooms and gynecologic patients may be admitted to an adjacent medical surgical unit. At times of peak occupancy, selected high risk mothers may be asked to stay at home where they are carefully monitored to identify any changes that would require immediate admission.

Attachment 20, Table 2  
Total Obstetric Utilization in 2010 and 2011

Year	Patient Days Including Observation Days	Average Daily Census	Authorized Beds	Percent Occupancy	State Standard Occupancy Target
2010	16,287	44.6	39	114.4	78.0
2011	15,712	43.0	39	110.3	78.0

Source, APMC Internal Financial Data, and Declaratory Ruling approved on June 5, 2012.

Based on utilization for 2010 and 2011, the obstetric utilization at the Medical Center exceeded the State Standard Target Occupancy of 78 percent.

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

Because the Medical Center provides the highest category of perinatal services, the Medical Center almost never refers a patient to another facility. Rather than referring obstetric patients to other facilities, the Medical Center is a receiving hospital for high risk mothers. In 2011, the Medical Center received 124 maternal transports from at least 19 hospitals. These included all but two of the obstetric services in Planning Area A-04 (Adventist Lagrange Memorial and Metro South). These transfers do not include 148 neonatal transfers to the Medical Center and an additional 53 neonatal transfers to Advocate Hope Children's Hospital. The neonatal transfers to Hope are infants fewer than 28 days old.

Other hospitals depend on the Medical Center for mothers and babies too sick to be cared for locally.

B. Projected Referrals

The applicant shall provide the following:

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

Criterion ii) through iv) not included.

C. Projected Service Demand – Based on Rapid Population Growth

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

- i.) *The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;*
- ii.) *Population projections shall be produced, using, as a base, the population census or estimate for the recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH.*

Criterion iii) through vii) not included.

Advocate Christ Medical Center did not solicit obstetric referral letters from physicians. Many of the ACMC physicians have privileges at other area hospitals and when a patient is expected to have an uncomplicated delivery, physicians may keep these patients at their local community hospital with their primary care physicians and support network including family and friends. The Medical Center's service area does not meet the criteria as a rapid population growth area. Because bed need could not be justified using either physician referral letters or the rapid population growth options suggested by the application, the Medical Center used the following methodologies to determine obstetric bed need.

Current Bed Need

The Medical Center's obstetric utilization in 2011 including patient and observation days was 15,712 days. This volume of patient days equates to the need for 55 obstetric beds; the Medical Center has only 39 authorized obstetric beds.

$$15,712 \text{ patient days} \div 365 \text{ days per year} = 43.0 \text{ average daily census}$$

$$43.0 \text{ average daily census} \div 78 \text{ percent State Standard Target Occupancy} = 55 \text{ obstetric beds}$$

### Projected Obstetric Bed Need

The Medical Center prepared CAGR (compound annual growth rate) trend lines to estimate the number of obstetric beds that would be needed in the future.

First the Medical Center prepared a CAGR trend line of the combined obstetric/gynecology utilization. That trend line is included as Attachment 20, Exhibit 4. The historical years in the trend line recognize the obstetric observation days. The obstetric beds are expected to be open in October of 2015; hence, the second full year of utilization is 2017. By 2017 the trend line shows the need for 62 beds; by 2019, project completion, the trend line shows the need for 65 beds. The Medical Center is conservatively requesting 56 beds.

Based on the current utilization and the projected bed need, the Medical Center examined future trends to determine the future mix of obstetric beds.

### Depressed Birthrate and Expected Recovery

According to the Demographic Intelligence LLC, an organization that provides demographic information and analysis has reported that approximately 1.1 million babies will have been postponed or foregone from 2008 to 2011 because some couples have been reluctant to have a child since the recession began in December of 2007. "Childbearing is partly an economic decision and clearly many couples feel like they cannot afford an additional child." Other recent articles support this finding.

The same group determined that Americans' ideal family size has risen from 2.39 in the late 1990s to 2.66 in 2010. The economically related reduction in births through 2011 has depressed any trend line. (<http://digitaljournal.com/pr/440086>)

The trend line analysis prepared by the Medical Center does not account for delayed pregnancies or the reported desire of young couples to have larger families.

### Aging of the Female Population of Childbearing Years

Several factors suggest that the average age of a mother at childbirth will be older than it is today.

First, the likely recovery of some of the delayed pregnancies described by Demographic Intelligence LLC above will result in older mothers.

Second, according to the National Health Statistics Report No. 49, *First Marriages in the United States* (March 22, 2012), women and men married for the first time at older ages than previously. The median age at first marriage was 25.8 for women; hence, having children will also occur at older ages. Together these factors suggest more women in the older childbearing age cohorts when high risk pregnancies are most likely to occur.

Attachment 20, Exhibit 5 shows population change in Illinois of women age 35 to 39, 40 to 44, and 45 to 49. For the purposes of planning for high risk obstetric service, the 35 to 39 and 40 to 44 age groups are most important. As shown on the exhibit, these groups are expected to report strong growth until the year the proposed replacement obstetric department will be available at the Medical Center and for years thereafter.

Attachment 20, Table 3  
Projected Change in Female Population Age 35-49

Age Cohort	Percent Change 2010 to 2020	Percent Change 2010 to 2025	Percent Change 2010 to 30
35-39	+9.5	+12.2	+15.0
40-44	-0.2	+7.4	+9.8
45-49	-9.5	-7.8	-7.5
Total	-0.2	+3.6	+5.5

Source: Illinois Department of Commerce and Economic Opportunity  
Impact of Higher Percentage of Longer Stay Antepartum Patients

A higher percentage of older mothers are likely to have complications related to:

- Diabetes
- Chronic hypertension
- Cardiovascular disease
- Marked obesity
- Multiple pregnancies
- Complications in previous pregnancies
- Risk of preterm labor
- Risk of having a child with a birth defect
- Rh sensitization, and
- Other high risk pregnancy complications.

### Expected Increase in Antepartum Patients at the Medical Center

Because of the changing demographics of the childbearing population, the Medical Center expects more mothers will benefit from having access to the unique capabilities to diagnose and treat high risk pregnancies. As shown on the CAGR projection on Attachment 20, Exhibit 6, antepartum (or high risk) obstetric cases are expected to increase. The high risk patients at the Medical Center currently have an average length of stay of 10.4 days.

### Summary Assumptions and Projection

The Medical Center used the following assumption to adjust the initial CAGR trend line projection.

The Medical Center:

1. Assumed that the 2017 projected obstetric (antepartum and postpartum) and gynecology days (17,636) was correct. The combined maternity and gynecology CAGR is provided in Attachment 20, Exhibit 4.
2. Assumed that the number of projected antepartum days was correct (3,864). The number of antepartum days was divided by current antepartum average length of stay (10.4) to determine antepartum admissions (372). The antepartum CAGR is provided in Attachment 20, Exhibit 6.
3. Assumed the number of gynecology days for 2017 was correct (2,738). The gynecology days were divided by the current gynecology average length of stay (2.4) to determine gynecology admissions (1,141). The gynecology CAGR is provided as Attachment 20, Exhibit 7.
4. Antepartum days and gynecology days were subtracted from combined days to arrive at postpartum days ( $17,636 - (3,864 + 2,738) = 11,034$  postpartum days). Postpartum days were divided by current postpartum average length of stay (2.5) to determine postpartum admissions (4,414).
5. Antepartum admissions and postpartum admissions were added to arrive at obstetric admissions (4,786).
6. Obstetric admissions were added to gynecology admissions to arrive at total admissions (5,927).

7. Total days were divided by total admission to determine projected average length of stay (3.0). This modest increase in length of stay from 2.9 days to 3.0 days reflects the higher proportion of longer-stay high risk patients. In 2011, 5.8 percent of obstetric admissions were antepartum; by 2017, the proportion of antepartum admissions is expected to increase to 7.8 percent.

The table below shows 2011 and 2017 projected utilization for the obstetrics / gynecology service.

Attachment 20, Table 4  
Obstetrics/GYN Utilization

	<u>Actual 2011</u>			<u>Projected 2017</u>		
	<u>Admissions</u>	<u>Days</u>	<u>ALOS</u>	<u>Admissions</u>	<u>Days</u>	<u>ALOS</u>
Antepartum	267	2,766	10.4	372	3,864	10.4
Postpartum	4,311	10,820	2.5	4,414	11,034	2.5
Total Obstetrics	4,575	13,561	3.0	4,786	14,898	3.1
GYN	880	2,151	2.4	1,141	2,738	2.4
Total OB/GYN	5,455	15,712	2.9	5,927	17,636	3.0

Source: APMC Internal Financial Data and Business Development.

Next the Medical Center reexamined current bed need and calculated future bed need based on State Standard Occupancy Targets.

Attachment 20, Table 5  
Obstetrics/GYN Bed Need

	<u>Percent Target Occupancy</u>	<u>Current, 2011</u>	<u>Projected, 2017</u>
Antepartum	78.0	10	14
Postpartum	78.0	<u>38</u>	<u>39</u>
Total Obstetric	78.0	48	49
GYN	90.0	<u>7</u>	<u>9</u>
Total Beds		55	58

Using this methodology, the Medical Center determined that current bed need is 55 beds and future bed need is 58 beds. The Medical Center is conservatively requesting 56 beds. Of these total beds, 8 will be located on Level 2 with the delivery functions. These beds will be utilized by unstable antepartum patients. Of the remaining 48 beds, 12 will be located on Level 6 and

36 will be located on Level 7. Based on daily census, these beds can be used for stable antepartum, postpartum, and gynecology patients. This arrangement allows for very efficient use of the beds.

### Summary

In summary, Advocate Christ Medical Center has reported a steady growth in obstetric utilization. The current deficit of 16 beds (current need – authorized bed) limits access to this high risk obstetric – neonatal service at the Medical Center. Based on trend line considerations and adjustments for patient mix in the future, the Medical Center has documented the need for 56 obstetric beds.

The proposed 56 obstetric beds will operate at 83.6 percent occupancy by 2017, the second full year of utilization.

$$\begin{aligned} \text{Projected days} \div 365 &= \text{projected ADC} \div \text{proposed beds} = \text{percent occupancy} \\ 17,636 \text{ days} \div 365 &= 48.3 \text{ ADC} \div 56 \text{ beds} = 86.3 \text{ percent occupancy} \end{aligned}$$

#### D. Category of Service

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

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

2) *Documentation shall include the most recent*

- A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
- B) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports

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

- A) Copies of maintenance reports
- B) Copies of citations for life safety code violations, and

C) Other pertinent reports and data.

There are no code deficiencies or licensure issues related to the obstetric service at Advocate Christ Medical Center (ACMC, Medical Center). See Plan of Correction in Appendix 1.

The square footage in the current obstetric units is below the State Guidelines, it is 472 GSF per bed compared to the State Guideline of 500 to 660 GSF per bed. Other related spaces—labor/delivery/recovery, surgical delivery rooms are similarly undersized. Hence it is not feasible to modernize in place because there is not enough space to develop an adequately sized and functional unit. Further, even if the space were available (which it is not), an in-place modernization would cause untold operational disruption.

It is not possible to create designated areas for baby and family in the small LDRs and patient rooms; this, in turn, detracts from family-centered care.

The current configuration of the obstetric unit does not include any dedicated antepartum beds. The current operational model places antepartum patients in LDR rooms (which in turn reduces access to these rooms by laboring patients). During peak utilization periods, stable antepartum patients are moved to postpartum rooms and moved back to an LDR if their condition deteriorates. This is undesirable because continuum of nursing care is disrupted.

Of the Medical Center's 39 authorized postpartum rooms, only 8 have showers within the rooms. All other patients must use a common shower located in the corridor on the unit. Air-conditioning on the current postpartum units is provided by very old window units.

*e) Staffing Availability—Review Criterion*

*The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCHAO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.*

Advocate Christ Medical Center attests to the fact that all obstetric licensure and JCHAO staffing requirements will be met when the new unit is ready for occupancy. Because the new obstetric department will not open until 2015, a longer term specific staff development plan is being developed.

The Medical Center has an ongoing physician recruitment program to bring new and replacement physicians onto the medical staff. The Medical Center's Human Resources Department has a waiting list of applicants who seek employment at the Medical Center.

Clinical specialists and associates seek employment at the Medical Center because of its reputation. ACMC is part of the Advocate Health Care System; Advocate has been named one of Chicago's Top 100 Workplaces for the second year in a row by the *Chicago Tribune*; in fact, Advocate ranks fourth among the city's top 20 large companies.

Advocate offers employees a medical plan that provides incentives for completing health activities. Advocate also provides 100 percent reimbursement for pursuing specific certification, degrees and licensure in high-demand areas, as well as in-house continuing education.

## NEWBORN NURSERY BASSINET NEED

Illinois hospital licensure requirements state that there “must be a number of bassinets at least equal to the number of postpartum beds and that when a rooming-in program is used, the total number of bassinets provided in these units may be appropriately reduced, but the full-term nursery may not be omitted.” (Section 250.1850.c) 1). Licensure also requires that “Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20 percent to accommodate multiple births, extended stay, and fluctuating patient loads.” [Section 250.1830 c) 1) B)]

To meet these requirements, the Medical Center will have 56 rooming in bassinets and 24 normal nursery bassinets; of the total bassinets, 8 will be on Level 6 and 16 will be on Level 7. This total of 80 bassinets meets licensure’s 20 percent requirement.

$$\begin{aligned} \text{Rooming-in bassinets} \times 1.20 \text{ licensure factor} &= \text{required bassinets} \\ 56 \text{ rooming in bassinets} \times 1.20 \text{ licensure factor} &= 68 \text{ bassinets} \\ 80 \text{ planned bassinets} &> 68 \text{ required bassinets} \end{aligned}$$

The full term nurseries at the Medical Center will be available for those times when a mother needs additional rest, for infant examinations by the pediatrician, as well as for minor procedures and treatments.

### Summary

As part of the Patient Tower project, Advocate Christ Medical Center proposes to develop 2 full term nurseries with a total of 24 bassinets; these will be in addition to the 56 rooming-in bassinets. At the conclusion of the project, the Medical Center will have enough bassinets to meet licensure requirements, to support Level 1 newborns, accommodate multiple births, provide respite time for new mothers, and for infants that must stay longer than their mothers.

## INTENSIVE CARE BED NEED

### 1110.530. b) Planning Area Need – Review Criteria

#### 2b) Service to Planning Area Residents

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

The dual purpose of the expansion of intensive care beds at Advocate Christ Medical Center (ACMC, Medical Center) is to provide necessary health care to both residents of the Medical Center's primary and secondary service areas as well as to the Medical Center's regional market that extends primarily to the south and southwest of the Medical Center's location in Oak Lawn. Further, it is to continue its essential role as a safety net provider.

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

Attachment 20, Exhibit 8 is a detailed profile of the Medical Center's primary and secondary service areas as well as the "Other Illinois" and "Other States" patients that depend on the Medical Center's tertiary and quaternary services. The exhibit and the summary table below include both adult and pediatric intensive care patients.

Attachment 20, Table 6  
Comparison of Total and Intensive Care Patient Origin, 2011

Service Area	Total Percent	Intensive Care Percent
Primary Service Area	68.8	61.7
Secondary Service Area	14.9	16.1
Subtotal	83.7	77.8
Other Illinois	14.6	18.6
Other States	1.8	3.6
Total	100.0	100.0

Source: ACMC Internal Financial Data

As expected, the total patient origin is concentrated in the defined service area while the intensive care service receives a higher percentage of patients from the "Other Illinois" and "Other States." This represents the broader market reach of the services that are not available at many of the local community hospitals and thus are referred to the Medical Center.

As the result of this project, the Medical Center does not anticipate any substantial change in the definition of its service area; at least 50 percent of admissions will continue to be from residents of the area.

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

Patient origin by zip code based on the patients' legal residence for both all patients and for intensive care patients is included as Attachment 20, Table 8.

4) b) Service Demand – Expansion of Existing Category of Service

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

*A) Historical Service Demand*

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

In both 2010 and 2011, the latest 2 years, Advocate Christ Medical Center's total intensive care utilization exceeded the State Agency's target occupancy of 60 percent.

The State Agency does not distinguish between adult and pediatric intensive care beds. At the Medical Center, adult patients currently are admitted to the existing 79 adult intensive care beds; pediatric patients are admitted to the existing 24 beds in the PICU and the PSHU (pediatric intensive care unit and pediatric surgical heart unit) at Advocate Hope Children's Hospital. In the table below, consistent with the State Agency's guideline, the utilization of all of the adult and pediatric intensive care beds is profiled. Occupancy of all beds ranged from 87.6 percent to 90.2 percent in 2010 and 2011, thus substantially exceeding the State Standard Target Occupancy of 60 percent occupancy.

Attachment 20, Table 7  
Total ICU Utilization in 2010 and 2011

Year	Patient Days			Average Daily Census			Authorized Beds	Percent Occupancy	State Agency Occupancy Target
	Adult	Pediatric	Total	Adult	Pediatric	Total			
2010	26,534	7,391	33,925	72.7	20.3	92.9	103	90.2	60.0
2011	26,147	6,787	32,934	71.6	16.6	90.2	103	87.6	60.0

Source: ACMC Annual Hospital Questionnaire and *Hospital Profiles, 2010*.

The 24 pediatric intensive care beds will remain unchanged as part of this project.

Focus on Adult Intensive Care Utilization

The utilization of the adult intensive care beds at the Medical Center was even higher than total intensive care bed occupancy and was consistently above the State Standard Target Occupancy. See below.

Attachment 20,  
Table 8  
Total Adult Utilization in 2010 and 2011

Year	Patient Days	Average Daily Census	Beds	Percent Occupancy	State Agency Occupancy Target
2010	26,534	72.7	79	92.0	60.0
2011	26,147	71.6	79	90.7	60.0

Source: ACMC 2011 Annual Hospital Questionnaire and *Hospital Profiles, 2010*.

Adjustment for Bypass Volume

The utilization provided in Attachment 20, Table 8 does not include bypass days. Bypass occurs when there are no available monitored (intensive care or telemetry) beds at the Medical Center and incoming ambulances must “bypass” the Medical Center and take patients to other facilities. Critical bypass occurs when the Emergency Department has a high number of high acuity patients waiting for a bed. Because ACMC is a destination hospital for many high risk patients and also a Level I Trauma Center (the highest designation), this inability to admit immediately to an intensive care bed can result in poor outcomes.

Bypass hours reported at the Medical Center have increased steadily over the last 6 years. Based on ACMC’s experience, for each hour that ACMC is on bypass, 2.5 admissions must be redirected to another facility. In 2011, there were 1,091.3 bypass hours or the equivalent of

2,728 admissions. Based on the number of redirected admissions that would have required an intensive care bed and the average length of stay for intensive care patients, the Medical Center determined that 331 additional intensive care admissions and 2,115 additional days would have been reported if an intensive care bed had been available. This volume does not include patients held in surgery or in the cardiac cath lab because no intensive care bed is available.

Attachment 20, Table 9  
Intensive Care Bypass Admissions and Days

Year	Admissions	Days
2006	54	310
2007	122	822
2008	163	1,206
2009	112	807
2010	228	1,597
2011	331	2,115
Percent Increase	513.0	682.3

Source: APMC Internal Financial Data

When actual days are adjusted to account for redirected bypass days, average occupancy increases to almost 100 percent.

Attachment 20, Table 10  
Total Potential Adult Utilization including Bypass in 2010 and 2011

Year	Patient Days	Bypass Days	Total Days	Average Daily Census	Beds	Percent Occupancy	State Agency Occupancy Target	Current Bed Need
2010	26,534	1,597	28,131	77.1	79	97.6	60.0	129
2011	26,147	2,115	28,262	77.4	79	98.0	60.0	129

Source: APMC Internal Financial Data

At these adjusted high overall average occupancies, it is evident that many days the existing intensive care beds would have been near 100 percent occupancy. At these extremely high occupancies, critical breakdowns are likely to occur.

According to the American Journal of Respiratory and Critical Care Medicine, online February 16, 2012 (<http://bit.ly/zk7aZS>) patients that were turned away (bypassed) had a higher risk of dying than patients who were admitted to an ICU right away.

Because patients initially directed to ACMC are very acutely ill, they must be retransferred to similarly advanced intensive care centers in downtown Chicago. According to the above article the following are among the reasons that bypassed patients have a higher risk of dying.

These additional transfers:

- Take time; patients may not survive the trip into downtown Chicago
- Require additional hand-offs and thereby increase risk and the chances for errors
- Take the patients and families away from their physicians and continuity of care suffers, and
- Take the patients and families away from their support network.

When intensive care beds are not available, it is also impossible to make needed in-house transfers. This occurs, for example, when a patient “codes” on a medical surgical unit. Under these conditions, the patient must remain on the medical surgical unit with an intensive care nurse until a bed can be made available.

As part of this application, the Medical Center is proposing to increase the adult intensive care bed complement from 79 to 165 beds. The 79 existing beds are located in 4 units.

The additional 108 adult intensive care beds will be located on 3 levels of the new tower; each new unit will have 36 beds. These units and their respective bed complements are:

Attachment 20, Table 11  
Current and Proposed Adult Intensive Care Bed Complements

Unit	Location	Number of Existing Beds	Number of Proposed Beds
SINI (Surgery and Neurosurgery)	Existing Hospital (OR/ICU Building)	20	2
SVTU (Vascular and Thoracic Surgery incl. Transplant Patients)	Existing Hospital (OR/ICU Building)	17	17
AHSU (Adult Heart Surgery Unit)	Existing Hospital (OR/ICU Building)	20	2
MICCU (Medical Intensive Critical Care)	Existing Hospital (South Patient Tower)	22	Decommissioned
Cardiac/Thoracic ICU including Transplant	Patient Tower	--	3
Neuro/Medicine	Patient Tower	--	3
Medical Intensive Care	Patient Tower	--	3
<b>Total</b>		<b>79</b>	<b>165</b>

Source: ACMC Records. <sup>1</sup> Note: Does not include 24 pediatric intensive care beds in AHCH.

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

Advocate Christ Medical Center’s intensive care service is a regional resource and a safety net for critically ill and injured patients. As shown on Attachment 20, Exhibit 8, patients that are treated in the Medical Center’s intensive care units come from a very large geographic area. In 2011, 18.6 percent of the intensive care patients were from Illinois beyond the Medical Center’s defined primary and secondary service areas and another 3.6 percent were from Other States. This broad geographic reach reflects the regional patient referrals to the Medical Center’s tertiary and quaternary services.

Case Mix Index (CMI) is used as a measure of the acuity of the patient mix at a hospital. The higher the CMI, the sicker the patients, the more complex the surgeries, and the more resources are required to treat them. The higher the case mix index, the higher the acuity of the patient mix at that facility.

The following table is a compilation of the medical and surgical case mix indices (CMIs) for the major teaching hospitals in the Chicago Area. The Medical Center’s CMIs rank with the other major teaching hospitals in the area.

Attachment 20, Table 12  
Case Mix Index of other Teaching Hospitals in the Chicago Area

Provider Facility	Medical CMI	Surgical CMI
University of Chicago Medical Center	1.17	3.12
Loyola University Medical Center	1.11	2.93
Advocate Christ Medical Center	1.02	2.89
Rush University Medical Center	1.15	2.68
University of Illinois Medical Center at Chicago	.97	2.64
Northwestern Memorial Hospital	.88	2.40

Source: Illinois Comp Data

As shown on Attachment 20, Table 13 of all the hospitals in Planning Area A-04, Advocate Christ Medical Center clearly has the highest case mix index and frequently receives high risk acutely ill transfers from other area hospitals. Referrals are from other Advocate hospitals, from hospitals in the Medical Center’s Health Planning Area (A-04), and from hospitals located in other areas. During an almost 6-month sample period from August 25, 2011 through

February 29, 2012, the Medical Center received at least 570 intensive care patients from the following hospitals:

Attachment 20, Table 13  
Direct Admissions to ACMC Intensive Care  
August 25, 2011 through February 29, 2012

Referral Source	Referrals
Palos Community	100
St. James	99
Advocate Trinity	67
Holy Cross	63
Advocate South Suburban	45
St. Margaret Mercy	38
Little Company of Mary	38
Roseland	36
Metro South	30
Ingalls	17
Methodist	9
St. Anthony	8
Munster Community	6
Advocate Good Samaritan	4
St Mary	3
University of Illinois	3
Silver Cross	2
South Shore	2
<b>Total</b>	<b>570</b>

Source: ACMC Transfer Report

As shown below, the case mix index also defines the level on acuity of the adult intensive care patients at the Medical Center.

Attachment 20, Table 14  
Case Mix Index of the Adult Intensive Care Units at ACMC

ICU Unit	Case Mix Index (CMI)
ASHU (Adult Surgical Heart Unit)	6.86
MICCU (Medical Intensive Critical Care Unit)	3.14
SINI (Surgery and Neurosurgery)	3.82
SVTU (Vascular and Thoracic Surgery)	3.67

Source: ACMC Internal Financial Data

Note: Case mix index is calculated by dividing weighted DRGs into total cases.

These very high intensive care CMIs clearly demonstrate the acuity of care being delivered on the Medical Center's adult intensive care units. The Medical Center can provide intensive care resources

that are not available at other area hospitals; these resources include specialty and subspecialty physicians, nurses with advanced training, and leading edge technology.

At the completion of the proposed project, the 7 adult intensive care units will be dedicated to patients with specific needs – for example, one will be for heart surgery patients, a second for thoracic and vascular and transplant (heart and kidney) patients, a third for neurosurgery patients, and a fourth for medical intensive care, and so on.

The specially trained nursing staff on the intensive care units is an important distinction between the units at the Medical Center and those at area hospitals. APMC is a Magnet certified facility.

Magnet status represents the highest honor in nursing excellence. APMC has also been awarded the Beacon award, American Nurses Credentialing Center's recognition for excellence in critical/intensive care nursing. New intensive care nurses are all bachelor prepared. All nurses must complete approximately 2 years working in the intensive care units at which time they are required to sit for board certification in their respective specialties. By the end of 2012, all intensive care nurses at the Medical Center will be certified.

Advance Practice Nurses provide continuing education for the intensive care nurses so their knowledge and skills are continually enhanced. APMC provides clinical training experience for nursing students from several colleges and universities.

APMC seldom refers patients to other facilities either in the planning area or beyond, as noted on Attachment 20, Table 15. Community hospitals do not provide the same acuity of care as the Medical Center.

Attachment 20, Table 15  
Case Mix Index of Hospitals in Planning Area A-04

Provider Facility	Medical CMI	Surgical CMI
Little Company of Mary	NA	NA
Franciscan St. James, Chicago Heights	0.94	2.00
Silver Cross	0.91	2.05
Advocate South Suburban Hospital	0.98	2.11
Ingalls Memorial	0.95	2.23
MetroSouth	1.03	2.28
Franciscan St. James, Olympia Fields	0.86	2.29
Palos Community	0.97	2.36
Adventist LaGrange Memorial	1.03	2.45
Advocate Christ Medical Center	1.02	2.89

Source: Hospital Profiles, 2010 and Illinois CompData

See Notes 1 and 2 on next page.

Note 1: In July 2008, Silver Cross Hospital, the Health Facilities and Services Review Board awarded Permit #07-148; this permit allowed the Hospital to establish a new hospital in New Lenox (Planning Area A-04) and discontinue the existing hospital in Planning Area A-13. The new hospital opened in 2011. The utilization data presented herein represents the Hospital's last full year of operation in Planning Area A-13.

Note 2: Little Company of Mary does not report to CompData.

## B. Projected Referrals

The applicant shall provide the following:

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

Criterion ii) through iv) not included.

## C. Projected Service Demand – Based on Rapid Population Growth

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

- i. *The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;*
- ii. *Population projections shall be produced, using, as a base, the population census or estimate for the recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH.*

Criterion iii) through vii) not included.

Advocate Christ Medical Center did not solicit referral letters from physicians. Many of the ACMC physicians have privileges at other area hospitals and when a patient's acuity permits, the physicians may prefer to keep these patients in their local community with their primary care physician and family support network.

The Medical Center does not meet the Rapid Population Growth Criteria.

Because bed need could not be justified using either the physician referral or the rapid population growth options suggested in the application, the Medical Center used the following methodology to determine current and future bed need.

Current Adult Intensive Care Bed Need

When current utilization is adjusted for bypass volume, the Medical Center can justify 129 adult intensive care beds. This calculation does not fully account for other unmet demands on the intensive care beds – such as patients held in surgery or the cardiac cath lab.

Today, the Medical Center has only 61 percent of the intensive care beds that can be justified.

$$79 \text{ existing adult intensive care beds} \div 129 \text{ current bed need} = 61.2 \text{ percent.}$$

Attachment 20, Table 16  
Current Adult Intensive Care Bed Need

Year	Patient Days	Bypass Days	Total Days	Average Daily Census			State Agency Target Occupancy	Current Bed Need		
				Patient Days	Bypass Days	Total		Patient Days	Bypass Days	Total
2010	26,534	1,597	28,131	72.7	4.4	77.1	60.0	121.2	7.3	129
2011	26,147	2,115	28,262	71.6	5.8	77.4	60.0	119.3	9.7	129

Source: APMC Financial Records, APMC Daily Bypass Report

Projected Bed Need

CAGR Trend Line Projection

Based on remarkable growth of the Medical Center’s intensive care service over the last several years, it would not be prudent to expand the capacity to only 129 beds. By so doing, the Medical Center’s intensive care beds would most likely be overcapacity on the day they opened requiring more costly and disruptive construction to begin immediately.

To test what future bed need would be, the Medical Center prepared a CAGR (compound annual growth rate) trend line projection of bed need to 2017 (the expected second full year of operation of the proposed intensive care bed expansion) and beyond. The CAGR trend line accounted for the lost bypass activity described above.

The CAGR methodology justifies the need for 174 adult intensive care beds in 2017, the second full year of utilization. The Medical Center extended the trend line to 2021 to show that continued growth is projected. The Medical Center is conservatively proposing to add 86 adult intensive care beds for a total of 165.

See Attachment 20, Exhibit 9 for full details of the projection methodology.

## Bed Projection Using CAGR Trend Line Methodology

Year	Projected Patient Days	Projected Average Daily Census	Bed Need at 60 Percent Occupancy
2017	37,975	104.0	174
2021	46,241	126.7	212

Source: ACMC Business Development

By 2017, the second full year of utilization, the proposed 165 adult intensive care bed complement is expected to operate at 63.0 percent occupancy, or higher than the State Standard Target occupancy of 60 percent. By 2021 these beds are expected to operate at 76.7 percent occupancy.

2017

$37,975 \text{ patient days} \div 365 \text{ days per year} = 104.0 \text{ average daily census}$

$104.0 \text{ average daily census} \div 165 \text{ beds} = 63.0 \text{ percent occupancy}$

$63.0 \text{ percent occupancy} > \text{State Standard Target Occupancy or } 60 \text{ percent occupancy}$

2021

$46,241 \text{ patient days} \div 365 \text{ days per year} = 126.7 \text{ average daily census}$

$126.7 \text{ average daily census} \div 165 \text{ beds} = 76.7 \text{ percent occupancy}$

$76.7 \text{ percent occupancy} > \text{State Standard Target Occupancy or } 60 \text{ percent occupancy}$

D. Category of Service Utilization

- 1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated of functionally obsolete and need to be replaced or modernized due to such factors as, but not limited to:
  - A) High cost of maintenance
  - B) Non-compliant with licensing or life safety codes
  - C) Changes in standards of care (e.g. private vs. multiple bedrooms); or
  - D) Additional Space for diagnostic or therapeutic services.
- 2) Documentation shall include the most recent Medicare and Medicaid Services (CMMS) inspection reports, and
- 3) Other documentation shall include the following as applicable to the factors cited in the application.
  - A) Copies of maintenance reports
  - B) Copies of citations for life safety code violations, and
  - C) Other pertinent reports and data.

There are no code deficiencies or licensure issues directly related to the Medical Intensive Critical Care Unit (MICCU) at Advocate Christ Medical Center (ACMC, Medical Center). See Plan of Correction in Appendix 1.

The Medical Center's MICCU is located on the fourth floor of the South Tower which was completed in 1986. The unit has been operating under the original existing conditions; it was designed to house 3 separate units and had two 6-bed pods and one 10-bed pod. Even though these pods have been transitioned to function as a single unit, due to the physical arrangement of the pods, the floor plan layout is in impediment and the unit has no capacity for expansion to accommodate current and projected volume of medical intensive care patients.

The unit is undersized; it is located in 8,746 GSF or 398 GSF per bed, compared to the State Guideline of 600 to 685 GSF per bed. The option of remodeling in place was rejected. If the unit were to be remodeled, it would be required to meet all current IDPH requirements. In that process the number of beds would be reduced at a time when the Medical Center needs more rather than fewer medical intensive care beds.

Nurse staff coverage on this unit is very difficult. Nurses are essentially confined to their pods. This causes some staff isolation and results in nurses traveling long distances which hinder direct visibility, communication and teamwork.

The most acutely ill medical intensive care patients are assigned to the 10-bed pod. This becomes a bed management and staffing issue when the acuity of one or more of the patients changes; this requires moving patients between the two smaller pods and the large pod depending on patient acuity and bed availability.

The configuration of the pods does not lend itself to centralizing support spaces for supplies and medication, soiled and clean rooms. Hence the amount of supplies, medications and equipment and technology is redundant in order to service the 3 pods that are not adjacent or contiguous to each other.

The location of the existing MICCU is remote from the main hospital towers where the other intensive care units are housed and where MRI, CT, and other imaging equipment and diagnostic services are located. The elevators in the current location are not sized sufficiently or designated to accommodate the patients, their care team and all of their equipment; MICCU bariatric patients are transported in the freight elevators because the regular patient elevators cannot accommodate the bariatric beds. Transport time is increased due to wait times and travel distances to other building elevators.

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

The response to b) 4) provides the justification for the proposed addition of 86 adult intensive care beds at Advocate Christ Medical Center. Based on current utilization at the Medical Center, need for 51 intensive care beds in the planning area as well as more in nearby planning areas and statewide, and a CAGR-trend line projection and supporting documentation, the Medical Center has justified the need for as many as 198 total intensive care beds and 174 adult intensive care beds. The Medical Center is conservatively maintaining the existing 24 pediatric intensive care beds as is and proposing to add 86 adult intensive care beds for a total of 165 adult intensive care beds and a combined total of 189 adult and pediatric intensive care beds.

#### Validation of the CAGR Projections

The CAGR trend line projection anticipates the need for 95 additional intensive care beds at Advocate Christ Medical Center.

Before accepting the CAGR projection, Medical Center leadership identified the factors that would impact future demand for adult intensive care services and found that, in fact, the 95-bed need projection is conservative.

#### Deficit of 51 Intensive Care Beds in Planning Area A-04

As of July 2012, the Illinois Department of Public Health identified the need for 51 additional intensive care beds in Planning Area A-04 (the planning area in which the Medical Center is located). Other nearby planning areas served by the Medical Center also showed an intensive care bed deficit. Further, the overall State deficit is 321 intensive care beds and the Medical Center serves patients from throughout the State.

The proposed intensive care bed expansion at the Medical Center will help alleviate the need for intensive care beds in Planning Area A-04, in other nearby planning areas, and statewide.

#### Current Utilization Justifies the Need for 50 Additional Adult Intensive Care Beds

In 2011, the Medical Center recorded 26,147 patient days and 2,115 bypass days or a planning base line of 28,262 days. Using standard formulas, this volume could support 129 beds at the State Standard Target of 60 percent occupancy. This is 50 more than the current number of authorized adult intensive care beds at the Medical Center.

28,262 patient days ÷ 365 days per year = 77.4 average daily census

77.4 average daily census ÷ 60 percent occupancy = 129 needed beds

129 needed beds > 79 authorized beds

The proposed bed addition will alleviate the existing intensive care bed shortage at the Medical Center.

Impact of New Physicians on the Medical Staff: New Physicians Increase the Need for Intensive Care Beds by 10 Beds

New physicians join the Medical Center's medical staff each year – these new physicians and their patients have direct implications for intensive care utilization.

Since 2009, 15 new physicians joined the medical staff and they are having a substantial impact on current and future need for intensive care beds by 2017, the second full year of utilization of the proposed additional beds. These physicians are not replacing retiring physicians; they are new physicians. These physicians are expected to achieve their productivity targets and increase other total activity by 837 admissions and 2,162 intensive care days by 2017. On the table below, total days have been adjusted by specialty to arrive at an expected number of future incremental additional intensive care days.

Attachment 20, Table 18  
New Physicians and Projected Patients

Physician	Specialty	Incremental Patients in 2017	Incremental Intensive Care Days in 2017
Elias Jweied	Cardiovascular	40	395
Anthony Rousou	Cardiovascular	21	207
Mini Sivadasan	Cardiovascular	18	176
Herron Burnetta	General Surgery	146	125
Adam Riker	General Surgery	49	42
Caleb Lippman	Neurosurgery	63	215
Kevin Waldron	Neurosurgery	87	297
Salman Chaudri	Orthopedic Surgery	50	17
Paul Papierski	Orthopedic Surgery	47	14
Nirav Shah	Orthopedic Surgery	26	9
Trista Brown	Vascular Surgery	112	207
Wade Kang	Vascular Surgery	111	206
Richard Belch	Gynecologic Surgery	40	140

Physician	Specialty	Incremental Patients in 2017	Incremental Intensive Care Days in 2017
Eloise Chapman-Davis	Gynecologic Surgery	16	56
Michael Patrick Lowe	Gynecologic Surgery	16	56
Total Patients		837	2,162

Source: APMC Business Development

The proposed 2,162 additional patient days translate into the need for 10 additional intensive care beds.

$$2,162 \text{ patient days} \div 365 \text{ days per year} = 5.9 \text{ average daily census}$$

$$5.9 \text{ average daily census} \div 60 \text{ percent occupancy} = 10 \text{ needed beds}$$

A letter from Mr. Kenneth Lukhard, the Medical Center's CEO, certifying that these physicians are on the Medical Center's medical staff is included as Attachment 20, Exhibit 10.

Aging of the Population Will Intensify the Need for at least 4 Additional Intensive Care Beds

The senior population, those 45 to 65+, is expected to increase over the next decade. To gauge the impact of aging, the Medical Center used the population residing within 30 miles. This population is expected to increase 7.2 percent, or approximately 0.7 percent per year. See Attachment 20, Exhibit 11.

In 2011, the Medical Center reported 26,147 intensive care days; the records show that patients age 45 and older accounted for 69 percent of these days. Hence, 18,041 days are related to this senior population.

$$26,147 \text{ intensive care days} \times 69 \text{ percent increase} = \\ 18,041 \text{ adjusted days}$$

Population within these age cohorts that live within 30 miles of the Medical Center are projected to increase 7.2 percent over the next decade, or by 4.3 percent in the second full year of utilization of the proposed intensive care beds.

$$18,041 \text{ intensive care days to seniors} \times 4.3 \text{ percent increase to 2017} = \\ 18,817 \text{ total intensive care days to seniors}$$

The increase in days suggests the number of intensive care beds that would be required due to aging and need to provide access to this population.

18,817 future senior intensive care patient days - 18,041 current senior intensive care patient days =  
776 new patient days  
776 new patient days ÷ 365 days per year = 2.1 average daily census  
2.1 average daily census ÷ 60 percent occupancy = 4 additional beds

#### Future Expansion of the Level I Trauma Center

The next proposed phase of development on the Medical Center's campus will include the expansion of the Level I Trauma Center.

Level I Trauma Centers are equipped and staffed to initiate care on very critically ill and seriously injured patients.

The Medical Center is the only Level I Trauma Center in Planning Area A-04 and, one of the busiest emergency departments in Illinois with 90,192 total visits in 2011. Of these 1,470 were trauma visits; the trauma visits accounted for 978 hospital admissions. Hence, 66.5 percent of trauma visits were admitted to the hospital, and many were admitted to an intensive care bed.

The Medical Center is in the process of developing detailed projections of future trauma volume in the modernized Level I Trauma Center and the impact on other areas of the hospital including intensive care. An adequately sized Level I Trauma Center will enhance access for local and referred patients and increase demand for intensive care beds.

An expanded Trauma Center and increased intensive care beds will support the Medical Center's role as a safety net hospital.

#### Advances in Medicine Will Increase the Need for Intensive Care Beds at the Medical Center

Exciting advances in medicine are available at the Medical Center and will continue to increase the need for intensive care beds.

The Medical Center is at the leading edge of many new clinical techniques and technology that have profoundly positive outcomes for patients. These innovations in advanced care require not only the technology, but teams of specially trained physicians, nurses, and professional staff; they also require consistent case volumes to maintain skills. Many of them also require immediate intervention.

For example, the Medical Center is at the leading edge of ventricular assist device (VAD) implementation. This complex procedure involves implanting a device within the thoracic cavity which provides life-saving assistance to a patient's heart which is no longer strong enough to pump sufficient quantities of blood throughout the body. VAD implementation is recognized as the most

advanced treatment option for congestive heart failure patients. Today, this technology is used as a bridge to transplant – that is, VAD devices are used to sustain a patient in advanced heart failure until a heart to be transplanted becomes available. The highly experienced VAD team also serves as the Medical Center’s heart transplant team. Today, the Medical Center is participating in clinical trials that would allow a VAD to be used as “destination therapy,” that is, it would sustain a patient without the need to have a transplant.

The Medical Center is a Primary Stroke Center which means that the neurosciences team is expert in assessing stroke patients effectively and administering treatments that can prevent disability. The Medical Center is taking the necessary steps to become a Comprehensive Stroke Center. More than 1,200 stroke patients are treated at ACMC each year; they are treated by interventional radiologists, neurosurgeons, neuro stroke physicians - all on call 24 hours per day/ 7 days per week.

At the Medical Center, a Level 1 Trauma Center is always prepared for incoming stroke patients. The life-saving stroke protocols at the Medical Center are 50 percent faster than the Joint Commission’s standard. There is also a dedicated neuro intensive care unit.

The stroke team is using the Pipeline device for treatment of brain aneurysms which are life threatening if they rupture. The team also uses the new “Solitaire” flow- restoration device that can restore circulation and remove clots at the same time. In addition, the physicians at the Medical Center are also planning to use fenestrated aortic (endovascular) grafts to treat abdominal aortic aneurysms; these grafts seal off the aneurysms so they do not rupture while at the same time maintaining the blood flow to vital organs.

Other advanced procedures are available at the Medical Center. For example, the Medical Center is one of few hospitals in the State to perform percutaneous valve surgery for patients too sick to undergo aortic valve replacement. Its teams are performing kidney and heart transplants with excellent outcomes, treating pulmonary hypertension, performing new electrophysiology hybrid a-fibulation procedures, and trauma as well as artificial heart surgery.

For many of these patients, any delay, even minutes, means living with unnecessary permanent mental or physical deficits; or it could mean loss of life.

Today, as the result of these new technologies and skills, many patients who were formerly thought to be too high risk to be treated, are now being treated with good outcomes. These patients often require long lengths of stay in the intensive care unit – 30 days or more is not uncommon.

For these patients **time is life**. When the Medical Center is on bypass and ambulances must travel many miles to the next tertiary/quaternary center, valuable minutes are lost. To ensure that the

Medical Center remains a safety net provider and all patients get the care they need – with these and other innovative interventions - the Medical Center must have more intensive care bed capacity.

### Summary

The Medical Center is conservatively requesting 165 adult plus the 24 pediatric for a total of 189 intensive care beds. By conservatively assuming that pediatric utilization remains constant at the 2011 level, the overall occupancy of the 189 total intensive care beds in 2017 would be at least 68.0 percent.

$$37,975 \text{ CAGR projected days} + 2,162 \text{ new physician days} + 6,790 \text{ pediatric days} = 46,927 \text{ total days}$$

$$46,927 \text{ total days} \div 365 = 128.6 \text{ average daily census}$$

$$128.6 \text{ average daily census} \div 189 \text{ beds} = 68.0 \text{ percent occupancy}$$

$$68.0 \text{ percent occupancy} > 60.0 \text{ percent State Agency target occupancy.}$$

Advocate Christ Medical Center believes the intensive care bed need projection is conservative.

### Conclusion

Today, Advocate Christ Medical Center has 103 intensive care beds – 79 adult beds and 24 pediatric beds. As part of this project, the number of pediatric beds will remain unchanged while the Medical Center proposes to increase the number of adult intensive care beds from 79 to 165. In 2011, the adult and pediatric intensive care beds at the Medical Center operated at over 90 percent; with the inclusion of by-pass patients, the utilization approached 100 percent. The ability to meet current and future community and regional need for advanced intensive care services is restrained because of the severely limited number of intensive care beds at the Medical Center.

The need for the additional beds is a function of several factors. The first is the ongoing expansion of tertiary and quaternary services at the Medical Center; these include the Level I Trauma Center, one of the busiest centers in the State, the largest heart surgery and VAD program (the busiest in the country), the stroke program and the heart and kidney transplant programs, to name a few. The second is ACMC's regional referral role and the need to care for patients from the community hospitals that have neither the depth of medical or surgical specialists and subspecialists, nor the specialty intensive care nurses, and professional staff, nor the technology to care for the acutely ill patients in the greater south and southwest Chicago area. The third is its critical role as a safety net provider.

These intensive care units are also essential teaching labs for the residents and fellows in a wide range of specialties and for nurses from more than 20 programs.

Most importantly, having the appropriate level of care – both specialist physicians and certified nurses, advanced technology as well as beds available as soon as the patient arrives at the Medical Center leads to lower mortality and better outcomes.

*e) Staffing Availability—Review Criterion*

*The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCHAO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.*

Advocate Christ Medical Center attests that all intensive care licensure and JCHAO staffing requirements will be met when the intensive care units are ready for occupancy. Because the new intensive care beds will not come on line until 2015, a longer term specific staff development plan is being developed.

The Medical Center has an ongoing physician recruitment program to bring new and replacement physicians onto the medical staff. The Medical Center's Human Resources Department has a waiting list of applicants who seek employment at the Medical Center.

Clinical specialists and associates seek employment at the Medical Center because of its reputation. APMC is part of the Advocate Health Care System; Advocate has been named one of Chicago's Top 100 Workplaces for the second year in a row by the *Chicago Tribune*; in fact, Advocate ranks fourth among the city's top 20 large companies.

Advocate offers employees a medical plan that provides incentives for completing health activities. Advocate also provides 100 percent reimbursement for pursuing specific certification, degrees and licensure in high-demand areas, as well as in-house continuing education.

## MEDICAL SURGICAL BED NEED

### Introduction

Advocate Christ Medical Center (ACMC, Medical Center) is currently authorized to operate 378 medical surgical beds. Of these, 376 beds are currently set up and staffed and 2 beds have been placed in reserve.

In July 2009, Illinois Governor Patrick Quinn signed the Amended Illinois Health Facilities Planning Act into law (20 ICLS 3960). One of the amendments allows a hospital to change its authorized bed capacity by as many as 20 beds over a 2-year period without obtaining a certificate of need permit. The Medical Center submitted an Assessment of Applicability form to the Health Facilities and Services Review Board (HFSRB) requesting a determination on whether the modernization of 17 medical surgical beds would require a certificate of need; this number of beds included 16 new beds consistent with the new amendments to the Planning Act and one of the existing reserve beds. On April 11, 2011, the Administrator of the Board acknowledged receipt of the letter and rendered an opinion that the modernization project would not require a certificate of need. See Attachment 20, Exhibit 12. At the time of filing this application, the letter was initially processed by HFSRB Staff and sent to the Illinois Department of Public Health (IDPH). IDPH has reviewed the plans and authorized the Medical Center to move forward with the modernization.

The Medical Center expects the modernization to be completed in early autumn of 2012 at which time IDPH will inspect the project and advise HFSRB of the project's compliance with all codes. The Medical Center will then advise HFSRB when the first patient is admitted to one of these beds and these beds then will be added to the IDPH Bed Inventory. Hence, it is anticipated that before the proposed Patient Tower project is heard by the HFSRB (currently scheduled for October 2012), the Medical Center will have 17 additional medical surgical beds that will be set up and staffed. At the time these beds are put into the Inventory, ACMC will have 394 medical surgical beds; of these 386 will be set up and staffed and 1 will remain in reserve. This action is independent of this Patient Tower project.

1110.530 b) 2) Service to Planning Area Residents

- A. *Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e. the planning or geographic service area, as applicable), for each category of service included in the project.*
- B. *Applicants proposing to add beds to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50 percent of admissions were residents of the area. For all other projects, applicants shall document that at least 50 percent of the projected patient volume will be from residents of the area.*
- C. *Applicants proposing to expand an existing category of service shall submit patient origin information by zip code based upon the patient's legal residence (other than health care facility).*

A., B., and C.

Advocate Christ Medical Center (ACMC, Medical Center) serves the local community as well as a broad regional market. The origin of medical surgical patients is more concentrated in the primary and secondary service areas than the total patient origin. The higher volume from Other Illinois and Other States in the total patient origin reflects the in-migration of patients from the regional market to the Medical Center's very specialized programs such as advanced cardiac and cancer care.

Attachment 20, Table 19  
Comparison of Total and Medical Surgical Patient Origin, 2011

Service Area	Total Percent	Medical Surgical Percent
Primary	68.8	74.4
Secondary	14.8	13.8
Total	83.7	88.2
Other Illinois	14.5	10.3
Other State	1.8	1.5
Grand Total	100.0	100.0

Source: ACMC Internal Financial Data and Declaratory Ruling approved by the HFSRB on June 5, 2012.

Attachment 20, Exhibit 13 provides the zip code detail of the above summarized medical surgical patient origin.

In 2011, 88.2 percent medical surgical patients at ACMC resided in the Medical Center's community service area. This is more than the 50 percent required by the review criterion. The Medical Center's primary purpose of the project will be to continue to provide services to residents of this area. In addition, it will continue to serve the regional market.

b) 4) Service Demand—Expansion of an Existing Category of Service

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

A) Historical Service Demand

i. *An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1110, for each of the latest two years.*

Attachment 20, Table 20  
Medical Surgical Utilization, 2010 and 2011

Year	Patient Days Including Observation Days	Average Daily Census	Authorized Beds	Percent Occupancy	State Standard Occupancy Target
2010	115,754	317.1	378	83.9	88.0
2011	113,723	311.6	378	82.4	88.0

Source: ACMC Internal Financial Data and Declaratory Ruling approved by the HFSRB on June 5, 2012

The Medical Center's medical surgical beds are operating at a very high occupancy when compared to all medical surgical beds in Illinois and in Planning Area A-04 (where the Medical Center is located). In the 2010 *Hospital Profiles* published by the Illinois Department of Public Health, the average medical surgical occupancy of all medical surgical beds statewide was 58.5 percent and comparable occupancy of the medical surgical beds in Planning Area A-04 was 57.8 percent.

Blocked Beds

Today, 33 percent of the Medical Center's medical surgical rooms are double occupancy. Frequently, one bed in a double room is blocked because the patient needs to be isolated because of a contagious condition, compromised immunity, a behavior issue or gender. Ventilator or hospice patients also require private rooms. Blocking a bed in a double room, takes the other bed out of service and reduces the number of available beds for other patients. Nor does this already high occupancy take into account when beds are necessarily out-of-service for routine and unexpected maintenance.

Implications of Bypass

As a result, in part, of the very high occupancy of the medical surgical telemetry beds, the Medical Center is on bypass and ambulances are diverted to other facilities. Diversions to another community hospital usually mean that the patient will be stabilized at the receiving

hospital that, in turn, will refer the patient back to the Medical Center as soon as a bed becomes available. Or, the patient may be referred to an academic medical center in downtown Chicago which separates the patient from his physicians and support network. Neither of these options is desirable.

Based on past experience, the Medical Center has been able to estimate the number of admissions per hour that are lost to the Medical Center when it is on bypass and has been able to convert those admissions into patient days. If the lost medical surgical days (8,364 in 2010 and 11,000 in 2011) are included in the calculation of current bed need (even without an adjustment for blocked beds or maintenance), a more realistic picture emerges of potential volume at the Medical Center. Had the Medical Center been able to accommodate the bypass patients, percent occupancy in each of the 2 years would have been 90.0 percent.

Attachment 20, Table 21  
Medical Surgical Utilization with Bypass, 2010 and 2011

Year	Patient Days Including Observation Days and Bypass Days	Average Daily Census	Authorized Beds	Percent Occupancy	State Standard Occupancy Target
2010	124,118	340.0	378	90.0	88.0
2011	124,723	341.7	378	90.4	88.0

Source: APMC Internal Financial Data and Declaratory Ruling approved by the HFSRB on June 5, 2012

**B. Projected Referrals**

The applicant shall provide the following:

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

Criterion ii) through iv) not included.

**C. Projected Service Demand – Based on Rapid Population Growth**

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

- iii. The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;*
- iv. Population projections shall be produced, using, as a base, the population census or estimate for the recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH.*

Criterion iii) through vii) not included.

Advocate Christ Medical Center did not solicit referral letters from the medical and surgical physicians. The Medical Center does not plan to add medical surgical beds as part of this project, but rather modernize rooms to accommodate 10 of the 17 medical surgical beds that will be taken out of service when the connector between the existing tower and the proposed Patient Tower is constructed. The remaining 7 beds will be put in reserve.

#### CAGR Bed Need Projection

The Medical Center did not solicit physician referral letters. Many of the Medical Center's medical surgical physicians have privileges at other area hospitals and may admit cases to them that do not need the resources available at the Medical Center.

The Medical Center's service area does not qualify as a rapid population growth area. Because bed need could not be justified using the physician referral letters or rapid population growth options suggested by the application, the Medical Center used the following methodology to determine medical surgical bed need.

The Medical Center prepared a CAGR (compound annual growth rate) trend line projection of potential need for medical surgical beds through 2017, the second full year that the proposed Patient Tower will be operational and beyond. This projection is included as Attachment 20, Exhibit 14 and shows that in 2017, the second full year of utilization, 384 medical surgical beds would be needed at 88 percent occupancy. The Medical Center's 386 staffed beds at project completion will operate at 87.4 percent occupancy.

Early in the Medical Center's planning for the new Patient Tower, an additional level of medical surgical beds was included. However, this level was removed from the new construction.

Several factors contributed to this decision.

- In April 2011, the HFSRB issued an opinion that the Medical Center could modernize space to house 17 medical surgical beds; of these 16 will be new beds and 1 will come out of reserve. These beds will increase the number of available medical surgical beds. This modernization is not part of this project.
- Consistent with State and Federal healthcare goals, the Medical Center's efforts to reduce length of stay as well as the number of unnecessary admissions and readmissions have been very successful, especially in the medical surgical service. The Medical Center is already seeing the impact of these efforts with a modest reduction in recent years of total medical surgical days.
- In late 2011, the Health Facilities and Services Review Board approved the Medical Center's request to construct an Outpatient Pavilion. The sophisticated ambulatory care

programs being developed in the Outpatient Pavilion have the potential to further reduce general medical surgical admissions.

- There will be a modest amount of shell space and vacated space in the Patient Tower. As noted in Attachment 16, the Medical Center's current plan is to modernize these spaces for private medical surgical beds, thereby reducing the currently high percentage of double occupancy rooms. Single occupancy rooms can be utilized at a higher occupancy rate than double occupancy rooms. This modernization is not part of this project.

There is little doubt that the Medical Center has among the most highly utilized medical surgical beds of all Illinois hospitals.

- ii. *If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including patient origin by zip code, name and specialty of referring physicians, for each of the latest two years.*

Because the medical center is a tertiary/ quaternary regional referral center; patients are seldom referred to other hospitals, except in the case of bypass noted above.

d) Category of Service

- 1) *If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized due to such factors but not limited to:*
  - A) *High cost of maintenance*
  - B) *Non-compliance with licensing or life safety codes*
  - C) *Changes in standards of care (e.g. private versus multiple bedrooms;*  
*or,*
  - D) *Additional space for diagnostic or therapeutic purposes.*
2. *Documentation shall include the most recent:*
  - A) *IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and*
  - B) *Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports.*
3. *Other documentation shall include the following, as applicable to the factors cited in the application:*
  - A) *Copies of maintenance reports*
  - B) *Copies of citations for life safety code violations, and*
  - C) *Other pertinent reports and data.*

The construction/modernization is not related to high cost of maintenance, noncompliance with licensing or life safety codes, changes in standards of care, or additional space for diagnostic or therapeutic services.

As part of this project 17 medical surgical beds will be taken out of service as part of the construction of a connector between the existing tower and the proposed Patient Tower. The Medical Center will remodel existing rooms to accommodate 10 of these beds and put the other 7 into reserve.

e) Staffing Availability—Review Criterion

*The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCHAO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.*

The Medical Center is currently staffing 376 of the 378 authorized medical surgical beds; the other two are in reserve. The Medical Center has the relevant professional staffing for the medical surgical beds at the completion of the modernization to staff the available medical surgical beds.

Advocate Christ Medical Center attests to the fact that all medical surgical licensure and JCHAO staffing requirements are currently being met and will continue to be met when the “connector” medical surgical beds are ready for occupancy.

The Medical Center has an ongoing physician recruitment program to bring new and replacement physicians onto the medical staff. The Medical Center’s Human Resources Department has a waiting list of applicants who seek employment at the Medical Center.

Clinical specialists and associates seek employment at the Medical Center because of its reputation. ACMC is part of the Advocate Health Care System; Advocate has been named one of Chicago’s Top 100 Workplaces for the second year in a row by the *Chicago Tribune*; in fact, Advocate ranks fourth among the city’s top 20 large companies.

Advocate offers employees a medical plan that provides incentives for completing health activities. Advocate also provides 100 percent reimbursement for pursuing specific certification, degrees and licensure in high-demand areas, as well as in-house continuing education.

## 1110.530 f) Performance Requirements

Advocate Christ Medical Center (ACMC, Medical Center) is located in a Metropolitan Statistical Area

### 1) *Medical Surgical*

*The minimum bed capacity for a medical surgical category of service within a Metropolitan Statistical Area (MSA) is 100 beds.*

ACMC is proposing to have 394 medical surgical beds at the completion of this project; these include the 378 current authorized beds plus 16 beds added with Board approval.

394 medical surgical beds exceed the State Agency's minimum bed capacity for a medical surgical category of service.

394 proposed medical surgical beds > State Agency's minimum capacity of 100 beds

### 2) *Obstetrics*

*A) The minimum unit size for a new obstetric unit within an MSA is 20 beds.*

*B) The minimum unit size for a new obstetric unit outside an MSA is 4 beds.*

ACMC currently provides obstetrical services. The proposed obstetric unit at the Medical Center will exceed the minimum size guideline.

56 proposed obstetrical beds > State Agency's minimum capacity of 20 beds

### 3) *Intensive Care*

*The minimum unit size for an intensive care unit is 4 beds.*

ACMC currently provides adult and pediatric intensive care services. The proposed complement of 189 intensive care beds will exceed the State Agency's minimum guideline.

189 proposed intensive care beds > State Agency's minimum capacity of 4 beds

1110.530 g) Assurances

*The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the understanding that, by the second year of operation after project completion, the applicant shall achieve and maintain the occupancy standards specified in*

*77 Ill. Adm. Code 1100 for each category of service involved in the project.*

The required assurance letter is included as Attachment 20, Exhibit 15.

The required certification that new physicians are on the medical staff is included as Attachment 20, Exhibit 10.

## ACMC INPATIENT OBSTETRIC PATIENT ORIGIN 2011

SERVICE AREA	Zip Code	Community	Number of Patients	% of Total
<b>Primary Service Area (PSA)</b>	60453	Oak Lawn	339	7.4
	60629	Chicago Lawn	212	4.6
	60477	Tinley Park	193	4.2
	60655	Mount Greenwood	184	4.0
	60459	Burbank	173	3.8
	60652	Ashburn	162	3.5
	60462	Orland Park	147	3.2
	60415	Chicago Ridge	142	3.1
	60620	Auburn Park	136	3.0
	60452	Oak Forest	129	2.8
	60643	Morgan Park	113	2.5
	60445	Midlothian	113	2.5
	60803	Alsip	109	2.4
	60805	Evergreen Park	100	2.2
	60638	Clearing	88	1.9
	60487	Tinley Park	83	1.8
	60455	Bridgeview	78	1.7
	60458	Justice	72	1.6
	60482	Worth	69	1.5
	60465	Palos Hills	64	1.4
	60467	Orland Hills	58	1.3
	60457	Hickory Hills	57	1.2
	60632	Elsdon	43	0.9
	60456	Hometown	39	0.8
60463	Palos Heights	36	0.7	
60636	Ogden Park	31	0.3	
60464	Palos Park	15	0.0	
<b>PSA Total</b>			<b>2,985</b>	<b>65.2</b>
<b>Secondary Service Area (SSA)</b>	60628	Roseland	98	2.1
	60448	Mokena	74	1.6
	60423	Frankfort	60	1.3
	60619	Grand Crossing	58	1.3
	60617	South Chicago	56	1.2
	60441	Lockport	55	1.2
	60451	New Lenox	55	1.2
	60406	Blue Island	47	1.0
	60491	Homer Glen	44	1.0
	60827	Riverdale	35	0.8
	60649	South Shore	28	0.6
	60609	New City	25	0.5
	60621	Englewood	24	0.5
	60428	Markham	21	0.5
	60426	Harvey	21	0.5
	60439	Lemont	14	0.3
<b>SSA Total</b>			<b>715</b>	<b>15.6</b>
<b>Other Illinois Total</b>			<b>810</b>	<b>17.7</b>
<b>Other States Total</b>			<b>65</b>	<b>1.4</b>
<b>Grand Total</b>			<b>4,575</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA

## ACMC INPATIENT GYN PATIENT ORIGIN 2011

SERVICE AREA	Zip Code	Community	Number of Patients	% of Total
Primary Service Area (PSA)	60453	Oak Lawn	57	6.5
	60643	Morgan Park	45	5.1
	60620	Auburn Park	44	5.0
	60652	Ashburn	40	4.5
	60477	Tinley Park	25	2.8
	60459	Burbank	24	2.7
	60803	Alsip	23	2.6
	60636	Ogden Park	21	2.4
	60655	Mount Greenwood	20	2.3
	60629	Chicago Lawn	19	2.2
	60415	Chicago Ridge	17	2.0
	60638	Clearing	17	2.0
	60462	Orland Park	16	1.8
	60805	Evergreen Park	16	1.8
	60445	Midlothian	14	1.6
	60452	Oak Forest	13	1.5
	60482	Worth	11	1.3
	60465	Palos Hills	11	1.3
	60467	Orland Hills	10	1.2
	60455	Bridgeview	8	0.9
	60487	Tinley Park	7	0.8
	60457	Hickory Hills	6	0.7
	60632	Elsdon	6	0.7
60458	Justice	5	0.5	
60463	Palos Heights	5	0.5	
60464	Palos Park	4	0.4	
60456	Hometown	4	0.4	
<b>PSA Total</b>			<b>488</b>	<b>55.5</b>
Secondary Service Area (SSA)	60628	Roseland	48	5.3
	60619	Grand Crossing	28	3.2
	60617	South Chicago	25	2.8
	60649	South Shore	19	2.1
	60448	Mokena	12	1.4
	60423	Frankfort	11	1.3
	60827	Riverdale	10	1.1
	60426	Harvey	9	1.0
	60428	Markham	8	0.9
	60621	Englewood	7	0.8
	60406	Blue Island	7	0.8
	60609	New City	4	0.5
	60491	Homer Glen	4	0.5
	60439	Lemont	4	0.5
	60451	New Lenox	4	0.5
60441	Lockport	4	0.4	
<b>SSA Total</b>			<b>204</b>	<b>23.2</b>
<b>Other Illinois Total</b>			<b>179</b>	<b>20.3</b>
<b>Other States Total</b>			<b>9</b>	<b>1.0</b>
<b>Grand Total</b>			<b>880</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA

## ACMC INPATIENT OB/GYN PATIENT ORIGIN 2011

SERVICE AREA	Zip Code	Community	Number of Patients	% of Total
Primary Service Area (PSA)	60453	Oak Lawn	396	7.2
	60629	Chicago Lawn	231	4.2
	60477	Tinley Park	218	4.0
	60655	Mount Greenwood	204	3.7
	60652	Ashburn	202	3.7
	60459	Burbank	197	3.6
	60620	Auburn Park	187	3.3
	60462	Orland Park	163	3.0
	60643	Morgan Park	159	2.9
	60415	Chicago Ridge	159	2.9
	60452	Oak Forest	142	2.6
	60803	Alsip	132	2.4
	60445	Midlothian	127	2.3
	60805	Evergreen Park	116	2.1
	60638	Clearing	105	1.9
	60487	Tinley Park	90	1.6
	60455	Bridgeview	86	1.6
	60482	Worth	80	1.5
	60458	Justice	77	1.4
	60465	Palos Hills	75	1.4
	60467	Orland Hills	68	1.3
	60457	Hickory Hills	63	1.1
	60636	Ogden Park	52	1.0
	60632	Elsdon	49	0.9
60456	Hometown	43	0.8	
60463	Palos Heights	41	0.7	
60464	Palos Park	19	0.3	
<b>PSA Total</b>			<b>3,473</b>	<b>63.6</b>
Secondary Service Area (SSA)	60628	Roseland	146	2.7
	60619	Grand Crossing	86	1.6
	60448	Mokena	86	1.6
	60617	South Chicago	81	1.5
	60423	Frankfort	71	1.3
	60451	New Lenox	59	1.1
	60441	Lockport	59	1.1
	60406	Blue Island	54	1.1
	60491	Homer Glen	48	1.0
	60649	South Shore	47	0.9
	60827	Riverdale	45	0.9
	60621	Englewood	31	0.8
	60426	Harvey	30	0.6
	60609	New City	29	0.5
	60428	Markham	29	0.5
	60439	Lemont	18	0.3
<b>SSA Total</b>			<b>919</b>	<b>16.9</b>
<b>Other Illinois Total</b>			<b>989</b>	<b>18.1</b>
<b>Other States Total</b>			<b>74</b>	<b>1.3</b>
<b>Grand Total</b>			<b>5,455</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>	2005	2006	2007	2008	2009	2010	2011
<b>Combined OB/GYN</b>							
Utilization	13,854	14,008	15,314	15,474	15,173	16,166	15,599
Est Bypass <sup>2</sup>	-	-	-	-	-	-	-
Observation Days	180	133	145	73	75	121	113
Utilization + bypass <sup>2</sup>	14,034	14,141	15,459	15,547	15,248	16,287	15,712
<i>Target % State Occ</i>	<i>78%</i>						
ADC	38.4	38.7	42.4	42.5	41.8	44.6	43.0
<b>Bed Need</b>	<b>49.3</b>	<b>49.7</b>	<b>54.3</b>	<b>54.5</b>	<b>53.6</b>	<b>57.2</b>	<b>55.2</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) <sup>^</sup> (1 / number of years) - 1

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Combined OB/GYN</b>										
Utilization	15,900	16,207	16,522	16,844	17,174	17,512	17,857	18,211	18,574	18,945
Est Bypass <sup>2</sup>										
Observation Days										
Utilization + bypass <sup>2</sup>	16,014	16,324	16,640	16,965	17,296	17,636	17,983	18,339	18,704	19,077
<b>Target % State Occ</b>	<b>78%</b>									
ADC	43.8	44.7	45.6	46.5	47.3	48.3	49.3	50.2	51.2	52.3
<b>Bed Need</b>	<b>56.1</b>	<b>57.3</b>	<b>58.4</b>	<b>59.6</b>	<b>60.6</b>	<b>61.9</b>	<b>63.2</b>	<b>64.4</b>	<b>65.7</b>	<b>67.0</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) ^ (1 / number of years) - 1

### Projected Change in Female Population Aged 35 – 49

Age Cohort	2010	2015	2020	2010 - 2020 Percent Change	2025	2010 - 2025 Percent Change	2030	2010 - 2030 Percent Change
35-39	448,326	456,223	490,861	+ 9.5	503,199	12.2	518,236	15.6
40-44	455,068	445,850	455,954	+ 0.2	488,681	7.4	499,447	9.8
45-49	491,695	451,679	444,884	- 9.5	453,495	-7.8	484,756	-7.5
Total	1,395,089	1,353,752	1,391,699	- 0.2	1,445,375	3.6	1,502,439	5.5

Source: Illinois Department of Commerce and Economic Opportunity

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>		2005	2006	2007	2008	2009	2010	2011
Antepartum	Utilization				2,353	2,301	2,479	2,776
	Annual Growth					(52)	178	297
	Percent Growth							
	<i>Target % State Occ</i>				<i>78.0%</i>	<i>78.0%</i>	<i>78.0%</i>	<i>78.0%</i>
	ADC				6.4	6.3	6.8	7.6
	<b>Bed Need</b>				<b>8.2</b>	<b>8.1</b>	<b>8.7</b>	<b>9.8</b>

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Antepartum	Utilization	2,933	3,099	3,275	3,461	3,657	3,864	4,083	4,314	4,558	4,817
	Annual Growth	157	166	176	186	196	207	219	231	244	258
	Percent Growth	5.67%	5.67%	5.67%	5.67%	5.67%	5.67%	5.67%	5.67%	5.67%	5.67%
	<b>Target % State Occ</b>	<b>78.0%</b>									
	ADC	8.0	8.5	9.0	9.5	10.0	10.6	11.2	11.8	12.5	13.2
	<b>Bed Need</b>	<b>10.3</b>	<b>10.9</b>	<b>11.5</b>	<b>12.2</b>	<b>12.8</b>	<b>13.6</b>	<b>14.3</b>	<b>15.2</b>	<b>16.0</b>	<b>16.9</b>

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>	2005	2006	2007	2008	2009	2010	2011
<b>Clean GYN</b>							
Utilization	1,690	1,764	1,772	2,039	2,036	2,619	2,151
Est Bypass <sup>2</sup>	-	-	-	-	-	-	-
Observation Days	-	-	-	-	-	-	-
Utilization + bypass <sup>2</sup>	1,690	1,764	1,772	2,039	2,036	2,619	2,151
Annual Growth	1,690	74	8	267	(3)	583	(468)
Percent Growth							
<b>Target % State Occ</b>	<b>90%</b>						
ADC	4.6	4.8	4.9	5.6	5.6	7.2	5.9
<b>Bed Need</b>	<b>5.1</b>	<b>5.4</b>	<b>5.4</b>	<b>6.2</b>	<b>6.2</b>	<b>8.0</b>	<b>6.5</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) ^ (1 / number of years) - 1

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Clean GYN</b>										
Utilization	2,239	2,331	2,427	2,526	2,630	2,738	2,850	2,967	3,089	3,215
Est Bypass <sup>2</sup>										
Observation Days										
Utilization + bypass <sup>2</sup>	2,239	2,331	2,427	2,526	2,630	2,738	2,850	2,967	3,089	3,215
Annual Growth	88	92	96	100	104	108	112	117	122	127
Percent Growth	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%
<b>Target % State Occ</b>	<b>90%</b>									
ADC	6.1	6.4	6.6	6.9	7.2	7.5	7.8	8.1	8.5	8.8
<b>Bed Need</b>	<b>6.8</b>	<b>7.1</b>	<b>7.4</b>	<b>7.7</b>	<b>8.0</b>	<b>8.3</b>	<b>8.7</b>	<b>9.0</b>	<b>9.4</b>	<b>9.8</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) ^ (1 / number of years) - 1

## ACMC INPATIENT ICU PATIENT ORIGIN 2011

SERVICE AREA	Zip Code	Community	Number of Patients	% of Total
PSA	60415	Chicago Ridge	210	3.2
	60445	Midlothian	94	1.4
	60452	Oak Forest	84	1.3
	60453	Oak Lawn	747	11.3
	60455	Bridgeview	179	2.7
	60456	Hometown	53	0.8
	60457	Hickory Hills	90	1.4
	60458	Justice	52	0.8
	60459	Burbank	364	5.5
	60462	Orland Park	123	1.9
	60463	Palos Heights	100	1.5
	60464	Palos Park	41	0.6
	60465	Palos Hills	105	1.6
	60467	Orland Hills	45	0.7
	60477	Tinley Park	126	1.9
	60482	Worth	54	0.8
	60487	Tinley Park	37	0.6
	60620	Auburn Park	266	4.0
	60629	Chicago Lawn	211	3.2
	60632	Elsdon	67	1.0
	60636	Ogden Park	123	1.9
	60638	Clearing	121	1.8
	60643	Morgan Park	216	3.3
	60652	Ashburn	189	2.9
60655	Mount Greenwood	131	2.0	
60803	Alsip	132	2.0	
60805	Evergreen Park	113	1.7	
<b>PSA Total</b>			<b>4,073</b>	<b>61.7</b>
SSA	60406	Blue Island	43	0.7
	60423	Frankfort	30	0.5
	60426	Harvey	60	0.9
	60428	Markham	30	0.5
	60439	Lemont	13	0.2
	60441	Lockport	26	0.4
	60448	Mokena	29	0.4
	60451	New Lenox	33	0.5
	60491	Homer Glen	12	0.2
	60609	New City	33	0.5
	60617	South Chicago	176	2.7
	60619	Grand Crossing	125	1.9
	60621	Englewood	55	0.8
	60628	Roseland	281	4.3
	60649	South Shore	57	0.9
60827	Riverdale	58	0.9	
<b>SSA Total</b>			<b>1,061</b>	<b>16.1</b>
<b>Other Illinois Total</b>			<b>1,228</b>	<b>18.6</b>
<b>Other States Total</b>			<b>237</b>	<b>3.6</b>
<b>Grand Total</b>			<b>6,599</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA - DATA EXCLUDES NORMAL NEWBORNS

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>		2005	2006	2007	2008	2009	2010	2011
<b>Adult Intensive Care</b>	Utilization	19,576	18,447	20,570	25,870	25,935	26,534	26,147
	Est Bypass <sup>2</sup>	649	310	822	1,206	807	1,597	2,115
	Observation Days	-	-	-	-	-	-	-
	Utilization + bypass <sup>2</sup>	20,225	18,757	21,392	27,076	26,742	28,131	28,262
	Annual Growth	(32)	(1,129)	2,123	5,300	65	599	(387)
	Percent Growth							
	<b>Target % State Occ</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>
	ADC	55.4	51.4	58.6	74.0	73.3	77.1	77.4
<b>Bed Need</b>	<b>92.4</b>	<b>85.6</b>	<b>97.7</b>	<b>123.3</b>	<b>122.1</b>	<b>128.5</b>	<b>129.1</b>	

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) <sup>^</sup> (1 / number of years) - 1

**Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis**

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Adult Intensive Care</b>										
Utilization	27,467	28,853	30,309	31,838	33,445	35,133	36,906	38,768	40,725	42,780
Est Bypass <sup>2</sup>										
Observation Days										
Utilization + bypass <sup>2</sup>	29,688	31,187	32,760	34,414	36,150	37,975	39,891	41,904	44,019	46,241
Annual Growth	1,320	1,386	1,456	1,530	1,607	1,688	1,773	1,862	1,956	2,055
Percent Growth	5.05%	5.05%	5.05%	5.05%	5.05%	5.05%	5.05%	5.05%	5.05%	5.05%
<b>Target % State Occ</b>	<b>60%</b>									
ADC	81.1	85.4	89.8	94.3	98.8	104.0	109.3	114.8	120.6	126.7
<b>Bed Need</b>	<b>135.2</b>	<b>142.4</b>	<b>149.6</b>	<b>157.1</b>	<b>164.6</b>	<b>173.4</b>	<b>182.2</b>	<b>191.3</b>	<b>201.0</b>	<b>211.1</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) <sup>A</sup> (1 / number of years) - 1

 **Advocate Christ Medical Center**

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || [advocatehealth.com](http://advocatehealth.com)

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July 17, 2012

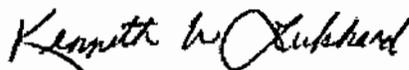
Mr. Dale Galassie,  
Chair  
Illinois Health Facilities Services and Review Board  
525 West Jefferson, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

Re: Assurance that Physicians Are Members of the Advocate Christ Medical Center Medical Staff

This letter provides the Health Facilities Services and Review Board with assurances that the physicians identified below are members of the Advocate Christ Medical Center Medical Staff. These physicians are:

- Dr. Elias Jweid
- Dr. Anthony Rousou
- Dr. Mini Sivadasan
- Dr. Herron Burnett
- Dr. Adam Riker
- Dr. Caleb Lippman
- Dr. Kevin Waldron
- Dr. Salman Chaudri
- Dr. Paul Papierski
- Dr. Nirav Shih
- Dr. Trista Brown
- Dr. Wade Kang
- Dr. Richard Reich
- Dr. Eloise Chapman-Davis
- Dr. Michael Patrick Lowe

Sincerely,



Kenneth W. Lukhard, Market President  
Advocate Christ Medical Center and Advocate Trinity Hospital

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



### Population Change of 45 to 65+ Populations

	2011			2016			2021			Percent Change	
	45-64	65+	Total	45-64	65+	Total	45-64	65+	Total	2011-2016	2011-2021
Primary Service Area	202,357	115,459	337,816	219,475	124,387	343,862	218,265	123,409	341,674	+ 1.79	+ 1.14
Secondary Service Area	158,572	73,391	231,963	161,039	81,833	242,872	163,768	82,486	246,254	+ 4.7	+ 6.2
30-mile Outside Traditional Service Area	1,421,624	669,631	2,091,255	1,475,358	759,280	2,234,638	1,494,746	769,258	2,264,004	+ 6.9	+ 12.6
<b>Total</b>	<b>1,802,553</b>	<b>858,481</b>	<b>2,661,034</b>	<b>1,855,872</b>	<b>965,500</b>	<b>2,821,372</b>	<b>1,876,779</b>	<b>975,153</b>	<b>2,851,932</b>	<b>+ 6.0</b>	<b>+ 7.2</b>

Source: Thomson Market Planner Plus, Claritas

STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 • FAX: (217) 785-4111

April 11, 2011

**CERTIFIED MAIL**  
**RETURN RECEIPT REQUESTED**

Patrick Lyons, Director Construction-Regional  
Advocate Christ Medical Center  
4440 W 95th Street  
Oak Lawn, Illinois 60143

**RE: Health Facilities Planning Act - Certificate of Need to Permit  
Assessment of Applicability**  
**Facility: Advocate Christ Medical Center**  
**Project Description: Replace current non-clinical office space with a new 17-bed medical  
surgical unit.**  
**Project Cost: \$8,959,800**

Dear Mr. Lyons:

This is in response to your above-captioned request for an Advisory Opinion on the applicability of Certificate of Need permit for your project.

Based upon the information you submitted and certified, your project:

- Is for a clinical service area of a health care facility as defined at 20 ILCS 9960/3, but the total project cost is less than the capital expenditure minimum of \$11,505,750.
- Does not propose the acquisition of major medical equipment.
- Does not establish or discontinue a health care facility.
- Does not propose increasing the bed capacity of a health care facility that is greater than 10% of the total bed capacity or 20 beds whichever is less in a two year timeframe.
- Is not a change of ownership as defined by the Illinois Health Facilities and Services Review Board.

Based upon the management attestation that you have provided to us the proposed project does not require a certificate of need at this time. At the completion of the project you will need to notify the Illinois Health Facilities and Services Review Board that the beds are operational.

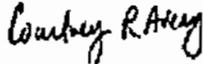
This opinion is based upon our understanding of the Illinois Health Facilities Planning Act (20 ILCS 9960) and the relevant sections of the Administrative Code.

Advisory Opinion  
Page 2 of 2

This is a staff advisory opinion and does not constitute a determination by the State Board. Should you wish to obtain a determination by the State Board, you may request a declaratory ruling pursuant to the provisions contained in 77 Ill. Adm. Code 1130.810, "Declaratory Rulings." Declaratory ruling requests must be made in writing and should be addressed to the Illinois Health Facilities and Services Review Board, 525 West Jefferson 2<sup>nd</sup> Floor, Springfield, Illinois 62761.

This opinion relates solely to the applicability of certificate of need requirements and is based upon the applicable statutory requirements, rules and regulations in effect as of this date. In addition you are advised that this opinion does not address the applicability of or need to comply with any other regulations or requirements of other programs or agencies, such as licensing or certification.

Sincerely,



Courtney Avery, Administrator  
Illinois Health Facilities and Services Review Board

**ACMC INPATIENT MEDICAL-SURGICAL PATIENT ORIGIN 2011**

<b>SERVICE AREA</b>	<b>Zip Code</b>	<b>Community</b>	<b>Number of Patients</b>	<b>% of Total</b>
<b>PSA</b>	60415	Chicago Ridge	956	3.6
	60445	Midlothian	472	1.8
	60452	Oak Forest	315	1.2
	60453	Oak Lawn	3,862	14.5
	60455	Bridgeview	950	3.6
	60456	Hometown	276	1.0
	60457	Hickory Hills	379	1.4
	60458	Justice	286	1.1
	60459	Burbank	1,585	5.9
	60462	Orland Park	482	1.8
	60463	Palos Heights	551	2.1
	60464	Palos Park	161	0.6
	60465	Palos Hills	419	1.6
	60467	Orland Hills	206	0.8
	60477	Tinley Park	422	1.6
	60482	Worth	269	1.0
	60487	Tinley Park	161	0.6
	60620	Auburn Park	1,387	5.2
	60629	Chicago Lawn	1,160	4.3
	60632	Elsdon	323	1.2
	60636	Ogden Park	546	2.0
	60638	Clearing	670	2.5
	60643	Morgan Park	1,027	3.8
	60652	Ashburn	1,124	4.2
	60655	Mount Greenwood	681	2.6
	60803	Alsip	628	2.4
	60805	Evergreen Park	582	2.2
<b>PSA Total</b>			<b>19,880</b>	<b>74.5</b>
<b>SSA</b>	60406	Blue Island	206	0.8
	60423	Frankfort	92	0.3
	60426	Harvey	135	0.5
	60428	Markham	69	0.3
	60439	Lemont	89	0.3
	60441	Lockport	92	0.3
	60448	Mokena	82	0.3
	60451	New Lenox	55	0.2
	60491	Homer Glen	84	0.3
	60609	New City	154	0.6
	60617	South Chicago	465	1.7
	60619	Grand Crossing	464	1.7
	60621	Englewood	256	1.0
	60628	Roseland	1,087	4.1
60649	South Shore	173	0.6	
60827	Riverdale	174	0.7	
<b>SSA Total</b>			<b>3,677</b>	<b>13.8</b>
<b>Other Illinois Total</b>			<b>2,751</b>	<b>10.3</b>
<b>Other States Total</b>			<b>391</b>	<b>1.5</b>
<b>Grand Total</b>			<b>26,699</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>		2005	2006	2007	2008	2009	2010	2011
<b>Medical/Surgical</b>	Utilization	119,808	112,961	117,495	120,882	115,540	113,631	112,263
	Est Bypass <sup>2</sup>	4,033	1,938	4,806	6,779	4,341	8,364	11,000
	Observation Days	2,446	3,081	2,682	3,128	3,782	2,123	1,460
	Utilization + bypass <sup>2</sup>	126,287	117,980	124,983	130,789	123,663	124,118	124,723
	Annual Growth	119,808	(6,847)	4,534	3,387	(5,342)	(1,909)	(1,368)
	Percent Growth							
	<b>Target % State Occ</b>	<b>88.0%</b>						
	ADC	346.0	323.2	342.4	357.3	338.8	340.0	341.7
	<b>Bed Need</b>	<b>393.2</b>	<b>367.3</b>	<b>389.1</b>	<b>406.1</b>	<b>385.0</b>	<b>386.4</b>	<b>388.3</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) ^ (1 / number of years) - 1

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Medical/Surgical</b>	Utilization	112,030	111,798	111,566	111,334	111,103	110,873	110,643	110,413	110,184	109,955
	Est Bypass <sup>2</sup>										
	Observation Days										
	Utilization + bypass <sup>2</sup>	124,464	124,206	123,948	123,691	123,434	123,178	122,923	122,668	122,413	122,159
	Annual Growth	(233)	(232)	(232)	(231)	(231)	(231)	(230)	(230)	(229)	(229)
	Percent Growth	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%	-0.21%
	<i>Target % State Occ</i>	<b>88.0%</b>									
	ADC	340.1	340.3	339.6	338.9	337.3	337.5	336.8	336.1	335.4	334.7
	<b>Bed Need</b>	<b>386.4</b>	<b>386.7</b>	<b>385.9</b>	<b>385.1</b>	<b>383.2</b>	<b>383.5</b>	<b>382.7</b>	<b>381.9</b>	<b>381.1</b>	<b>380.3</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) <sup>A</sup> (1 / number of years) - 1

 **Advocate Christ Medical Center**

4440 West 95th Street || Oak Lawn, IL 60453 || 1 708.684.8000 || [advocatehealth.com](http://advocatehealth.com)

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July 17, 2012

Mr. Dale Galassie  
Chair  
Illinois Health Facilities and Services Review Board  
525 West Jefferson, 2nd Floor  
Springfield, Illinois 62761

Re: Advocate Christ Medical Center – Modernization of Categories of Service  
Criterion 1110.530 (g) Assurances

Dear Mr. Galassie:

This letter provides the Health Facilities Services and Review Board the assurance required with our application to construct beds in the proposed new patient tower at Advocate Christ Medical Center in Oak Lawn.

We hereby state that it is our understanding, based upon information available to us at this time, that by the second year of operation after project completion, Advocate Christ Medical Center reasonably expects to operate complements of obstetric, intensive care, and medical surgical beds at the State Agency's target occupancy, which is the occupancy specified in 77 Ill. Adm. Code 1100.520 c) and 1100.530 c).

Sincerely,



Kenneth W. Lukhard, Market President  
Advocate Christ Medical Center and Advocate Trinity Hospital

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



Section 1110.730 – Acute Mental Illness and Chronic Mental Illness

1. *Applications proposing to establish, expand or modernize Acute Mental Illness or Chronic Mental Illness category of service must submit the following information.*

Advocate Christ Medical Center (ACMC, Medical Center) is not proposing to establish, expand or modernize either an acute or chronic mental illness category of service. The following information is merely informational.

In the 2011 Annual Hospital Questionnaire, the Medical Center reported 51 authorized acute mental illness beds. At the Health Facilities and Services Review Board meeting on July 23 and 24, 2012, the Board reduced the Medical Center's number of acute mental illness beds by 12, or from 51 to 39.

As part of the proposed Patient Tower project, one acute mental illness bed will be eliminated as part of the connector construction. The Medical Center is considering this bed as one of the beds reduced by the Board. At the end of the project, the Medical Center will have 39 acute mental illness beds.

2. *Indicate bed capacity changes by Service. Indicate the number of beds changed by actions.*

Category of Service	Number of Authorized Beds in the 2011 Annual Hospital Questionnaire	Number of Proposed Beds
Acute Mental Illness	51	39
Chronic Mental Illness	--	--

Source: Annual Hospital Questionnaire, 2011 HFSRB Action in July 2012

**D. Criterion 1110.930 - Neonatal Intensive Care**

This section is applicable to all projects proposing to add neonatal intensive care beds.

**Section 1110.930 Neonatal Intensive Care – Review Criterion**

- a) Staffing – Review Criterion
  - 1) The applicant must document that the personnel possessing proper credentials in the following categories are available to staff the service:
    - A) Full-time Neonatal Director – a neonatologist as defined in Section 1110.920.
    - B) Full-time Subspecialty Obstetrical Director – an obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of Maternal and Fetal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Obstetricians and Gynecologists.
    - C) Other neonatologists and obstetricians sufficient in number to serve the projected number of maternal and neonatal patients to be served by the facility and to ensure adequate back-up to the neonatal and obstetrical directors so that there will be continuity of patient care and consultation.
    - D) Full-time Nurse-Director of the obstetric-newborn nursing service who is experienced in perinatal nursing, and preferably holds a master's degree.
    - E) Other nurses adequate in number to serve the projected number of maternal and neonatal patients to be served by the facility.
    - F) Board-Certified Anesthesiologist with training in maternal, fetal and neonatal anesthesia (24-hour availability).
    - G) One or more licensed social workers.
    - H) Respiratory therapists with experience in neonatal care and adequate in number to ensure availability of a minimum of one respiratory therapist for every four patients on mechanical ventilators.
    - I) Registered dietician with experience in perinatal nutrition.

- 2) Documentation shall consist of:
  - A) letters of interest from potential employees;
  - B) applications filed with the applicant for a position;
  - C) signed contracts with required staff; or
  - D) a narrative explanation of how other positions will be filled.
- b) Letter of Agreement – Review Criterion. The applicant must document that a letter of agreement with the regional perinatal center for neonatal intensive care services has been signed. Such letter of agreement must fulfill the conditions for such letters found in the Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) and be approved by the Department of Human Services. A copy of the letter shall serve as documentation.
- c) Need for Additional Beds – Review Criterion
  - 1) The applicant must document that the proposed neonatal intensive care beds are needed. Bed need may be documented by any of the following:
    - A) no neonatal intensive care services exist within the planning area;
    - B) that for each of the last two years for which data is available, the yearly occupancy rate for the service at the affiliated perinatal center has exceeded the target occupancy rate;
    - C) existing providers of the service within the planning area cannot provide care to a patient caseload due to a limitation on funding for care providing; or
    - D) that for each of the last two years for which data is available, the yearly occupancy rate for the service at the applicant facility has exceeded the target occupancy rate.
- d) Obstetric Service – Review Criterion. The applicant must document the availability within the facility of an obstetric service capable of providing care to high-risk mothers. Documentation must include a detailed assessment of obstetric service capability. This requirement does not apply to a facility dedicated to the care of children.

APPEND DOCUMENTATION AS ATTACHMENT-23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section 1110.930 - Neonatal Intensive Care – Review Criterion

Introduction: ACMC’s Neonatal Program Draws Patients from Broad Geographic Area

Advocate Christ Medical Center (ACMC, Medical Center) is both a community and a statewide referral center for neonatal intensive care. Advocate is ranked nationally in *US News 2012-2013 Best Hospitals* as 25<sup>th</sup> in neonatology and 34<sup>th</sup> in pediatric cardiology and heart surgery.

At the time of birth, approximately 80 percent high risk neonatal patients are already patients of the specialists at the Medical Center; the others are referrals from across Illinois and beyond. ACMC has two teams available around the clock to transport these patients; each team has one nurse practitioner and one respiratory therapist.

In 2011, Advocate Christ Medical Center admitted 148 neonatal transports. See Attachment 23, Table 1.

Neonatal Transports to ACMC, 2011  
Attachment 23, Table 1

<u>Referring Hospital</u>	<u>Neonatal Transports to ACMC</u>
Advocate Trinity	32
Palos Community	19
Advocate South Suburban	19
Little Company of Mary	11
Porter Regional	7
Edward	6
Methodist North Lake County	5
Mount Sinai	5
Munster Community	5
St. Anthony Crown Point	5
Advocate Good Samaritan	4
Hinsdale	4
St. Margaret Mercy, Dyer	4
Lagrange Hospital	3
Metro South	3
St. Alexius	3
University of Chicago	3 <sup>1</sup>
Loyola	2
Methodist South Lake County	2
St. James Chicago Heights	2
Central Dupage Hospital	1
Provena St. Joseph	1
Rockford	1
St. Mary’s	1
Total ACMC	148

Source: ACMC Records

<sup>1</sup> Does not include 53 neonatal transports to Advocate Hope Medical Center.

In addition the Medical Center admitted 124 maternal transports. See Attachment 23, Table 2.

Maternal Transports to APMC, 2011  
Attachment 23, Table 2

Referring Hospital	Maternal Transports to APMC
Advocate Trinity	43
Advocate South Suburban	42
Little Company of Mary	8
Palos Community	8
St. James Chicago Heights	6
St. Margaret	3
Holy Cross	2
Gary	1
Ingalls	1
Kishwaukee	1
Munster Community	1
Oak Forest	1
Resurrection	1
Rockford	1
Roseland	1
Silver Cross	1
St. Margarets	1
St. Anthony Crown Point	1
Stroger	1
Total	124

Source: APMC Records

In total, the Medical Center recorded 272 maternal and neonatal transports. This number does not include the additional 53 transports (babies less than 28 days) transported to Advocate Hope Children's Hospital. Many of these referring hospitals have authorized neonatal intensive care beds.

As shown in Attachment 23, Table 3 and Attachment 23, Exhibit 1, 61.0 percent of the patients in the neonatal intensive care unit are from the Medical Center's service area, while 39.0 percent are from Other Illinois and beyond. This table demonstrates the extensive geographic reach of the Medical Center's neonatal program.

Neonatal Intensive Care Patient Origin  
Attachment 23, Table 3

Service Area	Number of Patients	Percent of Total	Cumulative Percentage of Patients
Primary Service Area	286	43.7	43.7
Secondary Service Area	113	17.3	61.0
Other Illinois Total	211	32.3	93.3
Other States Total	44	6.7	100.0
Grand Total	654	100.0	100.0

Source: APMC Internal Financial Data

### The Medical Center's Status as a Level IIIC Perinatal Center

The Medical Center is one of only six Level IIIC Perinatal Centers in the State of Illinois. Of the other five, three are located in Chicago (Ann and Robert H. Lurie Children's Hospital of Chicago, Rush University Medical Center, and University of Chicago Medical Center), one is located in Park Ridge (Advocate Lutheran General Hospital), and the fifth is located in Peoria (Children's Hospital of Illinois).

The Medical Center's service area extends primarily south and southwest of its Oak Lawn location. There are no other Level IIIC neonatal units serving the area to the south and west until Peoria, which is 157 miles away. There are no centers south of Peoria. This also helps explain the statewide reach of the Medical Center's neonatal service.

The American Academy of Pediatrics and the American College of Obstetrics and Gynecology has defined levels of neonatal care; being designated as a Level IIIC unit means that a program is able to care for the very sickest of newborns. A Level IIIC has all the capabilities of a Level IIIB unit which include.

- Comprehensive care for infants born at 28 weeks of gestation or less and weighing 1,000 grams or less
- Advanced respiratory support, such as high-frequency ventilation and inhaled nitric oxide
- Advanced imaging with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography
- Prompt on-site access to a full range of pediatric medical subspecialists (the physicians at Hope meet this criterion)
- Pediatric surgical subspecialties and pediatric anesthesiologists on site or at a closely related institution to perform major surgery (again, the physicians at Hope meet this criterion).

In addition to the Level IIIB criteria, a Level IIIC designation means that the unit can also provide:

- Extracorporeal life support, and
- Open heart surgery for repair of complex, congenital cardiac malformations.

### Neonatal Intensive Care Model at APMC

In 2004, the Medical Center filed a certificate of need application to increase the number of authorized neonatal intensive care beds from 24 beds to the current complement of 37 beds. In that application, the Medical Center outlined the rationale for having Level II+ and Level III babies in a single neonatal unit. The application was approved as Permit #04-042 in December 2004 and the Medical Center has been operating with all neonates and as many Level II+ babies as can be safely accommodated in the neonatal intensive care unit. At times of extremely high census, soon-to-be

discharged babies may be transferred to the normal newborn nursery with appropriate additional nurse staffing. Additionally, after the baby stabilizes and when necessary resources are available at the birth hospital, some babies are transferred back to their birth hospital. This usually puts them closer to their parents' home.

A neonatal unit that can care for both Level II+ and Level III babies is very beneficial for the babies and their families. The babies stay in one area and a personal linkage develops between the family and caregivers during the entire time that the baby is at the Medical Center. Further, the flow of critical information among clinicians and with the family is enhanced.

Having a single unit also has very important staffing implications. First, having all the high-risk babies managed in a single unit permits greater staffing flexibility and efficiency than having them in two units. Secondly, in a unit that can accommodate the continuum of neonatal care, a nurse can be assigned to a baby or babies and the family. That nurse follows the baby as it progresses from Level III to Level II+. In this way, one nurse is not assigned to a full caseload of very fragile Level III babies with the potential for stress and burnout. Instead, the nurse has a balance of Level III and Level II+ babies and can take satisfaction in the infants' progress. Since the average length of stay of all neonatal babies is 23.0 days, Level IIIC babies' average stay is 36.6 days; the nurse can readily identify changes that either require the immediate attention of a neonatologist or that indicate improvement in the infant's condition.

For these reasons, the proposed replacement neonatal intensive care unit has been sized to continue to accommodate both Level III and Level II+ infants. These beds will all be authorized Level III beds equipped for the care of all neonates and staffed to care for the level of acuity of the neonates on the unit at any time. The neonatal charge structure has been designed to reflect the acuity of the neonates.

#### Staffing – Review Criteria

Advocate Christ Medical Center currently provides Level IIIC neonatal services with a staff of highly qualified physicians, nurses, and essential clinical support staff. The following discussion identifies members of the Medical Center's multidisciplinary neonatal team.

- i. *The applicant must document that the personnel possessing proper credentials in the following categories are available to staff the service.*

Note: All requested CV's can be found in Appendix 2

A) *Full time Neonatal Director –a neonatologist as defined in Section 1110.920.*

*Section 1110.920 defines a neonatologist as a physician who is certified by the American Board of Pediatrics Sub Specialty Board of Neonatology/Perinatology medicine or a licensed osteopathic physician with equivalent training and experience and Certified by the American Osteopathic Board of Pediatricians.*

Thomas Myers, MD, is the full time director of Neonatal Intensive Care at Advocate Christ Medical Center; he is a board certified neonatologist. His CV is appended.

- B) Full-time Subspecialty Obstetrical Director – an obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of Maternal and Fetal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Obstetricians and Gynecologists.*

Helen Kay, MD, Director of Maternal and Fetal Medicine; she is board certified by the American Board of Obstetrics and Gynecology in Maternal-Fetal Medicine. Her CV is appended.

- C) Other neonatologists and obstetricians sufficient in number to service the projected number of maternal and neonatal patients to be served by the facility and to ensure adequate back-up to the neonatal and obstetrical directors so that there will be continuity with patient care and consultation.*

There are 8 other neonatologists, 7 maternal and fetal medicine physicians, and 72 obstetricians/gynecologists on APMC's medical staff. This staff is sufficient to serve the projected number of maternal and neonatal patients at the Medical Center in order to ensure quality continuity of care and consultation. In addition, there are many other physicians that support the obstetrics and gynecology at the Medical Center. They include, for example, 2 Family Practice/OBGYNs, 12 gynecologists, 4 GYN oncologists, and 3 GYN urologists.

- D) Full-time Nurse Director of the obstetric-newborn nursing service who is experienced in perinatal nursing, and preferably holds a master's degree.*

Andrea Miller RN, BSN, MHA, NEA-BC is the full-time Director of Obstetrics and Newborn Nursing Services. She has more than 32 years of nursing experience. She has a Masters of Health Administration degree. Her CV is appended.

- E) Other nurses adequate in number to serve the projected number of maternal and neonatal patients to be served by the facility.*

There are 60 nurses assigned to OB triage, labor/delivery/recovery, surgical delivery suite, PACU, and high risk antepartum. There are 57 additional nurses assigned to postpartum, stable antepartum, and normal newborn nursery. Of these, 4.3 FTEs are lactation RNs.

*F) Board Certified Anesthesiologist with training in maternal, fetal and neonatal anesthesia (24-hour availability).*

There are 38 board certified anesthesiologists with special training in maternal, fetal, and neonatal anesthesiology. There is at least one specially trained anesthesiologist available 24 hours each day.

Adam Block, MD is Director of OB Anesthesia; his CV is appended.

*G) One or more licensed social workers.*

ACMC/AHCH has 2 licensed social workers that support the neonatal and obstetrical services. Stacey Roberson, LCSW and Anne Pendergast, LCSW.

CVs for both are appended.

*H) Respiratory therapists with experience in neonatal care and adequate in number to ensure availability of a minimum of one respiratory therapist for every four patients on mechanical ventilators.*

There are 3 respiratory therapists that care for infants in the neonatal unit. Respiratory therapy staffing is typically 6:1 on the unit; however, staffing is adjusted by the patient acuity on the unit so that there is a minimum of one respiratory therapist for every four patients on mechanical ventilators. The CV of Traci Wolfe, RCP, RRT-NPS is appended.

*I) Registered dietician with experience in perinatal nutrition*

ACMC/AHCH has two full-time dieticians with special training in perinatal nutrition; they are Tammy Starks, RD, LDN and Anne Marie Uzueta, RD, LDN. The CVs of Ms. Starks and Ms. Uzueta are appended.

Joseph Pavese, MD, is Chairman of Obstetrics and Gynecology at the Medical Center. His CV is included in the Appendix.

*b) Letter of Agreement – Review Criterion. The applicant must document that a letter of agreement with the regional perinatal center for neonatal intensive care services has been signed. Such letter of agreement must fulfill the conditions for such letters found in the*

*Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) and be approved by the Department of Human Services. A copy of the letter shall serve as documentation.*

A letter of agreement between University of Illinois at Chicago on Behalf of Its Perinatal Center and EHS Christ Hospital and Medical Center (now known as Advocate Christ Medical Center) was executed in 1994. A copy of that letter is included as Attachment 23, Exhibit 2.

A letter of support for the project from Ms. Maripat Zeschke, Perinatal Administrator, is included as Attachment 23, Exhibit 3.

c) Need for Additional Beds – Review Criterion

*The applicant must document that the proposed neonatal intensive care beds are needed. Bed need may be documented by any of the following review criterion:*

- a) *No neonatal intensive care services exist in the planning area*
- b) *That for each of the last two years for which data is available, the yearly occupancy rate for the service at the affiliated perinatal center has exceeded the target occupancy.*
- c) *Existing providers of the service within the planning area cannot provide care to a patient caseload due to the limitation of funding for are provided, or*
- d) *That for each of the last two years for which data is available, the yearly occupancy for the service at the applicant facility has exceeded the target occupancy rate.*

The Medical Center is justifying neonatal intensive care bed need with a response to Criterion D.

As shown on Attachment 23, Table 4, in each of the last 2 years, the yearly occupancy of the Medical Center's Neonatal Intensive Care Unit (NICU) exceeded the State Standard Target Occupancy of 75.0 percent. If just Level III infants are considered in the calculation, the 2 years' occupancy rates were 80.8 and 81.6 percent compared to the State Standard Target Occupancy of 75 percent. When both neonatal intensive care and Level 2+ babies are considered in the calculation, the occupancy rates were 107.6 and 108.1 percent.

Utilization of the Neonatal Intensive Care Unit, 2010 and 2011  
Attachment 23, Table 4

Year	Number of NICU Beds	NICU Days	NICU Average Daily Census	Pct. Occupancy	NICU and Level 2+ Babies	NICU and Level 2+ Babies Average Daily Census	Percent Occupancy	State Standard Target Occupancy
2010	37	11,037	30.2	81.6	14,604	40.0	108.1	75.0
2011	37	10,910	29.9	80.8	14,529	39.8	107.6	75.0

Source: APMC Financial Department Records

The NICU is never closed to either cardiac transfers or transfers from Advocate's South Market hospitals - Advocate South Suburban and Advocate Trinity hospitals. At periods of extremely high census, the procedure and isolation rooms may be used to accommodate neonates and Level 2+ infants may be admitted to the normal newborn nursery on a temporary basis in the best interest of the patient. However, there have been instances of extremely high census when requests to transfer a mother or infant could not be accommodated.

The Medical Center is conservatively requesting 64 neonatal intensive care beds.

APMC's Determination of Neonatal Intensive Care Bed Need

The State Agency has not developed a bed need formula for neonatal intensive care beds. The State determines neither beds needed nor excess beds for the neonatal category of hospital service. It is the responsibility of the applicant to document the need for the number of neonatal intensive care beds proposed by complying with the Review Criteria contained in 77 Ill. Adm. Code 1110. In its determination of neonatal intensive care bed need, the Medical Center has complied with the Review Criteria contained in 77 Ill Adm. Code 1110.

Bed Need Based on Current Utilization

The utilization of the NICU by neonatal intensive care and Level 2+ babies for each of the past 2 years justifies from 51 to 52 beds.

2010

14,604 patient days ÷ 365 days per year = 40.0 average daily census

40.0 average daily census ÷ 78 percent State Agency Target Occupancy = 52 beds

2011

14,529 patient days ÷ 365 days per year = 39.8 average daily census

39.8 average daily census ÷ 78 percent State Agency Target Occupancy = 51 beds

The Medical Center has only 37 authorized neonatal intensive care beds.

#### Bed Need Based on Based on Projected Volume

Advocate Christ Medical Center projected future neonatal intensive care bed need based on a CAGR trend to 2019. The Medical Center proposes to modernize the existing NICU space as well as vacated obstetric space to expand the NICU from 37 to 64 beds, or by 27 beds. The obstetric space must be vacated before the proposed NICU modernization can begin. The project schedule has construction of the NICU beginning in 2016 and completed in 2017, with 2019 being the second full year of utilization. This CAGR trend line analysis is provided as Attachment 23, Exhibit 4.

Although the CAGR trend line suggests the need for as many as 80 neonatal intensive care beds by 2019, the Medical Center is conservatively requesting only 64 beds. The increase in NICU capacity reflects the expectation that there will be more high risk infants as the number of women in the older childbearing age cohorts continues to increase and more high risk infants will need the unique services available at the Medical Center.

*d) Obstetrical Service – Review Criterion. The applicant must document the availability within the facility of an obstetric service capable of providing care to high risk mothers. Documentation must include a detailed assessment of obstetric service capability. This requirement does not apply to a facility dedicated to the care of children.*

Advocate Christ Medical Center is a designated Level IIIC Perinatal Center and is included in the Perinatal Network of the University of Illinois Medical Center Chicago. It is deemed in compliance with the perinatal care standards as promulgated by the Illinois Department of Public Health Regionalized Perinatal Care Code (77 Ill. Adm. Code 640) by the State of Illinois Perinatal Advisory Committee.

Advocate Christ Medical Center Neonatal Intensive Care Unit (NICU) meets a demonstrated regional need, with 39 percent of the patients being from “Other Illinois” and “Other States.”

The Medical Center is a Level IIIC Perinatal Center. This is the highest designation for a neonatal program and means that it is able to care for the sickest of newborns. The Center’s neonatal program has received national recognition.

The NICU’s current volume substantially exceeds the State Standard Target Occupancy for the existing 37 beds. The need for 64 beds has been justified based on current volume and projected volume. The projections are based on the expectation that there will be more high risk infants as the number of women in the older childbearing age cohorts continues to

increase; older mothers are more likely to have high risk pregnancies and babies than younger mothers.

The Obstetrical Service at the Medical Center is capable of caring for high risk mothers.

The Medical Center provides close medical and surgical coordination, multidisciplinary consultation, and supervision for mothers and infants requiring highly specialized treatment by highly trained personnel. The Medical Center's status as a Level IIIC Perinatal Center confirms that it provides 24-hour access to anesthesia for labor, as well as perinatologists and neonatologists – specialists in maternal, fetal and newborn care.

The Medical Center provides a full range of obstetric services and staff specialists:

- Clinical Services
  - Prenatal classes for parents-to-be
  - Prenatal testing
  - High risk pregnancy and genetic testing
  - Maternal and neonatal transport services
  - Obstetric triage
  - 24-hour availability of general laboratory, blood bank, blood gas testing, radiology including diagnostic ultrasound, and respiratory therapy
  - Labor/Delivery and Recovery (LDR) and dedicated operating rooms and recovery area for obstetric patients
  - Capability to perform emergency Cesarean section procedures within 30 minutes' notice
  - Intensive care for obstetric emergency patients
  - High risk antepartum, intrapartum, postpartum and gynecology care
  - Transition and stabilization care
  - Family-centered mother-baby care including the father
  - Rooming-in for the baby (bassinet in the mother's room)
  - Normal newborn nursery bassinets
  - Lactation education
  - Continuous patient education
  - Postpartum depression screening for new mothers
- Obstetric staffing
  - 24-hour in-house attending physicians
  - 24-hour coverage by anesthesiologists
  - 24-hour coverage by maternal and fetal medicine physicians
  - 24-hour coverage by obstetric residents

- 24-hour coverage by pediatric residents
- 24-hour coverage by laboratory, radiology, and respiratory therapy
- 24-hour availability of maternal and infant transport team
- Advance Practice Nurses coverage for LDR, postpartum, and gynecology
- Specially trained nurses for the continuum of obstetric care
- Lactation Nurse Specialists
- Social workers
- Neonatal Staffing
  - 24-hour coverage of in-house attending neonatologists
  - Neonatal nurse clinicians
  - 24-hour coverage by laboratory, radiology, respiratory therapy, and physical and occupational therapy
  - Staff trained in extracorporeal membrane oxygenation (ECMO) and jet ventilation for babies with severely immature lungs.
  - Cardiologists and cardiovascular surgeons for cardiac-compromised infants. These physicians are part of The Heart Institute for Children at Advocate Hope Children's Hospital. The Heart Institute and its staff are internationally renowned for expertise in cardiac care for infants and children. The Heart Institute is also a pioneer in advances in cardiac echo imaging, including trans-telephonic transfer of echocardiograms from satellite sites and three-dimensional imaging during multi plane transesophageal echo cardiology.
  - High risk infants also benefit from the immediate availability of more than 175 physicians including general pediatricians as well as specialists and subspecialists in more than 30 areas of expertise. These include:
    - Pediatric cardiologists and cardiac surgeons
    - Pediatric neurologists and neurosurgeons
    - Pediatric hematologists
    - Pediatric oncologists
    - Pediatric nephrologists
    - Pediatric endocrinologists
    - Pediatric gastroenterologists
    - Pediatric infectious disease specialists
    - Pediatric pulmonologists
    - Pediatric urologists, and
    - Pediatric general surgeons.

The physicians and nurses that attend the high risk births and care for the high risk neonates meet regularly to discuss the high risk infants that are expected to be delivered at the Medical Center in the foreseeable future. The following is a list of cases they have recently reviewed; these cases provide an insight into the complexity of these high risk births: The pre-delivery diagnoses of these fetuses include:

- Interrupted aortic arch/VSD/polyhydramnios
- Diaphragmatic hernia, dextracardia
- Maternal CHD/pulmonary atresia, fetal coarctation
- Fetal D-transposition of great arteries, surrogate, FOB has CHD and Gilbert Syndrome
- Ebstein severe, pericardial effusion
- HLHS with aortic stenosis. Plan delivery in the cath lab.
- DORV, malposed great vessels, unbalanced AV canal
- Truncus arteriosus with interrupted aortic arch
- CPAM, suspect right kidney absence versus dysplastic kidney
- Rh sensitization
- Fetal Trisomy 21
- Triplets
- Fetal levo-TOGV, Ebstein's anomaly; maternal nephrolithiasis-S/P stent
- Double outlet right ventricle, dextrocardia, pleural effusion-hernia; previous C-section 2x
- Fetal duct constriction vs. coarctation
- HLHS with aortic stenosis
- Gastroschisis, IURG, normal female karyotype
- Mono/di twins—Twin A bilateral renal agenesis/anhydramnios

Neonatology is a destination program for high risk neonates, especially those with cardiac abnormalities. As noted above, in these cases the mother may be delivered in the cardiac catheterization laboratory so the pediatric cardiologist can initiate an immediate intervention upon birth.

These diagnoses demonstrate the intensity of care required by mothers and infants at the Medical Center.

Advocate Christ Medical Center has an obstetric service capable of providing care to high risk mothers.

## Summary

Advocate Christ Medical Center is a Level IIIC Perinatal Center, the highest designation given and only one of six in the State of Illinois. The Medical Center is nationally ranked as 25<sup>th</sup> in neonatal intensive care and 34<sup>th</sup> in pediatric cardiology and heart surgery by *US News 2012-2013 Best Hospitals*.

The Medical Center receives both maternal and neonatal transfers from not only the local community but also from a regional referral market because the community hospitals do not have the specialists, technology and other resources to take care of complicated pregnancies and high risk infants.

The Medical Center's 37-bed neonatal intensive care bed complement is inadequate to support either current or projected volume. The Medical Center is conservatively requesting 64 authorized neonatal beds. These beds will be redeveloped in space that includes the current unit as well as space vacated by the surgical delivery room, Phase I recovery rooms, and OB Triage.

The Medical Center has provided a Letter of Agreement between the University of Illinois on Behalf of its Perinatal Center and EHS Christ Hospital and Medical Center (now known as Advocate Christ Medical Center), a letter of support from the Perinatal Network Administrator, and an overview of the Medical Center's full range of obstetric services, and CV's of specially trained anesthesiologists, specialists in maternal and fetal maternal care, neonatologists, specially trained nurses and other clinical support staff.

## ACMC INPATIENT NICU PATIENT ORIGIN 2011

SERVICE AREA	Zip Code	Community	Number of Patients	% of Total
PSA	60415	Chicago Ridge	14	2.2
	60445	Midlothian	11	1.7
	60452	Oak Forest	12	1.9
	60453	Oak Lawn	23	3.6
	60455	Bridgeview	5	0.8
	60456	Hometown	5	0.8
	60457	Hickory Hills	7	1.1
	60458	Justice	9	1.4
	60459	Burbank	8	1.2
	60462	Orland Park	21	3.3
	60463	Palos Heights	2	0.3
	60465	Palos Hills	7	1.1
	60467	Orland Hills	5	0.8
	60477	Tinley Park	13	2.0
	60482	Worth	6	0.9
	60487	Tinley Park	9	1.4
	60620	Auburn Park	15	2.3
	60629	Chicago Lawn	21	3.3
	60632	Elsdon	5	0.8
	60636	Ogden Park	6	0.9
60638	Clearing	10	1.6	
60643	Morgan Park	19	3.0	
60652	Ashburn	8	1.2	
60655	Mount Greenwood	18	2.8	
60803	Alsip	10	1.6	
60805	Evergreen Park	11	1.7	
<b>PSA Total</b>			<b>286</b>	<b>43.7</b>
SSA	60406	Blue Island	5	0.8
	60423	Frankfort	2	0.3
	60426	Harvey	5	0.8
	60428	Markham	1	0.2
	60439	Lemont	3	0.5
	60441	Lockport	6	0.9
	60448	Mokena	10	1.6
	60451	New Lenox	6	0.9
	60491	Homer Glen	3	0.5
	60609	New City	7	1.1
	60617	South Chicago	22	3.4
	60619	Grand Crossing	8	1.2
	60621	Englewood	1	0.2
	60628	Roseland	24	3.7
60649	South Shore	6	0.9	
60827	Riverdale	2	0.3	
<b>SSA Total</b>			<b>113</b>	<b>17.3</b>
<b>Other Illinois Total</b>			<b>211</b>	<b>32.3</b>
<b>Other States Total</b>			<b>44</b>	<b>6.7</b>
<b>Grand Total</b>			<b>654</b>	<b>100.0</b>

SOURCE: ACMC INTERNAL FINANCIAL DATA

**Letter of Agreement**

**University of Illinois at Chicago  
on Behalf of Its Perinatal Center**

**and**

**EHS Christ Hospital and Medical Center**

**Executed 1994**

## Letter of Agreement

### Definitions and Introduction

The University of Illinois is designated by the Illinois Department of Public Health (IDPH) as a Perinatal Center, which means "a referral facility intended to care for the high-risk patient before, during or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services" (77 Illinois Administrative Code, Section 640.20 Definitions of the Regionalized Perinatal Health Care Code). The IDPH has also designated the University's Departments of Obstetrics and Gynecology and Pediatrics as the responsible agent for the administration and implementation of the Department's Perinatal Health Care Program within a Regional Perinatal Network, which is defined in the Regionalized Perinatal Health Care Code as "any number and combination of hospital-based maternity and newborn facilities functioning at one of three levels of perinatal care" (77 Illinois Administrative Code, Section 640.20).

Consistent with its role as the administrative unit of the Perinatal Center, the University of Illinois establishes this Letter of Agreement with EHS Christ Hospital and Medical Center for the purpose of: 1) providing for the collaboration of EHS Christ Hospital and Medical Center and the University of Illinois, in conjunction with Michael Reese Hospital and Medical Center and/or any facility with Co-Center status, as the Perinatal Center serving a regional Network, and 2) recognizing EHS Christ Hospital and Medical Center as a Level III facility, consistent with the conditions specified for such facilities in the Regionalized Perinatal Health Care Code.

Implementation of this Letter of Agreement is the responsibility of the Chiefs of the Departments of Pediatrics and Obstetrics and Gynecology at EHS Christ Hospital and Medical Center and the Heads of the Departments of Pediatrics and Obstetrics and Gynecology at the University of Illinois, in conjunction with the Center Co-Directors (one with responsibility for Neonatology and one with responsibility for Maternal/Fetal Medicine).

Upon implementation of this agreement, "EHS Christ" will be incorporated into the name of the Perinatal Center and the Network served by this Center shall be known as the University of Illinois/Michael Reese/EHS Christ Perinatal Center. However, for simplicity, this Letter of Agreement will refer to the UIC Perinatal Center and the University of Illinois Perinatal Network. The basic ground rules for collaboration between the University of Illinois and EHS Christ Hospital and Medical Center in the operation of the Perinatal Center follow:

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University of Illinois/EHS Christ Hospital & Medical Center

1. The programs of the UIC Perinatal Center shall include both perinatal education and perinatal medicine. Programs in Neonatology and Obstetrics may be conducted at the University of Illinois Hospital and Clinics and at EHS Christ Hospital and Medical Center and at any other institution recognized as a component of the Perinatal Center.
2. The Perinatal Center and the programs funded by IDPH to serve the Network shall be directed by a Co-Director in Maternal and Fetal Medicine and a Co-Director in Neonatology. The Head of the Department of Obstetrics and Gynecology, University of Illinois College of Medicine, shall appoint the Co-Director in Maternal and Fetal Medicine; and the Head of the Department of Pediatrics, University of Illinois College of Medicine, shall appoint the Co-Director in Neonatology. These appointments will be made in consultation with the Chiefs of Obstetrics and Pediatrics at EHS Christ Hospital and Medical Center as well as the obstetrical and neonatal chiefs of any other institution recognized as a component of the Perinatal Center.
3. The University of Illinois Hospital and Clinics and EHS Christ Hospital and Medical Center shall each, independently and separately, appoint Program Directors for Neonatology and Obstetrics to direct each institution's programs associated with the Perinatal Center. Such Program Directors shall also be appointed for any other institution recognized as a component of the Perinatal Center. (An institutional Program Director may serve as a Perinatal Center Co-Director.)
4. The Perinatal Center Co-Directors shall approve selection of a full-time Network Administrator who will work collaboratively with the Co-Directors. The Administrator shall have responsibility for assuring management of grants and other monies provided for the administration of the UIC Perinatal Center.
5. An Executive Committee for the Perinatal Center shall be established to consist of the Center Co-Directors, the Program Directors of any institution recognized as a component of the Perinatal Center, and the Network Administrator. Each institution recognized as a component of the Perinatal Center shall also designate a representative of hospital administration as an "ex-officio" member of the Executive Committee.

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University of Illinois/EHS Christ Hospital & Medical Center

One of the Co-Directors shall chair the Executive Committee. It shall be responsible for the development of the programs, guidelines, and procedures of the Center and Network Program to include, but not limited to, the following:

- a. Network composition and membership, and any plans relevant to changes in Network membership,
- b. Patient referrals and consultation,
- c. Educational programs,
- d. Procedures for transporting patients,
- e. Morbidity and mortality reviews, and
- f. Data collection and reporting.

Implementation of this Letter of Agreement is the responsibility of the Chiefs of Obstetrics and Pediatrics at EHS Christ Hospital and Medical Center and the Heads of the Department of Obstetrics and Gynecology and the Department of Pediatrics at the University of Illinois.

I. Obligations/Responsibilities of Parties

A. Communications

A 24-hour obstetrical and neonatal "hot-line" shall be maintained at both the University of Illinois Hospital and EHS Christ Hospital and Medical Center to provide for immediate consultation, referral, or transport of perinatal patients.

24-Hour Perinatal Hotline Numbers:

University of Illinois Hospital: 312/666-0555

EHS Christ Hospital:     Maternity 708/346-4010  
                                  Neonatal 708/422-0066

In addition, facsimile machines shall be maintained in the labor and delivery areas and the neonatal intensive care nurseries of both hospitals, and in the Perinatal Center administrative office:

Facsimile Machine Numbers:

University of Illinois Hospital

L & D: 312/996-9350

NICU: 312/996-2328

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University of Illinois/EHS Christ Hospital & Medical Center

EHS Christ Hospital  
L & D: 708/346-2053  
BCN: 708/346-4272

Perinatal Center Administrative Office: 312/413-0263

B. Identification, Referral and Acceptance of Patients with Problems

Attending physicians associated with hospitals in the University of Illinois Perinatal Network are expected to utilize appropriate risk assessment tools to identify the levels of care required by patients. The Regionalized Perinatal Health Care Code (77 Illinois Administrative Code, Sections 640.61 through 640.43) and the Letters of Agreement negotiated with the hospitals with which attending physicians are associated should assist them as they determine whether consultation should be sought from specialists at Level III facilities or as they consider the need for referral, transfer, or transport of patients to Level III facilities.

Perinatologists and neonatologists at both the University of Illinois Hospital and EHS Christ Hospital shall also consider the Regionalized Perinatal Health Care Code and the Letters of Agreement hold with Network hospitals as decisions are made regarding acceptance of patients at their respective Level III facilities.

The Level III facilities of both University of Illinois Hospital and EHS Christ Hospital agree to accept all medically eligible obstetrical and neonatal patients. As specified in the Regionalized Perinatal Health Care Code (77 Illinois Administrative Code, Section 640.43), "medical eligibility is to be determined by the obstetrical or neonatal director or their designee based on the Department's (IDPH's) standards for 'Criteria for High-Risk Identification (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists).'" (Appendix A provides illustrative categorization or guidelines for the types of patients to be served at Level III facilities.)

The University of Illinois Hospital will continue to serve as the primary center for coordinating referrals from hospitals presently within the Network. The University of Illinois Hospital and EHS Christ Hospital each agree to serve in a reciprocal manner as backup

Level III referral facilities to the other when staffing and bed availability permit.

As Level III facilities, the University of Illinois Hospital and EHS Christ Hospital are recognized to have the capability of caring for the full range of maternal and neonatal patients with specialized needs. However, when patients are encountered who have needs beyond the resources and expertise immediately available at one of these hospitals, consultation with neonatologists, perinatologists, or other specialists at the other hospital is encouraged.

C. Referral and Placement Responsibilities

If the Level III facilities of the University of Illinois Hospital and other Level III Network facilities are all unable to accept a referred maternal or neonatal patient because of bed unavailability or lack of other resources, staff of the Level III facility receiving the original request for referral shall have responsibility for ensuring admission of the patient to another facility capable of providing the appropriate level of care. However, if needed, Network administrative staff will provide assistance in the referral process.

D. Consultation/Referral/Transportation of Perinatal Patients

The UIC Perinatal Center will periodically distribute written protocols for the mechanisms of consultation and referral, transfer and transport of patients; the Executive Committee will have responsibility for reviewing and updating these guidelines as necessary.

In addition, EHS Christ Hospital shall have policies and procedures which govern the transportation of neonatal and obstetrical patients referred to its Level III facility. These policies and procedures will be forwarded to the administrative office of the Perinatal Center, preferably as a component of the institution's Maternity and Neonatal Services Plan, Chapter 2, "Interhospital Care of the Perinatal Patient," of the Guidelines for Perinatal Care (Third Edition, 1992, published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecology) should be utilized as guidelines for the development of transfer/transport policies.

When a neonate is to be transferred, decisions regarding transport and mode of transport will be made by a neonatologist in collaboration with the referring physician.

Decisions regarding transport, transfer, and mode of transport or transfer of obstetrical patients will be made by a perinatologist in collaboration with the referring physician.

Physicians who are specialized in maternal and fetal medicine shall have the responsibility for decisions regarding the need for patient stabilization before transfer and the preferred alternatives for patient care and transport to a Level III facility.

**E. Communications to Referring Physician**

When patients are referred for care to EHS Christ Hospital from a physician associated with another facility, a written summary of patient management and outcome will be sent to the referring physician of record and to the hospital's chart. When patients are hospitalized for a long period of time, referring physicians will be provided periodic reports of their patients' progress, in addition to discharge summaries.

**F. Return of Patients to Referring Hospitals**

It shall be the policy of both the University of Illinois Hospital and EHS Christ Hospital to transfer patients back to the referring hospital when medically feasible in accordance with physician to physician consultation.

**G. Quality Assurance/Morbidity and Mortality Reviews**

The Executive Committee of the UIC Perinatal Center shall determine mechanisms and procedures for the collaborative conduct of periodic joint morbidity and mortality reviews within Network hospitals. Assignments for oversight of morbidity and mortality committees at all Network hospitals will be made by the Executive Committee. Reviews shall be in compliance with the Regionalized Perinatal Health Care Code (77 Illinois Administrative Code, Section 640.70 g), and Appendix B, Guidelines for Joint Morbidity and Mortality Reviews (or updated Guidelines which may be issued by the Center's Executive Committee in the future).

H. Data Reporting and Quality Monitoring Responsibilities

EHS Christ Hospital and Medical Center agrees to provide input into the redesign of a Network perinatal database and to participate in this database once it becomes operational. In addition, EHS Christ Hospital agrees to fulfill its reporting responsibilities to the state (Illinois Department of Public Health) and to provide timely reports under the perinatal activities reporting system. To the extent feasible, data collection and reporting required of members of the University of Illinois Perinatal Network will not be redundant or unnecessarily duplicative of data and reporting requirements of the Illinois Department of Public Health.

The UIC Perinatal Center shall utilize reports provided by the IDPH as well as statistical data provided through the Network database to periodically assess the progress of the Network in reducing perinatal morbidity and mortality and promoting maternal and child health.

The Executive Committee shall have access to the perinatal data collected by staff of the Center's administrative offices. However, the appropriate subcommittees of the Network Managers' Group (that is, those relating to data and research) shall be responsible for development and implementation of guidelines for the use of perinatal data and the protection of confidentiality (as pertains to patient-specific and institution-specific data).

I. Regional Perinatal Management Group

The University of Illinois Perinatal Network will have a "Regional Perinatal Management Group," which is defined in the Regionalized Perinatal Health Care Code as "an organization of representatives of perinatal services, providers and service related agencies and organizations within a regional perinatal network that is responsible for the planning, development, evaluation and operation of the network and the establishment of regional priorities and policies for system support activities and staff" (77 Illinois Administrative Code, Section 640.20). EHS Christ Hospital and Medical Center agrees to designate medical, nursing, and administrative representatives to this Group and to ensure their active involvement in Management Group meetings, which are held at least quarterly.

J. Outreach and Educational Services

The University of Illinois Department of Obstetrics and Gynecology's Division of Maternal and Fetal Medicine and the Department of Pediatrics, Division of Neonatology, provide a range of educational opportunities for all levels of perinatal care providers. Postgraduate course presentations and outreach activities with Network hospitals are provided on an on-going basis. Conference schedules for both divisions are circulated to Network hospitals. Network staff includes an Outreach Coordinator who has responsibility for maintaining contact with Network hospitals, performing an annual assessment of educational needs, and developing an action plan, in cooperation with the Center Co-Directors, to address these needs.

EHS Christ Hospital and Medical Center will be provided the opportunity to collaborate in the provision of educational services provided through the Network's program for health professionals.

EHS Christ Hospital will be encouraged to continue current educational outreach programs. And within the constraints of the grant provided by the Illinois Department of Public Health for administration of the Perinatal Network, expenses incurred by EHS Christ Hospital and Medical Center for collaborative educational services will be reimbursed.

K. Assessment and Referral of Neonates At-Risk for Handicapping Conditions and Developmental Disabilities

As a Level III facility, EHS Christ Hospital and Medical Center is expected to have the capability of identifying neonates having or at-risk for developing handicapping conditions or developmental disabilities. These neonates will be provided the appropriate level of care during their inpatient stay, and parents of such neonates shall be furnished information, counseling, and referral services to assist them in securing services which may be required after discharge. Based upon established procedures (which include obtaining parental consent and permission to release information), EHS Christ Hospital and Medical Center will facilitate further developmental assessment, if required, and appropriate referral to the services of state and local educational agencies.

EHS Christ Hospital and Medical Center may refer discharged neonates and other young infants to its own programs for follow-up or it may refer them to the Developmental Follow-up Program which is based at the University of Illinois Hospital. Network staff assigned to the Follow-up Program are available for the provision of inservices and assisting EHS Christ Hospital and Medical Center with other activities designed to promote early identification and intervention for handicapping conditions and developmental disabilities affecting infants and young children.

EHS Christ Hospital will provide the Perinatal Center administrative office with a list of available specialties and specialized services which can accommodate referrals of infants and young children, and EHS Christ Hospital and Medical Center will collaborate with the University of Illinois in the development and strengthening of developmental and medical diagnostic services within the Network.

L. Medical and Home Nursing follow-up and Referral

EHS Christ Hospital and Medical Center will describe any medical and home nursing follow-up and referral programs which it provides in its Maternity and Neonatal Services Plan. In addition, EHS Christ Hospital shall comply with IDPH reporting requirements mandated for Level III facilities, submitting appropriate forms to the local Health Department or other local health agency designated by IDPH to provide follow-up services in the areas in which high-risk patients reside.

M. Local Health Departments and Community Resources

The University of Illinois Perinatal Network has a staff with responsibility for liaison with the Chicago and Cook County Departments of Health. In addition, Network staff have responsibilities for facilitating referrals of clients from local community-based case management agencies to perinatal services and for referring eligible patients for case management and other community-based services. Network staff are available to work with EHS Christ Hospital and Medical Center to assist with liaison activities with local health departments and with other community-based programs participating in initiatives to reduce perinatal morbidity and mortality and to promote maternal and infant health.

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University of Illinois/EHS Christ Hospital & Medical Center

II. Conditions of Agreement

- A. This agreement will be valid until such time as it is renegotiated or terminated as hereinafter provided.
- B. Either EHS Christ Hospital and Medical Center or the University of Illinois may initiate discussions pertinent to changing this agreement.
- C. If either EHS Christ Hospital and Medical Center or the University of Illinois wants to terminate this agreement, written notification must be given to the other party at least 90 days in advance.

Signatures and Dates

Board of Trustees, University of Illinois

Craig A. Boyer 5-18-94  
Charles D. Thompson 5-19-94

University of Illinois, College of Medicine

Ken M. M. M. 4/20/94  
Dean

EHS Christ Hospital  
and Medical Center

E.H. Wilcox M.D. 3-7-94  
Chief, Obstetrics

[Signature] 7/29/94  
Chief, Pediatrics

UIC  
Perinatal Center

[Signature] 2-11-94  
Head, Department of  
Obstetrics and Gynecology

[Signature]  
Head, Department of  
Pediatrics

Other Affected Parties

[Signature] 4/6/94  
CEO, EHS Christ Hospital and  
Medical Center

[Signature] 4/28/94  
Hospital Director, University  
of Illinois Hospital



Changing medicine. For good.

Perinatal Center (MC 808)  
820 South Wood Street  
Chicago, Illinois 60612  
T 312-996-4390  
F 312-413-0264

Perinatal Consultation/Transport  
Maternal  
T 312-666-0555  
F 312-996-9350

Neonatal  
T 312-996-4150  
F 312-996-2328

June 6, 2012

Courtney R. Avery, Administrator  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761

Dear Courtney:

Please accept this letter of support from the University of Illinois Administrative Perinatal Center for Advocate Christ Medical Center (ACMC) as they petition for a Certificate of Need for their NICU expansion and renovation project. This project includes not only additional beds but also private rooms for newborns, which will allow for a Family Centered Care approach.

The goals of this expansion project are as listed:

**Increase capacity:**

The NICU expansion project will increase the number of Level III NICU beds from 37 to 64 beds. The increased beds would allow ACMC to serve the growing needs of the high risk population in the community. This will include increasing the number of isolation rooms and special procedure rooms in order to provide the best quality care.

**Move to Family Centered Care:**

- a) The project will incorporate single patients rooms with the availability to have parents spend the night at the bedside, increase privacy and reduce the activity level/noise that the neonate is subjected to.
- b) The project would substantially increase the available family support space to include private consult rooms and private family space.
- c) The project will provide family support services, such as social services, care management and discharge planner at the point of care within the NICU.

**Modernize the facilities:**

- a) Increase net square footage for each Level III bed space to accommodate updated standards: allowing for advances in technology
- b) Decrease noise and activity level within the patient care areas, by installation of noise reducing ceiling tiles, flooring and walls.
- c) Decrease workload of staff by configuring workspaces, nursing stations, supplies, and medication towers to better facilitate the best workflow processes.
- d) Increase dedicated family space adjacent to patient.

Sincerely,

Maripat Zeschke RNC-EPM, MSN, LC  
Perinatal Network Administrator  
University of Illinois Administrative Perinatal Center  
820 S. Wood Street, M/C 808  
Chicago, IL 60612  
T: 312-996-4190  
F: 312-413-0264

**Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis**  
**Actual Days 2002 - 2011 Projected to 2019**

CAGR Method <sup>1</sup>		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NICU	Utilization			6,930	6,874	8,534	7,791	9,743	10,541	11,037	10,910
	Est Bypass <sup>2</sup>			-	-	-	-	-	-	-	-
	Observation Days			-	-	-	-	-	-	-	-
	Utilization + bypass <sup>2</sup>			6,930	6,874	8,534	7,791	9,743	10,541	11,037	10,910
	Annual Growth			6,930	(56)	1,660	(743)	1,952	798	496	(127)
	Percent Growth										
	Target % State Occ			75%	75%	75%	75%	75%	75%	75%	75%
	ADC			18.9	18.8	23.4	21.3	26.6	28.9	30.2	29.9
	Bed Need			25.2	25.1	31.2	28.5	35.5	38.5	40.3	39.9

CAGR Method <sup>1</sup>		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NICU with Level 2+	Utilization			6,930	6,874	8,534	7,791	12,536	13,034	11,037	10,910
	Utilization Level 2+			3,216	3,823	2,993	3,188	3,234	3,242	3,567	3,619
	Est Bypass <sup>2</sup>			-	-	-	-	-	-	-	-
	Observation Days			-	-	-	-	-	-	-	-
	Utilization + bypass <sup>2</sup>			10,146	10,697	11,527	10,979	15,770	16,276	14,604	14,529
	Annual Growth			6,930	(56)	1,660	(743)	4,745	498	(1,997)	(127)
	Percent Growth										
	Target % State Occ			75%	75%	75%	75%	75%	75%	75%	75%
	ADC			27.7	29.3	31.6	30.1	43.1	44.6	40.0	39.8
	Bed Need			37.0	39.1	42.1	40.1	57.4	59.5	53.3	53.1

Note:

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) <sup>1/n</sup> (n = number of years) - 1

Advocate Christ Medical Center/Ad  
Actual Days 2002 - 2011 Projected to 2019

CAGR Method <sup>1</sup>		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NICU	Utilization	11,641	12,420	13,252	14,140	15,087	16,098	17,176	18,326	19,554	20,863
	Est Bypass <sup>2</sup>										
	Observation Days										
	Utilization + bypass <sup>2</sup>	11,641	12,420	13,252	14,140	15,087	16,098	17,176	18,326	19,554	20,863
	Annual Growth	731	780	832	888	947	1,011	1,078	1,150	1,227	1,310
	Percent Growth	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%
	Target % State Occ	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	ADC	31.8	34.0	36.3	38.7	41.2	44.1	47.1	50.2	53.6	57.2
	Bed Need	42.4	45.4	48.4	51.7	55.0	58.8	62.7	66.9	71.4	76.2

CAGR Method <sup>1</sup>		2012	2013	2014	2015	2016	2017	2018	2019	2019	2019
NICU with Level 2+	Utilization	11,484	12,089	12,725	13,395	14,100	14,842	15,623	16,445	17,311	18,222
	Utilization Level 2+										
	Est Bypass <sup>2</sup>										
	Observation Days										
	Utilization + bypass <sup>2</sup>	15,294	16,099	16,946	17,838	18,777	19,765	20,805	21,900	23,053	24,267
	Annual Growth	574	604	636	670	705	742	781	822	868	911
	Percent Growth	5.26%	5.26%	5.26%	5.26%	5.26%	5.26%	5.26%	5.26%	5.26%	5.26%
	Target % State Occ	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	ADC	41.8	44.1	46.4	48.9	51.3	54.2	57.0	60.0	63.2	66.5
	Bed Need	55.7	58.8	61.9	65.2	68.4	72.2	76.0	80.0	84.2	88.6

Note:

<sup>1</sup>CAGR Formula (Ending Year / Beginning

## 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"/> OB Triage	9	12
<input checked="" type="checkbox"/> Labor/Delivery/Recovery	15	15
<input checked="" type="checkbox"/> Surgical Delivery Rooms	3	4
<input checked="" type="checkbox"/> Phase I Recovery Stations	3	4
<input checked="" type="checkbox"/> Morgue	1	1

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

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

The following Clinical Service Areas are included in Attachment 37:

1. OB Triage
2. Labor/Delivery/Recovery
3. Surgical Delivery Rooms/C-Section Suite
4. Post Anesthesia Recovery (PACU), Phase I, and
5. Morgue.

The total obstetric program and the neonatal intensive care unit will be located in new construction on Levels 2, 6, and 7 of the proposed Patient Tower and in modernized space on Level 2 of the existing tower. The mother and baby functions located in both buildings will be connected to allow for easy transport and communication between the two buildings. (See Narrative - Stacking Diagram, Attachments 20, 23, and 37-1 through 4.)

c) Service Modernization

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

1) Deteriorated Equipment and Facilities

*The proposed project will result in the replacement of facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiencies involving the proposed project.*

There are no code deficiencies or licensure issues directly related to the OB Triage area at the Medical Center. See Plan of Correction, Appendix 1.

The OB Triage area at the Medical Center (ACMC, Medical Center) is currently located in very cramped space within the LDR area on Level 2 of the existing tower. It will be relocated to space vacated by obstetric beds on Level 2 of the same tower.

2) Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

OB Triage is a vital function in the obstetric service and one that has proven to safely reduce unnecessary obstetric admissions, reduce obstetric length of stay, and increase patient satisfaction.

The Medical Center's OB Triage service is open 24 hours a day, 7 days a week. Triage currently has 9 rooms. In 2011, a total of 6,288 patients were seen the OB Triage area.

The Medical Center's OB Triage service provides two major functions:

1. Scheduled C-section patients are admitted to this unit (except on Saturdays, Sundays and holidays) to be prepped before being moved to the surgical delivery suite.
2. The OB Triage area is used by patients who have unexplained symptoms or who are otherwise concerned about the progress of their pregnancy and either do not have a

primary care physician or cannot see their physician. These patients arrive around the clock in a random pattern.

Of the total number of patients seen in OB Triage, 51 percent can be discharged home; these patients stay on average 4 hours. Scheduled C-section patients typically stay in OB Triage from 2 to 3 hours, depending on whether or not their lab work is complete; however, they could stay longer if, for any reason, the surgery schedule is delayed. Patients who are determined to be in active labor are moved to a labor/delivery/recovery room as soon as one is available.

Total volume of OB Triage patients at the Medical Center is directly related to deliveries. Total number of OB Triage patients equals 160 percent of deliveries.

The OB Triage area is expected to open in 2016; hence the second full year of utilization will be 2018. To determine future OB Triage volume, the Medical Center first derived patients by dividing 2018 patient days by projected average length of stay. Projected obstetric patient days are posted on Attachment 37, Exhibit 1.

The calculated number of patients was then reduced by 88.3 percent; recent experience is that 88.3 percent of the patients result in a delivery. The number of deliveries was then expanded by 160 percent to arrive at 2018 OB Triage patients.

$$15,155 \text{ patient days} \div 3.1 \text{ average length of stay} = 4,889 \text{ patients}$$

$$4,889 \text{ patients} \times 88.3 \text{ percent} = 4,317 \text{ deliveries}$$

$$4,317 \text{ deliveries} \times 160 \text{ percent factor} = 6,907 \text{ OB Triage patients}$$

Next the Medical Center allocated the OB Triage patients into the categories of pre-op C-section patients and all others. Based on experience, the Medical Center assumed that the vast majority of C-section patients would be delivered on a week day, or on 250 days of the year. Hence there would be on average of from 3 to 4 scheduled C-section patients per day in OB Triage.

Consequently, there would be 6,032 all other patients, or on average 24 all other patients per day and a total of 27 to 28 patients per day.

$$6,907 \text{ OB Triage patients} - 845 \text{ C-section patients} = 6,032 \text{ other patients}$$

$$845 \text{ C-section patients} \div 250 \text{ days} = 3 \text{ to } 4$$

$$6,032 \text{ other patients} \div 250 \text{ days} = 24$$

$$3 \text{ to } 4 + 24 = 27 \text{ to } 28$$

The Medical Center reported the average number of monthly deliveries at in 2011 was 328. Not only does volume vary by month, it also varies by day of the week. Consideration of this variation in patient flow is very important in the delivery of obstetric care – if the number of deliveries is high, the demand for LDRs, surgical delivery suites, and obstetric beds is also high. During periods of high utilization, the OB Triage area is also increasingly busy and serves as a safety valve in the flow of maternity patients. For that reason, ACMC also considered the need for OB Triage rooms at the level to support the highest three months of reported volume.

The average delivery volume of the three peak months is 369 deliveries or approximately 12.5 percent higher than the average. This higher volume would suggest that on the peak months the OB Triage area would report 7,770 annual visits. Of these 845 would continue to be scheduled C-section patients and 6,925 all other or 27 to 28 all other patients plus 3 to 4 C-section patients per day for a total of 30 to 32 patients per day.

Because of the potential emergent nature of many of the patients who present to OB Triage and the random nature of their arrival, as well as the actual experience in OB Triage, the Medical Center determined that 12 rooms would be required in the future. Of these, 3 would continue to be primarily prep rooms for scheduled C-section patients and the other nine would be primarily for all other patients. However, all 12 of the proposed rooms will have dual capability and be able to accommodate OB Triage patients as well as scheduled C-section patients. This dual capability gives the area added flexibility.

b) 3) A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months of acquisition.*

NA. There is no OB Triage equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

*Projects involving 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 section c) 2) Necessary Expansion.*

There is no State Standard for utilization of OB Triage rooms in Appendix B.

Justification for the proposed 12 OB Triage Rooms is presented in C) 2) Necessary Expansion.

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

As shown in c) 2) Necessary Expansion, the Medical Center has justified the need for 12 OB Triage Rooms to support the obstetric service.

Section 1110.3030 – Clinical Service Areas Other than Categories of Service--Review Criteria

c) Service Modernization

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

1) Deteriorated Equipment and Facilities

*The proposed project will result in the replacement of facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiencies involving the proposed project.*

**Notes:**

There are no code deficiencies or licensure issues directly related to the Labor/Delivery/Recovery area at Advocate Christ Medical Center (ACMC, Medical Center). See Plan of Correction in Appendix 1.

Although the labor/delivery/recovery area at the Medical Center has 15 LDR rooms the configuration of these rooms is not functional. A pod of 9 rooms is located remote from another pod of 6 rooms; the 9 rooms have neither toilets nor showers. The smaller pod is only used when the 9 rooms are all being used; these 6 rooms have bathrooms. There is a long walking distance for the nurses because of the poor visibility between the nurse station and the pod of 6 LDRs. This distance makes the unit work flow inefficient and does not support optimal patient care and staff work environment.

The LDR rooms are very small compared to State Guidelines. The existing LDRs average only 630 GSF per room compared to the State Guideline of 1,120 to 1,600 GSF per room.

Patient showers are in the hall and must be cleaned between each use.

The LDR area has a severe shortage of storage space.

c) Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to historical utilization, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Changes in industry standards and changes in scope of services offered required the replacement of the number of labor/delivery/and recovery rooms at the Medical Center.

Contemporary Use of LDRs in a High Risk Obstetric Program

At Advocate Christ Medical Center, the LDRs are used by:

- Labor, delivery and recovery of uncomplicated vaginal delivery patients including clinically necessary inductions
- Labor of uncomplicated pregnancies that ultimately require a C-Section
- Labor of patients with threatened abortions (miscarriages) and false labor
- Other patients with high risk pregnancies, and
- Other patients that labor or have labor-like symptoms but do not deliver.

Many patients are admitted to LDRs at the Medical Center who may later deliver in the surgical operating suite or who may not deliver at all. Further, many C-section births are not admitted to an LDR – instead they are prepped in OB Triage and then moved directly to the surgical operating rooms.

The State Agency Standard for LDRs is 400 births per LDR room. The derivation of the Standard is not explained. This Standard does not appear to capture the full range of obstetric services that benefit from the LDRs, in that the Standard is based only on births.

Two delivery models are most frequently used for obstetrical departments. In the first model, most patients stay in one room for labor, delivery and recovery (LDR Model) and are then moved to a postpartum room where they stay until they are discharged. In the second model, the patient stays in the same room for labor, delivery, recovery and postpartum care (LDRP Model). For high risk deliveries and C-section deliveries, modifications of these basic models have been developed. (See Attachment 20 for the description of the Medical Center's high risk program.)

The Medical Center has chosen to redevelop the obstetric program essentially using the LDR model. The purpose of an LDR room is to provide mothers-to-be with family centered maternity care. Mothers with an uncomplicated pregnancy are able to labor, deliver, and recover in a more home-like atmosphere. They may have visitors with them through this very special time. An LDR room typically includes a fully adjustable birthing bed, adjustable lighting, chairs for visitors, television, telephone, and a private bath with a shower. A sleeper sofa is available for a guest.

A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months of acquisition.*

NA. There is no labor/delivery/recovery equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

*Projects involving 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 section c) 2) Necessary Expansion.*

In 2011, the Medical Center reported 4,042 births. These births justify the need for 10 LDRs.

$$4,042 \text{ births} \div 400 \text{ births per LDR} = 10 \text{ LDRs}$$

However, there are other uses of the LDRs that are not accounted for using this State Standard. Therefore, the need for LDRs at the Medical Center cannot be based solely on the number of births reported annually.

Average Hours per LDR Stay at the Medical Center

In addition to volume (other than births) that does not appear to be accounted for in the State Standard, actual time per occasion appears to be understated for a unit that treats many high risk patients.

For planning purposes, 50 to 60 percent occupancy is used in planning for an LDR because of the unscheduled demand for this service. At this occupancy, the average length of stay in an LDR would be from 11 to 13 hours.

Total available hours per LDR = 24 hours per day x 365 = 8,700 hours

Available hours at 50 percent occupancy = 4,380 available hours

4,380 available hours ÷ 400 births per room = 11 hours per birth

Available hours at 60 percent occupancy = 5,220 available hours

5,220 available hours ÷ 400 births per room = 13 hours per birth.

The Medical Center has monitored the time that each patient spends in an LDR as well as the amount of turnover time for each use. Using this data, the Medical Center determined 18.2 hours per use of a LDR or from 40 to 65 percent higher than the estimated State Standard of 11 to 13 hours.

Based on actual times, the LDRs at the Medical Center have the capacity for only 241 to 289 patients each year.

Available hours at 50 percent occupancy = 4,380 available hours

4,380 available hours ÷ 18.2 hours per patient = 241 annual LDR patients per room

Available hours at 60 percent occupancy = 5,220 available hours

5,220 available hours ÷ 18.2 hours per patients = 289 annual LDR patients per room

#### Projected Number of Labor/Delivery/Recovery Rooms

Based on occasions of use and the average time per occasion, the Medical Center determined that there is a current need for from 14 to 16 LDRs. (See Attachment 37, Exhibit 2)

Average hours per occasion x number of occasions = total hours of use

18.2 hours per occasion x 3, 766 occasions = 68,541 hours of use

Total hours of use ÷ available hours per year = number of LDRs at 50 percent occupancy

68,541 hours of use ÷ 4,380 hours per room = 15.6 or 16 rooms

Total hours of use ÷ available hours per year = number of LDRs at 60 percent occupancy

68,541 hours of use ÷ 5,220 hours per room = 13.1 or 14 rooms =

13.1 or 14 rooms LDRs needed at 60 percent occupancy

See Attachment 37, Exhibit 2 for details.

Based on the adjusted methodology presented in c) 2) (Necessary Expansion) and by using actual utilization factors (time per visit and total visits), the Medical Center is conservatively requesting 15 LDRs.

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

The applicants used actual number of occasions and actual occasion time to determine the need for LDRs in the Patient Tower project. The applicants have documented the need for 14 to 16 LDRs by 2017 and are conservatively requesting only 15.

c) Service Modernization

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

1. Deteriorated Equipment and Facilities

*The proposed project will result in the replacement of facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiencies involving the proposed project.*

There are no code deficiencies or licensure issues related to the Surgical Delivery Rooms/C-Section Suite at Advocate Christ Medical Center (ACMC, Medical Center). See Plan of Correction in Appendix 1.

The Medical Center's C-Section Suite has not been renovated since its original construction. Existing conditions that were part of the original suite include a defined semi-restricted and restricted area within the suite; however, the size and configuration of key rooms are small and lack sufficient space to accommodate the latest technology and medical equipment requirements. For example, the square footage of the existing 3 surgical delivery areas is only 657 GSF per room, compared to the State Guideline of 2,075 GSF per room.

2. Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

The Medical Center is a designated Level IIIC Perinatal Center and provides care to very high risk mothers and babies. Attachment 20, Exhibits 1-3 and Attachment 23, Exhibit 1, show that both obstetrics and especially neonatology have not only community but also regional service areas. The Medical Center's service area is

focused to the south and southwest of Chicago; in that direction, the closest Level III Perinatal Center is in Peoria, more than 150 miles away. In 2011, 19 hospitals transferred 124 high risk mothers to the Medical Center.

C-section deliveries at the Medical Center accounted for 36.3 percent of the total deliveries. See Attachment 37, Exhibit 2. Consistent with best practice, the obstetric team is working very hard to reduce the number of preterm deliveries—either vaginal or C-section. See Attachment 13, Empirical Evidence. It is important, unless medical circumstances require otherwise, for the mother to carry the baby to term (39 weeks). Even so, the Medical Center expects C-sections to increase as the percentage of high risk pregnancies increases. Most high risk pregnancies are C-section deliveries or are performed in a surgical suite because of the potential for complications. The Medical Center expects C-section deliveries to increase from 1,427 in 2011 to 1,697 in 2017, the second full year that the proposed new surgical delivery rooms will be available. This is almost a 20 percent increase.

#### Future Need for Surgical Delivery/ C-section Rooms

The increased volume of C-section deliveries will place additional stress on the already undersized surgical capacity for C-sections and other obstetric surgeries. By the second full year of operation, the projected surgical volume will require more surgery capacity. The Medical Center is expecting to need capacity for 1,734 procedures or 5,142 hours of operating room utilization.

Surgical Procedures Performed in the Surgical Delivery Suite, 2017  
Attachment 37, Table 2

Type of Procedure	Number of Procedures	Average Hours per Case	Total Hours of Surgery
C-Section Deliveries	1,694	3.0	5,082
Other Obstetric Surgeries	40	1.5	60
Total	1,734	3.0	5,142

Source: ACMC Internal Financial Records

The State Guideline for surgical delivery rooms/C-section rooms is 800 procedures per room. The derivation of this guideline is not explained. However, there is another surgery related guideline; it is the guideline for general operating rooms or 1,500 hours per room. Based on the State Guideline for surgical delivery rooms, the Medical Center could justify 3 delivery rooms.

$$1,734 \text{ procedures} \div 800 \text{ procedures per room} = 2.2 \text{ or } 3 \text{ rooms}$$

However, the current utilization has proven that 3 rooms are inadequate.

Based on the State Guideline for general operating rooms (1,500 hours per room), the Medical Center could also justify 4 rooms.

$$5,142 \text{ hours of surgery} \div 1,500 \text{ hours per room} = 3.4 \text{ or } 4 \text{ rooms}$$

However, the State Guideline is based on the following formula:

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

The Medical Center has already established that the surgical delivery rooms/C-section rooms are seldom used on Saturday, Sunday and holidays. Hence, use of these rooms meets the criteria of 250 days per year. Medical Center records show that at least 60 percent of all C-section cases and all other obstetric surgeries are performed during the first shift—or 7.5 hours. Using this more conservative approach to calculating need based on the surgical operating room guideline the following formula was applied to projected 2017 C-section room utilization.

$$1,694 \text{ C-sections} \times 60.0 \text{ percent} + 40 \text{ surgeries} \times 100.0 \text{ percent} = \\ 1,057 \text{ procedures} \times 3 \text{ hours per procedure} = 3,171 \text{ hours} \\ 3,171 \text{ hours} \div 1,500 \text{ hours per room} = 2.1 \text{ or } 3 \text{ rooms.}$$

Based on these three methodologies, the Medical Center determined that at least 3 rooms were needed for projected volume.

None of these guidelines take into account the implications of the Medical Center's being a Level III C Perinatal Center and the requirement to have one operating room always available to accept an unscheduled C-section patient, a maternal transport, an injured pregnant emergency patient, a failed induction in the LDR, or a sudden life-threatening change of the status of an unstable antepartum patient or her fetus. The Medical Center determined that it would be unwise to request fewer than 4 operating rooms.

The Medical Center is conservatively requesting 4 surgical delivery/C-section rooms for the new Patient Tower.

c) 3) Utilization

A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve any applicable target utilization levels specified in Appendix B within 12 months after acquisition.*

NA. There is no surgical delivery room equipment in the proposed project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

*Projects involving the modernization of a service or a 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.*

Advocate Christ Medical Center proposes construct 4 surgical delivery rooms (C-section suites). The need for these rooms has been documented in c) 2) Necessary Expansion.

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.*

NA. The State has established utilization standards for both C-section suites and Class C Surgical Operating suites. Using these guidelines the Medical Center can justify 3 to 4 operating rooms. The Medical Center must always have an operating room available to accommodate emergency surgery for the high risk obstetric population whose condition can rapidly deteriorate and threaten the life of the mother, of the infant, or both. For that reason, the Medical Center is requesting 4 surgical operating rooms.

c) Service Modernization

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

1) Deteriorated Equipment and Facilities

*The proposed project will result in the replacement of facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiencies involving the proposed project.*

There are no code deficiencies or licensure issues directly related to the Phase I recovery at Advocate Christ Medical Center.

The Medical Center is proposing to relocate the obstetric beds, labor/delivery/recovery rooms, and C-section delivery rooms into new space. For efficient operation, the Phase I recovery stations must also be relocated.

The Medical Center currently provides 3 Phase I recovery stations; they are located in 600 GSF of space or 200 GSF per station. While this square footage exceeds the State Guideline of 180 GSF per station, the physicians, nurses and other health professionals who care for the recovering mothers and infants find that it is inadequate.

The Phase I recovery area has not been renovated. The recovery areas are curtained cubicles that offer little privacy. The area does not provide sufficient storage for supplies, linen, equipment and other support functions. Often, C-section patients cannot recover in the same room with their baby due to lack of space.

2) Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

According to definitions in Section 1100.220 of the Rules, Post Anesthesia Recovery Phase I refers to the phase of surgical recovery that focuses on providing transition from a totally anesthetized state to one requiring less acute intervention. The purpose of this phase is for patients to regain physiological homeostasis and receive appropriate nursing intervention as needed.

The total need for recovery space at the Medical Center is dependent on the number of operating rooms in the main operating suite, in the Ambulatory/Outpatient Pavilion, and in the new Patient Tower.

The only recovery space that is part of the Patient Tower project is the Phase I Recovery stations that are adjacent to the surgical delivery rooms on. C-section deliveries and selected obstetric surgeries are recovered in these rooms.

#### Code Required Ratios for Phase I Recovery Stations

The Illinois Hospital Licensure Code requires 1 Phase I recovery station for each inpatient key room. The Medical Center has justified 4 surgical operating rooms and is requesting 4 Phase I recovery stations.

### 3) Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B. within 12 months after acquisition.*

NA. There is no major medical equipment in this project

#### 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).*

The State Guidelines provide no volume per unit factor for Phase I Post Anesthesia Recovery. However The Illinois Hospital Licensure Code requires one Phase I Post Anesthesia Recovery station for each operating 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.*

Since there are no State Guidelines for Phase I Recovery Stations, Advocate Christ Medical Center justified the 4 proposed recovery stations based on the need for 4 operating rooms and the licensure requirement that the number of Phase I recovery stations must be at least equal to the operating rooms.

c) Service Modernization

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

1) Deteriorated Equipment and Facilities

*The proposed project will result in the replacement of facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiencies involving the proposed project.*

The Medical Center is proposing to relocate and expand the existing morgue. The morgue was sized and built when the original 191-bed Christ Hospital was constructed more than 50 years ago. In the intervening years, the size of the morgue has not increased from its original 979 GSF, even though the number of beds (and of patients) at the Medical Center has more than tripled. The department is landlocked. The existing morgue's location results in long travel distances between the morgue and the Emergency Department, the intensive care units, and the high risk obstetric and neonatal services.

The design of the existing morgue detracts from efficient work flow and work space to enable code compliant infection control procedures within the area.

Because of the very limited space, there are no appropriate viewing and/or bereavement rooms for family and loved one. The cooler can only hold eight bodies and there are no accommodations for bariatric patients. The morgue does not have an adequate number of autopsy tables. The paraffin block/tissue slide storage room is undersized and all other storage space is very limited.

2) Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

A morgue in a hospital (or elsewhere) is used for holding human corpses awaiting identification, or removal for autopsy, or disposal by burial, cremation, or otherwise.

The State has not developed utilization guidelines for morgues.

The morgue at the Medical Center is severely undersized with only 979 GSF and needs to be expanded.

CANNON Design, architects for the Patient Tower project, researched best practices in the design of health care facilities and found a range of from 2.9 GSF to 4.5 GSF per bed for morgues; the 2.9 GSF guideline is an old Health Facilities Review Board guideline.

At the end of 2011, the Medical Center had 690 authorized beds. At project completion, there will be 824 authorized beds. See Facility Bed Capacity and Utilization, Exhibit 1.

$$824 \text{ beds} \times 2.9 \text{ GSF per bed} = 2,390 \text{ GSF proposed GSF}$$

$$824 \text{ beds} \times 4.5 \text{ GSF per bed} = 3,708 \text{ proposed GSF}$$

Based on these guidelines and the proposed number of beds at project completion, the Medical Center could justify from 2,390 to 3,708 GSF.

Over the last 3 years, the average number of bodies per year in the morgue ranged from 1,425 to 1,577.

Attachment 37, Table 2  
Annual Volume in the Morgue

Year	Number
2009	1,577
2010	1,495
2011	1,425

Source: ACMC Morgue Records

These volumes do not include specimens used for autopsy. Although annual volume appears to have stabilized, volume alone doesn't capture what is occurring in the morgue. For example, the number of days that bodies stay in the morgue has increased to as long as 7 days due to family dynamics and abandonment. Abandonment has increased due to the cost of burial and the state of the current economy.

The Medical Center is proposing to redevelop the morgue in 2,597 GSF which is well within the range of the square footage guidelines. The new morgue will have a 950 GSF cooler with capacity for 22 bodies and an organ harvesting room. The autopsy facilities will be larger and provide an infectious control table and a bariatric table. The design for the new morgue includes a family viewing area and needed storage

space for slides, paraffin cassettes, tissue samples, and space to meet other storage requirements.

### 3) Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B. within 12 months after acquisition.*

NA. There is no major medical equipment related to the relocation and expansion of the morgue at Advocate Christ Medical Center.

#### 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).*

There is no State Standard in Appendix B for morgues. APMC has justified the proposed square footage under 2) Necessary Expansion.

#### 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.*

Advocate Christ Medical Center has justified the proposed morgue and related square footage based on current volume and number of beds in the Medical Center.

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>	2005	2006	2007	2008	2009	2010	2011
<b>Maternity</b>							
Utilization	12,164	12,244	13,542	13,435	13,137	13,547	13,448
Est Bypass <sup>2</sup>	-	-	-	-	-	-	-
Observation Days	180	133	145	73	75	121	113
Utilization + bypass <sup>2</sup>	12,344	12,377	13,687	13,508	13,212	13,668	13,561
Annual Growth	12,164	80	1,298	(107)	(298)	410	(99)
Percent Growth							
<b>Target % State Occ</b>	<b>78%</b>						
ADC	33.8	33.9	37.5	36.9	36.2	37.4	37.2
<b>Bed Need</b>	<b>43.4</b>	<b>43.5</b>	<b>48.1</b>	<b>47.3</b>	<b>46.4</b>	<b>48.0</b>	<b>47.6</b>

<sup>1</sup>CAGR Formula (Ending Year / Beginning Year) ^ (1 / number of years) - 1

## Advocate Christ Medical Center/Advocate Hope Children's Hospital Patient Days Growth Analysis

Actual Days 2002 - 2011 Projected to 2021

Version: 07/03/2012

CAGR Method <sup>1</sup>	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Maternity</b>										
Utilization	13,660	13,876	14,095	14,318	14,544	14,774	15,007	15,244	15,485	15,730
Est Bypass <sup>2</sup>										
Observation Days										
Utilization + bypass <sup>2</sup>	13,775	13,993	14,214	14,438	14,666	14,898	15,133	15,372	15,615	15,862
Annual Growth	212	216	219	223	226	230	233	237	241	245
Percent Growth	1.58%	1.58%	1.58%	1.58%	1.58%	1.58%	1.58%	1.58%	1.58%	1.58%
<b>Target % State Occ</b>	<b>78%</b>									
ADC	37.6	38.3	38.9	39.6	40.1	40.8	41.5	42.1	42.8	43.5
<b>Bed Need</b>	<b>48.3</b>	<b>49.1</b>	<b>49.9</b>	<b>50.7</b>	<b>51.4</b>	<b>52.3</b>	<b>53.2</b>	<b>54.0</b>	<b>54.8</b>	<b>55.7</b>

<sup>1</sup>CAGR Formula  $(\text{Ending Year} / \text{Beginning Year})^{(1 / \text{number of years})} - 1$

Current and Projected Utilization of  
Labor/Delivery/Recovery Rooms and  
Surgical/Delivery Rooms (ORs), 2011 and 2017

Case Type	2011				2017			
	Total Deliveries	Percent	Utilization LDR	Utilization ORs	Total Deliveries	Percent	Utilization LDR	Utilization ORs
<u>Inpatient</u>								
Vaginal Delivery	2,503	63.7	2,503	-	2,660	61.1	2,660	-
C-Section Deliveries	1,427	36.3	714 <sup>1</sup>	1,427	1,694	38.9	847	1,694
Total	3,930		3,217	1,427	4,354		3,507	1,694
Other LDR Cases	549	12.0	549	-	608		608	-
All Other	96	2.1	-	36	106		-	40
Total	4,575		3,766	1,463	5,068 <sup>2,3</sup>		4,115	1,734

Source: Business Development

<sup>1</sup> 50 percent of C-Sections are scheduled and never use an LDR

<sup>2</sup> Projected patient days ÷ 2.91 ALOS

<sup>3</sup> 10.8 percent increase in obstetric admissions, 2011-2017

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.

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:**

<u>\$138,709,655</u>	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> <li>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</li> <li>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;</li> </ol>
_____	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;
<u>\$207,047,325</u>	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"> <li>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;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>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.;</li> <li>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;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>
_____	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.
<u>\$345,756,980</u>	<b>TOTAL FUNDS AVAILABLE</b>	

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

# Fitch Ratings

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-0B;
- \$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 (DOOH), 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 DOOH, 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

EBITDA of 9.6x and 10.6x in fiscal 2011 and 2010, respectively, which is favorable to Fitch's 'AA' category median of 6.0x.

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 (aka 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, 2006A-1, 2006A-2, 2006A-3 and 2006C-3B put bonds. As 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-remarked 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.

As 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 as 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](http://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](http://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, Aa2VMIG 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 \$1.3 billion of outstanding debt

ILLINOIS FINANCE AUTHORITY  
Hospitals & Health Service Providers  
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#### Opinion

NEW YORK, July 19, 2012 --Moody's Investors Service has affirmed the Aa2, Aa2VMIG 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 Aa2VMIG 1 ratings apply to the Series 2003A, Series 2003C, Series 2005A, and Series 2006C-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 2006C-1 and Series 2006C-2B, The Northern Trust Company for Series 2006C-2A and Bank of America, N.A. for Series 2006C-3A with new SBPAs for each Series. The new SBPAs will be provided by JPMorgan Chase Bank, N.A. for Series 2006C-1 and Series 2006C-2B, Wells Fargo Bank, National Association for Series 2006C-2A and The Northern Trust Company for Series 2006C-3A. The long-term and short-term other 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 2006C-3A as well as affirm the current short-term rating, VMIG 1, assigned to the Series 2006C-1, Series 2006C-2B and Series 2006C-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 1.8 times

\*Strong and growing liquidity position with 261 days of cash on hand as of March 31, 2012, providing a strong 258% 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 2006C bonds. There is a total of \$326 million of swaps associated with the Series 2006C 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 Chicagoand 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 one 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 Chicago-area hospitals 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 Chicago-area region is a relatively new strategy, which we believe carries some risk as the system integrates hospitals in further locations while striving 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 enhanced 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 \$480 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 grow significantly in fiscal year 2011, by \$230 million, to a very strong \$3.1 billion (266 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 insurance) 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/VMO 1 ratings on these bonds. As of June 30, 2012, the Series 2006A-1 (\$51 million), Series 2006A-2 (\$43

million) and Series 2009C (\$25 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 unmarketed 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 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 or of 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 15th 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; 186,756

\*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): \$1,583 million; \$1,783 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: 253 days; 209 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 2006D (\$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 (\$20 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/VMOG 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/VMOG 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/VMOG 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/VMOG 1

- Series 2011B Windows variable rate bonds (\$70 million): Aa2P-1

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Underwriter: Ryan Free, Director, OIG, 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.moody.com](http://www.moody.com) for a copy of this methodology.

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Please see [www.moody.com](http://www.moody.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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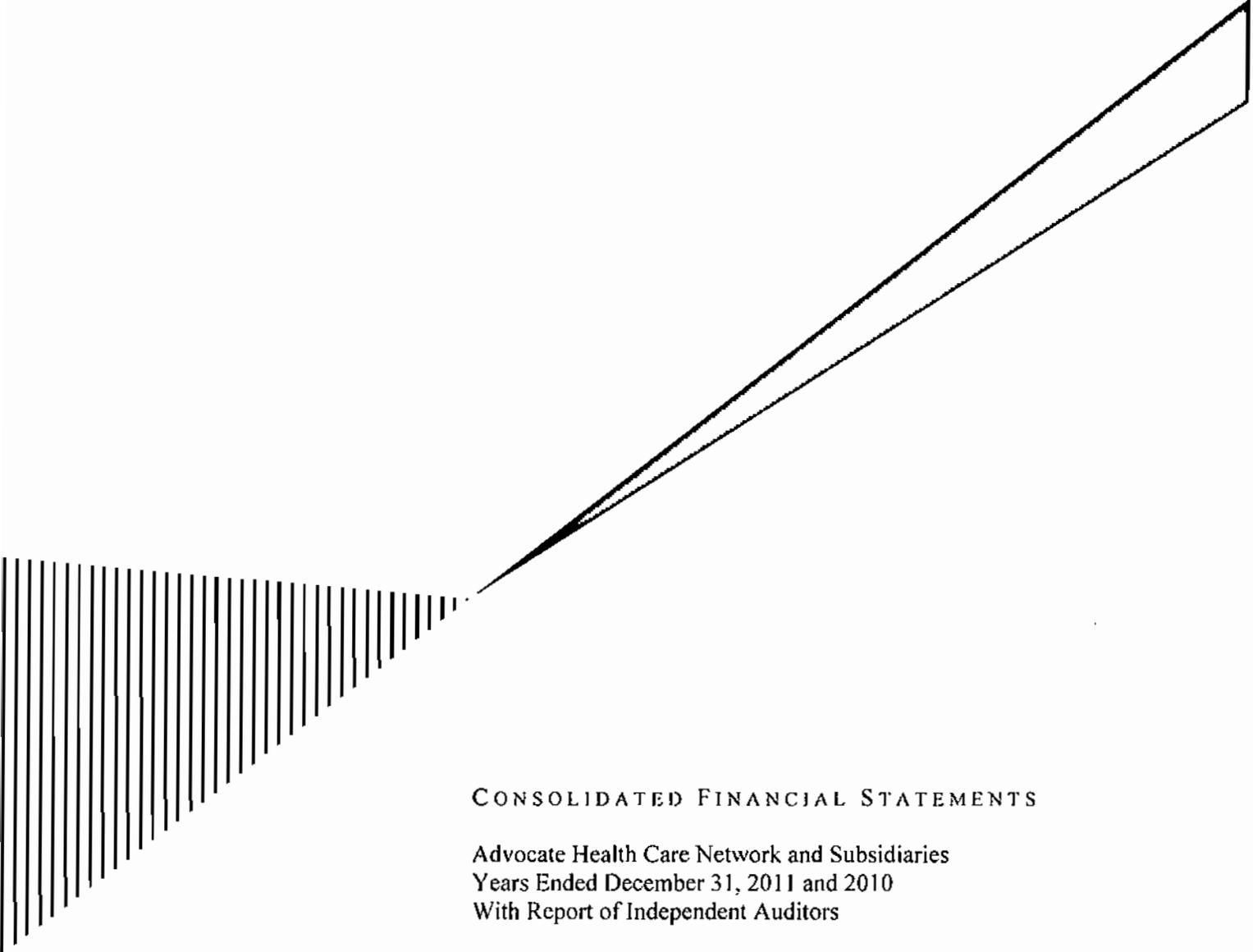
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CONSOLIDATED FINANCIAL STATEMENTS

Advocate Health Care Network and Subsidiaries  
Years Ended December 31, 2011 and 2010  
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

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.

*Ernst & Young LLP*

March 9, 2012

## Advocate Health Care Network and Subsidiaries

### Consolidated Balance Sheets

*(Dollars in Thousands)*

	December 31	
	2011	2010
<b>Assets</b>		
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
<b>Liabilities, net assets and shareholders' equity</b>		
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
<b>Unrestricted revenues, gains, and other support</b>		
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>
<b>Expenses</b>		
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
<b>Nonoperating (loss) income</b>		
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)

	<b>Year Ended December 31</b>	
	<b>2011</b>	<b>2010</b>
<b>Unrestricted net assets</b>		
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	<u>81,340</u>	<u>847,922</u>
<b>Temporarily restricted net assets</b>		
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	<u>545</u>	<u>10,072</u>
<b>Permanently restricted net assets</b>		
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	<u>9,669</u>	<u>11,221</u>
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	<u>\$ 3,559,505</u>	<u>\$ 3,468,018</u>

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
<b>Operating activities</b>		
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	(24,230)	(39,384)
Net cash (used in) provided by operating activities	(207,887)	95,902
<b>Investing activities</b>		
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)
<b>Financing activities</b>		
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.

## 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.

## 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:

	2011	2010
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
	3,731,473	3,282,292
Other financial instruments:		
Cash and cash equivalents and short-term investments	323,168	567,466
	\$ 4,054,641	\$ 3,849,758

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:

	2011	2010
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
	\$ 4,054,641	\$ 3,849,758

## 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
	\$ (33,698)	\$ 351,324

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
	\$ (33,698)	\$ 351,324

## 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)
<b>Assets</b>				
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	
<b>Liabilities</b>				
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)
<b>Assets</b>				
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	<u>\$ 218,777</u>		<u>\$ 218,777</u>	
<b>Liabilities</b>				
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	<u>\$ (219,052)</u>		<u>\$ (219,052)</u>	

## 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:

	<u>2011</u>		<u>2010</u>
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)

	<u>2011</u>	<u>2010</u>
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:

	<b>December 31</b>	
	<b>2011</b>	<b>2010</b>
<b>Consolidated balance sheet location</b>		
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:

	<b>Year Ended December 31</b>	
	<b>2011</b>	<b>2010</b>
<b>Consolidated statement of operations and changes in net assets location</b>		
Net cash payments on interest rate swap agreements (interest expense)	\$ 10,400	\$ 10,429
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>\$</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:

<u>Asset Category</u>	<u>Target</u>	<u>Actual Asset Allocation</u>	
		<u>2011</u>	<u>2010</u>
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
	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

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:

	<u>Hedge Funds</u>	<u>Private Equity</u>	<u>Real Estate</u>
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	<u>\$ 43,083</u>	<u>\$ 53,737</u>	<u>\$ 16,130</u>

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	<u>Fair Value Measurements at Reporting Date Using</u>			
	<u>Fair Value</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
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	<u>\$ 672,769</u>	<u>\$ 434,443</u>	<u>\$ 150,428</u>	<u>\$ 87,898</u>

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:

	<u>2011</u>	<u>2010</u>
<b>Deferred tax assets</b>		
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	<u>25,809</u>	<u>13,941</u>
Total deferred tax assets	43,711	28,980
Less valuation allowance	<u>25,809</u>	<u>13,941</u>
Net deferred tax assets, included in deferred costs and intangible assets and prepaid expenses, inventories, and other assets	<u>\$ 17,902</u>	<u>\$ 15,039</u>
<b>Deferred tax liabilities</b>		
Property and equipment	\$ (7,149)	\$ (3,110)
Other accrued expenses	(272)	-
Deferred gain on BroMenn acquisition	<u>(6,228)</u>	<u>(5,064)</u>
Total deferred tax liabilities, included in other noncurrent liabilities	<u>\$ (13,649)</u>	<u>\$ (8,174)</u>

## 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.

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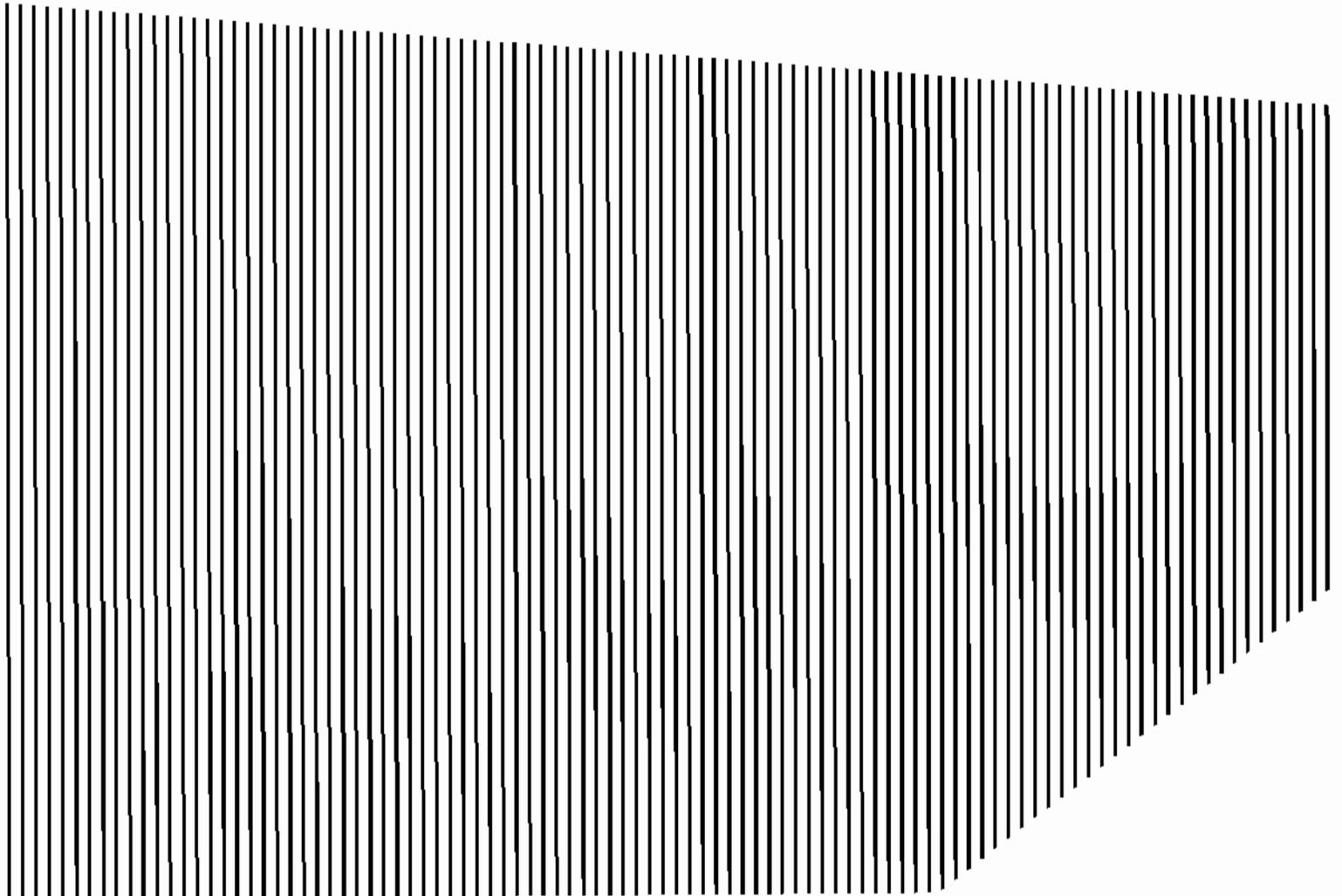
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**X. 1120.140 - Economic Feasibility**

**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.

**NA Advocate has an 'AA' bond rating from Fitch Rating.**

**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.

**See Attachment 49, Exhibit 2**

**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									
<b>TOTALS</b>									

\* 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.**

Projected operating costs and total effect of the project on capital costs are included in Attachment 42, Exhibit 3.

### Reasonableness of Project and Related Costs

	Cost and Gross Square Feet by Department or Service								
	A	B	C	D	E	F	G	H	
	Cost / Square Foot	Gross Square Feet		Gross Square Feet	Const. Cost		Mod. Cost	Total Cost	
Department	New	Mod.	New	Circ.	Mod.	Circ.	(AxC)	(BxE)	
<b>Clinical</b>									
OB Triage		\$ 276			5,409		\$ -	\$ 1,492,884	\$ 1,492,884
Labor/Delivery/Recovery	\$ 500		13,853				\$ 6,926,500	\$ -	\$ 6,926,500
C-Section Suite	\$ 650		3,525				\$ 2,291,250	\$ -	\$ 2,291,250
Phase I Recovery	\$ 500		1,618				\$ 809,000	\$ -	\$ 809,000
Obstetric Beds							\$ -	\$ -	\$ -
Antepartum beds	\$ 415		3,824				\$ 1,586,960	\$ -	\$ 1,586,960
Postpartum beds	\$ 375		28,878				\$ 10,829,250	\$ -	\$ 10,829,250
Newborn nursery bassinets	\$ 490		1,799				\$ 881,510	\$ -	\$ 881,510
Neonatal Intensive Care Beds		\$ 328			31,968		\$ -	\$ 10,485,504	\$ 10,485,504
Intensive Care Beds	\$ 510		66,698				\$ 34,015,980	\$ -	\$ 34,015,980
Medical Surgical Beds		\$ 365			2,191		\$ -	\$ 799,715	\$ 799,715
Morgue	\$ 235		2,597				\$ 611,386	\$ -	\$ 611,386
							\$ -	\$ -	\$ -
							\$ -	\$ -	\$ -
							\$ -	\$ -	\$ -
<b>Total Clinical / Average Cost / Sq. Ft.</b>	<b>\$471.95</b>	<b>\$322.94</b>	<b>122,792</b>	--	<b>39,568</b>	<b>0</b>	<b>\$ 57,951,836</b>	<b>\$ 12,778,103</b>	<b>\$ 70,729,939</b>
<b>Clinical Contingency</b>							<b>\$ 5,766,208</b>	<b>\$ 1,910,326</b>	<b>\$ 7,676,534</b>
<b>Clinical Subtotal</b>	<b>\$518.91</b>	<b>\$371.22</b>					<b>\$ 63,718,043</b>	<b>\$ 14,688,429</b>	<b>\$ 78,406,473</b>
<b>Non-Clinical</b>									
Administrative	\$425	\$408	27,343		9,160		11,620,775	3,737,672	15,358,447
Non Clinical Storage, Processing and Distribution	\$425	\$407	56,719		9,462		24,105,575	3,847,902	27,953,477
Public Amenities	\$425	\$407	95,426		18,075		40,556,050	7,353,147	47,909,197
Building Components	\$425	\$385	71,103		7,718		30,218,775	2,971,430	33,190,205
Shell Space	\$425	\$365	15,488				6,582,400	0	6,582,400
<b>Total Non-Clinical / Average Cost / Sq. Ft.</b>	<b>\$425.00</b>	<b>\$403.25</b>	<b>266,079</b>		<b>44,415</b>		<b>\$113,083,575</b>	<b>\$17,910,151</b>	<b>\$130,993,726</b>
<b>Subtotal / Average Cost / Sq. Ft.</b>	<b>\$439.83</b>	<b>\$ 365.41</b>							
<b>Non-clinical Contingency</b>	<b>\$28.93</b>	<b>\$31.88</b>					<b>\$11,251,816</b>	<b>\$2,677,568</b>	<b>\$13,929,383</b>
<b>Non-clinical Total</b>							<b>\$124,335,391</b>	<b>\$20,587,719</b>	<b>\$144,923,109</b>
<b>Total with contingency / Average Cost / Sq. Ft.</b>	<b>\$483.59</b>	<b>\$420.04</b>	<b>388,871</b>		<b>83,983</b>		<b>\$188,053,434</b>	<b>\$35,276,148</b>	<b>\$223,329,582</b>

4440 West 9<sup>th</sup> Street  
Oak Lawn, Illinois 60453  
Telephone 708.684.0000  
www.advocatehealth.com



July 20, 2012

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

Dear Ms. Avery:

The purpose of this letter is to attest to the fact that Advocate Health and Hospitals Corporation will use the selected form of debt financing for the Patient Tower Project described by this Certificate of Need application because it will be at the lowest net cost available, is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term, financing costs and other factors.

Sincerely,

A handwritten signature in black ink that reads "Kenneth W. Luskhard".

Kenneth W. Luskhard, Market President  
Advocate Christ Medical Center and Trinity Hospital

Subscribed and sworn before me this 20<sup>th</sup> day of July, 2012

A handwritten signature in black ink that reads "Dawn M. Hestoff".

Signature of Notary

Seal of the Notary



Related to the Evangelical Lutheran Church in America and the United Church of Christ

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



**ADVOCATE CHRIST MEDICAL CENTER  
EQUIVALENT PATIENT DAYS**

	Actual 2011	Projected								
		2012	2013	2014	2015	2016	2017	2018	2019	2020
Patient Days	210,044	206,000	207,000	208,000	209,000	210,000	224,000	230,000	235,000	238,000
<b>Ratio of Outpatient Revenue to Inpatient Revenue</b>										
Inpatient Revenue	\$ 1,780,717,000	\$ 1,890,000,000	\$ 1,994,417,000	\$ 2,094,138,000	\$ 2,198,846,000	\$ 2,308,787,000	\$ 2,470,000,000	\$ 2,540,000,000	\$ 2,595,000,000	\$ 2,630,000,000
Outpatient Revenue	632,388,000	675,000,000	708,750,000	788,838,000	869,696,000	949,710,000	970,000,000	990,000,000	1,100,000,000	1,115,000,000
Total Revenue	<u>\$ 2,413,105,000</u>	<u>\$ 2,565,000,000</u>	<u>\$ 2,703,167,000</u>	<u>\$ 2,882,976,000</u>	<u>\$ 3,068,542,000</u>	<u>\$ 3,258,497,000</u>	<u>\$ 3,440,000,000</u>	<u>\$ 3,530,000,000</u>	<u>\$ 3,695,000,000</u>	<u>\$ 3,745,000,000</u>
Ratio	35.5%	35.7%	35.5%	37.7%	39.6%	41.1%	39.3%	39.0%	42.4%	42.4%
Computed O/P Equivalent Days	74,593	73,571	73,561	78,351	82,664	86,383	87,968	89,646	99,615	100,901
Total Equivalent Patient Days	284,637	279,571	280,561	286,351	291,664	296,383	311,968	319,646	334,815	338,901

**ADVOCATE CHRIST MEDICAL CENTER  
OPERATING EXPENSES**

	Actual 2011	Projected 2020		
		Medical Center	Project	Total
Salaries and Benefits	\$ 395,996,000	\$ 505,000,000	\$ 35,845,000	\$ 540,845,000
Professional Fees	29,119,000	35,000,000	-	35,000,000
Services	79,022,000	95,000,000	10,178,000	105,178,000
Supplies	156,183,000	180,000,000	30,135,000	210,135,000
Bad Debts	43,565,000	-	-	-
Advocate System Allocations	48,097,000	62,000,000	-	62,000,000
Other	57,555,000	65,000,000	-	65,000,000
Insurance	20,166,000	64,000,000	3,818,000	67,818,000
Interest	4,837,000	17,907,000	10,500,000	28,407,000
Depreciation	21,573,000	33,400,000	11,929,000	45,329,000
<b>Total</b>	<b>\$ 856,113,000</b>	<b>\$ 1,057,307,000</b>	<b>\$ 102,405,000</b>	<b>\$ 1,159,712,000</b>

Note: Effective in 2012 bad debts are no longer reported as an operating expense but rather as a deduction from revenue

**ADVOCATE CHRIST MEDICAL CENTER  
OPERATING EXPENSES PER EQUIVALENT PATIENT DAY**

	2011		2020 Projected				Total	
	Amount	Per EPD	Amount		Per EPD		Amount	EPD
			Medical Center	Project	Medical Center	Project		
Operating Expenses	\$ 829,703,000	2,914.95	\$ 1,006,000,000	\$ 79,976,000	\$ 2,968.42	\$ 235.99	\$ 1,085,976,000	\$ 3,204.40
Capital Costs	26,410,000	92.78	51,307,000	22,429,000	151.39	66.18	73,736,000	217.57
<b>Total</b>	<b>\$ 856,113,000</b>	<b>3,007.73</b>	<b>\$ 1,057,307,000</b>	<b>\$ 102,405,000</b>	<b>\$ 3,119.81</b>	<b>\$ 302.17</b>	<b>\$ 1,159,712,000</b>	<b>\$ 3,421.98</b>

**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			
<b>Total</b>			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
Medicaid (revenue)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			

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

## **IX. Safety Net Impact Statement**

*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 provided \$571 million in charitable care and services in 2011. This contribution represents more than one-million lives touched in the communities Advocate serves throughout Chicagoland and Central Illinois.

Advocate provided \$95.3 million in free care and discounted charity care for the uninsured and underinsured, and supplied more than \$295 million in care without full reimbursement from Medicare, Medicaid or 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.

Also, Advocate contributed and supported other not-for-profit community-based organizations and increased the support of medical education and training programs in 2011.

Advocate Christ Medical Center (ACMC) provides a significant proportion of the System's community benefit efforts and support in the Chicago south market area.

In fact, all of ACMC's capital expansion projects are centered on increasing capacity to provide more services to the South Market communities and expand safety net services. The proposed Inpatient Bed Tower will improve accessibility and increase capacity for safety net services. The Patient Tower will be expanding capacity and thus making more accessible the services it has historically provided to the region, including services to a growing number of patients with financial barriers to healthcare, special needs, or other limitations.

*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.*

The Medical Center's development of a Patient Tower should not affect any other facilities' ability to cross-subsidize other safety net services. The patients expected to use the services in the Patient Tower, historically, have been served by ACMC.

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.

1. and 2.

In 2011, the Advocate system provided more than \$571 million in charitable care and services. This represents an \$109 million increase over 2010.

Advocate Christ 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.

**ACMC Charity Care and Medical  
Attachment 43, Table 1**

Safety Net Information per PA 96-0031				
CHARITY CARE				PERCENT CHANGE
Charity (# of patients)	Year 2009	Year 2010	Year 2011	
Inpatient	360	655	981	+172.5
Outpatient	1,069	1,477	1,925	+80.0
<b>Total</b>	1,429	2,132	2,906	+103.4
Charity (cost In dollars)*				
Inpatient	\$ 7,731,100	\$ 12,395,400	\$ 16,292,909	+110.7
Outpatient	\$ 1,397,900	\$ 1,706,800	\$ 3,226,096	+130.8
<b>Total</b>	\$ 9,129,000	\$ 14,102,200	\$ 19,519,005	+113.8

MEDICAID				
Medicaid (# of patients)	Year 2009	Year 2010	Year 2011	
Inpatient	7,969	8,038	7,784	2.3
Outpatient	76,306	81,623	76,133	-0.2
<b>Total</b>	<b>84,275</b>	<b>89,661</b>	<b>83,917</b>	<b>-0.03</b>
Medicaid (revenue) <sup>1</sup>				
Inpatient	\$ 75,262,244	\$ 90,817,092	\$ 82,665,000	+9.8
Outpatient	\$ 5,823,286	\$ 4,763,963	\$ 4,849,000	-34.8
<b>Total</b>	<b>\$ 81,085,530</b>	<b>\$ 95,581,055</b>	<b>\$ 87,514,000</b>	<b>+7.9</b>

Source: Annual Hospital Questionnaire

<sup>1</sup> In 2009, Medicaid Revenue of \$81,085,530 erroneously excluded the Proceeds from the Medicaid Assessment (\$33,274,000).

\*Charity Care numbers are the updated values 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.*

ACMC and AHCH continue to provide tertiary and quaternary services to the South market. The Medical Center continues its long history of providing high quality services to all communities in the south and southwest suburbs of Chicago. ACMC and AHCH continue to develop and maintain long-lasting relationships that not only promote health care services, but also protect the many vulnerable populations residing in the South Market. The following are examples of how the medical center actively supports the overall health condition of the South Market, while providing accessibility to most current services and clinical techniques.

The Women's Clinic:

The Women's Clinic is a vital safety net service meeting the needs of pregnant women in Oak Lawn and other south side Chicago communities. The Clinic serves primarily Medicaid, underinsured and uninsured women. Of the women seen at the Clinic, from 90 to 95 percent are on public aid. The Clinic is located in the Professional Office Building on the ACMC campus; deliveries are admitted to the Medical Center's obstetric service.

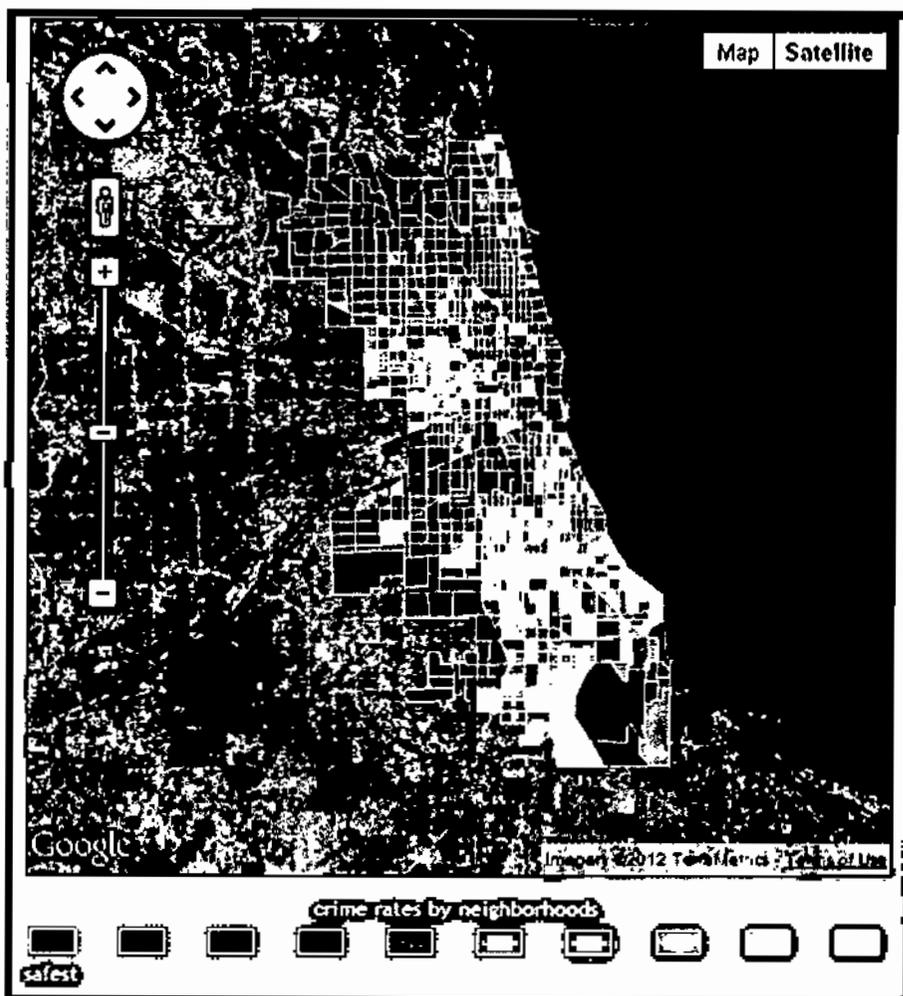
The Clinic is managed by the Advocate Medical Group Oak Lawn OB/GYNE. The group has 3 physicians; these physicians and a nurse practitioner provide counseling, prenatal, delivery, postpartum, and follow up care. Because volume is limited by physician availability a fourth physician is being added and additional physicians are aggressively being recruited to better meet this obvious need. Today, because of the increasing volume and lack of other available sources of care (including private community physicians who will not accept Medicaid patients), a patient may have to wait a month or more for an appointment for routine prenatal care. The ultimate goal is to have enough physicians and other staff to accommodate from 9 to 15 new patients per week and be able to see them within 3 to 5 days of their initial call to the Clinic. On occasion, patients who arrive at the Women's Clinic are in active labor. They are not allowed to leave without receiving all necessary care; they are never transferred to another facility.

The Women's Clinic is one of the many Medical Center services developed to provide a vital safety net to women and families in the community and beyond. As the Women's Clinic continues to expand to support this very vulnerable population, additional women's and infants services (including OB, Gyn, and NICU capacity) are included in this project to support the overall growing needs of the service area.

#### Trauma Services:

In addition to Women's Clinic, ACMC is the only Level 1 Trauma center in the South region. ACMC continues to reach extraordinarily high levels of occupancy in the existing ICUs and is forced to go on bypass status. Unfortunately, when ACMC is on bypass status, many patients are diverted and forced to endure longer travel times and to travel longer distances, before proper patient care can be administered. Trauma patients, who are much more time sensitive and could significantly benefit from receiving care immediately, are transported over long distances through inner city traffic to receive care within one of the city hospitals. This special population is adversely impacted by the hardships associated with not only having to struggle to receive timely medical attention, but also in terms of being transported away from family, friends, and other established support systems.

ACMC is the only Level 1 Trauma service supporting the South Region including some neighborhoods that are racially diverse and income challenged with a higher incidence of crime. The map below exhibits that ACMC serves some of the areas with the highest crime rates in Chicago. ACMC continues to be the only South region hospital in the trauma network to serve this very vulnerable population. All other hospitals in the South Region have abandoned the provision of Level 1 trauma services. Any time ACMC is on bypass status, the lack of access significantly impacts the residents of this very at risk service area. Additionally, there is a history of collaboration with the Chicago-based outreach program, CeaseFire, to help reduce the incidence of violence in the community.



Source: <http://www.neighborhoodscout.com/il/chicago/crime/>

### Ronald McDonald Care Mobile® and Ronald McDonald House Charities:

As an example of the safety net services and community benefits provided, ACMC/AHCH in partnership with the Ronald McDonald House Charities (RMHC) operates Ronald McDonald Care Mobile®. This is a 40-foot, mobile pediatric medical clinic with a clinical staff that provides free health care services to children in underserved areas of Chicago and surrounding communities. Services include (but are not limited to) school physicals, immunizations, asthma care, health screenings, prenatal instruction and education, and well-baby care throughout the community. In 2011, the Ronald McDonald Care Mobile® team served 2,138 children and administered over 2,600 vaccines and 2,073 physicals. Their goal is to find a “medical home” for all the children who visit the Care Mobile. As ACMC/AHCH’s partner, RMHC provides financial support of the Care Mobile’s annual operating budget.

ACMC/AHCH partnered with the Ronald McDonald House Charities® of Chicagoland and Northwest Indiana (RMHC) in the opening of a 16-bed Ronald McDonald House in Oak Lawn for families of children being treated at Hope Children’s Hospital. In cooperation with RMHC, the Medical Center also provides Happy Hearts and Homes, a nine-week parenting program for at-risk, first-time parents.

### Health Outreach and Wellness:

In addition to free and subsidized care, and in alignment with its Magnet Status, ACMC/AHCH also offers programs and services that respond to communities’ unique healthcare needs. The hospital sponsors outreach efforts to address the health and welfare needs of the communities it serves, including health and disease prevention programs such as health fairs and free health screenings; free medical clinics for underserved patients; support groups; homeless shelters, school supply drives, coat drives, food drives for local food pantries, and school-based health centers. Also provided are language-assistance services, interpreters and non-English educational materials.

Blood pressure screenings are provided monthly as part of ACMC/AHCH’s participation in the Oak Lawn Community Partnership. Those screenings are performed in conjunction with the Oak Lawn firefighters. The Medical Center provided portable, 12-lead EKG monitors for the ambulances in the Chicago suburbs of Oak Lawn and Burbank and trained paramedics in their use. ACMC/AHCH provides staff for “Ask the Pharmacist” offered twice a year, as well as “Ask

the Cardiac RN,” and “Ask the Diabetes Educator.” Hearing screenings are offered by the Medical Center’s audiologists three times a year.

During Prostate Cancer Awareness month and Skin Cancer Awareness Month, free screenings are offered to the community. During Colon Cancer Awareness Month, at-home test kits are distributed and are read at the laboratory free of charge.

The Medical Center partners with the American Cancer Society through a sponsorship of the Southland Region’s seven Relay for Life events. The Medical Center is also a presenting sponsor of the Orland Park “Making Strides Against Breast Cancer.” Both events are significant fundraisers for American Cancer Society in the region. In the coming year, the American Cancer Society will be providing a Patient Services Navigator for outpatients receiving cancer-related services at the Medical Center.

Advocate Health Care also supports the American Heart Association. In 2011, Advocate Health Care was a major corporate fundraiser for the 2011 Heart Walk, raising over \$415,000. Associates at the Medical Center kicked off the heart walk fundraising campaign with a captain’s luncheon in August. Fundraising and heart walk activities included raffles, bake sales, contests and collecting spare change in the cafeteria. ACMC/AHCH registered 58 teams and 423 walkers. Funds raised will support the American Heart Association’s educational programs and research to further improve heart care.

Chicago area’s South Suburban Public Action to Deliver Shelters (P.A.D.S. Homeless Shelters) are supported by ACMC/AHCH with free laundry service. These shelters are held in a different local church each night of the week. The Medical Center solicits volunteers for shelter help every year.

Since 2004, AHCH has had a standing partnership with Dawes Elementary School in Chicago (94 percent low-income student population) to provide health services through the Ronald McDonald Care Mobile, health education seminars for parents and students, mentoring, health fairs and fundraising support through the hospital’s annual employee giving campaign. In addition, Advocate Christ Medical Center formed a collaborative arrangement with Carson Scholars Fund to provide funding for a reading room at Charles Gates Dawes Elementary School as well as grant money for more scholarships for local students through the Carson Scholar’s Fund.

The Advocate Physicians Partners has established a Clinical Integration Program with new initiatives to address diabetes, asthma, coronary artery disease and congestive health 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.

#### Medical Education and Training:

In addition to patient care services, ACMC/AHCH is involved in hospital-based education by providing resident training programs in Anesthesiology, Cardiology, Family Medicine, Emergency Medicine, Pediatrics, Pediatric Cardiology, and Surgery to train physicians in these specialties. The Medical Center is also affiliated with multiple schools of nursing and provides clinical experiences to hundreds of nurses, radiology technicians, physical therapists, and a host of others to meet the growing need for skilled health care professionals.

The hospital trains more than 2,500 emergency medical technicians, paramedics and other providers of emergency care each year through the Emergency Medical Services (EMS) Academy — one of the largest EMS training programs in Illinois.

ACMC/AHCH provides Medic Training for the Illinois Army National Guard to prepare them for deployment. The medics shadow trauma surgeons who conduct the initial evaluation of injured patients, perform surgeries on gunshot and stabbing victims, all with the goal of providing medics the experience they will need to function effectively in combat support hospitals.

#### Health Education:

The Medical Center has also partnered with the Village of Oak Lawn to get 1,300 high school students and their teachers certified in specialized first aid skills including resuscitation procedures, use of automatic defibrillators, immobilization of trauma victims, and control of bleeding.

*Live...from the Heart* is a joint project between the Museum of Science and Industry in Chicago and ACMC/AHCH. This is a videoconference – based education program that offers high school aged students and teachers a dramatic exploration of the human heart. Through a live, two-way, closed circuit feed, participants watch open heart surgery – typically coronary artery bypass surgery – being performed at the Medical Center. The presentation, while somewhat

variable each week, aims to cover the following topics during the program: heart disease risk and prevention, diagnostic procedures leading up to heart surgery, the evolution and future of heart surgery, professional careers and opportunities in health sciences. The program takes students through the pre-surgical disease process, diagnosis, consent process, through the actual live surgery with opportunities to pose questions to the surgeon during the procedure. With the use of advanced technology and science education, ACMC/AHCH is reaching the next generation of health care providers. Since the opening of the program in 2002 – through the 2010-2011 school year, over 30,000 individuals have participated in the program.

For the past 11 years, AHCH has sponsored a free half-day conference for school nurses from the Chicago Public Schools and suburban areas featuring the latest in medical information, treatment, and ways to improve student compliance with medical treatment. School nurses representing over 50,000 students also receive a monthly email health tips publication from the hospital, which they are encouraged to share with their school community.

Clinical staff regularly visits area high schools to discuss careers in health care.

Research:

Advocate is also engaged in multiple research projects that will result in new techniques, drugs, and devices to improve the health and well-being of patients everywhere. ACMC/AHCH provides care and rehabilitation services for children with developmental disabilities, sleep disorders, allergies and asthma. Its outpatient pediatric cancer program is the largest in the Midwest. The Medical Center is also home the Heart Institute for Children, a national center for research and development and the largest pediatric cardiology program in the Midwest.

**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.

## 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.*

The following table, Advocate Christ Medical Center, Charity Care 2009 to 2011 includes the amount of charity care for the last three audited years, the cost of charity care, and the ratio of that charity care cost to net patient revenue.

ACMC Charity Care, 2009 – 2011  
Attachment 44, Table 1

Charity Care			
	Year 2009	Year 2010	Year 2011
Net Patient Revenue	\$ 871,478,000	\$ 913,879,000	\$ 880,368,000
Amount of Charity Care (charges)	\$ 32,556,000	\$ 49,393,000	\$ 54,888,000
Cost of Charity Care	\$ 9,129,000	\$ 14,102,200	\$ 19,519,005*
Charity Care as percent of total net patient revenue	1.0%	1.5%	2.2%

Source: Annual Hospital Questionnaire and hospital records.

\*Charity Care numbers are the updated values 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.

### Charity/Financial Assistance Guidelines

Consistent with Advocate Health Care's values of compassion and stewardship, it is Advocate's policy to provide charity care to patients in need, as shown in Attachment 44, Exhibit 1.

Advocate prides itself on assisting those individuals.

Advocate patients are encouraged to communicate with their hospital's financial counselor if they anticipate difficulty paying their portion of the hospital bill. Our counselors make every effort to help patients who are uninsured or face other financial challenges that may prevent them from paying for the health care services we provide. Counselors may assist patients in applying for a government-funded program (such as Illinois Medicaid, Kid Care, Family Care or crime victim funds), setting up an extended payment plan or applying for Advocate charity care.

Advocate's charity care program provides discounts (up to 100 percent of hospital charges) to patients who meet financial eligibility guidelines.

A key provision of charity care requires the cooperation of the patient in providing health insurance information, applying for available government programs, completing an Advocate charity care application, and providing any requested supporting documentation. Given the sensitive nature of these requests, all communications with the patient or family members will be handled in strict confidence and in a compassionate manner.

Advocate's provision of charity care is voluntary and discretionary and nothing in the web page or the process is intended to create a contract. The availability of charity care is dependent on financial viability and the condition of the hospital at the time of the determination.

*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.*

The above reporting of charity care is for Advocate Christ Medical Center.

*3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payor source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.*

Not Applicable. Advocate Health and Hospitals Corporation d/b/a as Advocate Christ Medical Center is an existing facility.

## Advocate Health Care Charity Care Policy Attachment 44, Exhibit 1



### SUMMARY OF ADVOCATE HEALTH CARE'S CHARITY CARE POLICY<sup>1</sup>

It is the policy of Advocate Health Care to provide financial assistance to patients in need. Advocate hospitals will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under the following criteria. This summary applies to patients of Advocate Hospitals (i) who have no private health insurance or public health coverage (such as Medicare, Medicaid or other government programs) or (ii) whose co-payments and deductibles equal or exceed \$5,000 in a calendar year.

Charity Care decisions are based on the family's "gross income," which means gross earnings reportable to the federal government. An uninsured patient whose family's gross income does not exceed six times the Federal Poverty Level ("FPL") may qualify for Charity Care. The FPL varies with the size of the family and is updated annually. For example, as of January 23, 2009, an uninsured family of four may be eligible for Charity Care if its household income is less than \$132,300 per year. You may also be granted Charity Care if your family income is higher than six times FPL if you can show extenuating financial circumstances (such as large outstanding medical bills).

The following table will be used to make the Charity Care determinations:

Multiple of FPL	0 - 2	2 - 3	3 - 4	4 - 6 <i>Uninsured Florida residents with a balance &gt; \$500</i>
Expected Payment	\$0	Hospital's Cost of Services Provided	Hospital's Cost of Services Provided	135% of the Hospital's Cost of Services
Maximum Expected Payment	\$0	5% of Family Income	10% of Family Income	25% of Family Income

To qualify for Charity Care, you must complete the attached application form and mail or deliver it to the Advocate Hospital where you were treated. All communications with the patient or family members will be handled in strict confidence and in a compassionate manner. The application requires you to certify your family's current monthly income, and provide proof in the form of W-2 forms, tax return or pay stubs if available. If you cannot provide such documents, the determination will be based on your certification of your family's income. It is your responsibility to cooperate with Advocate by filling out the application and providing the requested information if possible, and also by helping Advocate seek payment from health insurers or the government if such payment might be available. While your application for Charity Care is pending, Advocate will not try to collect the bills for which you are seeking assistance.

If you apply for Charity Care, the Advocate Hospital will notify you whether your application has been approved or denied. If you disagree with Advocate's decision, you may appeal the decision to the Ombudsperson within 45 days. The Ombudsperson is Kathleen Hobbins and can be reached at (630) 575-3446. You may also contact the Ombudsperson if you have questions about the Charity Care process, or you may contact the Advocate Hospital's financial counselors at 708-684-6069.

Return your completed application and documents to the hospital at the following address:

Advocate Christ Medical Center  
ATTN: Business Office / Financial Counselor  
4440 West 95<sup>th</sup> Street  
Oak Lawn, IL 60453

<sup>1</sup> This is a summary created pursuant to a settlement agreement in *Cistiani v. Advocate Health Care* and applies only to patients covered by that agreement. If there are any differences between this summary and the settlement agreement, the terms of the settlement agreement control. This summary does not guarantee or grant any third party or person any rights, claims, benefits or privileges beyond those that may exist under the Cistiani settlement. This summary does not constitute an offer to any particular patient and creates no contractual rights or obligations.

## Appendices

### Appendix 1

Plan of Correction

### Appendix 2

The following pages include curriculum vitae's for:

Adam Block  
Helen Kay, MD  
Andrea Miller  
Tom Myers, MD  
Joseph Pavese, MD  
Anne Pendergast  
Stacey Roberson  
Tammy Starks  
Anne Marie Uzeueta  
Traci Wolfe

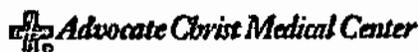
Appendix 1  
ACMC Plan of Correction

CMS completed a full survey of Advocate Christ Medical Center (ACMC, Medical Center) on November 2, 2007. ACMC is addressing the findings of that survey; the Plan of Correction is included in Appendix 1.

Many of the issues identified in the CMS survey will be eliminated with the construction of the proposed Patient Tower and the subsequent renovation of vacated areas.

Several deficiencies are impractical to correct. These include insufficient concrete floor thickness to provide 2-hour floor-to-floor rating, vertical shafts (including stairways of less than 2-hour rating, as well as a few oversized smoke zones and excess travel distances on the first and lower levels. These deficiencies are being addressed by completing the installation of a full coverage, quick response automatic sprinkler system for the entire existing hospital building and establishing fire-rated corridors as required by and approved Fire Safety Equivalency System Analysis.

4440 West 95<sup>th</sup> Street  
Oak Lawn, Illinois 60453-2699  
Telephone 708.684.8100  
www.advocatehealth.com



March 23, 2012

**COPY**

Ms. Pam Hastings, Project Designer  
Design Standards Unit  
Division of Health Care Facilities and Programs  
Illinois Department of Public Health  
525 West Jefferson Street, 4<sup>th</sup> floor  
Springfield, IL 62761-0001

RE: Advocate Christ Medical Hospital and Medical Center, Oak Lawn (140208)  
Federal Monitoring Survey of 1/12/2012  
Statement of Deficiencies and Plan of Correction

Dear Ms. Hastings:

Please find attached revised Plan of Correction for the statement of deficiencies cited on CMS Form 2567 from the follow up survey of January 12, 2012 for Advocate Christ Medical Center.

If you should have any questions regarding the information submitted, please do not hesitate to contact Tom Breitzke, Regional Director, Facilities Management at 708-684-3144.

Sincerely,

A handwritten signature in black ink that reads "Marguerite DeYoung".

Marguerite DeYoung  
Vice President, Customer and Support Services  
Advocate Christ Medical Center  
Advocate Hope Children's Hospital

cc: Colleen Perez, Director Quality and Regulatory Compliance

Related to the Evangelical Lutheran Church in America and the United Church of Christ

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(02) MULTIPLE CONSTRUCTION A. BUILDING 01 - GENERIC ALL BLDGS B. WING _____		(03) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 93TH STREET OAK LAWN, IL 60453		
(K) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COR COMPLETION DATE	
(K 000)	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 20224</p> <p>This Form 2567 is Generic to all Buildings excluding the office building located in Patco Heights.</p> <p>A Federal Monitoring Survey was conducted on January 12, 2012, by surveyor 12796. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on May 12, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on August 18 - 17, 2010, by surveyor 07113. A revised PoC, revised FSSES(s) and revised LS Plans have been requested.</p> <p>04/13/10: The surveyor for Building 03 was partially modified under K018 to reflect use of an FSSES that was submitted after the PoC was submitted.</p> <p>A Federal Monitoring Survey was conducted on February 4 and 5, 2010, by surveyors 07113 and 12796. A revised PoC has been requested.</p> <p>A Federal Monitoring Survey was conducted on September 24 - 26, 2009, by surveyor 07113. A revised PoC has been requested.</p> <p>A Federal Monitoring Survey was conducted on December 11 - 12, 2008, by surveyor 07113.</p> <p>A federal Monitoring Survey was conducted on 08/07/08 and 08/08/08 by surveyor 16339.</p>	(K 000)			

LABORATORY CORRECTED BY PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE: *Marguerite DeYoung* TITLE: Vice President Customer and Support Services, DATE: March 23, 2012

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(02) MULTIPLE CONSTRUCTION A. BUILDING 01 - GENERIC ALL BLDGS B. WING _____	(03) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 95TH STREET OAK LAWN, IL 60463	
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(06) COMPLETION DATE
{K 000}	<p>Continued From page 1</p> <p>On October 29 - November 2, 2007, the Life Safety Code portion of a Medicare Full Survey, Due to a Complaint, was conducted at (Advocate) Christ Hospital and Medical Center of Oak Lawn.</p> <p>The following buildings and/or building locations were surveyed under the 2000 Edition of Life Safety Code (NFPA-101), Chapter 19 Existing Healthcare Occupancy:</p> <ol style="list-style-type: none"> <li>1. (01) Generic All: For citations applicable to all buildings and for tracking and record keeping</li> <li>2. (02) Hope Hospital</li> <li>3. (03) Surgery Building</li> <li>4. (04) East/West Building</li> <li>5. (05) South Building</li> <li>6. (06) Annex Building</li> </ol> <p>The following building was surveyed under the 2000 Edition of the Life Safety Code (NFPA-101), Chapter 39, Existing Business Occupancies.</p> <ol style="list-style-type: none"> <li>7. (10) Palms Heights - Advocate Christ Hospital and Medical Center Outpatient Clinic</li> </ol> <p>Unless otherwise indicated all deficiencies were found by direct observation, staff interview and document review.</p> <p>Unless otherwise noted, these codes sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as</p>	{K 000}		

FORM CMS-8567(02-99) Previous Versions Obsolete

Event ID: 031825

Facility ID: IL092V

If continuation sheet Page 2 of 7







DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER/SURVEYOR/CLIA IDENTIFICATION NUMBER:  140200		MULTIPLE CONSTRUCTION A. BUILDING 01 - GENERAL ALL BLDGS B. WING _____		DATE SURVEY COMPLETED R 01/12/2012	
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 85TH STREET OAK LAWN, IL 60453			
DEF ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DEF ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DEF ID PREFIX TAG	COMPLETION DATE		
(K 130)	<p>Continued From page 5</p> <p>currently directed to an exit discharge at the Loading Dock.</p> <p>UPDATE 1/12/12: Chains were installed across the truck loading areas.</p> <p>The Loading Dock has unprotected drop offs that lack adequate interim life safety measures. This condition lacks specific interim measures.</p> <p>The Loading Dock is routinely used to hold supplies that are left in front of the door that is identified as the exit discharge path from the corridor to the Loading Dock.</p> <p>UPDATE 1/12/12: The door was provided with a guard rail to prevent supplies from blocking the door. The facility is currently maintaining a 48" clear path to the stairs to exit the elevated loading dock area.</p> <p>The corridor/exit passageway from Stair # 7 to the Loading Dock is routinely used for storage and as a holding area for carts, boxed supplies, palletted supplies, empty wood pallets, etc.</p> <p>UPDATE 1/12/12: condition continues.</p> <p>05/12/11: The above locations will be monitored on all future surveys until Stair # 7 is in full compliance with 7.7.1 or 7.7.2</p> <p>b) Deleted 02/23/11</p> <p>c) 05/13/11 - Exit access corridors of South Building are routinely obstructed by furniture, equipment, unattended computers, TV stands, etc., Particularly on multiple upper floors at the south cross over corridor/end of building.</p> <p>UPDATE 1/12/12: condition continues.</p>	(K 130)	<p>130-A2c ( Rev 3/23/2012) Administrative directive for keeping corridors clear of equipment not in use has been periodically re-issued. Safety department is conducting bi-weekly checks and reporting results to the clinical directors for appropriate action. Hazard surveillance rounds specifically incorporated a review of hallway clutter into their checks. Compensation for this chronic deficiency is that the staff's diligence in clearing all corridor obstructions in response to a fire alarm is carefully noted during drills and immediately corrected as needed. The two chronic contributors, computers-on-wheels (COWs) and the carts that seem to go with them) and the lack of storage space, require yet another unit by unit evaluation. Project to install wall mounted fold-up workstations alternative to COWs was completed in March 2011. COWs are being removed. Another unit by unit storage space audit and resulting corrective action or construction, each unit taking 2-3 weeks will be completed by 30 Aug 2012 with focus on south tower. Finally, the Facilities and Safety Departments continue to work together with patient transport, linen and EVS to enforce the practice of not leaving carts unattended in the corridor and in identifying appropriate staging locations for carts not in use. To monitor progress and highlight specific problem areas, Safety will continue to perform a bi-weekly audit of the corridors and report results to the Facilities Director, the VP Support Services, the VP Nursing, and the Clinical Nursing Directors.</p>		03/02/2012		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GENERIC ALL BLDGS B. WING _____		(X3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 96TH STREET OAK LAWN, IL 60453		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(K 130)	Continued From page 6 d) Corroded 02/22/11 e) Corroded 02/22/11 f) Deleted 02/23/11 g) Deleted 02/22/11	(K 130)			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(02) MULTIPLE CONSTRUCTION A. BUILDING 04 - EAST / WEST BUILDING B. WING _____		(03) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 85TH STREET OAK LAWN, IL 60483		
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(05) PREPOC TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETION DATE	
(K 000)	<p>INITIAL COMMENTS</p> <p>Surveyor: 20224</p> <p>This Form 2567 is for the East/West Building. This building was considered partially sprinkler protected.</p> <p>A Federal Monitoring Survey was conducted on January 12, 2012, by surveyor 12798. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on May 12, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on August 16 - 17, 2010, by surveyor 07113. A revised PoC, revised FSES(s) and revised LS Plans have been requested.</p> <p>Federal Monitoring Survey was conducted on February 4 and 5, 2010, by surveyors 07113 and 12798. A revised PoC has been requested.</p> <p>Refer to Form 2567 Generic to All Buildings for a detailed description of the survey.</p> <p>A Federal Monitoring Survey was conducted on September 24 - 25, 2009, by surveyor 07113. A revised PoC was requested.</p> <p>A Federal Monitoring Survey was conducted on December 11 - 12, 2008, by surveyor 07113.</p> <p>A federal Monitoring Survey was conducted on 08/07/08 and 08/08/08 by surveyor 16339.</p> <p>Unless otherwise indicated all deficiencies were</p>	(K 000)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: \_\_\_\_\_ TITLE: \_\_\_\_\_ DATE: March 23, 2012  
*Markusite DeYoung* 3/23/12  
 Markusite DeYoung, Vice President Customer and Support Services

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140206	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - EAST / WEST BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 95TH STREET OAK LAWN, IL 60453	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) CORRECTION DATE
(K 000)	Continued From page 1 found by direct observation, staff interview and document review.	(K 000)		
(K 012)	Unless otherwise noted, those codes sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code.  NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1  This STANDARD is not met as evidenced by: Surveyor: 07113	(K 012)		
(K 042)	A) (Now 02/05/10): Based upon the FSES dated October 8, 2009, for the South Building, the East/West Building and the South Annex Building, the construction type is less than Type II (222) construction. Although the buildings are constructed of reinforced concrete, the slab thickness between concrete beams or concrete ribs has been identified with less than a one hour fire rating. Based upon the FSES, these three buildings are Type II (000) Construction, as defined by NFPA 220 and they do not comply with 19.1.6.2.  NFPA 101 LIFE SAFETY CODE STANDARD  Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 19.2.5.2	(K 042)	012.A Rev. 3/23/2012. FIA FSES 041326.01 dated October 7, 2009 /revised 8/24/2010 was attached as Tab 04-012.A to the 293sep2011 POC. The FSES notes, among other things, on installing quick acting automatic sprinklers throughout the hospital building (i.e. E-W building, South building & Annex). As a phased project started in April 2011, all the work will be complete by 12/31/2012. See Tab 04-K012.A for detailed listing of actions required by the FSES and a schedule.	12/31/2012

FORM CMS-2567(02-02) Provider/Supplier Obedience

OMB ID: 0938-0391

File by ID: 00000

If continuation sheet Page 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - EAST / WEST BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 98TH STREET OAK LAWN, IL 60453		
DO ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DO ID PREFIX TAG	COMPLETION DATE
(K 042)	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20224</p> <p>A). (Modified 09/25/09) The Second floor Mechanical room referred to as the OB/UCU mechanical room or as the 2 West Mechanical room is a three-story space. Access to this room is gained through Stair #8 located on the First floor. The stair is open to the Mechanical Room on the 2nd Floor and is open to the third floor level of this open mechanical space at the south end. Stair #8 is not an exit (it does not comply with 7.7.1). It is only an exit access. The previous reference to 19.2.6.2 is for patient areas. The PoC does not indicate how this mechanical area complies with 7.12.2 or 42.2.A, 42.2.5 and 42.2.6.</p> <p>A 2nd complying means of egress from the above space is not provided.</p> <p>The above item will not be corrected until the project for this has been completed, certified and inspected by IDPH. Identify the completion date for the project and the IDPH Project Number.</p> <p>UPDATE 1/12/12: This citation can be eliminated upon inspection of project #B145. Pending submital of documentation.</p>	(K 042)	<p>042-A - Rev. 3/23/2012. To provide a second exit from the mechanical room that meets travel distance standards, we will use a door in the south west of the mech room, out onto the roof to a new exterior stair to the public right-of-way 1 story down. IDPH project #B145. Inspected by IDPH 2/17/2012. Estimated completion of punchlist 4/16/2012.</p>		4/15/2012

FORM CMS-2567(02-99) Provider/Supplier/CLIA

Event ID: OAH-29

Facility ID: K0109

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0930-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - SOUTH BUILDING  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 65TH STREET OAK LAWN, IL 60453	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 20224</p> <p>*This Form 2567 is for the South Building. This building was considered partially sprinkler protected.</p> <p>A Federal Monitoring Survey was conducted on January 12, 2012, by surveyor 12798. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on May 12, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on February 22 - 23, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on August 16 - 17, 2010, by surveyor 07113. A revised PoC, revised FSSES(s) and revised LS Plans have been requested.</p> <p>Federal Monitoring Survey was conducted on February 4 and 5, 2010, by surveyors 07113 and 12798. A revised PoC has been requested.</p> <p>Refer to Form 2567 Qonorio to All Buildings for a detailed description of the survey. - Unless otherwise indicated all deficiencies were found by direct observation, staff interview and document review.</p> <p>A Federal Monitoring Survey was conducted on September 24 - 26, 2009, by surveyor 07113. A revised PoC was requested.</p>	(K 000)		

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Marguerite DeYoung* MARGUERITE DEYOUNG, Vice President Customer and Support Services, March 23, 2012

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(02) MULTIPLE CONSTRUCTION A. BUILDING 05 - SOUTH BUILDING B. WING _____	(03) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 65TH STREET OAK LAWN, IL 60453	
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETION DATE
{K 000}	Continued From page 1  A Federal Monitoring Survey was conducted on December 11 - 12, 2008, by surveyor 07113.  A federal Monitoring Survey was conducted on 08/07/08 - 08/08/08 by surveyor 10339.  Unless otherwise noted, those codes sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code.	{K 000}		
{K 012}	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1  This STANDARD is not met as evidenced by: Surveyor: 07113	{K 012}		
{K 033}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 033}	012A Rev. 3/23/2012. RJA FSES C41372.01 dated October 7, 2008 revised 02/4/2010 was attached as Tab 04-012A to the 28Sep2011 POC. The FSES relies, among other things, on installing quick acting automatic sprinklers throughout the hospital building (i.e. E-W building, South building & Annex). As a phased project started in April 2011, all the work will be complete by 12/31/2012. See Tab 04-K012-A for detailed listing of systems required by the FSES and a schedule.	12/31/2012

FORM CMS-2567 (02-09) Previous Versions Obsolete

Event ID: 010123

Facility ID: L0002V

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0091

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		POC PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140206	Q2) MULTIPLE CONSTRUCTION A. BUILDING 05 - SOUTH BUILDING B. WING _____		Q3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 12TH STREET OAK LAWN, IL 60453		
Q4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL ICD-9-CM OR ILSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	Q5) COMPLETION DATE	
(K 033)	<p>Continued From page 2</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 0.2.5.2, 19.9.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14416</p> <p>A). Corrected 02/23/11 Surveyor: 20224</p> <p>B). Deleted 02/23/10</p> <p>C). Modified 12/12/08: Ground floor or First floor- Stair #4 - Surveyor observed a continuous unprotected path of travel to the exterior which does not comply with 7.7.1 or 7.7.2:</p> <p>1. This stair appears to discharge to the interior into an existing one hour exit passageway that remains to be completed. This matches the enclosure of Stair # 4. A fire rated ceiling will not be required if penetrations are sealed in accordance with 7.1.3.2.1e) exception # 1 and if all duct penetrations have fire dampers</p> <p>2. Corrected 08/08/08. 3. Corrected 12/12/08 4. Corrected 12/12/08 5. Corrected 12/12/08 6. Deleted 6/12/11</p>	(K 033)	<p>033-C1 Rev. 4/8/2011. The RIA exit study was revised and the life safety drawings revised to reflect Stair #4 as 7.7.1. The exit passageway has been noted on revised life safety plan provided with prior POC 9/28/2010. For Stair #4 to comply with 7.7.1 requires modifications to the exit passageway. IDPH project # 9144. Inspected by IDPH 2/17/2012. Estimated completion of patches: 4/15/2012.</p>	4/15/2012	

FORM CMS-2567(02-09) Previous Versions Obsolete

Event ID: 041818

Facility ID: L002V

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(02) MULTIPLE CONSTRUCTION A. BUILDING 05 - SOUTH BUILDING B. WING _____		(03) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 83TH STREET OAK LAWN, IL 60453		
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETION DATE	
(K 033)	Continued From page 3 UPDATE 1/12/12: This deficiency will be cleared upon completion of project #9144. Pending submittal of necessary documentation and inspection are required.	(K 033)			
(K 038)	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 16339  A: Corrected 02/05/10 1) Moved to K018 -07113 2) Corrected 02/04/10 - 12788  Surveyor: 20224  D). (Modified 02/05/10) Required exits do not comply with the requirements for exit discharge in accordance with 7.7.1 or 7.7.2:  e) (Modified 03/17/10): Mechanical Room 006N: multiple ducts have fire dampers but no fire damper identification numbers. Some of the walls are designated two hour barriers; multiple duct penetrations of these walls lack fire dampers.  02/23/11: The above item was cited as part of an exit enclosure. It is no longer required to comply as an exit enclosure but will remain under K038 until it is resolved. The PoC for the above item	(K 038)	004-01a, Rev. 2/23/2012 Fire dampers were all labeled by 4/30/2011. Ducts in the east wall of each room 006N all have dampers. On the life safety plan the north and west walls showed a light blue 2hr fire wall. This is not a required barrier. Tab 05-038-01e (1). Life safety drawings revised. Tracing the green 2hr fire/wall on the light blue 2 hr fire it does appear that there is a continuous barrier from outside wall to outside wall. Tab 05-038-01e (2) Tracing a combination of the green and blue fire/walls and fire walls yields the zones K shown in Tab 05-038-01e (3). This issue of the oversized suite is acknowledged and taken into account by the RJA FSES 04138.01 dated October 7, 2008 / revised 9/24/2010 attached to the 29SEP2011 POC.	complete	

FORM CMO-2507(06-07) Previous Versions Obsolete

Event ID: C/PS 22

Facility ID: 510124

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - SOUTH BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4400 W 65TH STREET OAK LAWN, IL 60453	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 038)	<p>Continued From page 4</p> <p>does not resolve the citation. How will it be corrected?</p> <p>Two walls of the above mechanical room are identified in the FSES and on the latest Life Safety Plan as two hour fire barriers. It is not clear from the Life Safety Plans how a continuous two hour fire barrier is maintained from outside wall to outside wall. It is also not clear how the Zone K, as defined by the FSES, is separated from the area south and east by a one hour smoke barrier or as a two hour barrier.</p> <p>UPDATE 1/12/12: The facility is investigating redefining the suite perimeters to include the mechanical room or split the area into two suites. The surveyor indicated that the mechanical room is not accessible from the existing suite and that the existing suite is already oversized based on the FSES. Clarification on the corrective action is required.</p> <p>g) Removed 1/12/12</p> <p>2) (Modified 02/05/10) Stair # 7 is identified as complying with 7.7.2. According to the PoC, Stair # 6 and Stair # 7 will not comply with 7.7.2 until Stair # 4 is corrected to comply with 7.7.1. Stair # 7 does not currently comply with 7.7.1 or 7.7.2.</p> <p>a) Stair # 7 discharges into a Ground Floor east/west corridor. This same corridor is identified as an exit path east, for the main corridor to the west. This corridor is still used for storage. Adequate interim measures have not been implemented.</p>	(K 038)	<p>038-82a Rev. 3/27/2012. The discharge of Stair#7 will ultimately be corrected by a major dock reconfiguration recently approved, currently under design, and scheduled for construction by the end of 2013. In the meantime, the discharge path from Stair #7 on the ground level must continue to be directed east toward the loading dock. A previous plan to modify the door configuration adjacent to the SW #7 enable discharge to be directed to the west instead of east has required a redesign. Pending completion of work by 1/1/2012, since the enclosed corridor between Stair #7 and the loading dock still constitutes an exit access corridor from the dock area, we will continue our efforts keep the corridor clear of obstructions and the loading dock as safe as possible.</p>	8/1/2012

FORM CMS-2567(12-88) (Use only Version 010-01)

Event ID: OAH 19

Facility ID: L0029

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X0) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - SOUTH BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W. 95TH STREET OAK LAWN, R. 00453	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CITED-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 038)	Continued From page 5 Once it is demonstrated that Stair # 7 can comply with 7.7.2, the exit access corridor at this location will still either be a dead end corridor or a corridor with a discharge through the Loading Dock (hazardous area).	(K 038)		
(K 007)	UPDATE 1/12/12: Designated exits through the loading dock remains an issue. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2  This STANDARD is not met as evidenced by: Surveyor: 14416  Note: 08/23/11 - abandoned kitchen exhaust duct; does it penetrate any shaft or floor without a fire damper? What is the rating on the shaft? Check against FSES. Cite any deficiencies under K020. LWM  A) Through direct observation and staff interview the surveyor determined that the ventilation shafts duct penetrations serving the induction ventilation units on floors 6 thru 9 are not protected with fire dampers in accordance with NFPA 90A, 3-3.4.  Based upon the last submitted PoC, corrections are required at the 8th Floor. Compliance with	(K 007)	057-A: Revised 4/2/2011 - There is a 12" ventilation supply duct between every two rooms from the 9th floor down to the 4th floor (12 in aft) fed from trunk duct above the ceiling on the 8th floor which in turn is fed from the 10th floor penthouse. There is a fire damper at the floor of the penthouse at the duct penetration. The ducts were properly terminated at the floor line of the 4th floor when the 3rd floor was remodeled several years ago. The POC is covered by RJA FSES 041228D1 dated October 7, 2009 as Revised Sep 24, 2010 (copy provided with 29SEP2010 POC). The FSES takes a penalty for the shafts as corrated-smoke-tight vs. 2 HR rated. To meet the conditions of the FSES, corrective action is required to repair the shafts to smoke tight standard, namely to complete a non-combustible, smoke-tight shaft above the plaster ceiling to the underside of the floor slab above and repair where the 4th supply ducts leave a shaft. The plan also includes installation of fire dampers on the 4th floor above the ceiling, and where the 4th, take-offs leave the shaft to feed the induction units in each room per precedence set by CMS. (note: The exception under NFPA 90A, 3-3.4 in effect in 1972 to delete requirement for dampers for the 4th ducts is not applicable because the shaft was never constructed to any rating). See Tab 04-K012-A for detailed listing and schedule for the corrective actions required by the FSES. See 0911 Project # 8210 for design. Current design for duct/damper work was rejected as incomplete and will be resubmitted by 4/15/2011. Construction start April 2011. Construction complete by 12/31/2012.	12/31/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QM119

Facility ID: 11072V

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(03) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(07) MULTIPLE CONSTRUCTION A. BUILDING: 05 - SOUTH BUILDING B. WING: _____	(04) DATE CORRECTIVE ACTION COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 4400 W 65TH STREET OAK LAWN, IL 60453	
(05) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDE ITD PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(06) COMPLETION DATE
(K 067)	Continued From page 6 NFPA 90A - 1875 for the induction units and shaft enclosure at these units will need to be confirmed in the field.	(K 067)		
(K 072)	UPDATE 1/12/12: The 7th and 8th floors are now complete and fire dampers have been installed. The facility is currently working on the 8th floor. NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Surveyor: 16339  B). Deleted 2/22/11 - see Bldg 01, K130  5. (New 08/17/10): The ground floor exit access corridor outside of the kitchen (near Room or door 0015, is still used for staging and storage.  UPDATE 1/12/12: The exit access corridor is still being utilized for staging in the AM. Most items are removed by the PM.	(K 072)	K072-85. Rev. 3/23/2012. Kitchen is weekly inventoried for the patient population served, so there is no acceptable staging place for waste, packaging or food deliveries within the unit. A hazardous material storage room for the trash carts was constructed adjacent to the dry goods entrance in early January 2012 to correct the trash problem. However, as noted by the surveyor, unpeeling and pulling away food deliveries still requires using the corridor outside dry goods for staging for most of the morning. An area on the ground floor adjacent to the loading dock will become available in April which may result in an alternative staging plan for dietary. A new plan will be implemented by the end of May.	6/31/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OAHLE

Facility ID: IL602V

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140200	(K2) MULTIPLE CONSTRUCTION A. BUILDING 09 - ANNEX BUILDING D. WING _____	(K3) DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4440 W 95TH STREET OAK LAWN, IL 60453	
(K4) ID PREFIX TAG	BRIEF STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL INDUSTRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
(K 000)	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 20224</p> <p>This Form 2567 is for the Annex Building. This building was considered fully sprinkler protected.</p> <p>A Federal Monitoring Survey was conducted on January 12, 2012, by surveyor 12789. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on May 12, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on February 22 - 23, 2011, by surveyor 07113. A revised Plan of Correction was requested for this survey.</p> <p>A Federal Monitoring Survey was conducted on August 16 - 17, 2010, by surveyor 07113. A revised PoC, revised FSES(e) and revised LS Plans have been requested.</p> <p>Federal Monitoring Survey was conducted on February 4 and 6, 2010, by surveyors 07113 and 12798. A revised PoC has been requested.</p> <p>Refer to Form 2567 Generic to All Buildings for a detailed description of the survey.</p> <p>A Federal Monitoring Survey was conducted on September 24 - 25, 2009, by surveyor 07113. A revised PoC has been requested.</p> <p>A Federal Monitoring Survey was conducted on December 11 - 12, 2008, by surveyor 07113.</p>	(K 000)		

LABORATORY DIRECTOR OR PROVIDER/CLIA REPRESENTATIVE'S SIGNATURE: *Marguerite DeYoung* TITLE: Vice President Customer and Support Services DATE: March 23, 2012

Any deficiency statement ending with "1" denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are dischargeable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are dischargeable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required for continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(P1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  140208	(K2) MULTIPLE CONSTRUCTION A. BUILDING 06 - ANNEX BUILDING B. WING _____	POC DATE SURVEY COMPLETED  R 01/12/2012
NAME OF PROVIDER OR SUPPLIER  ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 W 65TH STREET OAK LAWN, IL 00463	
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
(K 000)	Continued From page 1 A federal Monitoring Survey was conducted on 08/07/08 and 08/08/08 by surveyor 16339.  Unless otherwise indicated all deficiencies were found by direct observation, staff interview and document review.  Unless otherwise noted, those codes sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1998) are taken from the 2000 Edition of the NFPA 101 Life Safety Code.	(K 000)		
(K 012)	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1  This STANDARD is not met as evidenced by: Surveyor: 07119  A) (New 02/05/10): Based upon the FSES dated October 9, 2009, for the South Building, the East/West Building and the South Annex Building, the construction type is less than Type II (222) construction. Although the buildings are constructed of reinforced concrete, the slab thickness between concrete beams or concrete ribs has been identified with less than a one hour fire rating. Based upon a preliminary FSES, these three buildings are Type II (000) Construction, as defined by NFPA 220 and they do not comply with 19.1.6.2.	(K 012)	012.A Rev. 3/13/2012. RJA FGCS C41328 01 dated October 7, 2009 revised 8/24/2010 was attached as Tab 04-012.A to the 29Sep2011 POC. The FSES refers, among other things, on installing quick acting automatic sprinklers throughout the hospital building (i.e. E-W building, South building & Annex). As a phased project started in April 2011, all the work will be complete by 12/31/2012. See Tab 04-10012-A for detailed listing of actions required by the FSES and a schedule.	12/31/2012

FORM CMS-6567(10-09) Provider Version Complete

Item ID: 04-1029

Facility ID: 140208

If continuation sheet Page 2 of 2



ATTACHMENT C  
 Bureau Life Safety Measures  
 X-700-100

Item	Priority	Category	Responsible Agency	Completion Date	Status
1. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
2. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
3. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
4. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
5. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
6. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
7. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
8. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
9. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed
10. Installation of fire alarm system in the main building.	High	Fire Safety	Fire Department	12/15/83	Completed

Attachment C contains a list of life safety measures that are being implemented in the main building. The measures are listed in order of priority and include the following:

- 1. Installation of fire alarm system in the main building.
- 2. Installation of fire alarm system in the main building.
- 3. Installation of fire alarm system in the main building.
- 4. Installation of fire alarm system in the main building.
- 5. Installation of fire alarm system in the main building.
- 6. Installation of fire alarm system in the main building.
- 7. Installation of fire alarm system in the main building.
- 8. Installation of fire alarm system in the main building.
- 9. Installation of fire alarm system in the main building.
- 10. Installation of fire alarm system in the main building.

Advocate Christ Med Center  
 Survey Date 12/13/83  
 TAB 01-K1102 of 3



Interim Life Safety Measures (ILSM) are administrative actions taken to temporarily compensate for the hazards posed by maintenance, construction or identified building deficiencies. Interim Life Safety Measures are a series of administrative actions required to temporarily compensate for significant hazards posed by Life Safety Code deficiencies or construction activities. They are intended to provide a level of safety comparable to that described in NFPA 101 Life Safety Code (2000 Edition), NFPA 241 Standard for Safeguarding Construction, Alteration, and Demolition Operations and NFPA 51B Standard for Fire Prevention During Welding, Cutting, and Other Hot Work. Here are the Interim Life Safety Measures in place as they are related to this POC:

Corridor Obstructions in Main Building (Main, East, West, and South)

- A. Existing exit paths are currently impaired.
  - 1. Public Safety conducts fire observations rounds.
    - a. Public Safety revised its practice to include an accurate description of any noted deficiencies noted on these rounds.
    - b. All Public Safety Associates will be reeducated on Fire Surveillance Rounds, with this education being documented.
    - c. As part of the fire (life safety) surveillance rounds Public Safety will ensure associates are provided the proper resources to have any items in corridors be removed upon findings.
  - 2. Additional fire drills are conducted within the affected buildings.
  - 3. Will be monitored by a multi discipline team, during Environment of Care rounds.
  - 4. Safety department will monitor.
    - a. Information as to items in the corridors is shared with the department Managers Immediate Director.
- B. Education To Staff
  - 1. Environmental Services shall conduct education to their staff advising them of not keeping carts in egress corridors
  - 2. Equipment Processing And Distribution shall conduct education to their staff advising them of not keeping transport carts in egress corridors
  - 3. Linen Services shall conduct education to their staff advising them of not keeping transport carts in egress corridors

Delivery Carts in the Corridors

- A. Existing Corridor width is currently reduced.
  - 1. Safety Department shall monitor to ensure corridor width during noted hazard complies with 2000 NFPA Life Safety Code, maintaining 32 inches of clearance.
- B. There is an increase in flammable hazards and fire load.
  - 1. Will provide additional handheld fire extinguisher for the hazardous area.
  - 2. Additional fire drills are conducted within the affected buildings.
  - 3. Storage of flammable or combustible materials will be kept for a limited time frame.
    - a. Carts will be emptied every 4 hours.
    - b. On off hours carts shall be placed in a hazardous rated location.
    - c. Fire alarm activation carts will be cleared from hallway.

Advocate Christ Medical Center  
Survey Date 02/23/2010  
TAB 01-8130





Advocate Christ Medical Center  
 141118 000007 2007 Annual Listing  
 141118 000007 2007 Annual Listing  
 141118 000007 2007 Annual Listing

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

Appendix C-14 Medical Center  
 141118 000007 2007 Annual Listing  
 141118 000007 2007 Annual Listing





Advanced Critical Medical Center  
 10000 E. Harvard Avenue  
 Denver, Colorado 80231  
 Attention: Safety Department  
 (303) 755-3333

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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Advanced Critical Medical Center  
 10000 E. Harvard Avenue  
 Denver, Colorado 80231  
 Attention: Safety Department  
 (303) 755-3333

Advocate Child Medical Center  
 1414 S. Dearborn, Chicago, IL 60610  
 Phone: 773.462.1000 Fax: 773.462.1001  
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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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Advocate Child Medical Center  
 1414 S. Dearborn, Chicago, IL 60610  
 Phone: 773.462.1000 Fax: 773.462.1001



Advanced Child Medical Center  
 1001 Parkland Blvd, Suite 1300 Dallas, TX 75245  
 214.756.1000 • Fax: 214.756.1001  
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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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Advanced Child Medical Center  
 Survey Conducted 11/20/12  
 Survey ID: 140348724

0 of 0

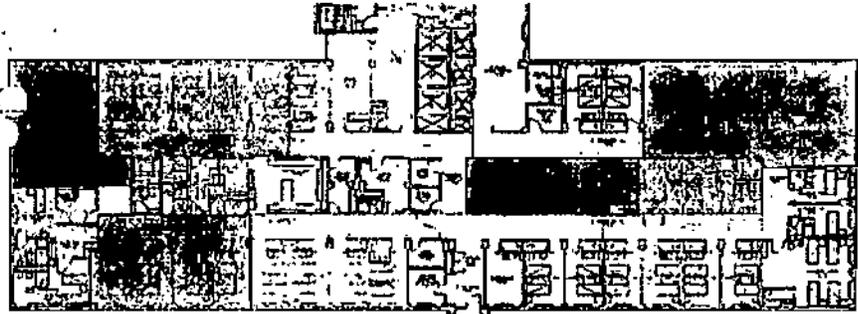
12/17/12



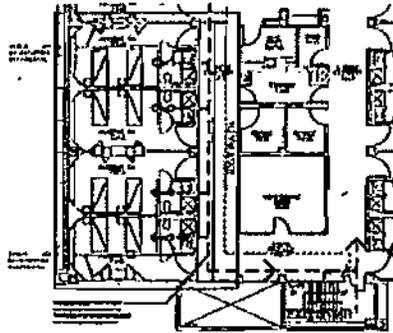
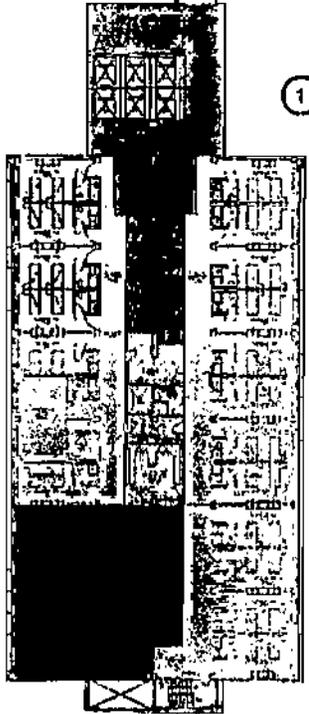
Bed Types (ICU) Available: 1000  
 Admitted: 1000  
 Discharged: 1000  
 Total: 1000

Room No.	Room Type	Room Description	Room Status	Room Date	Room Time	Room Location	Room Notes
101	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
102	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
103	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
104	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
105	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
106	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
107	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
108	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
109	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
110	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
111	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
112	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
113	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
114	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
115	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
116	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
117	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
118	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South
119	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	West
120	ICU	ICU Room	Occupied	07/13/2011	08:00	ICU	South

Advocate Christ Medical Center  
 Survey date 07/13/2011  
 TAG 04-4012-A



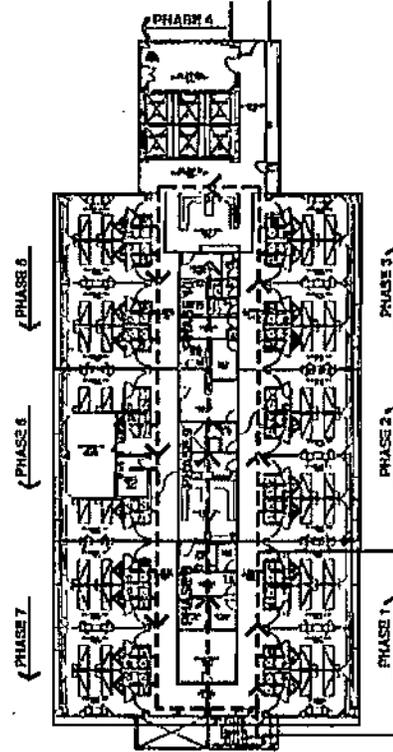
1 TYPICAL BED TOWER PHASING PLAN  
102'-1'-0"



3 1 WEEK SAMPLE PHASE PLAN  
117'-1'-0"

- 1 DAY: EMPTY ROOMS
- 2 DAYS: WORK WEEK
- BUILD DUST PARTITION
- INSTALL PARTING
- REPAIR PARTITIONS AND CEILING
- REMOVE DUST PARTITION
- 1 DAY: CLEAN AND APPROVE
- 7 DAYS TOTAL

- ITEMIZE LIFE SAFETY
- MAINTAIN 8'-0" CLEARANCE IN CORRIDOR
- 247 FIRE WATCH
- COORDINATION WITH UNIT STAFF, INSPECTOR CONTROL, ETC.



2 10 WEEK SAMPLE PHASE PLAN  
102'-1'-0"

- EXTEND SPRINKLER MAIN PIPE DOWN CORRIDOR ABOVE CEILING AND BRANCH OFF INTO PATIENT ROOMS AND CORE
- PHASE 1
- PHASE 2
- PHASE 3
- PHASE 4
- PHASE 5
- PHASE 6
- PHASE 7
- FIRE SPRINKLER RISER IN STAIRWELL

HDR

Advocate Christ Medical Center  
FSDS Bed Towers Sprinkler Renovation  
Date: 02/23/11

PROJECT: 107-6511  
Project Manager: M. Bickel  
Date: 07.30.10

DATE: 02/23/11  
DRAWN BY: [Blank]  
CHECKED BY: [Blank]

Advocate Christ Medical Center  
Survey date: 02/23/2011  
TAB 04-RD12-A

TYPICAL BED TOWER FLOOR PHASING PLAN

## Appendix 2 – Curriculum Vitae's

### Adam Block, D.O., M.P.H., B.A.

7541 Brown Street – Unit D

Forest Park, IL 60130

Home Phone (708) 488-9335

Mobile Phone (312) 622-6200

AdamBlock2000@yahoo.com

#### EDUCATION

2000-2003 Anesthesiology Residency, Rush University – Chicago, Illinois

1999-2000 Internship, Brookdale Hospital – Brooklyn, New York

1995-1999 Chicago College of Osteopathic Medicine – Chicago, Illinois

1992-1995 Master of Public Health, University of Miami – Miami, Florida

1988-1992 Bachelor of Arts – Anthropology/Biology, Emory University – Atlanta, Georgia

#### CERTIFICATION

American Board of Anesthesiology – Board Eligible

National Board of Osteopathic Medical Examiners – Steps I,II,III - Passed -Diplomate

#### RESEARCH EXPERIENCE

1993-1995 Thesis Investigator, University of Miami

Investigation of Insulin, Lipoprotein Profile, and Ethnicity - Thesis

1993-1995 Research Investigator, University of Miami

Miami Community Health Study – Multiethnic Cardiovascular Risk Factor Research

1993 Research Investigator, University of Miami

Peer Counselor Educator Project – Alternative High School Health Education

1991 Research Investigator, University of Miami

Investigation of Leukemia Chemotherapy – in vitro DNA flow cytometric analysis of chemotherapeutic drug effectiveness

1990, 1989 Research Investigator, University of Miami

Investigation of Prostate Cancer Heat Shock Protein Translocation – in vitro DNA flow cytometry

#### PUBLICATIONS

Block AR and Block NL. Leiomyoma of the epididymis, Journal of Urology. 153(3 Pt 2):1063-5, 1995 March

#### Honors and Awards

1995-1997 Student Government – CCOM

1993-1994 Graduate Student Council – University of Miami

1992 Lambda Alpha – Anthropology Honor Society – Emory University

## CURRICULUM VITAE

Helen H. Kay, M.D.  
November, 2011

<b>Citizenship</b>	United States	
<b><u>EDUCATION</u></b>		
<b>B.A. Biology</b>	University of Chicago	1975
<b>M.D.</b>	Yale University	1979
<b><u>TRAINING</u></b>		
<b>Residency</b>	Department of Obstetrics and Gynecology George Washington University Washington, D.C.	1979-1983
<b>Fellowships</b>	Medical Staff Fellow National Institutes of Health National Institute of Child Health and Human Development Pregnancy Research Branch Bethesda, MD	1983-1984
	Maternal Fetal Medicine Department of Obstetrics and Gynecology Duke University Medical Center Durham, NC	1985-1987
<b><u>APPOINTMENTS</u></b>		
<b>Assistant Professor</b>	Department of Obstetrics and Gynecology Duke University Medical Center Durham, NC	1984-1985
<b>Assistant Professor</b>	Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology Duke University Medical Center Durham, NC	1987-1993
<b>Assistant Professor</b>	Department of Radiology Duke University Medical Center Durham, NC	1993-1997
<b>Co-Director</b>	Fetal Diagnostic Center Department of Obstetrics and Gynecology and Radiology Duke University Medical Center Durham, NC	1993-1997

<b>Associate Professor</b>	Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology Duke University Medical Center Durham, NC	1993-1997
<b>Associate Professor</b>	Director, Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology University of Wisconsin-Madison Madison, WI	1997-2000
<b>Professor</b>	Director, Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology University of Wisconsin-Madison Madison, WI	2001-2002
<b>Director</b>	Maternal Fetal Medicine Edward Hospital Naperville, IL	2002-2003
<b>Professor and Chair</b>	Department of Obstetrics and Gynecology University of Arkansas for Medical Sciences Little Rock, AR	2003-2007
<b>Residency Program Director</b>	Department of Obstetrics and Gynecology University of Arkansas for Medical Sciences Little Rock, AR	2007
<b>Professor and Director</b>	Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology University of Chicago Chicago, IL	2007-2009
<b>Chief of Obstetrics</b>	Chicago Lying-In Hospital University of Chicago Chicago, IL	2007-2009
<b>Professor</b>	Washington University School of Medicine Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology St. Louis, MO	2010-2011
<b>Medical Director</b>	Labor and Delivery Barnes Jewish Hospital St. Louis, MO	2010-2011
<b>Medical Director</b>	Maternal Fetal Medicine Advocate Christ Medical Center Oak Lawn, IL	2011-present

**OTHER APPOINTMENTS**

<b>Board Examiner</b>	American Board of Obstetrics and Gynecology	1995-2009
-----------------------	---	-----------

<b>Consultant</b>	GE Medical Systems Luminary site for perinatal medicine	1997-2002
<b>Consultant</b>	Maternal-Fetal Medicine consultant South African Initiative to study Fetal Alcohol Syndrome, Capetown, Sponsored by National Institute of Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health, Washington, D.C.	1999-2003
<b>Member</b>	Board of Directors Society for Maternal-Fetal Medicine	2000-2003
<b>Member</b>	Board of Directors Wisconsin Association for Perinatal Care	2000-2002
<b>Member</b>	Editorial Board <i>Obstetrics and Gynecology</i>	2001-2004
<b>Member</b>	Editorial Board <i>Placenta</i>	2008-present
<b>Consultant</b>	Abbott Laboratories Abbott Park, IL	2008-2009
<b>Member</b>	Regional advisory board Watson, Inc	2011

#### **CERTIFICATION**

Diplomat, American Board of Obstetrics and Gynecology, 1985  
 Recertified 1998  
 Maternal Fetal Medicine and American Board of Obstetrics and Gynecology, 1990  
 Recertified 1998  
 Annual recertification 2006, 2007, 2008, 2009, 2010, 2011

#### **ACTIVE LICENSURE**

Wisconsin #38969, issued 7/25/97  
 Illinois #036-106086, issued 1/11/02  
 Missouri #2010005269, issued 2/16/10

#### **PROFESSIONAL SOCIETIES/ASSOCIATIONS**

Society for Maternal-Fetal Medicine  
 Society for Gynecologic Investigation  
 American College of Obstetrics and Gynecology  
 American Medical Association  
 North American Society for the Study of Hypertension In Pregnancy  
 International Society of Ultrasound In Obstetrics and Gynecology

American Diabetes Association  
Preeclampsia Foundation  
Central Association of Obstetricians and Gynecologists

### **TEACHING AWARDS and RECOGNITION**

- APGO Excellence in Teaching Award, 2006
- Red Sash Award for Outstanding Medical Student Teaching, University of Arkansas  
College of Medicine, Class of 2006, 2007
- Best Doctors In America (every year since 1994)
- Top 10% of reviewers for *Obstetrics and Gynecology*, 2007, 2008, 2009

### **COMMITTEES**

#### **National committees**

Site visit, National Institutes of Health General Clinical Research Center Commonwealth University of Virginia Richmond, VA	April, 2001
Scholarly Activities Committee Society for Maternal-Fetal Medicine Foundation	2007-2011
Nominations Committee Society for Gynecologic Investigation	2007

#### **University committees**

Institutional Review Board Department representative Duke University Medical Center	1985-1997
Clinical Sciences Faculty Council on Academic Affairs Department representative Duke University Medical Center	1993-1996
Search Committee, cytogenetics laboratory director, Department of Pathology Duke University Medical Center Durham, NC	1993
Long Range Planning Committee University of Wisconsin Medical Foundation University of Wisconsin-Madison	1998-1999
Search Committee Director of Neonatology, University of Wisconsin-Madison	1999
Medical School Faculty Equity and Diversity Committee	1999-2002

4

University of Wisconsin-Madison Madison, WI	
Council of Departmental Chairs University of Arkansas for Medical Sciences Little Rock, AR	2003-2007
Faculty Group Practice Committee College of Medicine University of Arkansas for Medical Sciences Little Rock, AR	2003-2007
Women's Health Nurse Practitioner Advisory Board Member UAMS College of Nursing Little Rock, AR	2005-2007
Member, Search Committee for Dermatology Chair University of Arkansas for Medical Sciences Little Rock, AR	2007
Co-Chair of Search Committee for Radiology Chair University of Arkansas for Medical Sciences Little Rock, AR	2007
Search Committee for Chair of Pediatrics University of Chicago Chicago, IL	2008
Faculty Focus Advisory Group University of Chicago Chicago, IL	2008
Clinical Medicine Working Group Implementation Planning Phase of the Pritzker Initiative University of Chicago School of Medicine Chicago, IL	2008
<b><u>Department Committees</u></b>	
Appointment, Promotions and Tenure Committee Department of Obstetrics and Gynecology Duke University Medical Center Durham, NC	1996-1997
Executive Committee Department of Obstetrics and Gynecology University of Wisconsin-Madison Madison, WI	1997-2002
Search Committee for Maternal Fetal Medicine faculty Department of Obstetrics and Gynecology University of Wisconsin-Madison	1998-2001

Madison, WI

Compensation Committee 2000-2002  
Department of Obstetrics and Gynecology  
University of Wisconsin-Madison  
Madison, WI

Departmental Business Manager Search Committee 2001  
Department of Obstetrics and Gynecology  
University of Wisconsin-Madison  
Madison, WI

**Hospital committees**

Clinical Data Repository (CDR) 1997  
Clinical Workstation TAG Team  
Meriter Hospital  
Madison, WI

Executive Steering Committee 1998-2002  
Meriter Hospital  
Madison, WI

Practice Committee (chair) 1999-2002  
Department of Obstetrics and Gynecology  
Meriter Hospital  
Madison, WI

Cesarean Section Operating Room Committee 1999-2001  
Meriter Hospital  
Madison, WI

Obstetric Induction Committee 2001  
Meriter Hospital  
Madison, WI

Medical Care and Education (MCE) Committee 2002-2003  
Edward Hospital  
Madison, WI

Hospital Medical Board 2003-2004  
Executive Committee  
University Hospital of Arkansas  
Little Rock, AR

Surgical Services Board 2003-  
University Hospital of Arkansas  
Little Rock, AR

Faculty Group Practice Executive Committee 2003-2006  
University of Arkansas for Medical Sciences  
Little Rock, AR

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Clinical Care Improvement Council University Hospital of Arkansas Little Rock AR	2006-2007
Labor and Delivery Operations Committee Chicago Lying-In Hospital University of Chicago	2007-2009
OB Operations Committee Barnes Jewish Hospital St. Louis, MO	2010-present

### **RESEARCH INTERESTS**

Role of the placenta in the pathophysiology of preeclampsia  
 Clinical perinatology  
 Nuclear magnetic resonance spectroscopy of normal and abnormal placentas  
 Magnetic resonance imaging in pregnancy  
 Ultrasound imaging in Obstetrics  
 Doppler flow studies in high risk pregnancies  
 Intrauterine growth retardation  
 Preeclampsia / hypertensive diseases in pregnancy  
 Placental metabolism and effects of oxygen tension and hypoxia  
 Oxidative stress and the human placenta  
 Fetal Alcohol Syndrome  
 Ethanol effects in the placenta  
 Obesity and pregnancy  
 HPV infection and adverse pregnancy outcome

### **GRANT AWARDS**

- Principal Investigator;** Josiah Charles Trent Memorial Foundation, Inc. Award; "Exploration of the utility of NMR spectroscopy as a non-invasive method for assessing placental metabolism and transport of glucose to the fetus", 1984. \$5000
- Principal Investigator;** Clinical Investigator Award; National Institute of Child Health and Human Development, National Institutes of Health; "NMR spectroscopy of normal and growth retarded placentas", 1987-1990. \$182,675
- Principal Investigator;** Walker Inmann Fund; "NMR spectroscopy of cultured human trophoblast cells"; Small Research Grant, 1990. \$5000
- Principal Investigator;** FIRST Award, National Institute of Child Health and Human Development, National Institutes of Health; "Magnetic resonance spectroscopy of the human placenta". January, 1994-1999. \$350,000.
- Principal Investigator;** Dianon Systems, Inc.; "Fetal cell isolation/fluorescent in situ hybridization clinical study". August, 1993 - 1995. \$5000
- Consultant;** Ron Wakal (PI) National Institutes of Health; "Fetal and neonatal magnetoencephalography" 7/1/98-6/30/01.

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**Co-Principal Investigator;** Ron Wakal (PI) National Institutes of Health; "Optimized measurement and signal processing of fetal MCG". 7/1/99-6/30/03. \$1,211,354, 10% effort.

**Principal Investigator (sponsor for Dr. Stephen Tsoi, postdoctoral fellow);** Meriter Foundation, "Gene expression patterns in preeclampsia", \$10,000. 1999-2000.

**Co-Principal Investigator;** Dr. Stephen Tsoi (PI), "Hypoxic regulation of lactate dehydrogenase (LDH) isozymes and hypoxia-inducible factor 1 (HIF1) in HUVE and JEG cell lines". Wisconsin Association for Perinatal Care. \$10,000, 2000.

**Principal Investigator;** "Ethanol exposure on nitric oxide production and angiogenesis in the human placenta." \$489,089, subcomponent in Program Project Grant, National Institutes of Health, NICHD "Placental angiogenic factors and UA/PA endothelial NO production", Ronald R. Magness (PI) 7/1/01-6/30/06, \$4,642,747. (did not initiate due to relocation)

**Co-Principal Investigator,** Dr. Michael F. Fleming (PI), "Brief alcohol intervention: The healthy moms project", National Institutes of Health, NIAAA, 7/1/01-6/30/06, \$1,963,061, 5% effort. (ended when I left the Institution)

**Co-Principal Investigator;** "Perinatal Conference/Prematurity Summit", \$10,000, Arkansas March of Dimes Community Grant Program, 2004.

**JOURNALS, regular and ad hoc reviewer**

Obstetrics and Gynecology  
American Journal of Obstetrics and Gynecology  
Placenta  
American Journal of Perinatology  
Reproductive Sciences (formerly Journal of the Society of Gynecologic Investigation)  
American Journal of Reproductive Immunology  
Fetal Diagnosis and Therapy  
Journal of Maternal Fetal Medicine and Neonatology  
American Journal of Physiology: Endocrinology and Metabolism  
Gynecologic and Obstetric Investigation

**OTHER ACADEMIC ACTIVITIES**

The Perinatal Research Society, Montreal, Canada, September, 1991 (Invited fellow guest).

Medical consultant, Time Life Medical Video Series, "Pregnancy", 1996.

Moderator, Slide Session, "Trophoblast Function and Differentiation", Annual Meeting, Society for Gynecologic Investigation, Philadelphia, Pennsylvania, March, 1996.

Poster judge, Annual Meeting, Society of Maternal Fetal Medicine, Miami Beach, Florida, February, 1998.

Oral presentation judge, Annual Meeting, Society of Maternal Fetal Medicine, San Francisco, California, 1999.

Chair, Breakfast Session, "Antenatal steroid treatment and adverse fetal effects: What is the evidence?", Annual Meeting, Society for Gynecologic Investigation, Atlanta, Georgia, March, 1999.

Oral presentation judge, Annual Meeting, Society of Maternal Fetal Medicine, Miami Beach, Florida, 2000.

Moderator, oral session, "Placenta", Annual Meeting, Society for Gynecologic Investigation, Chicago, Illinois, March, 2000.

Moderator, oral session, "Genetics, Ultrasound", Annual Meeting, Society for Maternal Fetal Medicine, Reno, Nevada, February, 2001.

Poster judge, "Clinical Obstetrics, Genetics, Ultrasound", Annual Meeting, Society for Maternal Fetal Medicine, Reno, Nevada, February, 2001.

Director, Postgraduate course, "Optimizing Antepartum and Intrapartum Obstetrical Care for Health Care Providers", Division of Maternal Fetal Medicine, Department of Obstetrics and Gynecology, and Meriter Hospital, Madison, Wisconsin, October 5, 2001.

Chair, Postgraduate Courses, Annual Meeting, Society for Maternal Fetal Medicine, New Orleans, LA, January, 2002.

Chair, Scientific posters, Annual Meeting, Society for Maternal Fetal Medicine, San Francisco, CA, February, 2003.

Program Chair, Annual Meeting, Society for Maternal Fetal Medicine, New Orleans, LA, February, 2004.

Program committee, Annual Meeting, Society for Gynecologic Investigation, Los Angeles, CA, March, 2005.

Concurrent session judge, Society for Maternal-Fetal Medicine, Reno, Nevada, February 11, 2005.

Charles A. Hunter, Jr. Lectureship (Lecturer, Visiting Professor), Department of Obstetrics and Gynecology, Indiana University, June 17, 2005.

Program Committee, Annual Meeting, Society for Gynecologic Investigation, Toronto, Canada, March, 2006.

Visiting Professor, Resident Research Day, Department of Obstetrics and Gynecology, University of Mississippi, Jackson, MI, June 16, 2006

Program Committee, Annual Meeting, Society for Gynecologic Investigation, Reno, Nevada, March, 2007.

Grant reviewer, Philip Morris External Research Program, June 2007.

Program Committee, Annual Meeting, Society for Gynecologic Investigation, San Diego, CA, March, 2008.

Special Emphasis Panel (SEP), NIH-NICHD, August 12, 2008.

Program Committee, Annual Meeting, Society for Gynecologic Investigation, Glasgow, Scotland, March, 2009.

Member, Faculty of 1000 Medicine Reports, 2008-present.

Diplomat, Society for Gynecologic Investigation In collaboration with Proctor and Gamble, Cincinnati, Ohio, to investigate joint research and educational endeavors with Chinese departments of Obgyn, May, 2009.

Member, HLA-G External Advisory Board, University of Kansas Medical Center, Drs. Joan Hunt, Carole Ober and Peggy Petroff (Principal Investigators), June, 2009.

Director, CME course, "Contemporary Issues In Hypertensive Pregnancy Management", The Department of Obstetrics and Gynecology, University of Chicago Pritzker School of Medicine and The North American Society for the Study of Hypertension in Pregnancy, Chicago, Illinois, October 23, 2009.

Program Committee, Annual Meeting, Society for Gynecologic Investigation, Orlando, Florida, March, 2010.

## **PUBLICATIONS**

### **Refereed Publications**

1. Morley CGD and **Ho H**: The regulation of mouse liver ornithine decarboxylase by metabolites. *Biochem Biophys Acta* 438:551-62, 1976.
2. Galardy RE, Stafford SS, Schaefer ML, **Ho H**, LaBorgna KA and Jamieson JD: Biologically active derivatives of angiotensin for labeling cellular receptors. *J Med Chem* 21:1279-83, 1978.
3. **Kay HH** and Hobbins JC: Amniotic fluid estrogens and their correlation with L/S ratios. *J Reprod Med* 29:222-6, 1984.
4. Saltzman DH, **Kay HH**, Eron LJ and Sites JC: Single dose antibiotic prophylaxis in high risk patients undergoing cesarean section. *Obstet Gynecol* 65:655-7, 1985.
5. Mahony BS, Bowie JD, Killam AP, **Kay HH** and Cooper C: Epiphyseal ossification centers in the assessment of fetal maturity: Sonographic correlation with the amniocentesis lung profile. *Radiology* 159:521-4, 1986.
6. Tamas DE, Mahony BS, Bowie JD, Woodruff WW and **Kay HH**: Prenatal sonographic diagnosis of hemifacial microsomia (Goldenhar-Gorlin Syndrome). *J Ultrasound Med* 5:461-3, 1986.
7. **Kay HH**, Knop RC and Mattison DR: Magnetic resonance imaging of monkey placenta with manganese enhancement. *Am J Obstet Gynecol* 157:185-9, 1987.
8. Wiener MD, Bowie JD, Baker ME and **Kay HH**: Sonography of subfascial hematoma after cesarean delivery. *Am J Roentgen* 148:907-10, 1987.

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9. Mattison DR, **Kay HH**, Miller RK and Angtuaco T: Magnetic resonance imaging: A noninvasive tool for fetal and placental physiology. *Biology of Reproduction* 38:39-49, 1988.
10. **Kay HH**, Herfkens R and Kay BK: Effects of magnetic resonance imaging on *Xenopus laevis* embryogenesis. *Magnetic Resonance Imaging* 6:501-6, 1988.
11. Baker ME, **Kay HH**, Mahony BS, Cooper CJ and Bowle JD: Sonography of the low transverse incision cesarean section: A prospective study. *J Ultrasound Med* 7:389-93, 1988.
12. Haynes BF, Martin ME, **Kay HH** and Kurtzberg J: Phenotypic characterization and immunohistologic localization of T cell precursors in early human fetal tissues. *J Experimental Med* 168:1061-80, 1988.
13. Hertzberg BS, **Kay HH** and Bowle JD: Fetal choroid plexus lesions: Relationship of antenatal sonographic appearance to clinical outcome. *J Ultrasound Med* 8:77-82, 1989.
14. Rice JP, **Kay HH** and Mahony BS: The clinical significance of uterine leiomyomas in pregnancy. *Am J Obstet Gynecol* 160:1212-16, 1989.
15. **Kay HH**, Carroll B, Bowle J, Killam AP and Hertzberg B: Nonuniformity of fetal umbilical systolic/diastolic ratios as determined with duplex Doppler. *J Ultrasound Med* 8:417-20, 1989.
16. **Kay HH**, Carroll B, Dahmus M and Killam AP: Sonographic measurements with umbilical and uterine artery doppler analysis in suspected intrauterine growth retardation. *J Reprod Med* 36:65-8, 1991.
17. **Kay HH**, Gordon JD, Ribello AA and Spicer LD: Phosphorus-31 magnetic resonance spectroscopy of human placenta and quantitation with perchloric acid extracts. *Am J Obstet Gynecol* 164:80-7, 1991.
18. Wang Y, **Kay HH** and Killam AP: Decreased levels of polyunsaturated fatty acids in preeclampsia. *Am J Obstet Gynecol* 164:812-18, 1991.
19. Hug G, Chen YT, **Kay HH** and Bossen EH: Chorionic villus ultrastructure in Type II Glycogen Storage Disease. *New Engl J Med* 324:342-3, 1991.
20. **Kay HH** and Spritzer CE: Preliminary experience with magnetic resonance imaging in patients with third trimester bleeding. *Obstet Gynecol* 78:424-9, 1991.
21. **Kay HH**, Hage ML, Kurtzberg J and Dunsmore KP: Alloimmune thrombocytopenia may be associated with systemic disease. *Am J Obstet Gynecol* 166:110-11, 1992.
22. Park H, **Kay HH**, McConkie-Rosell A, Lanman J and Chen YT: Prenatal diagnosis of Pompe's disease (type II glycogen storage disease) in chorionic villi biopsy using maltose as a substrate. *Prenatal Diagnosis* 12:169-73, 1992.

23. **Kay HH**, Gordon JD, Hawkins SR, Wang Y, Ribelro AA and Spicer LD: Comparative analysis of normal and growth retarded placentas using phosphorus NMR spectroscopy. *Am J Obstet Gynecol* 167:548-53, 1992.
24. Wang Y, Walsh SW and **Kay HH**: Placental lipid peroxides and thromboxane are both increased and prostacyclin decreased in women with preeclampsia. *Am J Obstet Gynecol* 167:946-9, 1992.
25. Walsh SW, Wang Y, **Kay HH** and McCoy MC: Low-dose aspirin inhibits lipid peroxides and thromboxane, but not prostacyclin, in pregnant women. *Am J Obstet Gynecol* 167:926-30, 1992.
26. **Kay HH**, Hawkins SR, Wang Y, Mika DE, Ribelro AA and Spicer LD: <sup>31</sup>P Magnetic resonance spectroscopy of human placental villi perfused under varying oxygen concentrations. *Am J Obstet Gynecol* 168:246-52, 1993.
27. Spritzer, C.E., Evans, A.C. and **Kay, H.H.**: Magnetic resonance imaging of deep venous thrombosis in pregnancy. *Obstet Gynecol* 85:603-7, 1995.
28. Hurteau JA, Rodriguez GC, **Kay HH**, Berchuck A, Soper J, and Clarke-Pearson DL: Villoglandular adenocarcinoma of the cervix: A case report. *Obstet Gynecol* 85:906-8, 1995.
29. McCoy MC, Wang Y, Coffman TM, Killam AP, and **Kay HH**: Effects of low-dose aspirin therapy on plasma levels of polyunsaturated fatty acids: A preliminary investigation. *Am J Perinatology* 12:371-374, 1995.
30. Nesbitt TH, **Kay HH**, McCoy MC, Herbert WNP: Endoscopic management of biliary disease during pregnancy. *Obstet Gynecol* 87:806-9, 1996.
31. Hertzberg BS, Kilewer MA, Maynor C, McNally PJ, Bowie JD, **Kay HH**, Hage ML and Livingston, EG: Non-visualization of the fetal gallbladder: Frequency and prognostic significance. *Radiology* 199:679-682, 1996.
32. Kilewer MA, Hertzberg BS, Freed KS, DeLong DM, **Kay HH**, Jordan SG, Peters-Brown TL and McNally PJ: Dymorphologic features of the fetal pelvis in Down syndrome: Prenatal sonographic depiction and diagnostic implications of the iliac angle. *Radiology* 201:681-684, 1996.
33. Shellhaas CS, Coffman TM, Dargie PJ, Killam AP, and **Kay HH**: Intravillous elcosanoid compartmentalization and regulation of placental blood flow. *J Soc Gynecol Invest* 4:58-63, 1997.
34. Hertzberg BS, Kilewer MA, Freed KS, McNally PJ, Bowie JD and **Kay HH**: Fetal third ventricle: Size and appearance in normal fetuses through gestation. *Radiology* 203:641-44, 1997.
35. Perkins KY, Johnson JL and **Kay HH**: Clinical features of simple ovarian cysts on a first trimester ultrasound scan. *J Reprod Med* 42:440-4, 1997.
36. Ashby AM, Robinette B and **Kay HH**: Gestational age and labor effects on plasma and erythrocyte nonesterified polyunsaturated fatty acid levels. *Am J Perinatol* 14:623-9, 1997.

37. Talbot GT, Goldstein RF, Nesbitt T, Johnson J and **Kay HH**: Is size discordancy an indication for delivery of preterm twins? *Am J Obstet Gynecol* 177:1050-4, 1997.
38. **Kay HH**, Robinette B, ShIn YY, Siew P, Shellhaas CS and Tyrey L: Placental villous glucose metabolism and hormone release respond to varying oxygen tensions. *J Soc Gynecol Invest* 4:241-6, 1997.
39. Qumsiyeh MB, Adhvaryu SG, Peters-Brown T, Fry-Mehlretter L, Kath SM and **Kay HH**: Discrepancies in cytogenetic findings in chorionic villi. *J Mat Fet Med* 6:351-55, 1997.
40. Boggess KA, Oury TD, **Kay HH** and Crapo JD: Extracellular superoxide dismutase localization and activity within the human placenta. *Placenta* 19:417-22, 1998.
41. Shelton SD, Paulyson K and **Kay HH**: Prenatal diagnosis of thrombocytopenia absent radius (TAR) syndrome vaginal delivery. *Prenatal Diagnosis* 19:54-57, 1999.
42. Krishnamurthy P, Martin CB, **Kay HH**, Diesner J, Friday RO, Weber CA and Droste S: Catheter-directed thrombolysis for thromboembolic disease during pregnancy: A viable option. *J Matern-Fetal Med* 8:24-27, 1999.
43. Brown T, Kliewer M, Hertzberg BS, Ruiz C, Stamper T, Rosnes J, Lucas A, Wright L, Chescheir N, Farmer L, Jordan S and **Kay HH**: A role for maternal serum screening in detection of chromosomal abnormalities in fetuses with choroid plexus cysts: A prospective multicenter study. *Prenatal Diagnosis* 19:405-410, 1999.
44. **Kay HH**, Grindle K, Magness RR: Ethanol exposure induces oxidative stress and impairs nitric oxide availability in the human placental villi: A possible mechanism of toxicity. *Am J Obstet Gynecol* 182:682-8, 2000.
45. Boggess KA, **Kay HH**, Crapo JD, Moore WF, Suliman HB and Oury TD: Differential localization of placental extracellular superoxide dismutase as pregnancy progresses: Relationship to placental vascular development. *Am J Obstet Gynecol* 183(1):199-205, 2000.
46. **Kay HH**, Bird IM, Coe CL and Dudley DL: Antenatal steroid treatment and adverse fetal effects: What is the evidence? *J Soc Gynecol Invest* 7:269-78, 2000.
47. Tsoi SCM, Zheng J, Xu FH and **Kay HH**: Differential expression of lactate dehydrogenase isozymes (LDH) in human placenta with high expression of LDH-A isozyme in the endothelial cells of preeclamptic villi. *Placenta* 22:317-22, 2001.
48. Trampe BS, Pryde PG, Stewart KS, Droste S, Zieher S and **Kay HH**: Color Doppler imaging can distinguish myomas from uterine contractions in pregnancy. *J Reprod Med* 46:791-4, 2001.
49. Benson KD, Luchansky JB, Elliott JA, Degnan AJ, Willenberg HJ, Thronberry J and **Kay HH**: Pulsed-field fingerprinting of vaginal Group B Streptococcus in pregnancy: Correlation of restriction profiles with serotype. *Obstet Gynecol* 100:545-51, 2002.
50. Tsoi SCM, Cale J, Bird I and **Kay HH**: cDNA microarray analysis of gene expression profiles in human placenta: Up-regulation of the transcript encoding muscle subunit of

- glycogen phosphorylase (GP-M) in preeclampsia. *J Soc Gynecol Investig* 10(8):496-502, 2003.
51. You H, Liu Y, Agrawal N, Prasad CK, Chiriva-Internati M, Lowery CL, **Kay HH**, Hermonat PL: Infection, replication, and cytopathology of human papillomavirus type 31 in trophoblasts. *Virology* 316(2):281-9, 2003.
  52. Burlleigh DW, Stewart K, Grindle KM, **Kay HH**, Golos TG: Influence of maternal diabetes on placental fibroblast growth factor-2 expression, proliferation, and apoptosis. *J Soc Gynecol Investig* 11(1):36-41, January, 2004.
  53. Yong L, Maurizio C I, Changxuan Y, Rongcheng L, Hong Y, Prasad CK, Grizzi F, Cobos E, Klimberg SV, **Kay HH**, Mehta J L, and Hermonat PL: Use and specificity of breast cancer antigen/milk protein BA46 for generating anti-self-cytotoxic T lymphocytes by recombinant adeno-associated virus-based Gene loading of dendritic cells. *Cancer Gene Therapy* 12:304-312, 2005.
  54. Santin A D, Bellone S, Siegel E R, Palmieri M, Thomas M, Cannon M J., **Kay H H**, Roman J J., Burnett A, Pecorelli S: Racial differences in the overexpression of epidermal growth factor type II receptor (HER2/neu): A major prognostic indicator in uterine serous papillary cancer. *Am J Obstet Gynecol* 192: 813-818, 2005.
  55. Collins L R, Hall R W, Dajani N K, Wendel P J, Lowery C L, **Kay H H**: Prolonged morphine exposure in utero causes fetal and placental vasoconstriction. *J of Matern Fetal Med* 17(6):417-21, 2005.
  56. Santin AD, Zhan F, Bignotti E, Siegel ER, Cane S, Bellone S, Palmieri M, Anforssi S, Thomas M, Burnett A, **Kay HH**, Roman JJ, O'Brien TJ, Tian Erling, Cannon MJ, Shaughnessy J, Pecorelli S: Gene expression profiles of primary HPV16 and HPV18-infected early stage cervical cancers and normal cervical epithelium: Identification of novel candidate molecular markers for cervical cancer diagnosis and therapy. *Virology* 331:269-91, 2005.
  57. Wang Y, Walsh S W, and **Kay H H**: Placental tissue levels of non-esterified polyunsaturated fatty acids in normal and preeclamptic pregnancies. *Hypertension in Pregnancy* 24(3): 235-45, 2005.
  58. Tsoi S, Park KC, **Kay HH**, O'Brien TJ, Podor E, Sun G, Douglas SE, Brown LL and Johnson SC: Identification of a transcript encoding a soluble form of toll-like receptor 5 (TLR5) in Atlantic salmon during *Aeromonas salmonicida* infection. *Veterinary Immunology and Immunopathology* 109 (1-2): 183-7, 2006.
  59. **Kay HH**, Tsoi S, Grindle K, Magness RR: Markers of oxidative stress in placental villi exposed to ethanol. *J Soc Gynecol Investig* 13:118-21, 2006.
  60. McKelvey SS, **Kay HH**: Magnetic resonance spectroscopy of the placenta. *Placenta* 28: 369-377, 2007.
  61. **Kay HH**, Zhu S, Tsoi SS: Hypoxia and lactate production in trophoblast cells. *Placenta* 28:854-60, 2007

62. Kang, BY, Tsoi SCM, Zhu S, Su S, **Kay HH**: Differential gene expression profiling in HELLP syndrome placentas. *Reprod Sci* 15(3): 285-94, 2008.
63. Reutrakul S, Zaldi N, Wroblewski K, **Kay HH**, Ismail M, Ehrmann DA, Van Cauter E. Sleep disturbances and their relationship to glucose tolerance in pregnancy. *Diabetes Care* November, 2011.
64. Ding D, Scott N, Torres R, Billstrand C, Thompson EE, Murray K, Levy S, Dexheimer P, Ismail M, **Kay H**, Ober, C. Massively parallel sequencing reveals an excess of rare protein coding mutations in the mitochondrial genome of African American women with preeclampsia. (submitted for publication)

#### **Non-refereed Publications**

1. Mattison DR, **Kay HH** and Heinrichs L: The widening window of magnetic resonance imaging. *Contemporary OB/GYN*, October, 1984.
2. **Kay HH** and Mattison DR: Effect of radiation and chemotherapy on ovarian and testicular function. *Contemporary OB/GYN*, July, 1985.
3. **Kay HH**: Book Review for American Scientist, "Cardiac Problems in Pregnancy: Diagnosis and Management of Maternal and Fetal Disease", U. Elkayam and N. Gleicher (eds), 1990, second edition, Alan R. Liss, Inc., New York, March-April, 1992.
4. **Kay HH**: Magnetic Resonance Imaging in Obstetrics and Gynecology. *Postgraduate Obstetrics and Gynecology*, Vol. 13, No. 4, February, 1993.

#### **Books**

1. **Kay HH (Senior book editor)**, Nelson DM and Wang Y (co-editors), "The Placenta: from Development to Disease" by Wiley Blackwell, March, 2011.

#### **Chapters in Books**

1. **Kay HH** and Mattison DR: Nuclear magnetic resonance spectroscopy and imaging in Perinatal Medicine. *Animal Models in Fetal Medicine (V)*, Nathanielsz, P.W., (ed.), Perinatology Press, Ithaca, New York, 1986.
2. Mattison DR, **Kay HH**, Angtuaco T, Miller RK, Panigel M, Plowchalk D, Jordan J and Thomford PJ: The role of nuclear magnetic resonance imaging and spectroscopy in clinical and experimental obstetrics. *Reproductive Physiology Using Magnetic Spectrometry and Imaging*. Haseltine, F.P. and McCarthy, S. (eds), Slack Publishers, New Jersey, 1987.
3. **Kay HH** and Spritzer CE: Magnetic Resonance Imaging in Gynecology, *GYNECOLOGY AND OBSTETRICS*, Droegemueller, W and Sclarra, JJ (eds) Harper and Row Publishers, 1991.
4. **Kay HH**, Gordon JD, Ribeiro AA and Spicer LD: 31P nuclear magnetic resonance (NMR) spectroscopy of human placenta and placenta extracts. *Trophoblast Research Volume 5*, VERAV Medical Publishers, University of Rochester, Rochester, NY, 1991.

5. **Kay HH:** Electromagnetic fields. Reproductive Hazards of the Workplace. Frazier, LM and Hage, ML (eds), Van Nostrand-Reinhold Publishers, New York, N.Y. pp 391-400, 1998.
6. Pryde PG and **Kay HH:** Fetal macrosomia: Antenatal diagnosis and management. Contemporary Therapy In Obstetrics and Gynecology Issues and Controversies 2000/2001. Ransom, SB, Dombrowski, MP and Evans, MI (eds), W.B. Saunders, Philadelphia, PA. pp 203-206, 2002.
7. **Kay HH:** Placenta previa and abruption. Danforth's Obstetrics & Gynecology 9<sup>th</sup> edition, Gibbs RS, Haney A, Karlan B and Scott JR (eds), Lippincott, Williams & Wilkins pp 365-380, 2003.
8. **Kay HH:** Pregnancy before age 20 and after age 35. Clinical Obstetrics: The fetus and mother, 3<sup>rd</sup> edition. E.A. Reece and J.C. Hobbins (eds), Blackwell Publishing, Oxford, UK, 2007.

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E-Mail: andrea.miller@advocatehealth.com

## Andrea Miller

**Summary** Over 20 years of experience in women's and children's health care and management. During this time I have acquired expertise in personnel management, budget preparation and administration, leadership, program development, education, facility design, and strategic planning.

**Experience** 1997 - Present Advocate Christ Medical Center Oak Lawn, IL

2005 to Present

Director of Women and Infant's Health - ACMC is a 695-bed tertiary care hospital with Level I Trauma Services located in the southwest suburbs of Chicago. Currently this position reports to the Chief Operating Officer /Chief Nurse Executive. Operational responsibilities including strategic business planning, personnel management, budget administration, program development, facilities design, and clinical design.

- Co-Chair of a house wide initiative to improve patient satisfaction.
- Assisting in development and implementation of an inpatient acuity system.

1997 - 2005

Manager - Family Centered Care and/or Labor and Delivery

- Responsible for Family Centered Care and Women's Resource Center with 118 FTE's.
- Facilitated preparation of Magnet application and site visit for department and medical center.
- Co-Developed hospital wide acuity system to meet Magnet standards.
- Member of the Summit Group for Outstanding Leaders.
- Interim director for Women's Health Services
- Increased employee satisfaction scores in Family Centered Care from 20% to 98%.
- Facilitated and established a new unit for Gyne patients (8 West). This new unit has consistently ranked at the top of the Parkside survey for patient satisfaction.
- Revised the Charge Master System for Labor & Delivery, reducing billing errors while improving patient satisfaction.
- Implemented Central Fetal Monitoring & bedside documentation throughout all areas of Labor & Delivery resulting in improved documentation.
- Initiated and maintained competency reviews for fetal monitoring in Labor & Delivery and the Autepartum area.
- Established a new Triage Area in Labor & Delivery leading to improved outcomes while maintaining existing FTB's, remaining budget neutral.
- Implemented a plan of action to replace all outdated equipment, resulting in improved staff morale and increased patient satisfaction.

1994 -1997 St. Margaret Mercy Healthcare Centers Dyer, IN

Nurse Manager - Family Birthing Center/Pediatrics Unit

- Established new service line for this community hospital acquired thru merger. Coordinated the design, implementation, staffing, opening and operation of a new Family Birthing Center and Pediatrics unit.
- Responsible for development and implementation of both the Operating and Capital Budget of the Family Birthing Center.

1988 - 1994 St. Margaret Mercy Healthcare Centers Hammond, IN

Nurse Manager - Family Birthing Center/Pediatrics Unit

- Coordinated the design, implementation, opening and operation of a new Birthing Center and NICU.
- Assisted in the preparation of the Healthy Start Initiative grant for Northwest Indiana and the March of Dimes grant enabling the delivery of prenatal care to the indigent population. Administered the yearly renewal of these grants.
- Developed protocols to respond to reductions in LOS for obstetrical and newborns while maintaining quality of care.
- Created a Postpartum/Newborn Care Clinic in response to reduced LOS.
- Assisted in the development of all patient and staff educational materials.
- Developed and implemented a plan of action to cross train all Women's Health staff nurses from a traditional delivery model to Single Room Maternity Care.

1987 -1988

Nurse Educator

- Responsible for the development and implementation of staff and patient education in all areas regarding antenatal, labor, delivery, post partum and care for the newborn.
- Developed and implemented program for staff nurses for Basic and Advanced Electrical Fetal Monitoring.
- Responsible for programs certifying staff competency.

1985 - 1987

Emergency Department

- Staff Nurse

1979 - 1985

Labor and Delivery

- Staff Nurse

Education

1998 Indiana University

- Master of Health Administration

1986 Purdue University

- Bachelor of Science in Nursing

1979 Purdue University

- Associate Degree in Nursing

## CURRICULUM VITAE

### PERSONAL DATA

Thomas Francis Myers, M.D., M.B.A.  
Birth Date: September 26, 1949  
Residence: 6901 W. 96<sup>th</sup> Place  
Oak Lawn, IL 60453

Married: (1973) Harriet L. Myers  
Children: Erin M. Myers (1976)  
Rachel F. Myers (1982)  
Bryan E. Myers (1984)

Phone: (708) 684-5722  
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Email: Thomas.Myers@advocatehealth.com

### CURRENT APPOINTMENTS

President, Renaissance Medical Group, Inc.	2000 - Present
Director, Division of Neonatology Advocate Christ Medical Center/ Advocate Hope Children's Hospital	1999 - Present
Member, Perinatal Advisory Committee to the Illinois Department of Health and Human Services	1996 - 2005
Professor of Pediatrics, Department of Pediatrics, Loyola University School of Medicine Maywood, Illinois	1994 - 2005
Co-Chairman, Perinatal Centers of Illinois, Illinois Department of Public Health	1996 - 2003
Member, Expert Advisory Panel on Pulmonary Disease, The United States Pharmacopoeial Convention	1996 - 2003
Accreditation Council for Graduate Medical Education Panel for the Certification of Training Programs in Neonatal-Perinatal Medicine	1999 - 2003
Board of Directors M.B.A. Program for Healthcare Executives Benedictine University	1999 - 2002

### PREVIOUS APPOINTMENTS

Medical Director Midwest NeoPed Associates, Ltd.	1999 - 2000
Co-Director, Loyola Regional Perinatal Center	1992 - 1998

Thomas F. Myers, M.D.

Director, Division of Neonatology Loyola University School of Medicine	1992 - 1998
Loyola University Physicians Foundation Board of Directors	1995 - 1998
Associate Professor, Department of Pediatrics, Loyola University School of Medicine	1987 - 1994
Associate Director, Division of Neonatology	1987 - 1991
Assistant Professor, Department of Pediatrics Loyola University School of Medicine	1981 - 1986
Major, USAF, MC: Chief Newborn Medicine David Grant USAF MC.	1979 - 1981
Clinical Instructor, University of California, Davis.	1979 - 1981

**EDUCATION AND TRAINING**

Benedictine University Lisle, Illinois	1997-1998	Business School (M.B.A., 1998)
The New York Hospital/ Cornell University Medical College	1977-1979	Fellowship Neonatology/Perinatology
The New York Hospital/ Cornell University Medical College	1977-1979	Fellowship Clinical Pharmacology
St. Christopher's Hospital for Children Temple University, Philadelphia	1975-1977	Residency Pediatrics
Temple University Philadelphia, Pennsylvania	1971-1975	Medical School (M.D., 1975)
Cornell University Ithaca, New York	1967-1971	Premedical (A.B., 1971)

**LICENSURE AND CERTIFICATION**

Pediatrics, Board Certification, American Board of Pediatrics, No. 155790, 1980.

Neonatology, Subspecialty Board Certification, American Board of Pediatrics/Neonatal-Perinatal Medicine, No. 984, 1981.

Licensure, State of Pennsylvania, MDO18292E

Licensure, State of New York, 130708

Licensure, State of California, G44774

Licensure, State of Illinois, 036-062088

Licensure, State of Indiana, 01052595A

**PROFESSIONAL ORGANIZATIONS**

American Federation for Clinical Research 1980 - Present

Midwest Society for Pediatric Research 1980 - Present

**AWARDS**

Outstanding Healthcare Administrator Award 2005

March of Dimes – Indiana Chapter

**PUBLICATIONS**

1. Martin LG, Myers TF, Wertenberger GE. Effect of Aging on Ability to Acclimate to Chronic Hypoxia of Simulated High Altitude. *Proceedings Indiana Academy of Science* 81:390-400, 1972.
2. Myers TF, Milsap RL, Krauss AN, Auld PAM, Reidenberg MM. Low Dose Theophylline Therapy in Idiopathic Apnea of Prematurity. *Journal of Pediatrics* 96(1):99-103, 1980.
3. Anderson CL, Collin MF, O'Keefe JP, Challapalli M, Myers TF, Caldwell CC, Ahmed GS, Earl A, Huber S. A Widespread Epidemic of Mild Necrotizing Enterocolitis of Unknown Etiology. *American Journal of Diseases of Children* 138:979-983, 1984.
4. Caldwell CC, Hurley RM, Anderson CL, Ahmed GS, Myers TF. Nonimmune Hydrops Fetalis Managed with Peritoneal Dialysis. *American Journal of Perinatology* 2:211-213, 1985.
5. Caldwell CC, Stankiewicz J, Anderson CL, Ahmed GS, Myers TF. Intubation-Related Tracheal Stenosis in Very-Low-Birth-Weight Infants. *American Journal of Diseases of Children*. 139:618-620, 1985.

6. Myers TF, Ahmed GS, Anderson CL, Addelson R, Moyer J. A Modification of the International Classification of Diseases for Uniform Coding of Diagnosis, Procedures, and Medications - The Perinatal Intensive Care Computer System, *American Journal of Perinatology* 2:240-242, 1985.
7. Myers TF, Anderson CL. Neonatal Resuscitation. In: Rakel RE, ed. *Conn's Current Therapy*: 849-855. Philadelphia: W.B. Saunders, 1987.
8. Myers TF, Patrinos ME, Muraskas J, Caldwell CC, Lambert GH, Anderson CL. Dynamic Trend Monitoring of Cerebral Blood Flow Velocity in Newborn Infants. *Journal of Pediatrics*, 110:611-616, 1987.
9. Kaler SG, Patrinos ME, Lambert GH, Karlman R, Anderson CL, Myers TF. Hypertrichosis and Congenital Anomalies Associated with Maternal Use of Minoxidil. *Pediatrics* 79:434-436, 1987.
10. Anderson CL, Ahmed GS, Myers TF, Caldwell CC. The Pediatrician's Role in Selection of a Facility for Delivery of High - Risk Infants. *Neonatology-Perinatology*, 4:16-19, 1987.
11. Coker SB, Bellran RS, Myers TF, Hmura L. Neonatal Stroke: Description of Patients and Investigation into Pathogenesis *Pediatric Neurology* 4:219-223, 1988.
12. Myers TF, Anderson CL. Neonatal Resuscitation. In: Rakel RE, ed. *Conn's Current Therapy*: 891-897. Philadelphia: W.B. Saunders, 1988.
13. Myers TF, Anderson CL. Neonatal Resuscitation. In: Rakel RE, ed. *Conn's Current Therapy*: 914-920. Philadelphia: W.B. Saunders, 1989.
14. Lambert GH, Muraskas J, Anderson CL, Myers TF. Direct Bilirubinemia Associated With Chloral Hydrate Administration in the Newborn. *Pediatrics* 86:277-281, 1990.
15. Bennett LN, Jandreski M, Myers TF, Kahn S, Hurley RM. A Comparison of Two Common Clinical Methods with High Pressure Liquid Chromatography for the Measurement of Creatinine Concentrations in Neonates. *Pediatric Nephrology* 5:379-382, 1991.
16. Hoekstra RE, Jackson JC, Myers TF, Frantz ID III, Stern ME, Powers WF, Maurer M, Raye JR, Carrier ST, Gunkel JH, Gold AJ. Improved Neonatal Survival Following Multiple Doses of Bovine Surfactant in Very Premature Neonates at Risk for Respiratory Distress Syndrome. *Pediatrics* 88:10-18, 1991.
17. Ferrara TB, Hoekstra RE, Couser RJ, Jackson JC, Anderson CL, Myers TF, Raye JR. Effects of Surfactant Therapy on Outcome of Infants with Birth Weights 600-750 grams. *Pediatrics* 119:455-457, 1991.
18. Rizvi ZB, Aniol HS, Myers TF, Zeller WP, Fisher SG, Anderson CL. Effects of Dexamethasone on the Hypothalamic-Pituitary-Adrenal Axis in Preterm Infants. *Journal of Pediatrics* 120:961-965, 1992.

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19. Singh HP, Hurley RM, Myers TF. Neonatal Hypertension Incidence and Risk Factors. *American of Journal Hypertension* 5:51-55, 1992.
20. Muraskas JK, Myers TF, Lambert GH, Anderson CL. Intact survival of 280-g infant: an extreme case of growth retardation with normal cognitive development at two years of age. *Acta Paediatrica Scandinavia Supplement* 382:16-20, 1992. Also abstracted in *Key Obstetrics and Gynecology* 6(3):19-20, 1993. Also abstracted in the 1994 Year Book of Obstetrics and Gynecology.
21. Fitzgerald MJ, Goto M, Myers TF, Zeller WP. Early Metabolic Effects of Sepsis in the Preterm Infant: Lactic Acidosis and Increased Glucose Requirement. *Journal of Pediatrics* 121:951-955, 1992.
22. Merritt TA, Smith SJ, Myers TE. Drugs Used in Bronchial Disorders. In: *Drug Evaluations*. Chicago: American Medical Association, 1993, pp. 1097-1109.
23. Muraskas JK, Husain A, Myers TF, Anderson CL, Black PR. An Association of Pulmonary Hypoplasia With Unilateral Agenesis of the Diaphragm. *Journal of Pediatric Surgery* 28:999-1002, 1993.
24. Holmes JM, Cronin KM, Squires P, Myers TF. A Randomized Clinical Trial of Surfactant Prophylaxis in Retinopathy of Prematurity. *Journal of Pediatric Ophthalmology and Strabismus* 31:189-191, 1994.
25. Ionides SP, Weiss MG, Angelopoulos M, Myers TF, Handa RJ. Plasma Beta-Endorphin Concentrations and Analgesia/Muscle Relaxation in the Newborn Infant Supported by Mechanical Ventilation. *Journal of Pediatrics* 125:113-116, 1994.
26. Jain R, Isaac RM, Myers TF. Transient Central Hypothyroidism As A Cause of Failure to Thrive in Newborns and Infants. *Journal of Endocrinological Investigation* 17:631-634, 1994.
27. Gunkel JH et al (The Survanta Multidose Study Group). Two-year Follow-up of Infants with Treated for Neonatal Respiratory Distress Syndrome with Bovine Surfactant. *Journal of Pediatrics* 124:962-967, 1994.
28. Tholl DA, Wager MS, Sajous CH, Myers TF. Morphine Use and Adverse Effects in a Neonatal Intensive Care Unit. *American Journal of Hospital Pharmacists* 51:2801-2803, 1994.

Thomas F. Myers, M.D.

29. Tholl DA, Miller TQ, Henderson WG, Myers TF. Meta-analysis of phenobarbital usage for prevention of intraventricular hemorrhage in premature infants: factors related to variation in outcome. *Clinical Trials and Meta-Analysis* 29:177-190, 1994.
  30. Miles RH, DeLeon SY, Muraskas J, Myers T, Quinones JA, Vitullo DA, Bell TJ, Fisher EA, Pifarre R. Safety of Patent Ductus Arteriosus Closure in Premature Infants Without Tube Thoracostomy. *Annals of Thoracic Surgery* 59:668-70, 1995.
  31. Jain R, Shareef M, Rowley A, Raible MD, Husain A, Myers TF. Disseminated Herpes Simplex Virus Infection Presenting As Fever in the Newborn - A Lethal Outcome. *Journal of Infection* 32:239-241, 1996.
  32. Bennett LN, Myers TF, Lambert GH. Cecal Perforation Associated with Sodium Polystyrene Sulfonate-Sorbitol Enemas in a 650 gram Infant with Hyperkalemia. *American Journal of Perinatology* 13:167-170, 1996.
  33. Jain R, Myers TF, Kahn S, Zeller WP. How Accurate is Glucose Analysis in the Presence of Multiple Interfering Substances in the Neonate? *Journal of Clinical Laboratory Analysis* 10:13-16, 1996.
  34. Thomasma DC, Muraskas J, Marshall P, Myers TF, Tomich P, O'Neill JA. The Ethics of Caring for Conjoined Twins: The Lakeberg Twins *Hastings Center Report* 26(4):4-12, 1996.
- Also published in *Bioetica y Ciencias de la Salud*, II(3):30-38, 1997.
35. Fatayerji N, Engelmann GL, Myers TF, Handa RJ. In Utero Exposure to Ethanol Alters mRNA for Insulin-Like Growth Factors and Insulin-Like Growth Factor-Binding Proteins in Placenta and Lung of Fetal Rats. *Alcoholism: Clinical and Experimental Research* 20:94-100, 1996.
  36. Farolan LR, Goto M, Myers TF, Anderson CL, Zeller WP. Perinatal Nutrition Enriched with Omega-3 Polyunsaturated Fatty Acids Attenuates Endotoxic Shock in Newborn Rats. *Shock* 6:263-266, 1996.
  37. LaMear NS, MacGilvray SS, Myers TF. Dexamethasone Induced Myocardial Hypertrophy In Neonatal Rats. *Biology of the Neonate* 72:175-180, 1997.
  38. Jain R, Jarosz CR, Myers TF. Decreasing Blood Donor Exposure in the Neonates by Using Dedicated Donor Transfusions. *Transfusion Science* 18:199-203, 1997.
  39. Muraskas J, Marshall PA, Tomich P, Myers TF, Gianopoulos JG, Thomasma DC. Neonatal Viability in the 1990's: Held Hostage by Technology. *Cambridge Quarterly of Healthcare Ethics* 8:160-172, 1999.
  40. Myers TF, Venable HH, Hansen JA. Computer Enhanced Neonatology Practice Evolution in an Academic Medical Center. *Journal of Perinatology* 18:S38-S44, 1998.

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41. Myers TF, Wy CA, Goto M, Young R, Muraskas J. Prophylactic Treatment of Endotoxic Shock with Monophosphoryl Lipid A in Newborn Rats. *Biology of the Neonate* 2000;77:191-195.

#### MANUSCRIPTS IN PREPARATION

1. Myers TF, Saijous CH, Swanson S, Naber MM. Improved Quality and Reduced Length of Stay: An Integrated NICU Home Care Program. In preparation.

#### INVITED PRESENTATIONS, NATIONAL MEETINGS

1. Bennett LN, Jandreski SE, Kahn SE, Myers TF, Hurley RM. Evaluation of Two Clinical Methods Versus High Performance Liquid Chromatography (HPLC) for Determination of Serum and Urine Creatinines in Neonates. *Pediatric Nephrology* 3:C132, 1989.
2. Bennett LN, Jandreski SE, Kahn SE, Myers TF, Hurley RM. Serum and Urine Creatinine Method Comparison in the Neonate At Annual Barklay Conference on Perinatal Research, 1989.
3. Myers TF, Paveza GJ, Diamond MV. Cardiogenic Decrease in Cerebral Blood Flow velocity During Indomethacin Therapy in Very Low Birth Weight Infants. *Pediatric Research* 27:63A, 1990. Poster Symposium - Potential Therapies For Neonatal Brain Injury, Society for Pediatric Research, Anaheim, May 9, 1990.
4. Rizvi Z, Darling H, Myers TF, Zeller PW, Fisher SG, Anderson CL. The effects of Dexamethasone on the Hypothalamic-Pituitary-Adrenal Axis in Preterm Babies. *Pediatric Research* 29:303A, 1991. Poster Presentation - Society for Pediatric Research, New Orleans, May 5, 1991.
5. The Survanta Study Group. Follow-up of Infants with Multiple Doses of Bovine Surfactant. Platform Presentation, American Academy of Pediatrics, New Orleans, October 28, 1991.
6. Visiting Professor, 5th Medical Congress of the Carta Medas Medical Society, University of Cartagena, Cartagena, Columbia, 1991.
7. Elsayed MH, Myers TF, Anderson CL, Castro AJ. Fetal tissue survives transplantation into a rat model of neonatal Hypoxic-Ischemic brain damage. *Neuroscience A-87*, 473.6, 1992. Presented at the Society for Neuroscience, 1992.

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8. Elsayed MH, Myers TF, Anderson CL, Castro AJ. Fetal Neocortical Tissue Survives Transplantation into a Rat Model of Neonatal Hypoxic-Ischemic Brain Damage. *Pediatric Research* 31:348A, 1992. Poster Presentation - Society for Pediatric Research, Baltimore, May 6, 1992.
9. MacGilvray SS, Myers TF, Anderson CL, Thomas JX Jr. Glucocorticoids exert a trophic effect on myocardial mass. *Pediatric Research* 31:20A, 1992. Poster presentation - Society for Pediatric Research meeting, Baltimore, MD, May 1992.
10. MacGilvray SS, Myers TF, Anderson CL, Thomas JX Jr. Functional implications of dexamethasone and isoproterenol induced myocardial hypertrophy. *Pediatric Research* 31:20A, 1992. Poster Presentation - Society for Pediatric Research meeting, Baltimore, MD, May 1992.
11. Muraskas J, Husain A, Myers T, Anderson C, Black P. An Association of Agenesis of the Hemidiaphragm and Pulmonary Hypoplasia. Presented at 39th International Congress of Pediatric Surgeons. University of Leeds, England, July 22-24, 1992.
12. Ionides SP, Weiss MG, Angelopoulos MM, Handa RJ, Myers TF. Serum Beta-Endorphin Levels and Analgesia/Muscle Relaxation in the Ventilated Newborn. *Pediatric Research* 33:64A, 1993. Joint Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 3, 1993.
13. Visiting Professor, 6th Medical Congress of the Carta Medas Medical Society, University of Cartagena, Cartagena, Columbia, 1993.
14. Myers TF, Venable H, Tholl D, Anderson CL. Total Quality Management and Cost Reduction in an Academic NICU: An On-Line Educational Approach. Poster Presentation, American Academy of Pediatrics Section on Perinatal Pediatrics Workshop on Perinatal Challenges, Scottsdale, AZ, April 8-10, 1994.
15. Farolan LR, Goto M, Myers TF, Anderson CL, Zeller WP. Perinatal Diet Enriched with Omega-3 Polyunsaturated Fatty Acids (Ω3 PUFA) is beneficial in suckling rate endotox shock. *Pediatrics Research* 35:311A, 1994. Joint Poster Session - Society for Pediatric Research meeting, Seattle, WA, May 3, 1994.
16. Fatayerji N, Engelmann GL, Myers TF, Handa R. Exposure to Ethanol Alters mRNA for Insulin-Like Growth Factors (IGF's) and IGF Binding Proteins in Fetal Rats. *Pediatric Research* 35:66A, 1994. Joint Poster Session - Society for Pediatric Research meeting, Seattle, WA, May 2, 1994.
17. Farolan LR, Goto M, Myers TF, Anderson CL, Zeller WP. Omega-3 Fatty Acids Decrease Mortality and Metabolic Changes in Suckling Rat Endotox Shock. Seventeenth Annual Conference on Shock, Big Sky, Montana, June 5-8, 1994.

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18. Jain R, Jarosz CR, Myers TF. Limiting Donor Exposure in the Neonatal Intensive Care Unit. Presented at: Mead Johnson Nutritionals, 17th Annual Midwestern Conference on Perinatal Research, Great Lakes, September, 1994.
19. Muraskas JK, Myers TF. Conjoined Twins - Who Lives? Who Dies? Who Decides? Presented at Paediatric Week Holland 1994 (Sponsored by the European Society for Paediatric Research, Society for Pediatric Research). Rotterdam, The Netherlands, July 3-6, 1994.
20. Myers TF, Venable H, Tholl D, Anderson CL. Direct Physician Order Entry: A Vehicle for Cost Reduction. Presented at the 1994 Medical Information Systems Physicians' Association (MISPA) Conference, Tarpon Springs, FL, November 15, 1994.
21. Myers TF, Venable H, Tholl D, Anderson CL. Direct Physician Order Entry: A Vehicle for Cost Reduction. Presented at the IBM Healthcare Forum, Palisades, NY, January 17, 1995.
22. Shareef MJ, Myers TF, Mathews HL. Neonatal Lymphocytes Affect the Growth of Candida Albicans. *Pediatric Research* 37:299A, 1995. Joint Poster Session - Society for Pediatric Research meeting, San Diego, CA, May 9, 1995.
23. Nath S, Weiss MG, Myers TF. Early Discharge of Mother and Baby After Delivery - At What Emotional Cost? *Pediatric Research* 37:112A, 1995. Joint Poster Session - Society for Pediatric Research meeting, San Diego, CA, May 11, 1995.
24. Jain R, Myers TF, Zeller WP, Wagner R. Total Body Bone Mineral Content (TBBMC) In Preterm Infants At Birth Using Dual Energy X-ray Absorptiometry (DEXA). *Journal of Investigative Medicine*. Vol. 44, no. 7, 1996. MSPR, Page 353A. Presented at: American Federation for Clinical Research, Midwest Section Meeting, Chicago, Illinois. September, 1996.
25. Jain R, Jarosz CR, Myers TF. Limiting Donor Exposure in the Neonatal Intensive Care Unit. *Journal of Investigative Medicine*. Vol. 44, No. 1, 1996. WSPR, Page 146A. Presented at: American Federation for Clinical Research, Western Section Meeting, Carmel California, February, 1996.
26. Muraskas JK, Weiss MG, Myers TF. Neonatal Viability in the 1990's: Held Hostage by Technology. *Pediatric Research* 39:41A, 1996. Platform Session - Society for Pediatric Research meeting, Washington, D.C., May 9, 1996.
27. Shareef MJ, Myers TF, Mathews HL. Bound Neonatal Lymphocytes Affect the Growth of Candida Albicans. *Pediatric Research* 39:301A, 1996. Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 9, 1996.

28. Skalski MS, Farolan LR, Goto M, Zeller WP, Myers TF. Omega-3 Fatty Acid Enriched Diet Attenuate Exercise Induced Lactacidemia and Increased Liver c-AMP in the 10 Day Old Suckling Rat. *Pediatric Research* 39:320A, 1996. Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 8, 1996.
29. LaMear NS, MacGilvray SS, Kowal-Vern A, Myers TF. Dexamethasone Induced Left Ventricular Hypertrophy of the Neonatal Rat Myocardium. *Pediatric Research* 39:31A, 1996. Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 9, 1996.
30. Nath S, Pildes RS, Myers TF. Plasma Glucose Levels in Exclusively Breastfed Term Newborns. *Pediatric Research* 39:233A, 1996. Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 8, 1996.
31. Myers TF, Sajous CH, Naber MM. Total Quality Management and Cost Reduction in an Academic Nicu: an On-line Educational Approach. Presented in Poster Form at the National Association of Children's Hospitals and Related Institutions Meeting, San Diego, CA, October 3, 1996.
32. Sajous CH, Naber MM, Swanson SC, Myers TF. Innovative Neonatology - Integrating Transitional Care into the Home. *Pediatric Research* 41:174A, 1997. Joint Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 2, 1997.
33. Koschnitzki KG, Goto M, Myers TF, Zeller WP. A Mechanism of Hypoglycemia in Infants of Diabetic Mothers. *Pediatric Research* 41:235A, April 1997. Joint Poster Session, Society for Pediatric Research, Washington, D.C., May 3, 1997.
34. Shareef MJ, Witek-Janusek L, Myers TF, Mathews HL. Effect of Neonatal Lymphocytes Upon the Growth of *Candida Albicans*. *Pediatric Research* 41:226A, 1995. Joint Poster Session - Society for Pediatric Research meeting, Washington, D.C., May 5, 1997.
35. Bhola M, Goto M, Zeller WP, Myers TF, Chen HY. The Effect of Polyclonal Anti-TNF Antibody on TNF Gene Expression, Lethality and Glucoregulation in Suckling Rats with Endotoxic Shock. *Pediatric Research* 43:235A, April 1998. Poster Presentation, Society for Pediatric Research, New Orleans, LA, May 4, 1998.
36. Weiss MG, Muraskas J, Conrad H, Myers T. Contribution of Gastro-Esophageal Reflux to Apnea in Infants. *Pediatric Research* 43:302A, April 1998. Poster Presentation, Society for Pediatric Research, New Orleans, LA, May 2, 1998.
37. Myers TF. Medical Information Systems to Change Physician Practice: Improve Delivery of Care While Reducing Costs. Presented at "Redesigning Neonatal Intensive Care for Managed Care," sponsored by AIC Conferences, Chicago, October 16, 1997.

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38. Myers TF. Changing Physician Practice to Improve Delivery of Care While Reducing Costs. Presented at "Neonatal Intensive Care Conference," sponsored by Cambridge Health Resources, Fort Worth, Texas, January 30, 1998.
39. Myers TF. Information Systems to Change Physician Practice to Improve Delivery of Care While Reducing Costs. Presented at "Redesigning Neonatal Intensive Care for Managed Care," sponsored by AIC Conferences, Miami, Florida, June 23, 1998.
40. Myers, TF. Cost Effective Clinical Practice of the Very Low Birth Weight Infant. Presented at the "National Conference of Neonatal Nursing," Chicago, Illinois, March 25, 1999.
41. Myers, TF. Early Discharge. Presented at the "Eleventh Annual North Central Neonatology Issues Conference", Elkhart Lake, Wisconsin, June 13, 1999.
42. Myers, TF. Management of Apnea. Presented at the "Eleventh Annual North Central Neonatology Issues Conference", Elkhart Lake, Wisconsin, June 13, 1999.

#### **GRANTS - FUNDING**

Ross Laboratories Division of Abbott Laboratories. Survanta Multiple Dose Prevention Study, 1989, \$100,000.

Loyola University, Stritch School of Medicine, Dean's Discretionary Fund. Cerebral Blood Flow Research and Apnea Testing. 1984, \$70,000.

#### **PROFESSIONAL ACTIVITIES**

Reviewer, American Journal of Perinatology, Auld PAM, and Krauss AN, eds, New York: Thieme Medical Publishers, Inc..

Reviewer, Journal of Pediatrics, Garfunkel JM, Editor, C.V. Mosby Co.

Reviewer, Drug Evaluations, Steven J Smith, Editor, Chicago: American Medical Association, Neonatal Drugs, 1993 - present.

#### **LABORATORY/TECHNICAL EXPERIENCE**

Pulmonary function testing in neonates and carbon dioxide sensitivity by the rebreathing method of Read, et al.

Pharmacology Laboratory: Serum Theophylline concentration by the HPLC and EMIT methods.

Enzymology: Measurement of B-glucuronidase and leucine aminopeptidase by spectrophotometric method; measurement of N-acetylglucosaminidase by fluorometric methods.

Continuous Doppler cerebral blood flow velocity in infants; intermittent and semi-continuous

recording research.

Sleep apnea screening and diagnostic evaluation. Active in setting up laboratory, initiating clinical protocols, and administering regional apnea program which evaluates 300 patients per year.

Computing, analog to digital physiologic signal processing using Zenith 386 PC, Data Translation 2821-F and DOS - MacMillan Asyst Software.

Establishing and maintaining clinical database and merging clinical and financial databases.

### **OUTCOMES RESEARCH - COST EFFECTIVENESS**

1993 - Present:

Instituted a comprehensive program to reduce the cost of neonatal intensive care while maintaining quality outcomes. The approach includes:

1. *Clinical Practice Change* - A comprehensive assessment and reformulation of all NICU care practices. With change introduced via an on-line education approach to direct physician order entry, this approach has reduced NICU cost per patient by 30 to 40% in less than two years.
2. *Integrated Home Care* - Physiologic rather than weight related discharge criteria, plus flexing NICU nurses into home care with uniform protocols allowed much earlier discharge of NICU infants with oral transition feeding in the home. Length of stay has been reduced by seven to fourteen days in very low birth weight infants.
3. *Case Management* - Was used to define ideal birth weight related resource utilization and outliers with case management intervention to shrink outliers.

This comprehensive program has reduced NICU cost by 30 to 40% in two years, representing a \$4 million cost savings, which has preserved NICU contribution margin in the face of revenue reduction and reduced hospital days. This program is a part of a strategy for survival and maintenance of quality care in a changing financial environment.

### **TEACHING**

Recipient Loyola Pediatric Residents Teaching Award, 1986-87.

Numerous lectures on infantile apnea, perinatal asphyxia, cerebral blood flow, and surfactant.

Lecturer in pulmonary organ systems course, 1983 - 1994.

Lecturer in biostatistics course, 1983 - 1989.

Seminar leader, Medical Humanities. 1988 - present.

MDL Seminar leader, Genetics organ systems course, 1988 - present.

### **ADMINISTRATION**

Medical Director for a Neonatal Group Practice employing forty neonatologists and twenty neonatal nurse practitioners. 1999 - 2000

Thomas F. Myers, M.D.

Chief Medical Officer for an Academic Neonatal Program which includes nine attending neonatologists, six neonatology fellows and ten neonatal nurse practitioners, serving one university tertiary care facility and two community hospitals. 1992 - 1999

Designer, *NEO MEDS*, *NEO LAB*, and *NEO RESP*, on-line physician order entry system for Technicon Hospital Systems, 1993.

Designer, Research Fellowship Training Program, 1989 - present.

Respiratory Therapy, NICU advisor, 1984 - present.

Editor, NICU Manual, 1984-present. Institutional 500 page document which sets standards for care.

Pediatric Pulmonary Laboratory, director, 1984-present. Lab personnel include two technicians. Testing includes pulmonary functions, sweat chloride, and apnea screening.

Co-designer of 50 bed NICU, 1986-1988. Responsible for design and implementation of technology, 1988.

Computing, co-designer of LUMC Perinatal computerized Data Base, 1983.

Computing, co-designer LUMC-NICU laboratory data bedside display system, 1983.

#### COMMITTEES

##### Hospital

Surgical addition monitoring committee 1984 - 85. Responsible for specification, evaluation, and standardization of patient monitoring for surgical addition.

Advanced Practice Steering Committee, 1995.

Clinical Goals Committee/Operations Restructuring and Clinical Resource Management Oversight Group, 1994 - present.

ICU Utilization Workgroup, 1994 - present.

ICU Committee, 1995 - present.

Center for Clinical Effectiveness Steering Council, 1995 - present.

##### University

Loyola University Internal Capital Campaign, Department Captain, 1991.

Artificial intelligence advisory group, 1986 - present.

Educational resources committee, 1985 - present.

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Biostatistics course planning group, 1984-1989.

Loyola University Physicians' Foundation

Loyola Medical Practice Plan/Loyola Physicians Associates Clinical Practice Committee, 1994 - present.

Loyola University Physicians' Foundation Board of Directors, 1995 - 1998

JOSEPH M. PAVESE, M.D., F.A.C.O.G., F.A.C.S.

CURRICULUM VITAE

MARITAL STATUS: Married

SS#: [REDACTED]

HOME ADDRESS: 8940 Royal Drive  
Burr Ridge, Illinois 60521

HOME TELEPHONE: (630) 887-7461

ACADEMIC EDUCATION:

COLLEGE:

Northeastern Illinois University  
Chicago, Illinois  
Dates Attended: 1973-1977  
Degree: B.S. Biology, May, 1976  
Graduate Work: Protozoology, 1976-1977

Research Papers and Topics:

1. Excystment Stimuli in the Protozoan Tetrahymena Rostrata
2. Culturing of the Protozoan Tetrahymena Rostrata on Millipore Filter/Agar Media
3. Cytologic Staining of Ciliate Protozoa Cultured on Membrane Filters. McArdle, E.W. Transactions of the American Microscopical Society: Vol. 97, No. 4 (Oct., 1978)

PROFESSIONAL EDUCATION:

MEDICAL SCHOOL:

Southern Illinois University  
School of Medicine  
Springfield, Illinois  
Dates Attended: 1977-1980  
Degree: M.D., June 1980

INTERNSHIP/RESIDENCY TRAINING:

OBSTETRICS AND GYNECOLOGY:

Rush-Presbyterian-St Luke's Medical Center  
Chicago, Illinois  
Dates Attended: 1980-1984  
Administrative Chief Resident, June, 1983 - June, 1984

LICENSURE:

Illinois, 1984 (License#: 036-062600)

JOSEPH M. PAVESE, M.D., F.A.C.O.G., F.A.C.S., CURRICULUM VITAE - Page 2

RESEARCH PAPERS:

Analysis of urinary tract infections in an outpatient antepartum population.  
Christ Hospital and Medical Center, Oak Lawn, IL (1984)

Effectiveness of Antimicrobial Prophylaxis in Abdominal and Vaginal Hysterectomy:  
A comparison of Moxalactam Sodium and Cefazolin Sodium, (presented at  
Rush Network OB/GYN Symposium, June 1984 and at American College of OB/GYN  
Junior Fellow District Meeting, June, 1984).

PUBLICATIONS:

Pavese, J.M.; et al.  
Acute Intraoperative Hemorrhage in a Newborn Secondary to Ruptured Adrenal Neuroblastoma - Journal of Advocate Health Care 2004;6

AWARDS:

- 1) Junior Resident Award, June, 1982
- 2) Senior Resident Thesis Award, June, 1984
- 3) Resident Of The Year Award, Christ Hospital and Medical Center, June, 1984
- 4) Rush Presbyterian, St. Luke's Medical Center Residency Program/Christ Hospital and Medical Center, Attending Physician Teacher Of The Year, June, 1992
- 5) American Medical Society Physician Recognition Award for continuing medical education, 1991 - 2000
- 6) Castle and Connolly Medical Ltd. Top Doctors In Chicago Metro Area, 1999 - present
- 7) Consumer Research Council of America  
Guide to America's Top Obstetricians and Gynecologists, April 2006, 2007, 2008, 2009, 2010
- 8) Chicago Magazine Top Doctors in Chicago, January 2008, 2010

MEDICAL LICENSE CERTIFICATION:

Diplomat of the National Board of Medical Examiners, July, 1981

HOSPITAL APPOINTMENTS:

Active Staff, Advocate Christ Medical Center, Oak Lawn, IL 1984 - present  
Vice Chairman, Department of OB/GYN, Advocate Christ Medical Center 1998 - 2002  
Chairman, Department of OB/GYN, Advocate Christ Medical Center 2002 - present

FACULTY APPOINTMENTS:

- 1) Assistant Professor, Department of Obstetrics and Gynecology, Rush Presbyterian, St Luke's Medical Center, June 1983 - 1995.
- 2) Program Director, Department of Obstetrics and Gynecology, Christ Hospital and Medical Center, January 1987 - July, 1987.
- 3) Associate Program Director, Department of Obstetrics and Gynecology, Christ Hospital and Medical Center, July 1987 - March, 1988.
- 4) Assistant Professor, University of Illinois, College of Medicine, Chicago, IL 1975 - present.

JOSEPH M. PAVESE, M.D., F.A.C.O.G., F.A.C.S., CURRICULUM VITAE - Page 3

BOARD CERTIFICATION

Diplomat  
American Board of Obstetrics and Gynecology, November 1986  
10 year Recertified 1995, 1998  
Annual recertification 1999 - present

MEDICAL SOCIETY MEMBERSHIPS:

Fellow, American College of Obstetrics and Gynecology, 1988 - present  
Fellow, American College of Surgeons, 1987 - present

PRIVATE PRACTICE:

SOUTHWEST OBSTETRICS & GYNECOLOGY, LTD.  
4225 West 95th Street  
Oak Lawn, IL 60453  
June, 1984 - present

**ANNE M. PENDERGAST**

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6751 West 122<sup>nd</sup> Street  
Palos Heights, IL 60463  
(708) 396-1761 Home  
(708) 684-5262 Work  
[anne.pendergast@advocatehealth.com](mailto:anne.pendergast@advocatehealth.com)

**PROFILE**

Ambitious, hardworking and task focused individual who has a passion for working with people. Healthcare professional with over twenty years experience advocating on the behalf of patients and families. Recognized leader in assessing and handling critical situations.

**PROFESSIONAL EXPERIENCE**

Advocate Christ Medical Center, Oak Lawn, IL 2007-Present

**Neonatal Social Worker**

- Provide emotional support to parents and monitor mothers for signs of postpartum depression
- Attend patient planning rounds and identify psychosocial factors impacting visitation or discharge
- Organize meetings between medical staff and families to enhance communication and to address any questions
- Link parents with housing, transportation and financial resources to help alleviate additional stressors while their baby is hospitalized

Advocate Christ Medical Center &  
Hope Children's Hospital, Oak Lawn, IL 2006-2007

**Maternal Child Social Worker**

- Assisted with the implementation of the postpartum depression screening process and instructed staff on facilitating a support group
- Educated patients on the signs/symptoms of postpartum depression, assessed those who were determined to be at risk and advised the medical staff of any concerns
- Participated in weekly patient care rounds and team conference meetings to discuss individual care plans and to clarify post hospital needs
- Counseled mothers dealing with substance abuse issues, provided referrals for treatment, and initiated contact with the Department of Children & Family Services when warranted to ensure the wellbeing of the baby

**ANNE M. PENDERGAST**

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- Advised young mothers on financial, educational and community services to help them in their new parental role
- Coordinated home health, durable medical equipment, outpatient services, transportation and pharmaceutical assistance to enable patients to safely transition home

Advocate Hope Children's Hospital, Oak Lawn, IL 1998-2006

**Intake Coordinator/Case Manager in Pediatric Rehabilitation & Development**

- Assessed the ongoing psychosocial needs of patients/families and coordinated the appropriate services to ensure positive outcomes upon discharge
- Collaborated with a multidisciplinary team, insurance case managers and various outside agencies to provide comprehensive services to patients and families
- Provided crisis intervention and counseling to assist families with life altering situations
- Spearheaded teambuilding activities to develop a more cohesive staff and to enhance the work life environment
- Directed and implemented the Attendance Commitment policy for outpatients which has resulted in improved access to therapy services for the community and enhanced the utilization of staff resources
- Designed and developed the *Hope and Fitness* weight management program for adolescents and their families
- Served as a Field Instructor and mentor for graduate students in the field of medical social work
- Facilitated the Culture of Safety training sessions for associates

Advocate Christ Medical Center, Oak Lawn, IL 1987-1998

**Oncology/Medical Social Worker** 1988-1998

- Provided psychosocial assessments to determine patient and family needs in order to facilitate post hospital care arrangements
- Counseled patients and led a support group for families dealing with life threatening illnesses
- Presenter at the annual Cancer Education Series
- Initiated the expansion and the enrichment of our social work student program
- Functioned independently to provide social work services for weekends on the medical campus

**ANNE M. PENDERGAST**

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**Psychiatric Social Worker**

1987-1988

- Established care plans, completed detailed psychosocial assessments, and participated in a multidisciplinary treatment approach in working with geriatric patients
- Performed short term therapy with patients and their families
- Co-facilitated weekly therapy groups for patients and their families
- Assessed patients' discharge needs, made referrals to community agencies, and assisted with placement procedures
- Organized and implemented a Geriatric Bereavement Group

**EDUCATION**

M.A. in Organizational Leadership  
Lewis University, Romeoville, IL  
December 2006

Masters in Social Work  
University of Illinois, Chicago, IL  
June 1987

B.S. in Child Development and Family Life  
Western Illinois University, Macomb, IL  
August 1982

**Professional Affiliation and Credentials:**

National Association of Social Workers  
Licensed Clinical Social Worker  
Academy of Certified Social Workers

**References:**

Available upon request

**STACEY ROBERSON**  
464 Monarch Lane  
Bolingbrook IL 60440  
(773) 818-9495

**EDUCATION:**

Bachelor of Arts  
Alma College, Alma, Michigan  
Major: Psychology Minor: Sociology  
December 1994

Master of Arts  
University of Chicago, Chicago, Illinois  
Social Work  
June 1998

Licensed Clinical Social Worker  
License #: 149-011000

**EXPERIENCE:**

- 2008-present**      **ADVOCATE CHRIST MEDICAL CENTER**    Oak Lawn, Illinois  
Medical Social Worker  
Complete discharge planning for antepartum and postpartum patients. Complete assessments and education regarding postpartum depression. Provide referrals to appropriate community resources. Communicate with other members of the treatment team as needed.
- 2007-2008**      **AMEDISYS HOME HEALTH SERVICES**    Joliet, Illinois  
Medical Social Worker  
Complete psychosocial assessments for home bound patients. Provide referrals to appropriate community resources. Assist and counsel home health patients and families with health related financial, social and emotional concerns. Communicate with other members of the treatment team as needed.
- 2007-2008**      **NATIONAL HOME HEALTH SERVICES**    Des Plaines, Illinois  
Medical Social Worker  
Complete psychosocial assessments for home bound patients. Provide referrals to appropriate community resources. Assist and counsel home health patients and families with health related financial, social and emotional concerns. Communicate with other members of the treatment team as needed.

2004-2007	<p>JOLIET PAINCARE CENTER                      Joliet, Illinois  <u>Patient Liaison</u>  Worked as part of an interdisciplinary team. Provided individual therapy, narcotic medication management and group therapy to adult patients suffering from various chronic pain conditions and sleep disorders. Provided education to patients regarding medications, medical diagnoses and clinic policies.</p>
2000-2006	<p>CONSULTING PROFESSIONALS, INC              Calumet City, Illinois  <u>Consultant</u>  Supervised Masters level interns. Managed adolescent Life Skills Program. Conducted client recruitment. Provided program consultation as requested.</p>
1998-2004	<p>LUTHERAN SOCIAL SERVICES OF ILLINOIS      Chicago, Illinois  <u>Child Welfare Supervisor</u>  Provided clinical supervision and training to direct service workers. Was Responsible for hiring and firing of staff members. Reviewed all written reports submitted to DCFS or Juvenile Court. Prepared monthly statistical reports for performance-based contract. Provided additional program support as needed.</p>
1998-2003	<p>LA RABIDA CHILDREN'S HOSPITAL              Chicago, Illinois  <u>Patient Satisfaction Surveyor</u>  Completed patient satisfaction surveys by phone, with the parents of discharged patients. Referred any complaints or concerns to the Planning and External Affairs Department of the hospital.</p>
1999-2001	<p>SOUTH SUBURBAN FAMILY SHELTER              Homewood, Illinois  <u>Adult Counselor</u>  Provided individual counseling to adult survivors of domestic violence. Facilitated a four-week domestic violence education class for new clients.</p>
1996-1998	<p>LUTHERAN CHILD AND FAMILY SERVICES      Chicago, Illinois  <u>Foster Care Lead Worker</u>  Performed supervisory duties including staffing cases, auditing files, and reviewing reports. Assisted front line staff with their case management responsibilities. Provided ongoing training and support to licensed foster parents.</p> <p><u>Foster Care Home Based Specialist II</u>  Performed casework duties including obtaining analyzing and evaluating data related to cases. Assisted clients in developing goal attainment strategies. Monitored level of client motivation, functioning, and progress. Guided foster parent applicants through the licensing process. Initiated client contact with appropriate community organizations through referral process. Facilitated support group for licensed foster parents.</p>

## Tammy L. Starks, RD, LDN

1005 Misty Brook Lane  
Joliet, IL 60432  
708-743-6497 tlsapple@aol.com

### CERTIFICATES

Registered Dietitian, Illinois, December 2000

Licensed Dietitian Nutritionist, Illinois, License No. 164-003590

Certified Nutrition Support Dietitian, American Society of Enteral and Parenteral Nutrition, December, 2006-2011

### EMPLOYMENT

- Advocate Christ Medical Center, Oak Lawn  
*Neonatal ICU Dietitian, Pediatric Dietitian*  
February 2001-present  
Neonatal ICU November 2003-present  
Duties: Neonatal ICU coverage, assist with pediatric patient unit coverage, nutrition screening, assessments, physician rounds, nutrition education for physicians and nursing, parenteral and enteral nutrition monitoring, discharge planning, quality improvement, voluntary committees, neonatal developmental clinic, human milk creatocrit assays
- Albertsons' Drug Store/Osco Drug Store, Franklin Park  
*Consultant Dietitian*  
June 2005-present  
Duties: Assist with the Eating Healthy With Diabetes program, store tours and meal plans
- Diamond Dialysis, Chicago  
*Consultant Dietitian*  
December 2002-September 2003  
Duties: Provided education to dietitian, reviewed assessments and recommendations
- Illinois Department of Human Services, Howe Center, Tinley Park  
*Registered Dietitian*  
September 2000-February 2001  
Duties: Individual nutrition assessments, menu committee, interdisciplinary team meetings
- El Valor Corporation, Chicago  
*Consultant Dietitian*  
January 2001-August 2001  
Duties: Individual nutrition assessments, menu planning, food safety and sanitation instruction and quality assurance

### EDUCATION

- University of Medicine and Dentistry of New Jersey, Newark, NJ  
Coursework in Master's in Clinical Nutrition Program
- University of Iowa, Iowa City, IA  
Intensive Course in Pediatric Nutrition, May 9-13, 2005
- Baylor College of Medicine, Houston, TX  
Three-Month Neonatal Nutrition Fellowship Program, completed June 25, 2004
- University of Illinois at Chicago, Chicago, IL  
*Human Nutrition and Dietetic Coordinated Program*  
Bachelor of Science in Human Nutrition and Dietetics, July 2000

### PERINATAL EDUCATION

- NICU Nutrition Workshop; July 19<sup>th</sup>, 2011; Des Plaines, Illinois
- 2011 Nourishing the Neonate; August 11<sup>th</sup>- 12<sup>th</sup>, 2011; Chicago, Illinois

Anne Marie Uzueta  
11320 S. Rockwell St.  
Chicago, IL 60655  
[amyanvossen@hotmail.com](mailto:amyanvossen@hotmail.com)  
773-595-6682

### **Education**

M.S., Clinical Nutrition. January 2009 – June 2011  
Rush University, Chicago IL.

B.S., Human Nutrition (Coordinated Program) December 2007  
University of Illinois at Chicago, Chicago, IL

Hope College, Holland, MI. Attended from 2003-2005

### **Employment**

**Advocate Christ Medical Center: Oak Lawn, IL January 2008 – present**  
Working as a clinical dietitian for the mother/baby, adult rehab, general  
medical/ventilator step-down, and cardiac floors. Perform nutrition  
assessments/evaluation/monitoring and diet educations.

### **Volunteer**

**Chicago Cares 2002 – present**  
Volunteer at various food pantries and the Greater Chicago Food Depository.

### **Interests**

**Triathlons 2004 – present**  
My interest in health and nutrition extend to exercise involvement therefore I have  
trained and participated in 10 triathlons of varying lengths.

**Chilean Semester 2001**  
My experiences abroad during a semester living and studying in Chile have increased my  
interests in different cultures and their cultural expression through food. This interest has  
been further expanded by tourist travel through 5/7 continents.

### **Awards**

Dean's List (for every college semester)

### **References**

Anne O'Malley, RD, LDN Clinical Nutrition Manager at Christ; 708-684-1773  
Diane Gallagher, RD, LDN at Advocate Christ Medical Center; 708-684-5566  
Dave Grotto, RD, LDN; founder of Nutrition Housecall; 630-415-9825

## **Traci Wolfe RCP, RRT-NPS**

8558 S. New Castle

Burbank, IL 60459

708-598-1370

Email: pedsrtrf@sbcglobal.net

### **QUALIFICATIONS:**

I am a diversely experienced Illinois licensed Respiratory Care Practitioner with comprehensive background in health care within the hospital setting. I excel at maintaining good working relationships with other professionals while striving to provide quality work. My background includes the following:

- Comprehensive background in inter-hospital transport, pediatric and neonatal critical care, emergency department, Extracorporeal Membrane Oxygenation (ECMO), Continuous Renal Replacement Therapy (CRRT), and general floors.
- Has knowledge of the duties required as Clinical Instructor for affiliated Respiratory Therapy Programs.
- Committed to clinical excellence as demonstrated by acting flexibly in changing environments, participation in various internet communities (including transport, respiratory care, PICU, CRRT, and ECMO), and regular attendance to healthcare conferences to identify best practices.
- Good working relationship with attending physicians and other professionals while striving to provide quality patient-centered care. Familiarity with various committees to include Policy and Procedure, Products Evaluations

### **EDUCATION:**

- 1984-1987: Associates in Applied Science, Respiratory Therapy, Moraine Valley Community College
- August 2008 – present: Currently enrolled in Bachelors of Science, Health Care Leadership, University of St. Francis

### **CERTIFICATIONS AND CREDENTIALS**

- RRT (NBRC)
- Perinatal/Pediatric Specialist (NBRC)
- ECMO Specialist
- Pediatric Advanced Life Support (PALS) Instructor
- Neonatal Resuscitation Provider (NRP) Instructor
- Basic Life Support (BLS) certified

- ACLS certified
- Successfully audited TNCC (Trauma Nurse Critical Care) and ENPC (Emergency Nurse Pediatric Care) courses

#### **EMPLOYMENT**

**May 2007- Current Advocate Hope Children's Hospital, Pediatric Respiratory Care, Clinical Education Specialist**

- Serves as the "clinical expert" in Pediatric Respiratory Care
- Plans, coordinates, and facilitates educational activities to support new trends, regulations, and/or clinical practices.
- Gathers and analyzes performance improvement data, then establishes guidelines, protocols, or policies to support improvement in these findings.
- Develops, implements, and coordinates educational activities to support the professional development needs of the respiratory care practitioners and other caregivers providing respiratory care procedures, to include physicians and nurses. These include providing education on all the job descriptions to follow
- Participates in house wide committees

**January 2006 - May 2007 Advocate Hope Children's Hospital, Pediatric Respiratory Care, Clinical Team Leader**

- Participated in Leadership Development classes to acquire knowledge for Front-line Leader job responsibilities, to include:
  - Motivating and leading associates
  - Effective Communication
  - Understanding different personality and leadership styles and how this applies to motivating associates with an opposite personality style
- Oversee shift-to-shift functionality of the department to ensure safe work environment with proper staffing
- Requires awareness in maintaining proper staffing within budgetary guidelines.
- Performing annual associate evaluations in a timely manner, and to provide guidance to direct reports with the goal of achieving high expectations
- Responsible for assuring supplies and equipment are available for timely and appropriate delivery of care
- Monitors customer satisfaction, both internally and externally, and reports any variances, resolutions, and outcomes to the Manager of Clinical Operations.

**August 2002 - January 2006 Advocate Hope Children's Hospital,**

*Neonatal-Pediatric Transport Team, Staff Respiratory Therapist*

- Above job responsibilities, with primary duties being with the Transport Team.
- Additional responsibilities include overseeing equipment maintenance, researching new equipment, and providing inservices to staff on new equipment.

*January 1987 - August 2002 Advocate Hope Children's Hospital, Pediatric Respiratory Care, staff therapist*

- Experienced with pediatric Transport Team
  - Specialized training in advanced procedures, such as intubation, chest tube insertion, cricothyroidotomy, Intraosseous needle placement, IV insertion, External Jugular IV insertion.
  - Experienced with the INOvent and Aeronox nitric oxide delivery systems
- Provide routine and intensive respiratory care in all inpatient units including medication administration, oxygen therapy, and chest physical therapy
- Experienced with HFOV and HFJV, including troubleshooting, setup, and maintenance
- Provision of invasive and non-invasive procedures, studies, and tests including arterial blood gas acquisition and testing, phlebotomy, and EKGs
- ECMO Specialist
  - Increased familiarity with the pre-ECMO patients needs
  - Enhanced knowledge of cardiopulmonary system, perfusion, acid-base balance
- In-depth knowledge of the equipment used for mechanical ventilation and the physiology involved treating various cardiopulmonary disorders/diseases
- Responsible for the administration of specialty medical gases (including Nitrogen, Helium, and Carbon Dioxide), with strong understanding of their purposes and how to manipulate them to improve effectiveness
- Assist in various quality improvement projects, one of which dramatically increased the patient satisfaction scores in phlebotomy
- Acted as charge therapist in the absence of the Clinical Team Leaders, assessing the current status, anticipating the changing needs, and implementing solutions to any problems that may arise.