

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

ORIGINAL**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND SERVICE****RECEIVED**

15-021

This Section must be completed for all projects.

APR 22 2015

Facility/Project Identification

Facility Name: OSF Saint Anthony Medical Center	HEALTH FACILITIES & SERVICES REVIEW BOARD		
Street Address: 5666 E. State Street			
City and Zip Code: Rockford 61108			
County: Winnebago			

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

Exact Legal Name: OSF Healthcare System d/b/a OSF Saint Anthony Medical Center
Address: 800 N.E. Glen Oak Avenue, Peoria, IL 61603
Name of Registered Agent: Sister Theresa Ann Brazeau
Name of Chief Executive Officer: Kevin Schoeplein
CEO Address: 800 N.E. Glen Oak Avenue, Peoria, IL 61603
Telephone Number: (309) 655-7455

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)**

Name: Clare Connor Ranalli
Title: Partner
Company Name: McDermott Will & Emery
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

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

Name: Mark Hohulin
Title: Senior Vice President Healthcare Analytics
Company Name: OSF Healthcare System
Address: 800 N.E. Glen Oak Avenue, Peoria, IL 61603
Telephone Number: (309) 624-2360
E-mail Address: mark.e.hohulin@osfhealthare.org
Fax Number: (309) 655-4794

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: David Stenerson
Title: Vice President and CFO
Company Name: OSF Saint Anthony Medical Center
Address: 5666 E. State Street, Rockford, IL 61108
Telephone Number: (815) 277-2161
E-mail Address: david.c.stenerson@osfhealthcare.org
Fax Number: (815) 395-5449

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: OSF Healthcare System
Address of Site Owner: 800 N.E. Glen Oak, Peoria, IL 61603
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 <u>ATTACHMENT-2</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: OSF Healthcare System d/b/a OSF Saint Anthony Medical Center
Address: 5666 E. State Street, Rockford, IL 61108
<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"> 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 <u>ATTACHMENT-3</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

Substantive

Non-substantive

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.

The project entails modernization of OSF Saint Anthony Medical Center ("OSF SAMC") via the construction of a 144,247 GSF four (4) story bed pavilion that will be attached to the current hospital building. It will house 78 private rooms for medical surgical beds and the existing hospital will convert semi-private rooms to private rooms, for a total of 112 private rooms in that space when the new bed pavilion is constructed. There will be no change in the number of medical surgical beds as a result of this project.

In addition, some ambulatory services will be offered on the first floor of the new bed pavilion. This will include prompt care (a walk in clinic) and women's health which will include the following services: mammography, ultrasound and bone density testing. There will be no additional imaging pieces of equipment as a result of the relocation of women's health. There will also be space in the new bed pavilion allocated to a retail pharmacy.

Certain non-clinical services will be located in the bed pavilion, including employee health and wellness, weight management (dietary consultation and healthy eating and cooking classes), a women's salon, offices to provide support for patients and their families regarding palliative care, pastoral care, administrative and additional lobby and circulation space.

There will be minor modernization of the existing space (4,244 GSF) primarily to accommodate the access to the new bed pavilion from the current hospital at the first floor and second floor levels.

The total cost of the project is \$85,292,193.00.

The project is non-substantive per HFSRB rules, as it does not involve the establishment or discontinuation of a health care facility or category of service.

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	\$ 283,541.00	\$ 339,707.00	\$ 623,248.00
Site Survey and Soil Investigation	\$ 15,923.00	\$ 19,077.00	\$ 35,000.00
Site Preparation	\$ 2,450,480.00	\$ 2,935,888.00	\$ 5,386,368.00
Off Site Work	\$ 0.00	\$ 0.00	\$ 0.00
New Construction Contracts	\$24,460,883.00	\$29,306,272.00	\$53,767,155.00
Modernization Contracts	\$ 606,014.00	\$ 726,058.00	\$ 1,332,072.00
Contingencies	\$ 1,997,832.00	\$ 2,393,576.00	\$ 4,391,408.00
Architectural/Engineering Fees	\$ 1,679,168.00	\$ 2,011,790.00	\$ 3,690,958.00
Consulting and Other Fees	\$ 113,735.00	\$ 136,265.00	\$ 250,000.00
Movable or Other Equipment (not in construction contracts)	\$ 3,284,915.00	\$ 3,935,615.00	\$ 7,220,530.00
Bond Issuance Expense (project related)	\$ 374,689.00	\$ 448,911.00	\$ 823,600.00
Net Interest Expense During Construction (project related)	\$ 3,133,712.00	\$ 3,754,460.00	\$ 6,888,172.00
Fair Market Value of Leased Space or Equipment	\$ 0.00	\$ 0.00	\$ 0.00
Other Costs To Be Capitalized	\$ 402,024.00	\$481,658.00	\$ 883,682.00
Acquisition of Building or Other Property (excluding land)	\$ 0.00	\$ 0.00	\$ 0.00
TOTAL USES OF FUNDS	\$38,802,916.00	\$46,489,277.00	\$85,292,193.00
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$444,565.00	\$532,628.00	\$977,193.00
Pledges			
Gifts and Bequests	\$1,023,617.00	\$1,226,383.00	\$2,250,000.00
Bond Issues (project related)	\$37,334,733.00	\$44,730,267.00	\$82,065,000.00
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$38,802,916.00	\$46,489,277.00	\$85,292,193.00
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price:	\$ _____	
Fair Market Value:	\$ _____	

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

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

Estimated start-up costs and operating deficit cost is \$ **N/A**.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

- None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): **March 31, 2018**

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

- Cancer Registry
 APORS
 All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
 All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: OSF Saint Anthony Medical Center			CITY: Rockford		
REPORTING PERIOD DATES:		From: 01/01/2014		to: 12/31/2014	
Category of Service	Authorized Beds	Admissions	Patient Days*	Bed Changes	Proposed Beds
Medical/Surgical	190	7,847	42,144	None	190
Obstetrics	13	639	1,346	None	13
Pediatrics	13	47	234	None	13
Intensive Care	38	2,174	8,504	None	38
Comprehensive Physical Rehabilitation	0				
Acute/Chronic Mental Illness	0				
Neonatal Intensive Care	0				
General Long Term Care	0				
Specialized Long Term Care	0				
Long Term Acute Care	0				
Other ((identify))	0				
TOTALS:	254	10,707	52,228	NONE	254

*Includes observation days for each bed service category. Excludes newborns and neonates.

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 manager 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 OSF Healthcare System, d/b/a OSF Saint Anthony 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.

Kevin Schoeplein
SIGNATURE

Kevin Schoeplein
PRINTED NAME

CEO, OSF Healthcare System
PRINTED TITLE

Paula Carynski
SIGNATURE

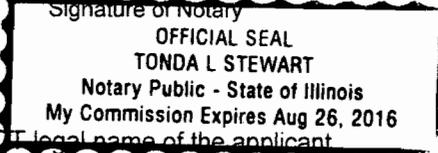
Paula Carynski
PRINTED NAME

CEO, OSF Saint Anthony Medical Center
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of April 2015

Tonda L Stewart
Signature of Notary

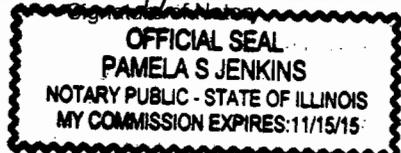
Seal



Notarization:
Subscribed and sworn to before me
this 13th day of April 2015

Pamela S Jenkins
Signature of Notary

Seal



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 Board 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:**NOT APPLICABLE – NO 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:****NOT APPLICABLE – NO SHELL SPACE**

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

1. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories 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 checked="" type="checkbox"/> Medical/Surgical	190	190
<input type="checkbox"/> Obstetric		
<input type="checkbox"/> Pediatric		
<input type="checkbox"/> Intensive Care		

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
1110.530(d)(3) - Documentation Related to Cited Problems			X
1110.530(d)(4) - Occupancy			X
110.530(e) - Staffing Availability	X	X	
1110.530(f) - Performance Requirements	X	X	X
1110.530(g) - Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

O. 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"/> Imaging Services	4 Mammography 2 ultrasound	4 2
<input checked="" type="checkbox"/> Ambulatory Care	0	6
<input checked="" type="checkbox"/> Pharmacy	0	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-34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

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

- Section 1120.120 Availability of Funds – Review Criteria N/A – BOND RATING OF A
- Section 1120.130 Financial Viability – Review Criteria OR BETTER
- 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.
_____	TOTAL FUNDS AVAILABLE

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

IX. 1120.130 - Financial Viability

NOT APPLICABLE – THE APPLICANT HAS A BOND RATING OF A OR BETTER – SEE ATT. 37

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, 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		N	/	A
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 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year

	Inpatient			
	Outpatient			
	Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, 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			

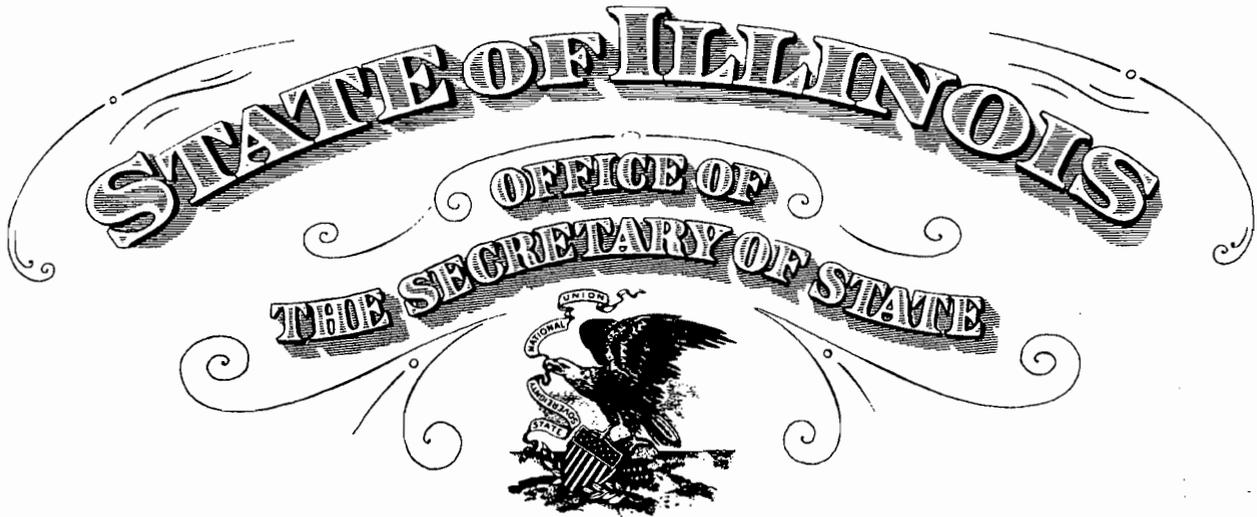
APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	23-24
2	Site Ownership	25-27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	28-31
5	Flood Plain Requirements	32-35
6	Historic Preservation Act Requirements	36-37
7	Project and Sources of Funds Itemization	37
8	Obligation Document if required	N/A
9	Cost Space Requirements	39
10	Discontinuation	N/A
11	Background of the Applicant	40-56
12	Purpose of the Project	57-62
13	Alternatives to the Project	63
14	Size of the Project	64
15	Project Service Utilization	65
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	66-90
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	N/A
27	Non-Hospital Based Ambulatory Surgery	N/A
28	Selected Organ Transplantation	N/A
29	Kidney Transplantation	N/A
30	Subacute Care Hospital Model	N/A
31	Children's Community-Based Health Care Center	N/A
32	Community-Based Residential Rehabilitation Center	N/A
33	Long Term Acute Care Hospital	N/A
34	Clinical Service Areas Other than Categories of Service	91-93
35	Freestanding Emergency Center Medical Services	91-93
	Financial and Economic Feasibility:	94
36	Availability of Funds	95-103
37	Financial Waiver	95-103
38	Financial Viability	95-103
39	Economic Feasibility	104-105
40	Safety Net Impact Statement	106-121
41	Charity Care Information	122

Certificate of Good Standing

See attached for applicant OSF Healthcare System.



To all to whom these Presents Shall Come, Greeting:

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

OSF HEALTHCARE SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 02, 1880, 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 #: 1502902570

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 29TH day of JANUARY A.D. 2015

Jesse White

SECRETARY OF STATE

Proof of Site Ownership

See attached.

Attachment 2

AGENCY CUSTOMER ID: 1002087

LOC #: _____



ADDITIONAL REMARKS SCHEDULE

Page ____ of ____

AGENCY McLaughlin & Sons, Inc.		NAMED INSURED OSF Healthcare System	
POLICY NUMBER		Attn: Deb Crow 800 NE Glen Oak Ave Peoria, IL 61603	
CARRIER	NAIC CODE	EFFECTIVE DATE:	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 24 **FORM TITLE:** Certificate of Property Insurance

CERTIFICATE NUMBER:

REVISION NUMBER:

LOCATION OF PREMISES / DESCRIPTION OF PROPERTY

OSF St. Mary Medical Center, OSF Holy Family Medical Center OSF Saint Elizabeth Medical Center, OSF Saint Luke Medical Center, OSF Saint Anthony Health Center and OSF Saint Francis, Inc.

SPECIAL CONDITIONS / OTHER COVERAGES

Total OSF and SFI Insurable Value on Chubb Policy: \$3,911,094,181

Loss Limit of Insurance per Scheduled Locations: \$1,000,000,000 each Occurrence

Newly Acquired or Newly Constructed Limit: \$15,000,000 each Occurrence

Any Other Location Limit: \$5,000,000 each Occurrence

Earthquake: \$100,000,000 "Annual Aggregate" or \$1,000,000 Newly Acquired and Any Other Locations

Flood: \$100,000,000 or \$10,000,000 (depending on Flood Zone) or \$10,000,000 Newly Acquired Locations

All Risk of direct physical loss/damage to covered property including Earthquake, Water Damage, Flood and Terrorism (TRIA) unless otherwise excluded, Business Income including 90 days of Ordinary Payroll and Extra Expense from Covered Causes of Loss subject to Endorsements, Terms & Conditions of policy. Mobile diagnostic Equipment with attached Trailers are scheduled. Emergency Trailers and Contents were Scheduled when added to this policy effective 01/03/2013.

Additional Coverages include-the Mobile Diagnostic Equipment Property Damage Limit is \$5,000,000 for scheduled Mobile MRIs and the Mobile Medical Trailer Property Damage Limit is \$1,000,000 for scheduled Trailers while away from a scheduled premises. The Mobile Equipment Trailer BI & EE sublimit is \$500,000. Deductible: \$50,000 Refer to Statements of Value for the "Mobile Diagnostic Equipment". See all other policy documents for full terms and conditions.

**Operating Entity
Certificate of Good Standing**

See attached.

OSF Saint Anthony Medical Center is not separately incorporated, and as a result the only relevant good standing certificate is that of OSF Healthcare System.



To all to whom these Presents Shall Come, Greeting:

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

OSF HEALTHCARE SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 02, 1880. 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.



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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 29TH day of JANUARY A.D. 2015 .

Jesse White

SECRETARY OF STATE

Organization Chart

OSF Healthcare System
d/b/a OSF Saint Anthony Medical Center

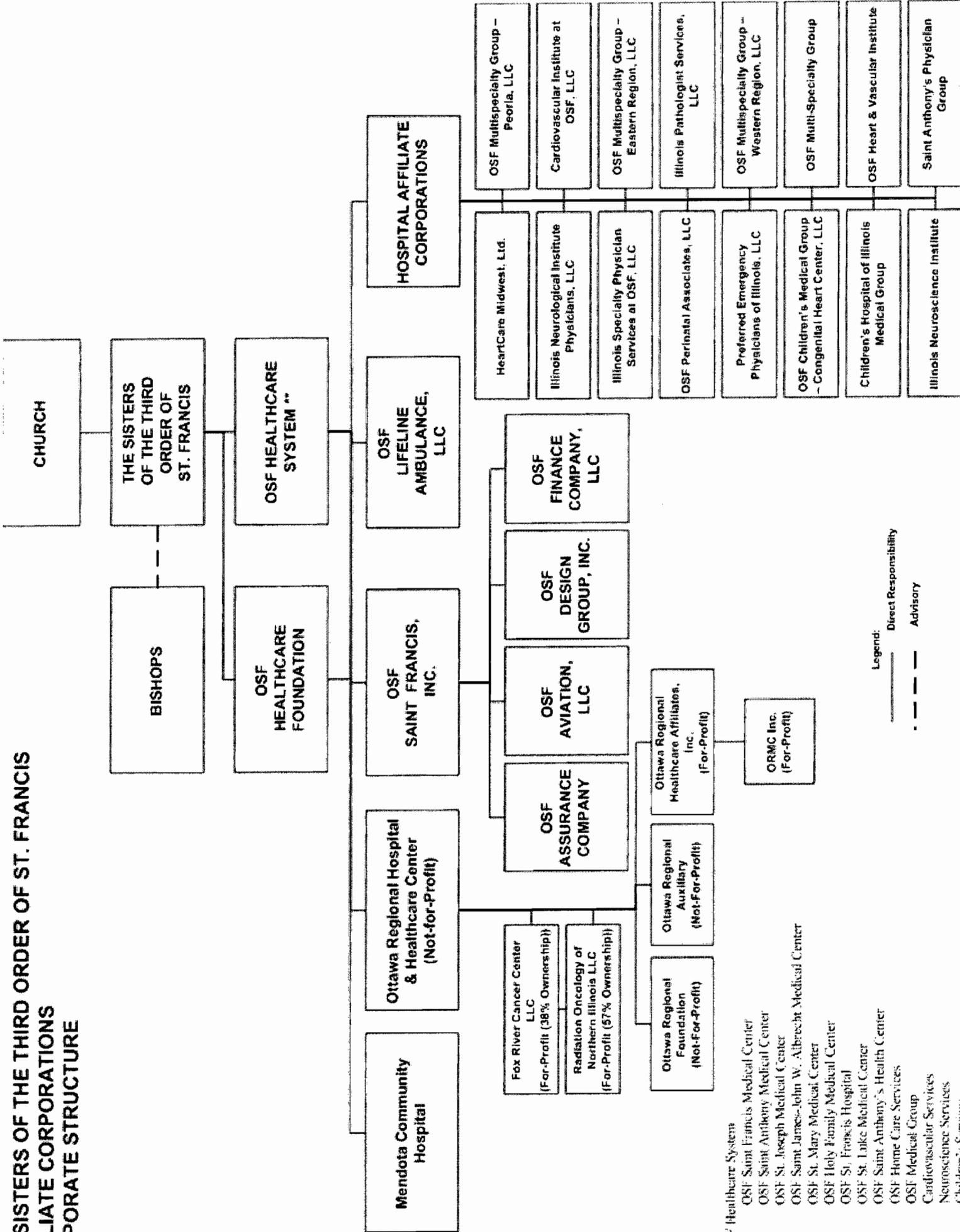
OSF Healthcare System,
an Illinois NFP



doing business as

OSF Saint Anthony Medical Center

THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS AFFILIATE CORPORATIONS CORPORATE STRUCTURE



Legend:
 — Direct Responsibility
 - - - Advisory

**OSF Healthcare System
 OSF Saint Francis Medical Center
 OSF Saint Anthony Medical Center
 OSF St. Joseph Medical Center
 OSF Saint James-John W. Albrecht Medical Center
 OSF St. Mary Medical Center
 OSF Holy Family Medical Center
 OSF St. Francis Hospital
 OSF St. Luke Medical Center
 OSF Saint Anthony's Health Center
 OSF Home Care Services
 OSF Medical Group
 Cardiovascular Services
 Neuroscience Services
 Children's Services
 Ambulatory Services

Flood Plain Map

See attached.

Attachment 5

LEGEND

PROPERTY
 1. 100% FIRM
 2. 75% FIRM
 3. 50% FIRM
 4. 25% FIRM
 5. UNINSURED
 6. UNINSURED (FIRM)
 7. UNINSURED (INDIVIDUAL)

CONSTRUCTION
 1. 100% FIRM
 2. 75% FIRM
 3. 50% FIRM
 4. 25% FIRM
 5. UNINSURED
 6. UNINSURED (FIRM)
 7. UNINSURED (INDIVIDUAL)

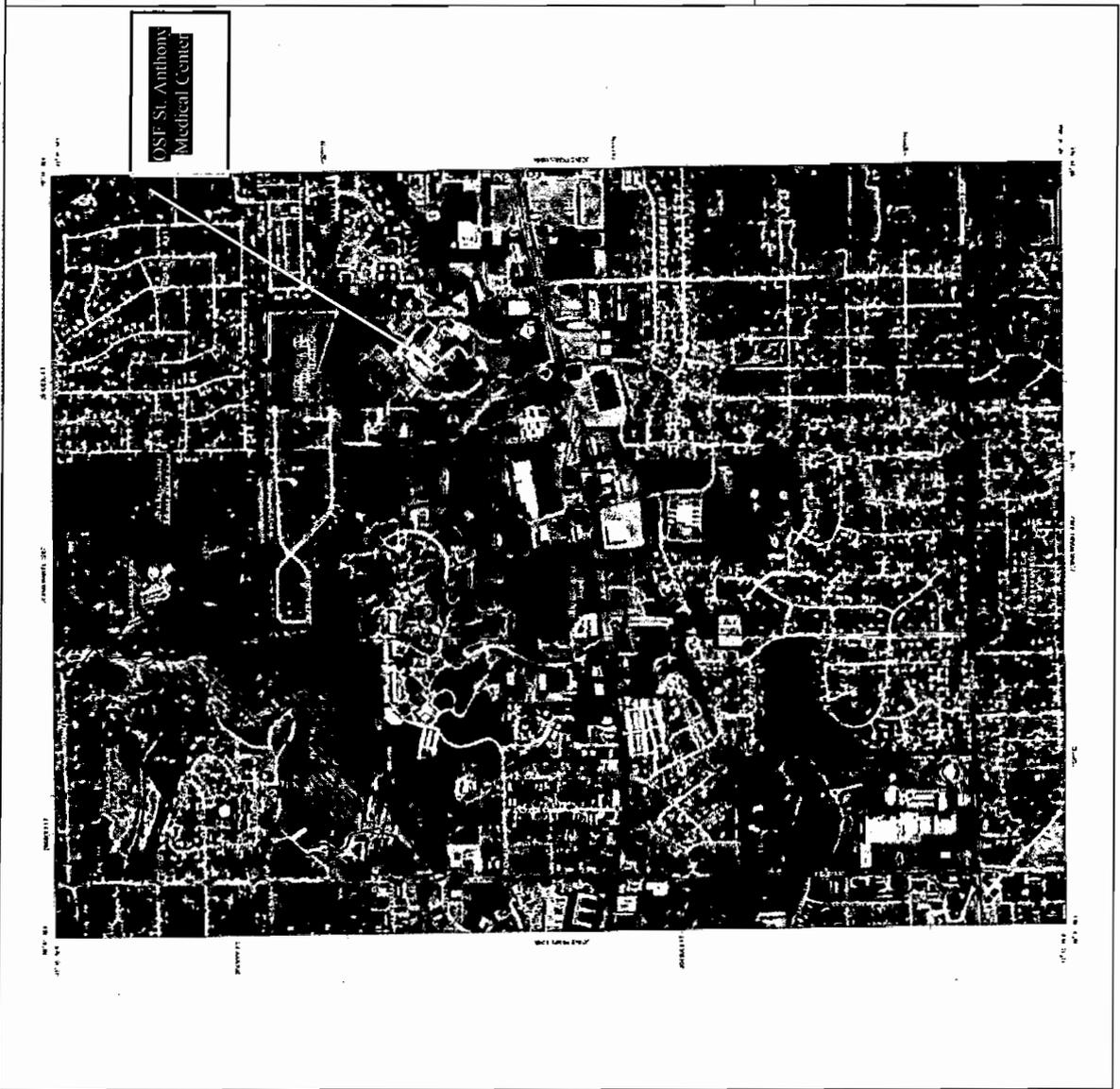
REMARKS
 1. 100% FIRM
 2. 75% FIRM
 3. 50% FIRM
 4. 25% FIRM
 5. UNINSURED
 6. UNINSURED (FIRM)
 7. UNINSURED (INDIVIDUAL)

NOTES TO USERS
 This map is a reproduction of the original map prepared by the National Flood Insurance Program. It is not a substitute for the original map. The original map is available for purchase from the National Flood Insurance Program. The original map is available for purchase from the National Flood Insurance Program. The original map is available for purchase from the National Flood Insurance Program.

NATIONAL FLOOD INSURANCE PROGRAM

FIRM
 FLOOD INSURANCE RATE MAP
 WINNEBAGO COUNTY,
 ILLINOIS
 AND INSURABLE AREAS

PANEL 208 OF 415
 MAP NUMBER
 1751020800
 EFFECTIVE DATE
 SEPTEMBER 8, 2010



NOTES TO USERS

This map is a reproduction of the original map prepared by the National Flood Insurance Program. It is not a substitute for the original map. The original map is available for purchase from the National Flood Insurance Program. The original map is available for purchase from the National Flood Insurance Program. The original map is available for purchase from the National Flood Insurance Program.

PANEL INDEX

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

I, Kevin Schoepfle, do hereby attest that the property located at 5666 E. State Street, Rockford, IL where OSF St. Anthony Medical Center is located is not in a flood plain, to the best of my knowledge.



Kevin Schoepfle
CEO, OSF Healthcare System

Historic Preservation Agency Letter

See attached.

Attachment 6



**Illinois Historic
Preservation Agency**

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX (217) 524-7525

www.illinoishistory.gov

Winnebago County

Rockford

CON - New Construction of 4 Story Building, OSF Saint Anthony Medical Center

5666 E. State St.

IHPA Log #018022715

March 11, 2015

Clare Connor Ranalli
McDermott Will & Emery
227 W. Monroe St.
Chicago, IL 60606-5096

Dear Ms. Ranalli:

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 217/785-5031.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

Items	Cost
Pre-Planning	\$623,248
Campus Master Plan	\$475,000
Other Consultant / PM Fees	\$148,248
Site Survey	\$35,000
Geotechnical & Surveying Services	\$35,000
Site Work	\$5,386,368
Site Preparation	\$1,750,000
Site Improvements	\$1,655,700
Site Utilities	\$1,855,368
Testing	\$125,300
Off-Site Work	\$0
New Construction Contracts	\$53,767,155
Construct New Bed Pavilion	
Modernization Contracts	\$1,332,072
Renovation of Existing for Building Tie-in	\$1,332,072
Contingencies	\$4,391,408
Architect / Engineering Fees	\$3,690,958
Architect / Engineering Basic Services	\$2,628,502
Enhanced Interior Design Services	\$280,000
Civil Engineering Services	\$75,000
Telecom Engineering Services	\$93,250
Equipment Planning Services	\$65,000
Reimbursable Expenses	\$145,000
Additional Consulting Services	\$404,206
Consulting & Other Fees	\$250,000
CON Preparation and Filing Fees	\$250,000
Movable / Other Equipment	\$7,220,530
1st Floor Prompt Care	\$289,970
1st Floor Women's Health	\$559,640
2nd Floor 26 Bed Med Surg - Cardiac	\$1,031,240
3rd Floor 26 Bed Med Surg - Ortho	\$855,740
4th Floor 26 Bed Med Surg	\$1,416,350
Other Misc Equipment	\$1,796,265
Furniture	\$1,271,325
Bond Issuance Expense	\$823,600
Net Interest Expense	\$6,888,172
Other Costs To Be Capitalized	\$883,682.00
Artwork	
Signage	
Miscellaneous	

Cost Space Requirements

Reviewable

Dept/Area	Cost	GSF		Amount of Proposed total GSF that is:			
		Exist.	Prop.	New Cust.	Mod ³	As Is	Vacated
Medical/Surgical	\$30,893,389	51,000	101,710	50,710	0	51,000	0
Ambulatory Care ¹	\$2,789,604	0	2,482	2,482	2,097	N/A	0
Imaging ²	\$4,037,890	5,400	6,628	6,628	0	4,005	0
Pharmacy	\$1,082,033	0	1,776	1,776	0	N/A	0

Non-Reviewable/Project Related

Lobby, Administrative, Pastoral Care, Weight Management, Salon, Patient Support for Palliative Care, Employee Health Wellness, Circulation, Elevator, Materials Management & Mechanical	Cost	GSF		Amount of Proposed total GSF that is:			
		Exist.	Prop.	New Cust.	Mod ⁴	As Is	Vacated
Non-Clinical	\$46,489,277						
		0	76,310	76,310	4,244	N/A	0

NOTE: The GSF of existing space in the current hospital that is not implicated by the project is not included in the above chart.

¹Walk in Clinic

²Diagnostic imaging (mammography/ultrasound) for Women's health

³The modernized space is current ambulatory care space that is used for lab draws which is adjacent to some of the non-clinical space to be modernized to allow for connectivity between the proposed and current hospital building.

⁴The modernized space is in the existing building which will be modernized to allow connection between the existing building and the new building. In addition, existing public bathrooms in the ED area will be modernized. The "existing space" for non-reviewable is project related to be modernized, and obviously not the total GSF of non-clinical space throughout the hospital.

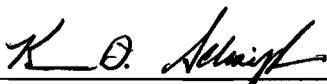
Background

1110.230

Attached are copies of the licenses/certifications for other hospitals owned by the applicant OSF Healthcare System.

No adverse action has been taken against the facilities over the past three (3) years.

HFSRB and IDPH are authorized to access documents necessary to verify information submitted, including official, licensing or certification records of Illinois or other states or records of certification agencies.



Kevin Schoepfle, CEO
OSF Healthcare System

Subscribed and sworn to before me this

16th day of April, 2015



Notary Public



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

HF107115

Illinois 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 Illinois Department of Public Health

Lamar Hasbrouck, MD, MPH

Acting Director

EXPIRATION DATE 12/31/2015	CATEGORY General Hospital	I.D. NUMBER 0002394
Effective: 01/01/2015		

**Saint Francis Medical Center
530 North East Glen Oak Avenue
Peoria, IL 61637**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 9/12

Exp. Date 12/31/2015
Lic Number 0002394

Date Printed 11/25/2014

Saint Francis Medical Center
530 North East Glen Oak Avenue
Peoria, IL 61637

FEE RECEIPT NO.

OSF Saint Francis Medical Center

Peoria, IL

has been Accredited by



The Joint Commission

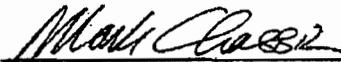
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

March 29, 2014

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7410
Print/Reprint Date: 06/09/2014


Mark R. Chassin, MD, FACP, MPP, MPH
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.





**Illinois Department of
PUBLIC HEALTH**

HF107117

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

**LaMar Hasbrouck, MD, MPH
Acting Director**

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/2015		0002535
General Hospital		
Effective: 01/01/2015		

**St. Joseph Medical Center
2200 East Washington Street
Bloomington, IL 61701**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

OSF St. Joseph Medical Center

Bloomington, 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

March 15, 2014

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7248

Print/Reprint Date: 05/16/2014

Mark R. Chassin, MD, FACP, MPP, MPH
President

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LaMar Hasbrouck, MD, MPH

Acting Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LIC NUMBER
12/31/2015	General Hospital	0002675
Effective: 01/01/2015		

**St. Mary Medical Center
3333 North Seminary Street
Galesburg, IL 61401**

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Exp. Date 12/31/2015
Lic Number 0002675

Date Printed 11/25/2014

**St. Mary Medical Center
3333 North Seminary Street
Galesburg, IL 61401**

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Nirav D. Shah, M.D., J.D.
Director

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the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
4/11/2016		0005439
Critical Access Hospital		
Effective: 04/12/2015		

Exp. Date 4/11/2016

Lic Number 0005439

Date Printed 3/20/2015

**OSF Holy Family Medical Center
1000 West Harlem Avenue
Monmouth, IL 61462**

**OSF Holy Family Medical Center
1000 West Harlem Avenue
Monmouth, IL 61462**

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O.S.F St. Mary Medical Center

Galesburg, IL

has been Accredited by

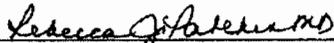


The Joint Commission

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

January 11, 2014

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7349
Print/Reprint Date: 03/24/2014


Mark R. Chassin, MD, FACP, MPP, MPH
President

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**Illinois Department of
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HF105694

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**LaMar Hasbrouck, MD, MPH
Acting Director**

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
5/14/2015		0005520
General Hospital		
Effective: 05/15/2014		

**Ottawa Regional Hospital & Healthcare Center
dba OSF-Saint Elizabeth Medical Center
1100 E. Norris Drive
Ottawa, IL 61350**

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Ottawa Regional Hospital and Healthcare Center

Ottawa, 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

September 13, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #7402
Print/Reprint Date 02/12/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

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**Illinois Department of
PUBLIC HEALTH**

HF107692

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Nirav D. Shah, M.D., J.D.

Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
3/31/2016	Critical Access Hospital	0005926
Effective: 04/01/2015		

**OSF St. Luke Medical Center
1051 West South Street
P.O. Box 747
P.O. Box 747
Kewanee, IL 61443**

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Exp. Date 3/31/2016

Lic Number 0005926

Date Printed 2/25/2015

**OSF St. Luke Medical Center
1051 West South Street
P.O. Box 747
Kewanee, IL 61443**

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Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
3/2/2016	General Hospital	0005264
Effective: 03/03/2015		

Saint James Hospital
2500 West Reynolds Street
Pontiac, IL 61764

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Exp. Date 3/2/2016
Lic Number 0005264

Date Printed 2/25/2015

Saint James Hospital
2500 West Reynolds Street
Pontiac, IL 61764

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Saint James Hospital

Pontiac, IL

has been Accredited by

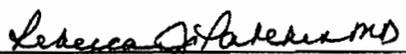


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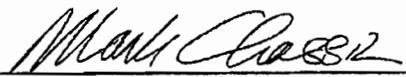
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

March 7, 2014

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7412
Print/Reprint Date: 05/22/2014


Mark R. Chassin, MD, FACP, MPP, MPH
President

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HF 107111

**Illinois Department of
PUBLIC HEALTH**



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LaMar Hasbrouck, MD, MPH

Acting Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LIC. NUMBER
12/31/2015	General Hospital	0002253
Effective: 01/01/2015		

**Saint Anthony Medical Center
5666 East State Street
Rockford, IL 61108**

Exp. Date 12/31/2015
Lic Number 0002253
Date Printed 11/25/2014

**Saint Anthony Medical Center
5666 East State Street
Rockford, IL 61108**

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51

OSF Saint Anthony Medical Center

Rockford, IL

has been Accredited by

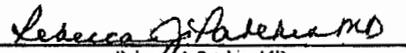


The Joint Commission

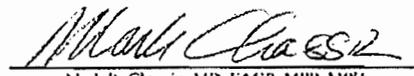
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

March 1, 2014

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7419
Print/Reprint Date: 12-09-2014


Mark R. Chassin, MD, FACP, MPP, MPH
President

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State of Illinois 1757033
Department of Public Health

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Lamar Hagbrouck, MD, MPR
Acting Director

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

EXPIRATION DATE	CATEGORY	ID NUMBER
10/31/15		0005942
General Hospital		
Effective: 11/01/14		

OSF Saint Anthony's Health Center
1 Saint Anthony's Way
Alton, IL 62002
2nd Campus at 915 East 5th Street
Alton, IL 62002

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State of Illinois 1757033
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION
OSF Saint Anthony's Health Center

EXPIRATION DATE	CATEGORY	ID NUMBER
10/31/15		0005942

General Hospital

Effective: 11/01/14

OSF Saint Anthony's Health Center
1 Saint Anthony's Way
Alton, IL 62002
2nd Campus at 915 East 5th Street
Alton, IL 62002

FEE RECEIPT NO.

Saint Anthony's Health Center

Alton, 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

January 21, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 7237
Print/Reprint Date: 04/30/12

Mark R. Chassin, MD, FACP, MPP, MPH
President

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ASSOCIATION



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Purpose (1110.230)

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.*

The primary purpose of the project is to address the limited space for medical surgical rooms and to expand the space to allow for private rooms, versus almost all semi-private rooms, which is the current situation (of the 190 beds, only 38 are in private rooms). The current semi-private rooms (almost 80% are semi-private in the MS category) create problems regarding infection control, patient privacy and patient stress. In addition, the current general room size of 242 GSF is small for a semi-private room. The new bed pavilion will allow for 100% private medical surgical rooms that will accommodate modern equipment, including beds and related monitoring machines. This will improve overall patient care and well-being.

Diagnostic imaging for women's services consisting of mammography and ultrasound will be moved to the new space. The current mammography space is located in the acute care hospital building which is congested and not conducive to a stress free outpatient breast imaging and guided biopsy experience. The current space must be vacated to allow for circulation between the existing hospital building and the new pavilion. The planned new space for women's health will be user friendly, with ample changing room, separate waiting areas for patients who are waiting screening imaging versus diagnostic, and space for biopsies and radiologist consultation. It will include ultrasound testing as it relates to breast imaging and guided biopsy procedures. The current women's health space is 5,400 GSF and the new space will be 6,628 GSF. The vacated space will be used for connecting corridors and back fill.

A new 2,482 GSF prompt-care clinic will be in the proposed bed pavilion (none exists currently). It will be user friendly, with a large waiting area, which is an important space in a walk-in clinic. The walk-in clinic is designed to accommodate some patients (as appropriate) from the ED, which should reduce healthcare costs and allow ED staff to focus on true emergency care.

The new space will host a non-hospital owned/operated retail pharmacy which will be convenient for all of the hospital's patients.

In addition to the clinical services above, the first floor of the bed pavilion will have a lobby with a coffee shop, a salon (for convenience of the women seen at the women's health center), a weight management area with a kitchen for healthy cooking classes and meeting rooms for weight watchers or similar healthy diet programs, employee health and wellness, offices with counselors for those patients (or family members) who want information and/or support relating to palliative care, pastoral care and administrative space.

Purpose

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

The market area is that of the existing hospital, including the greater Rockford and surrounding areas. Attached is a list of primary zip codes served by OSF Saint Anthony Medical Center, and a map of the service area.

OSF Saint Anthony Medical Center Primary Market Zip Code Area

Zip Code	Zip Type	Community	County	One OSF	CY13	CY14	CY13	CY14
					Inpatient	Inpatient	Outpatient	Outpatient
61008	Standard	Belvidere	Boone	Primary	1,215	1,284	17,908	19,620
61108	Standard	Rockford	Winnebago	Primary	1,138	1,060	22,081	22,470
61107	Standard	Rockford	Winnebago	Primary	1,042	1,000	20,197	21,112
61109	Standard	Rockford	Winnebago	Primary	718	698	15,526	16,312
61111	Standard	Loves Park	Winnebago	Primary	635	666	16,422	17,221
61115	Standard	Machesney Park	Winnebago	Primary	639	645	16,694	17,524
61114	Standard	Rockford	Winnebago	Primary	573	535	12,763	13,417
61068	Standard	Rochelle	Ogle	Primary	352	360	1,696	1,918
61104	Standard	Rockford	Winnebago	Primary	302	352	6,280	6,728
61073	Standard	Roscoe	Winnebago	Primary	421	333	8,651	9,536
61103	Standard	Rockford	Winnebago	Primary	332	330	9,819	10,175
61065	Standard	Poplar Grove	Boone	Primary	296	303	5,887	6,511
61102	Standard	Rockford	Winnebago	Primary	280	287	5,798	5,967
61101	Standard	Rockford	Winnebago	Primary	209	230	6,273	6,733
61016	Standard	Cherry Valley	Winnebago	Primary	169	192	3,740	3,618
61072	Standard	Rockton	Winnebago	Primary	135	140	3,780	3,958
61080	Standard	South Beloit	Winnebago	Primary	87	93	2,079	2,595
61011	Standard	Caledonia	Boone	Primary	77	78	1,671	1,700
61020	Standard	Davis Junction	Ogle	Primary	47	66	951	1,055
60146	Standard	Kirkland	DeKalb	Primary	69	59	883	880
61012	Standard	Capron	Boone	Primary	50	55	813	921
61038	Standard	Garden Prairie	Boone	Primary	33	36	502	609
61052	Standard	Monroe Center	Ogle	Primary	23	28	500	570
61112	Standard	Rockford	Winnebago	Primary	18	24	240	126
61125	PO Box	Rockford	Winnebago	Primary	8	11	185	188
61105	PO Box	Rockford	Winnebago	Primary	5	8	174	190
61049	Standard	Lindenwood	Ogle	Primary	4	6	133	154
61126	PO Box	Rockford	Winnebago	Primary	10	6	387	216
61110	PO Box	Rockford	Winnebago	Primary	2	5	127	101
61131	PO Box	Loves Park	Winnebago	Primary	2	3	43	63
60129	Standard	Esmond	DeKalb	Primary	4	2	37	41
61132	PO Box	Loves Park	Winnebago	Primary	5	2	202	209
61106	PO Box	Rockford	Winnebago	Primary	2	-	44	28
61130	PO Box	Loves Park	Winnebago	Primary	-	-	10	13
					8,902	8,897	182,496	192,479

% of Total Cases	80.0%	79.7%	88.0%	88.4%
Total All Service Areas	11,134	11,158	207,304	217,725

Source: HBI Utilization Highlight

Purpose

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.]*

See #1. Generally, the issues to be addressed relate to the need for space for private medical surgical bed rooms, to provide an onsite prompt care clinic and more user friendly and enhanced space for womens' health services.

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

The hospital's data and statistics: U.S. Census Bureau Statistics. IDPH population projections.

Purpose

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

The project will enhance patient care, as follows:

- Private rooms reduce patient stress and hospital acquired infections;
- Private rooms allow for patient privacy;
- The larger rooms/space allow for family visiting capacity and sleep over, which improves patient care and comfort;
- The new pavilion will allow for more modern equipment and bed sizes in all medical surgical rooms;
- Patients will no longer have to share a toilet or shower;
- The women's health area will be more patient-friendly with expanded changing areas, waiting areas and rooms allowing for private consultations regarding results of exams;
- The new walk-in clinic will reduce unnecessary utilization of the ED, which will reduce wait times, provide a better environment of care and reduce costs; and
- The new retail pharmacy will be convenient for patients and can link to the Hospital's records for hospital patients, which will allow for reduced medication errors. With over 10,500 annual discharges and 214,000 outpatient visits, a majority of which result in a script for medication which must be filled, the on-site pharmacy will be convenient for OSF SAMC patients.

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

A goal of the project is to reduce infection control and privacy issues associated with semi-private rooms. In addition, a goal is to provide a larger room for medical surgical inpatients, with private baths and space for modern beds and related equipment. Another goal is to provide for user friendly outpatient areas including womens' health services and ambulatory care. Lastly, an ancillary goal is to provide convenient retail pharmacy services for the Hospital's outpatients and inpatients. The time frame for achieving the goal(s) is March 31, 2018 (the completion date for the modernization project).

Size of Project

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE (actual size)	MET STANDARD?
Clinical				
Medical surgical	101,710	550 DGSF per room	535	Yes
Ambulatory Care	2,482/6 RMS	800 DGSF per room	414	Yes
Dx Imaging*	6,803/4 Mammo 2 US	900 DGSF per equipment	1,134	No (see justification)
Pharmacy	1,631	N/A	N/A	N/A
Non Clinical	76,310**	N/A	N/A	N/A

The clinical space consists of inpatient bed space (medical surgical) and Clinical Service Areas other than categories of service, including diagnostic imaging for women's health and ambulatory services (a prompt care clinic).

The new construction non-clinical space includes a lobby, coffee shop, weight management, palliative care support services, pastoral care and administrative space.

*Women's Center

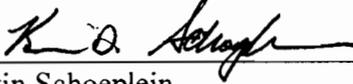
**New construction only

Justification For Overage on Women's Health: The new women's health space includes rooms for consultations and other women's health services besides simply imaging. It will include bone densitometry testing, rooms for consult and education rooms regarding positive test results. The standards relate to pure imaging services and the women's health area is a combined imaging and comprehensive women's health center.

1110.530

(b) Background of applicant

The applicant is OSF Healthcare System is a not for profit corporation. No person has an ownership interest in it. None of its Board members or officers have been convicted of a crime, and OSF Healthcare System and its licensed hospitals have not had any adverse actions taken against them. In addition, OSF Healthcare System is not in default of any judgment or governmental obligation.



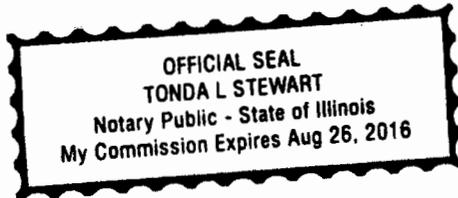
Kevin Schoepflein
CEO OSF Healthcare System

Subscribed and sworn to before me this

15th day of April, 2015



Notary Public



1110.530

(e) Deteriorated Facilities

1) The facilities are functionally obsolete as all medical surgical (“MS”) rooms at the Hospital are semi-private, and share a toilet. The rooms are approximately 275 GSF smaller than the state standard and yet there are two beds in the room. The rooms are not up to standard regarding infection control (patients share a bathroom) or privacy. Thirteen rooms do not have showers, requiring patients to use a communal shower area. In addition certain medical equipment is difficult to place at bedside given the size of the rooms and the fact they are semi-private. While the facility is ADA compliant based on its age it does have accessibility barriers that are inherent in its overall structure.

There are no IDPH or Joint Commission citations pertaining to the current MS rooms. However, attached is literature regarding the efficacy of private rooms as they improve quality of care, provide privacy and reduce stress on patients and their families.

The project does not involve an increase in MS beds. The service anticipates it will meet occupancy standards based on recent census and IDPH data projecting general population growth and aging population growth, and a peak census of 186 as recently as in this year (2015).

See attached information regarding historical utilization.

Architects endorse private hospital rooms

Recommend 0
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+1 0

Building design could cut down on medical errors, help stop infection

AP Associated Press
updated 7/17/2006 9:03:17 PM ET

CHICAGO — Private rooms would be standard in new U.S. hospitals under recommendations from an influential architects' group that says building design can help curb infectious diseases and medical errors.

Recommendations on hospital design from the American Institute of Architects are used as the basis for regulations in 42 states, and private rooms are increasingly favored by hospitals nationwide to address safety, noise and privacy issues, said Dale Woodin of the American Hospital Association.

Woodin is on a panel of the architects institute that created the 2006 guidelines, which involve adult acute-care hospitals and are to be highlighted at a Wednesday news conference in Chicago.

The panel includes doctors, hospital administrators, infection control experts, engineers and architects who voted unanimously to adopt the recommendations.

"This represents the most recent and the best thinking from a group that is solely dedicated to health care architecture," Woodin said Monday.

Less chance for mistakes

Woodin said single-patient rooms "reduce the potential" for doctors and nurses to misidentify patients, and decrease chances that sick patients will transmit disease to other patients and staff members.

"Patients are more willing to talk to their doctors if they don't feel they have an audience," said George Mills, a senior engineer at the Joint Commission on Accreditation of Healthcare Organizations, a hospital regulatory group.

Mills said his group supports the panel recommendations but does not require hospitals it accredits to have private rooms for patients.

Single-patient rooms are the best way for hospitals to comply with federal privacy rules, and anecdotal evidence shows most patients prefer them, panel members say.

Faster recovery, reduced cost

By improving patient satisfaction and potentially speeding recovery and reducing hospitalization time, private rooms also can help reduce costs, said panel member Joseph Sprague, a Dallas architect.

The recommendations for new hospital construction affect patients in medical and surgical units as well as mothers who have just given birth. They don't affect newborn nurseries, psychiatric units or geriatric facilities where some patients do better having roommates.

The recommendations "certainly make a lot of sense," said Jean Przybylek, vice president of operations for women's health at Chicago's Northwestern Memorial Hospital, which has had only private rooms since 1999. A new women's facility at Northwestern to open next year will extend that policy to a unit for premature infants and other babies with special needs, she said.

Illinois is among states that have adopted previous design recommendations from the group and will review the new ones, said Enrique Unanue, an architect with Illinois' Department of Public Health and a panel member.

"This is a great thing for patient outcomes," he said. "Everything pointed toward doing this."

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More women opting for preventive mastectomy - but should they be?



Rates of women who are opting for preventive mastectomies, such as Angelina Jolie, have increased by an estimated 50 percent in recent years. But many doctors are puzzled because it doesn't carry a 100 percent guarantee, it's more and women have other options, from a once-a-year careful monitoring.

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Report questioning salt guidelines riles health

CDC: 2012 was deadliest year for West Nile

What stresses moms most? Themselves, not

THE GLOBE AND MAIL 

Private hospital rooms lower risk of C. difficile

ANDRÉ PICARD

From Wednesday's Globe and Mail

Published Wednesday, Jan. 06 2010, 12:00 AM EST

Last updated Thursday, Aug. 23 2012, 1:47 PM EDT

The more roommates you have during a hospital stay, the greater your risk of acquiring a dangerous infectious disease such as *Clostridium difficile*, according to new Canadian research.

The study, published in the *American Journal of Infection Control*, shows that each roommate a patient is exposed to hikes his or her risk of infection by 10 per cent.

"That is a significant risk," Dick Zoutman, a professor of community health and epidemiology at Queen's University in Kingston, Ont., said in an interview. He noted that, in Canada, most hospital rooms have either two or four beds and "there is a lot of turnover," meaning that patients are routinely and unnecessarily exposed to a lot of infectious diseases.

Dr. Zoutman said that the research provides powerful evidence that single rooms are the safest, and should be the norm. "The take-home message is that our hospitals should be designed with private rooms for everyone," he said.

While there would be an up-front cost, Dr. Zoutman noted that, over the long-term, savings would be substantial: "This research provides the direct proof that should settle the discussion about the need for private rooms."

Earlier research showed that about 225,000 patients a year suffer from hospital-acquired infections that substantially extend their stays, and between 8,000 and 12,000 people die annually as a result. infection 4

The new study was conducted at Kingston General Hospital, which has 451 in-patient beds and about 17,000 patients a year. There are 107 single-occupancy rooms, 83 double-occupancy, six triple-occupancy and 19 quadruple-occupancy, plus open bay areas and specialized units such as intensive care.

The study, which began as a master's thesis by Queen's student Meghan Hamel, examined patient records from 2001 to 2006. The research team looked for patients who suffered from three common but dangerous infections - *C. difficile*, methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant *Enterococcus* (VRE) - and examined those patients' exposure to other patients.

For each roommate to whom a patient was exposed, the risk of contracting C. difficile increased 11 per cent; for MRSA, 10 per cent, for VRE, 15 per cent.

The median number of roommates was just over two, but some patients had as many as 46 roommates, whether due to a lengthy stay or to a heavy rotation of roommates.

Dr. Zoutman, who is also head of infection control at Kingston General, said that although the research was conducted at only one institution, "it is pretty typical of a Canadian hospital, and there is no reason to think this situation doesn't exist everywhere."

The infections that were studied - C. difficile, MRSA and VRE - are not airborne, but spread by contact.

Dr. Zoutman said the likely reason that roommates increase the risk of infection is that patients share a washroom. (The mantra in infection control is: One bum per toilet.) Another likely explanation involves inadequate handwashing by patients and health professionals alike; doctors sometimes don't wash their hands between patient visits in a single room.

"The goal should be private rooms, or at the least, semi-private rooms," Dr. Zoutman said. "But in the meantime, there are things we can do: We should be cleaning our hands, and we should really scrutinize how we clean our hospitals."

1110.530(d)(4) - Occupancy

Category of Service	Board Occupancy Standard	CY12	CY13	CY14
Medical/Surgical	75%	60%	62%	61%

Medical/Surgical Utilization

Medical/Surgical

Medical/Surgical	CY12	CY13	CY14
Admissions	7,510	7,909	7,847
Patient Days	36,036	37,890	37,502
Observation Days	5,730	5,480	4,642
TOTAL Days	41,776	43,370	42,144
ADC	115	119	116
Beds	190	190	190
Occupancy	60%	62%	61.1

Data reported on the Annual Hospital Questionnaire represent utilization based upon the midnight census. For Saint Anthony Medical Center, the midnight census represents the lowest point in the day for occupancy. Typical peak daily census occurs between 9:00 AM and 1:00 PM. There are several factors that contribute to this phenomenon, including the timing of discharges, incoming surgical admissions, emergency department volumes, day of week and outpatients occupying beds that are not observation patients.

The impact is as follows:

Discharge Day Census:

- The vast majority of discharges are generated out of the medical/surgical units. Typically, discharges occur beginning in the morning and peak between the hours of noon and 5:00 PM. An analysis was performed and, on average, 16 patients are occupying beds during the day time hours of peak activity that are not counted in the midnight census.
- Emergency department activity, of course, occurs throughout the 24-hour period of the day. As a result, admissions are occurring throughout the early morning hours and continue throughout the entire day. As admissions occur throughout the day, these contribute to needing additional beds prior to having enough discharges occurring to free up bed space. This overlap of activity is not represented in the midnight census counts and is best captured by the analysis noted in the previous bullet point.

Day of week:

- Saint Anthony Medical Center has a higher than typical ratio of surgical patients than medicine patients. Surgical patients are often able to be scheduled and those cases are performed on weekdays. As a result, the census at Saint Anthony Medical Center is typically higher on weekdays than on weekends and, on average, represents 3 additional patients per day.

Outpatients in a Bed:

- For certain patients, primarily those receiving catheterization lab services or surgical services, there is a need to recover those patients in an inpatient bed. These patients are not counted in the midnight census as observation charging is not appropriate. These patients represent approximately 1 patient per day.

ICU patients receiving medical/surgical Services:

- Due to issues surrounding unavailable medical/surgical beds, patients need to be boarded in the ICUs while waiting for transfer to a medical/surgical bed. These patients represent slightly less than 1 patient per day, on average.

The above circumstances increase daily census by 21 patients per day. When added to the midnight census data noted on the Annual Hospital Questionnaire, the percentage of occupancy in 2014 to 72.1%.

OSF SAMC's combined medical/surgical admissions has increased slightly or remained level over the last three years. Although historical utilization does not support OSF SAMC's current 190 MS beds, Rockford is the second largest city in Illinois and is growing (see attached). The Rockford Metro area grew from 320,176 to 349,431 from 2000 to 2010. Its projected total population in 2019 is 355,766 (approximate 11% growth rate over 19 years). Also see attached for Boone and Winnebago counties, which reflects significant population growth for these counties which OSF SAMC serves. More importantly to projected need for medical surgical beds is the growth in payers 65 and older. From 2000 to 2010 there was a 22.6% increase in ages 65-74 and 2.8% increase in ages 75 to 84. From 2014 to 2019 the increase is projected to increase by 24.2% for ages 65 to 74 and by 11.2% for ages 75 to 84. Patients ages 65 and older utilize inpatient hospital beds at a significantly higher percentage than the general population (see attached). According to SG2, for the Rockford region population growth and the aging of the current population is expected to generate a growth in admissions of 2.8% over the 10-year period of 2011 to 2020. When applying these circumstances to the OSF SAMC utilization, 2 years after the occupancy of the new bed configuration an additional 566 admissions are expected to occur. Multiplying these admissions by an average length of stay of 4.8 days, an additional 2,717 patient days are generated or an additional average daily census of approximately 8 inpatients. Furthermore, additional outpatient observation cases equate to an additional increase in average daily census of 1. If for whatever reason this growth does not occur, OSF SAMC plans to de-commission beds in the old hospital building, as these rooms are less likely choices for patient occupancy.

Combining all of the factors above indicates a need to accommodate an average of 146 medical/surgical patients per day. Applying the 75% ratio to 190 beds indicates an ability to accommodate 142 patients per day.

As recently as January, 2015, Saint Anthony Medical Center encountered a peak census of its medical/surgical units totaling 186 patients for combined inpatient and observation cases, which equates to 98% occupancy.

Table 3. Population Projections for Illinois Counties: 2010 to 2025 (as of July 1 of the specified years, except as noted)

State/County	Census April 1, 2010 ¹	Estimate 2010 ¹	Projections			2015- 2020 % Change	2015- 2025 % Change
			2015	2020	2025		
Illinois	12,830,632	12,841,980	12,978,800	13,129,233	13,263,662	1.2%	2.2%
Boone	54,165	54,176	57,712	61,503	65,315	6.6%	13.2%
Winnebago	295,266	295,142	298,259	302,259	306,088	1.3%	2.6%

¹ U.S. Census Bureau, 2010 Census

Source: Illinois Department of Public Health, Illinois Health Facilities and Services Review Board, Certificate of Need Population Projections Project, 2014

Boone & Winnebago Combined

Number of discharges from short-stay hospitals, by first-listed diagnosis and age: United States, 2010

[Discharges of inpatients from nonfederal hospitals. Excludes newborn infants. Diagnostic groupings and code numbers are based on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)]

Category of first-listed diagnosis and ICD-9-CM code	All ages		Under 15 years		15-44 years		45-64 years		65 years and over	
	Number	SE \ I	Number	SE \ I	Number	SE \ I	Number	SE \ I	Number	SE \ I
All conditions	35,079	3,746	1,974	528	10,031	1,081	9,483	991	13,591	1,440
Infectious and parasitic diseases					Number in thousands					
Septicemia	1,356	162	*	*	195	24	361	44	690	80
Neoplasms	808	97	*	*	65	11	212	29	524	64
Malignant neoplasms	1,400	239	*	*	251	30	643	77	673	82
140-209.36, 209.70-209.75, 209.79, 230-234	1,212	143	*	*	121	17	474	60	590	73
Malignant neoplasm of large intestine and rectum	136	18	*	*	*8	*2	54	9	74	12
Malignant neoplasm of trachea, bronchus, and lung	162,176.4, 197.0, 197.3, 209.21		*	*	*	*	57	10	116	17
Benign neoplasms	209.4-209.6, 210-229		*	*	124	16	150	19	57	10
Endocrine, nutritional and metabolic diseases, and immunity disorders	218-219		*	*	89	12	98	15	*	*
Diabetes mellitus	240-279		*	*	379	48	630	74	671	76
Volume depletion	249,250		*	*	167	24	255	29	198	25
Diseases of the blood and blood-forming organs	276.5		*	*	34	6	53	8	149	22
Anemias	280-289		51	14	138	21	116	14	225	29
Mental disorders	280-285		19	5	112	17	80	11	180	24
Psychoses	290-319		*	*	1,024	174	660	92	265	44
Schizophrenic disorders	290-299		*	*	742	143	495	74	209	41
Major depressive disorder	296.2-296.3		*	*	131	24	111	21	*	*
Diseases of the nervous system and sense organs	320-389		*	*	196	46	129	22	*	*
Diseases of the circulatory system	390-459		*	*	231	33	310	45	377	59
Essential hypertension	401		*	*	418	51	1,773	201	3,587	387
Heart disease	391-392.0, 393-398, 402, 404, 410-416, 420-429		*	*	47	8	131	20	101	16
Acute myocardial infarction	410		398	*	233	32	1,121	128	2,359	249
Coronary atherosclerosis	414.0, 414.2, 414.3		67	*	25	4	215	27	354	40
Other ischemic heart disease	411-413, 414.1, 414.8-414.9		103	*	28	5	247	34	373	52
Cardiac dysrhythmias	427		767	*	*10	*3	47	7	46	9
Congestive heart failure	428.0, 428.2-428.4		1,009	115	49	8	208	27	504	55
Cerebrovascular disease	430-438		1,015	139	49	8	234	31	720	82
Diseases of the respiratory system	460-519		3,446	408	317	41	867	95	663	94
Acute bronchitis and bronchiolitis	466		173	37	128	34	*	*	1,730	197
Pneumonia	480-486		1,128	140	156	36	14	*3	24	6
Chronic bronchitis	491		614	79	*	*	257	31	621	76
Asthma	493		439	66	*13	*3	203	29	398	52
Diseases of the digestive system	520-579		3,473	370	90	17	118	14	103	13
Appendicitis	540-543		275	40	154	39	822	94	13	13
Noninfectious enteritis and colitis	555-558		385	47	52	15	139	22	1,329	143
Intestinal obstruction	560		300	32	23	6	106	14	9	4
Diverticula of intestine	562		334	39	*9	*2	84	13	109	16
Cholelithiasis	574		276	35	54	10	117	14	205	27
Acute pancreatitis	577.0		245	35	111	16	102	13	156	18
Diseases of the genitourinary system	580-629		158	22	90	14	112	15	119	16
Calculus of kidney and ureter	592		558	68	459	63	583	70	70	11
Urinary tract infection	599.0		488	68	59	9	63	11	34	6
Complications of pregnancy, childbirth, and the puerperium \ 2	630-679		743	82	485	68	485	68	420	51
Diseases of the skin and subcutaneous tissue	680-709		71	18	192	25	243	27	238	25

Number of discharges from short-stay hospitals, by first-listed diagnosis and age: United States, 2010

[Discharges of inpatients from nonfederal hospitals. Excludes newborn infants. Diagnostic groupings and code numbers are based on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)]

Category of first-listed diagnosis and ICD-9-CM code	All ages		Under 15 years		15-44 years		45-64 years		65 years and over	
	Number	SE \ I	Number	SE \ I	Number	SE \ I	Number	SE \ I	Number	SE \ I
Number in thousands										
Cellulitis and abscess	681-682	603	63	49	11	164	21	203	22	187
Diseases of the musculoskeletal system and connective tissue	710-739	2,301	295	28	7	267	38	940	122	1,065
Osteoarthritis and allied disorders	715	1,057	152	*	*	31	6	453	71	570
Intervertebral disc disorders	722	318	49	*	*	87	15	157	28	75
Congenital anomalies	740-759	174	43	*	*	29	6	27	5	20
Certain conditions originating in the perinatal period	760-779	*	*	*	*	*	*	*	*	*
Symptoms, signs, and ill-defined conditions	780-799	185	41	*	*	42	8	*	*	*
Injury and poisoning	800-999	2,984	376	162	48	690	91	857	107	1,276
Fractures, all sites \3	800-829	1,113	156	*	*	202	33	255	42	586
Fracture of neck of femur	820	306	39	*	*	*	*	39	8	258
Poisonings	960-989	260	31	*	*	128	17	89	12	30
Certain complications of surgical and medical care	996-999	1,017	135	*	*	179	29	379	51	434
Supplementary classifications	V01-V89	4,767	524	*	*	4,092	458	240	38	348
Females with deliveries	V27	3,951	448	*	*	3,941	446	*	*	...

* Figure does not meet standards of reliability or precision. Estimates preceded by the asterisk should be used with caution.

... Category not applicable.

\1 SE is standard error.

\2 First-listed diagnosis for females with deliveries is coded V27, shown under "Supplementary classifications".

\3 Excludes fractures coded as 733.1, pathologic fracture.

SOURCE: CDC/NCHS National Hospital Discharge Survey, 2010.

More information about survey methodology can be found at:

http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHDS_2010_Documentation.pdf.

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Hospital Utilization among Oldest Adults, 2008

Lauren Wier, M.P.H., Anne Pfuntner, B.U.E.P., and Claudia Steiner, M.D., M.P.H.

Introduction

Between 2010 and 2030, the U.S. population age 65 and older is projected to grow by 79 percent from 40 million to 72 million, while the total U.S. population will grow by 20 percent.¹ By 2030, about one in five Americans will be over 65, up from one in eight Americans in 2010. Among the elderly, the population 75 and older will increase by 77 percent between 2010 and 2030, accounting for nearly half of the growth in the elderly population.

The growth of the elderly population has many implications for the U.S. health care system, including a higher demand for health services contributing to ever increasing health care costs. Adults 65 and older accounted for about 34 percent of personal health care spending in 2004,² even though they comprised only 12 percent of the population.¹ Health care costs for patients over 65 are three to five times higher than costs for patients under 65. As the elderly population grows, these higher costs are projected to result in a 25 percent increase in the United States' health care spending by 2030.³ This growth has implications for spending through federal programs, such as Medicare, which accounted for \$444 billion, or 23 percent of health care spending in 2008⁴ and 13 percent of the U.S. federal budget.⁵

¹ Calculated using the 2008 National Population Projections from the U.S. Census Bureau. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the U.S.: July 1, 2000 to July 1, 2050. Released 2008.

<http://www.census.gov/population/www/projections/downloadablefiles.html>

² National Health Expenditure Accounts.

<http://www.cms.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf>

³ Centers for Disease Control and Prevention and The Merck Company Foundation. The State of Aging and Health in America 2007. Whitehouse Station, NJ: The Merck Company Foundation; 2007.

⁴ Medicare Payment Advisory Commission. A Data Book: Healthcare Spending and the Medicare Program. June 2010.

<http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf>

⁵ Calculated using the Budget of the United States Government, Fiscal Year 2008, Table S-7. Budget Summary by Category. Office of Management and Budget, Washington, D.C. 2007.

<http://www.gpoaccess.gov/usbudget/fy08/browse.html>

Highlights

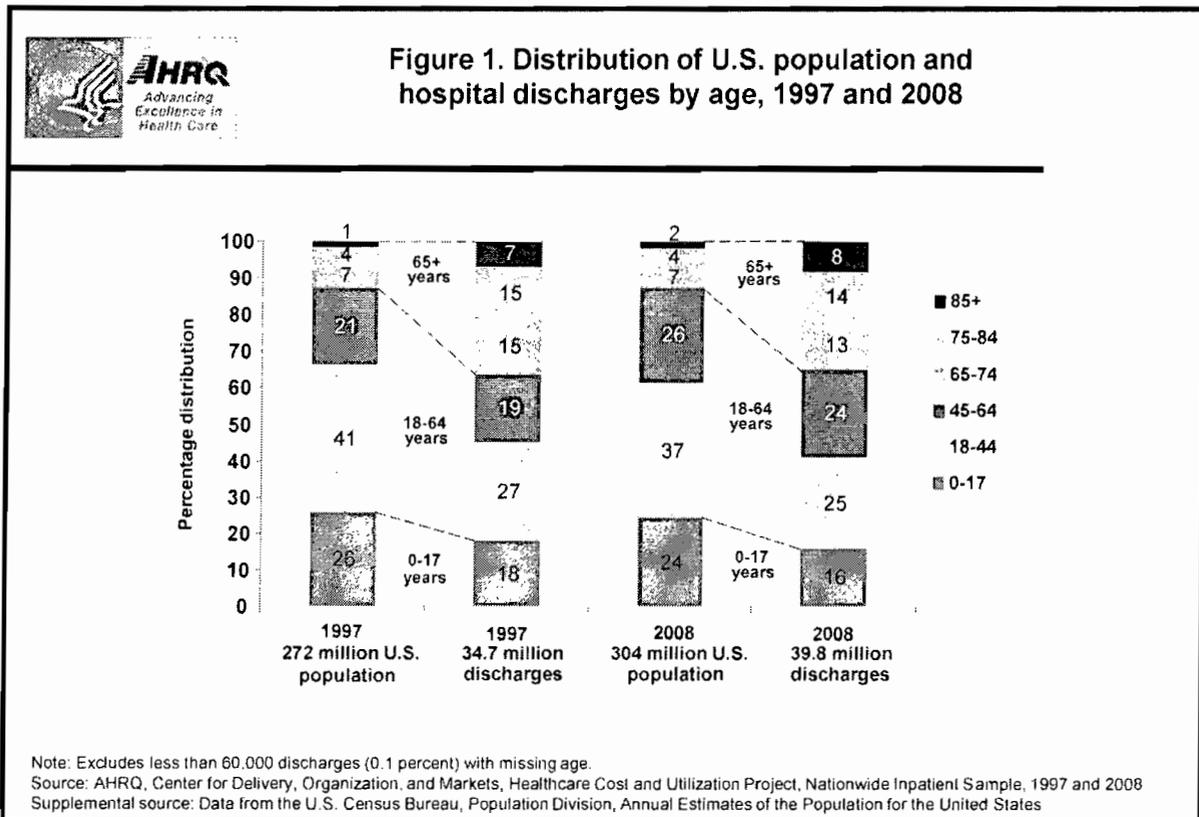
- Oldest adults made up a larger share of hospital discharges relative to their population size. In 2008, adults 85 and older accounted for only 1.8 percent of the population but 8.0 percent of all discharges; 75–84 year olds comprised 4.3 percent of the population but accounted for 13.8 percent of all discharges.
- Adults 85+ accounted for a relatively small share of hospital discharges (8 percent overall), but were more than twice as likely to be hospitalized as 65–74 year olds (577 versus 264 stays per 1,000 population).
- Increasing age was associated with a greater proportion of stays discharged to long-term care facilities, such as nursing homes. Indeed, patients 85 and older were about 2.5 times more likely to be discharged to long-term care than 65–74 year olds.
- Congestive heart failure was the most common reason for hospitalization among 75–84 year olds (23.2 stays per 1,000 population) and those 85+ (44.4 stays per 1,000 population). Other common conditions for those 75 and older were pneumonia, cardiac dysrhythmias, and septicemia.
- Blood transfusion was, by far, the most common procedure performed on any patient age 65 and older. Compared to 65–74 year olds, transfusion rates were 1.7 times higher for 75–84 year olds and 2.4 times higher for those 85+.

This Statistical Brief presents data from the Healthcare Cost and Utilization Project (HCUP) comparing patient characteristics and hospital utilization among the oldest adults, ages 75–84 and 85 plus, to those adults ages 65–74. In addition, this report examines the diagnoses most often associated with elderly hospitalizations and the procedures that are performed most frequently during these stays. All differences between estimates noted in the text are statistically significant at the 0.05 level or better.

Findings

In 2008, there were more than 14 million hospital stays among adults ages 65 years and older. These hospitalizations accounted for more than one-third of all U.S. community hospital stays and about 14 percent (\$157.7 billion) of total hospital costs.

Figure 1 shows the distribution of the U.S. population and hospital discharges by age in 1997 and 2008. In both years, adults 65 and older made up a larger share of hospital discharges (37 and 35 percent, respectively) relative to their population size (12 and 13 percent, respectively). This pattern was more pronounced with increasing age: in 2008, adults 85 and older accounted for only 1.8 percent of the population but 8.0 percent of all discharges—over four times higher. Adults 75–84 years old comprised 4.3 percent of the population but accounted for triple the proportion of all discharges (13.8 percent). In contrast, 65–74 year olds comprised 6.6 percent of the total population but accounted for twice the proportion of all discharges (13.2 percent).



Characteristics of hospital stays among the older elderly

Table 1 compares hospital utilization and patient characteristics of the oldest adults 75–84 and 85+ to patients age 65–74, in 2008. Adults 85+ accounted for a relatively small share of hospital discharges (8 percent overall), but were more than twice as likely to be hospitalized as 65–74 year olds (577 versus 264 stays per 1,000 population). Adults 75–84 years old had a 1.5 times higher rate of hospitalization relative to 65–74 year olds (418 versus 264 stays per 1,000 population, respectively).

Stays for patients 75–84 and 85+ were slightly longer (5.6 days) than for 65–74 year olds (5.3 days). The average cost per stay for adults 85+ was about \$3,000 less than the average cost of a stay for 65–74 year olds (\$9,400 versus \$12,400, respectively).

Table 1. Characteristics of hospital stays among patients ages 75–84 and 85+ compared to patients ages 65–74, 2008

	65–74 years	75–84 years	85+ years
Total number of discharges	5,271,200	5,489,500‡	3,195,600
Percentage of all discharges in U.S. community hospitals	13.2%	13.8%	8.0%
Rate of hospitalization per 1,000 population*	264.0	418.2	576.7
Utilization characteristics			
Mean length of stay, days	5.3	5.6	5.6
Mean hospital costs	\$12,400	\$11,400	\$9,400
Aggregate national costs, billions	\$65.2	\$62.3‡	\$30.2
Percentage of aggregate costs	17.9%	17.1%	8.3%
Percentage of elective admissions	28.5%	21.0%	12.5%
Patient characteristics			
Gender (rate per 1,000 population*)			
Male	277.9	442.7	615.1
Female	252.1	401.0	558.7
Community-level income (rate per 1,000 population*)			
Quartile 1 (poorest)	297.7	416.1	529.8
Quartile 2	267.6	407.7	544.0
Quartile 3	243.8	398.0	558.5
Quartile 4 (wealthiest)	221.9	424.3	665.5
Patient residence (rate per 1,000 population*)			
Large urban core	259.0	431.4	610.5
Large urban fringe (suburbs)	230.0	350.4	470.2
Small urban	300.9	440.2	573.5
Non-urban	274.8	404.4	542.9
Region (rate per 1,000 population*)			
Northeast	255.4	428.2	619.3
Midwest	284.7	457.5	608.6
South	283.8	431.3	579.1
West	215.6	342.7	491.3

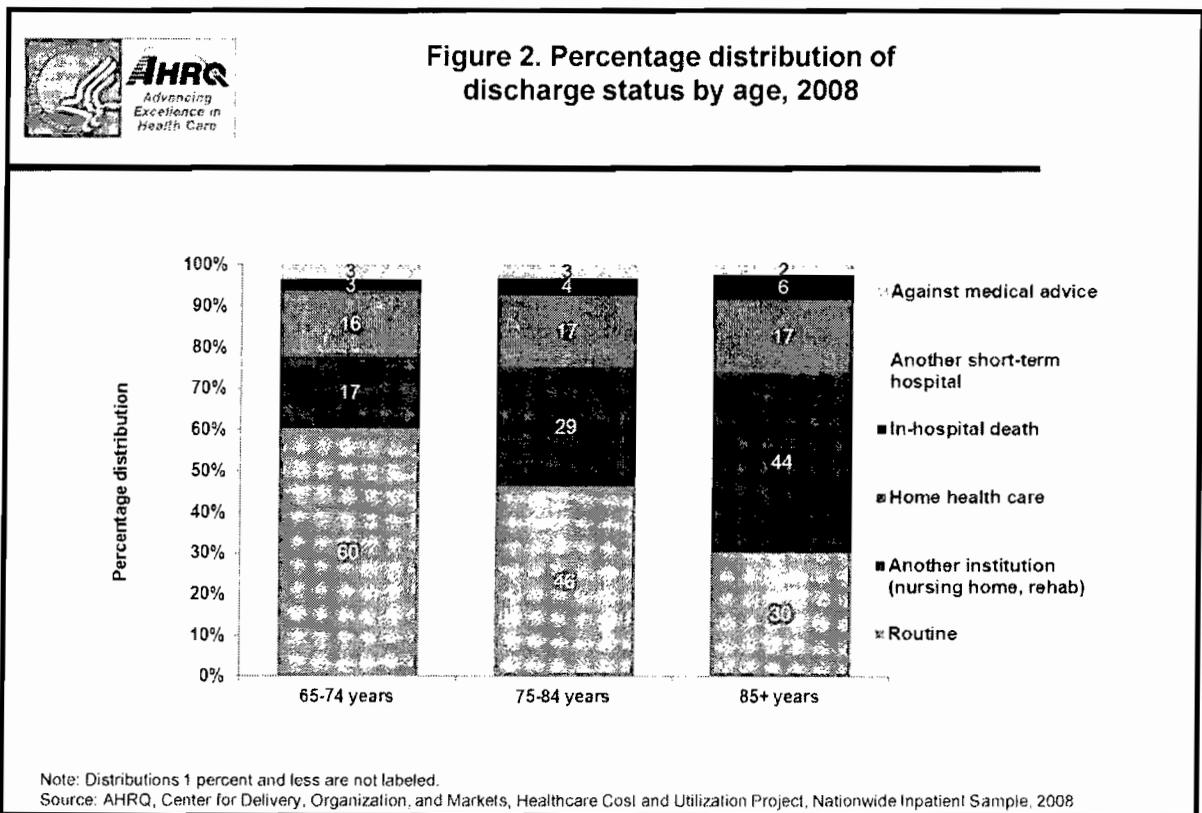
‡ Values are not statistically different from values for 65–74 age group at $p < 0.05$.

* Denominator data for rates were based on Claritas Population Estimates, 2008.

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2008

Across all three age groups, the rate of hospitalization was about 10 percent higher for males than females. Hospitalization rates for both genders increased with age. Among patients 75–84 and 85 and older, hospitalization rates were higher in the wealthiest communities (424 and 666 stays per 1,000 population, respectively). Across all three age groups, hospitalization rates were lower in the suburbs and in the western region of the U.S.

As age increased, the percentage of routine discharges decreased and discharges to long term care (e.g., nursing homes and rehab) increased (figure 2). Indeed, patients 85 and older were about 2.5 times more likely and patients 75–84 were about 1.7 times more likely to be discharged to long-term care than 65–74 year olds. In-hospital mortality was higher among patients 85 and older (6.2 percent) and 75–84 years old (4.2 percent) compared to stays for 65–74 year olds (2.9 percent).



Most frequent reasons for hospital stays

Table 2 highlights the 20 most frequent health conditions for which patients 75–84 and 85+ were hospitalized compared with 65–74 year olds.

Table 2. Most common principal diagnoses among hospitalized patients ages 75–84 and 85+ years, 2008

75–84 years			85+ years		
Top 20 principal diagnoses, CCS category	Rate per 1,000 population*	Relative rate**	Top 20 principal diagnoses, CCS category	Rate per 1,000 population*	Relative rate**
Congestive heart failure	23.2	2.2	Congestive heart failure	44.4	4.3
Pneumonia	19.7	2.1	Pneumonia	35.9	3.8
Irregular heart beat (cardiac dysrhythmias)	17.3	1.8	Blood infection (septicemia)	26.8	3.4
Blood infection (septicemia)	15.5	2.0	Urinary tract infections	24.3	6.0
Osteoarthritis	14.7‡	1.0	Irregular heart beat (cardiac dysrhythmias)	22.6	2.4
Chronic obstructive pulmonary disease and bronchiectasis	14.6	1.4	Fracture of hip	22.4	10.2
Coronary atherosclerosis and other heart disease	14.3‡	1.1	Stroke (acute cerebrovascular disease)	19.3	3.4
Stroke (acute cerebrovascular disease)	11.7	2.0	Heart attack (acute myocardial infarction)	16.8	2.4
Urinary tract infections	11.0	2.7	Fluid and electrolyte disorders	15.5	3.9
Heart attack (acute myocardial infarction)	10.9	1.6	Acute and unspecified renal failure	15.0	3.4
Rehabilitation care, fitting of prostheses, and adjustment of devices	9.4	2.0	Chronic obstructive pulmonary disease and bronchiectasis	13.6	1.3
Complication of device; implant or graft	9.2	1.3	Aspiration pneumonia	12.4	8.9
Acute and unspecified renal failure	8.7	2.0	Rehabilitation care, fitting of prostheses, and adjustment of devices	12.2	2.6
Fracture of hip	8.3	3.8	Gastrointestinal hemorrhage	11.7	3.3
Fluid and electrolyte disorders	8.3	2.1	Syncope	9.4	3.8
Respiratory failure	7.7	1.4	Respiratory failure	9.2	1.7
Nonspecific chest pain	7.2	1.2	Coronary atherosclerosis and other heart disease	8.3	0.6
Gastrointestinal hemorrhage	7.0	2.0	Delirium, dementia, and amnesic and other cognitive disorders	8.1	7.2
Back problems (disorders of intervertebral discs and bones in spinal column)	6.2‡	1.0	Intestinal obstruction without hernia	8.1	2.5
Complications of surgical procedures or medical care	5.7	1.2	Skin and subcutaneous tissue infections	8.0	2.3

* Denominator data for rates were based on Claritas Population Estimates, 2008.

** Relative to 65–74 age group.

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2008

Congestive heart failure (CHF) was the most common reason for hospitalization among 75–84 year olds (23.2 stays per 1,000 population) and those 85+ (44.4 stays per 1,000 population); these rates of hospitalization were more than double and quadruple the rate of patients 65–74 years old. Of the top 20

diagnoses among patients 75–84 years old, six were cardiovascular conditions: CHF, cardiac dysrhythmias, coronary atherosclerosis, acute cerebrovascular disease, acute myocardial infarction, and nonspecific chest pain. Together these conditions accounted for nearly 100 stays for every 1,000 adults 75–84 years old.

Infections were also common reasons for hospitalization. Pneumonia was the second most common reason for hospitalization among the 75–84 year olds and those over 85, accounting for 19.7 and 35.9 stays per 1,000 population, respectively. Again, these rates were two and four times higher than for patients 65–74 years old. Among 75–84 year olds, blood infection occurred in 15.5 stays per 1,000 population, which was twice the hospitalization rate for 65–74 year olds. For those 85+, the rate of hospitalization was nearly 3.5 times higher than among those 65–74 years old.

Hospitalization for hip fracture was one of the top ten conditions for the 85+ year olds. The hospitalization rate for hip fractures was ten times higher for those 85 and older (22.4 stays per 1,000 population) than for 65–74 year olds. Among patients 85+, delirium and dementia occurred in 8.1 stays per 1,000 population, which was more than seven times the hospitalization rate for 65–74 year olds.

Most frequent procedures performed during hospital stays

Table 3 shows the most frequent procedures performed during hospitalization among 75–84 year olds and patients 85 and older compared to the rates for these procedures with patients age 65–74.

Table 3. Most common all-listed procedures among hospitalized patients ages 75–84 and 85+ years, 2008

75–84 years			85+ years		
Top 20 all-listed procedures, CCS category	Rate per 1,000 population*	Relative rate**	Top 20 all-listed procedures, CCS category	Rate per 1,000 population*	Relative rate**
Blood transfusion	49.1	1.7	Blood transfusion	67.3	2.4
Diagnostic cardiac catheterization, coronary arteriography	22.6	1.2	Upper GI endoscopy	25.8	2.2
Upper GI endoscopy	20.7	1.7	Respiratory intubation and mechanical ventilation	22.1	1.6
Respiratory intubation and mechanical ventilation	20.0	1.5	Diagnostic cardiac catheterization, coronary arteriography	17.4	1.9
Diagnostic ultrasound of heart (echocardiogram)	14.5	1.6	Treatment of fracture or dislocation of hip and femur	16.1	7.4
Hemodialysis	11.3	1.2	Colonoscopy and biopsy	12.8	2.2
Percutaneous transluminal coronary angioplasty (PTCA)	11.2‡	1.1	Diagnostic bronchoscopy and biopsy of bronchus	11.9‡	0.6
Arthroplasty knee	10.6‡	0.9	Insertion, revision, replacement, removal of cardiac pacemaker or cardioverter/defibrillator	11.6	2.6
Colonoscopy and biopsy	10.5	1.8	Hip replacement, total and partial	11.0	2.1
Insertion, revision, replacement, removal of cardiac pacemaker or cardioverter/defibrillator	9.6	2.1	Incision of lining of lungs (pleura), removal of fluid through a needle, chest drainage	9.8	2.2

* Denominator data for rates were based on Claritas Population Estimates, 2008.

** Relative to 65–74 age group.

Table 3. Most common all-listed procedures among hospitalized patients ages 75–84 and 85+ years, 2008 (continued)

75–84 years			85+ years		
Top 20 all-listed procedures, CCS category	Rate per 1,000 population*	Relative rate**	Top 20 all-listed procedures, CCS category	Rate per 1,000 population*	Relative rate**
Hip replacement, total and partial	8.5	1.6	Tube feeding (intravenous or intestinal)	9.8	2.2
Incision of lining of lungs (pleura), removal of fluid through a needle, chest drainage	7.7	1.7	Physical therapy exercises, manipulation, and other procedures	9.5	2.9
Tube feeding (intravenous or intestinal)	7.2	1.6	CT (CAT) scan of head	8.8	3.7
Treatment of fracture or dislocation of hip and femur	6.5	3.0	Hemodialysis	8.1	0.9
Physical therapy exercises, manipulation, and other procedures	6.2	1.9	Indwelling catheter	7.9	3.9
Diagnostic bronchoscopy and biopsy of bronchus	5.7	1.3	Gastronomy, temporary and permanent	7.5	3.3
Arterio- or venogram (not heart and head)	5.7	1.4	Percutaneous transluminal coronary angioplasty (PTCA)	6.0	0.6
Colorectal resection	5.1	1.3	Arterio- or venogram (not heart and head)	4.9†	1.2
CT (CAT) scan of head	4.9	2.1	Conversion of cardiac rhythm	4.6	1.5
Contrast aortogram	4.8	1.4	Colorectal resection	4.3	1.1

* Denominator data for rates were based on Claritas Population Estimates, 2008.

** Relative to 65–74 age group.

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2008

Blood transfusion was, by far, the most common procedure performed on any patient 75–84 and 85+ (49.1 and 67.3 procedures per 1,000 population, respectively). Seven of the top twenty most frequent procedures among 75–84 year olds were diagnostic: cardiac catheterization, upper gastrointestinal endoscopy, echocardiogram, colonoscopy and biopsy, bronchoscopy, arteriogram or venogram, and CT (CAT) scan of head. Relative to 65–74 year olds, the rate of head CT scan was more than twice as high among patients 75–84 and was nearly four times higher among patients 85+. The rate of upper GI endoscopy and colonoscopy was about twice as high among patients 75–84 and 85+, compared to 65–74 year olds.

Procedures related to degenerative bone and joint disorders were common among patients 75–84 and 85+. Compared to 65–74 year olds, treatment for fractured or dislocated hip or femur was much more common among patients 75–84 and 85+ (3.0 and 7.4 times higher, respectively). Similarly, hip replacement was more frequently performed on patients 75–84 and 85+. Physical therapy procedures were about two and three times more common among patients 75–84 and 85+, respectively, than among patients 65–74.

Data Source

The estimates in this Statistical Brief are based upon data from the HCUP 2008 NIS. Historical data were drawn from the 1997 NIS. Supplemental sources included population estimates from 2008 Claritas data and from "Table 1: Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2009 (NST-EST2009-01)", Population Division, U.S. Census Bureau, Release date: December 2009 (<http://www.census.gov/popest/states/NST-ann-est.html>).

Definitions

Diagnoses and Procedures, ICD-9-CM, and Clinical Classifications Software (CCS)

The principal diagnosis is that condition established after study to be chiefly responsible for the patient's admission to the hospital. Secondary diagnoses are concomitant conditions that coexist at the time of admission or that develop during the stay.

The principal procedure is the procedure that was performed for definitive treatment rather than performed for diagnostic or exploratory purposes (i.e., the procedure that was necessary to take care of a complication). If two procedures appear to meet this definition, the procedure most related to the principal diagnosis was selected as the principal procedure.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses and procedures. There are about 14,000 ICD-9-CM diagnosis codes and 3,900 ICD-9-CM procedure codes. CCS categorizes ICD-9-CM diagnosis and procedure codes into a manageable number of clinically meaningful categories.⁶ This "clinical grouper" makes it easier to quickly understand patterns of diagnoses and procedures.

Types of hospitals included in HCUP

HCUP is based on data from community hospitals, defined as short-term, non-Federal, general and other hospitals, excluding hospital units of other institutions (e.g., prisons). HCUP data include OB-GYN, ENT, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Please note, a discharge of this nature will be included in the NIS if it occurred in a community hospital.

Unit of analysis

The unit of analysis is the hospital discharge (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in one year will be counted each time as a separate "discharge" from the hospital.

Costs and charges

Total hospital charges were converted to costs using HCUP Cost-to-Charge Ratios based on hospital accounting reports from the Centers for Medicare and Medicaid Services (CMS).⁷ Costs will tend to reflect the actual costs of production, while charges represent what the hospital billed for the case. For each hospital, a hospital-wide cost-to-charge ratio is used because detailed charges are not available across all HCUP States. Hospital charges reflect the amount the hospital charged for the entire hospital stay and does not include professional (physician) fees. For the purposes of this Statistical Brief, costs are reported to the nearest hundreds.

Urban-rural location of patient residence

Urban-rural measurement for patient residence was based on the U.S. Office of Management and Budget (OMB) definitions of Core-Based Statistical Areas. OMB classifies counties into metropolitan and micropolitan areas. For this Statistical Brief, the metropolitan areas were further divided into large and

⁶ HCUP CCS. Healthcare Cost and Utilization Project (HCUP). December 2009. U.S. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/toolsoftware/ccs/ccs.jsp

⁷ HCUP Cost-to-Charge Ratio Files (CCR). Healthcare Cost and Utilization Project (HCUP). 2001–2008. U.S. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/db/state/costtocharge.jsp

small metropolitan areas using the Urban Influence Codes (UIC). Thus, for this report, counties were classified into one of four categories:

- Large urban core includes metropolitan areas with 1 million or more residents.
- Large urban fringe includes metropolitan areas with fewer than 1 million residents.
- Small urban includes non-metropolitan areas having an urban cluster of 10,000 to 49,999 residents.
- Non-urban includes areas that are neither metropolitan nor micropolitan areas, i.e. counties with no town greater than 10,000 residents.

Median community-level income

Median community-level income is the median household income of the patient's ZIP Code of residence. The cut-offs for the quartile designation are determined using ZIP Code demographic data obtained from Claritas. The income quartile is missing for homeless and foreign patients.

Payer

Payer is the expected primary payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into more general groups:

- Medicare includes fee-for-service and managed care Medicare patients.
- Medicaid includes fee-for-service and managed care Medicaid patients. Patients covered by the State Children's Health Insurance Program (SCHIP) may be included here. Because most state data do not identify SCHIP patients specifically, it is not possible to present this information separately.
- Private insurance includes Blue Cross, commercial carriers, and private HMOs and PPOs.
- Other includes Workers' Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs.
- Uninsured includes an insurance status of "self-pay" and "no charge."

When more than one payer is listed for a hospital discharge, the first-listed payer is used.

Region

Region is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
- Midwest: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
- South: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
- West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii

Discharge status

Discharge status indicates the disposition of the patient at discharge from the hospital, and includes the following six categories: routine (to home), transfer to another short-term hospital, other transfers (including skilled nursing facility, intermediate care, and another type of facility such as a nursing home), home health care, against medical advice (AMA), or died in the hospital.

About HCUP

HCUP is a family of powerful health care databases, software tools, and products for advancing research. Sponsored by the Agency for Healthcare Research and Quality (AHRQ), HCUP includes the largest all-payer encounter-level collection of longitudinal health care data (inpatient, ambulatory surgery, and emergency department) in the United States, beginning in 1988. HCUP is a Federal-State-Industry Partnership that brings together the data collection efforts of many organizations—such as state data organizations, hospital associations, private data organizations, and the federal government—to create a national information resource.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

Arizona Department of Health Services
Arkansas Department of Health
California Office of Statewide Health Planning and Development
Colorado Hospital Association
Connecticut Hospital Association
Florida Agency for Health Care Administration
Georgia Hospital Association
Hawaii Health Information Corporation
Illinois Department of Public Health
Indiana Hospital Association
Iowa Hospital Association
Kansas Hospital Association
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
Maine Health Data Organization
Maryland Health Services Cost Review Commission
Massachusetts Division of Health Care Finance and Policy
Michigan Health & Hospital Association
Minnesota Hospital Association
Missouri Hospital Industry Data Institute
Montana MHA—An Association of Montana Health Care Providers
Nebraska Hospital Association
Nevada Department of Health and Human Services
New Hampshire Department of Health & Human Services
New Jersey Department of Health and Senior Services
New Mexico Health Policy Commission
New York State Department of Health
North Carolina Department of Health and Human Services
Ohio Hospital Association
Oklahoma State Department of Health
Oregon Association of Hospitals and Health Systems
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina State Budget & Control Board
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Texas Department of State Health Services
Utah Department of Health
Vermont Association of Hospitals and Health Systems
Virginia Health Information
Washington State Department of Health
West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About the NIS

The HCUP Nationwide Inpatient Sample (NIS) is a nationwide database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, non-rehabilitation hospitals). The NIS is a sample of hospitals and includes all patients from each hospital, regardless of payer. It is drawn from a sampling frame that contains hospitals comprising about 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at both the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use.

For More Information

For more information about HCUP, visit www.hcup-us.ahrq.gov.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at www.hcup.ahrq.gov.

For information on other hospitalizations in the U.S., download *HCUP Facts and Figures: Statistics on Hospital-based Care in the United States in 2008*, located at <http://www.hcup-us.ahrq.gov/reports.jsp>.

For a detailed description of HCUP, more information on the design of the NIS, and methods to calculate estimates, please refer to the following publications:

Steiner, C., Elixhauser, A., Schnaier, J. The Healthcare Cost and Utilization Project: An Overview. *Effective Clinical Practice* 5(3):143–51, 2002.

Introduction to the HCUP Nationwide Inpatient Sample, 2008. Online. May 2010. U.S. Agency for Healthcare Research and Quality. http://hcup-us.ahrq.gov/db/nation/nis/NIS_2008_INTRODUCTION.pdf

Houchens, R., Elixhauser, A. *Final Report on Calculating Nationwide Inpatient Sample (NIS) Variances, 2001*. HCUP Methods Series Report #2003-2. Online. June 2005 (revised June 6, 2005). U.S. Agency for Healthcare Research and Quality. <http://www.hcup-us.ahrq.gov/reports/CalculatingNISVariances200106092005.pdf>

Suggested Citation

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Acknowledgments

The authors would like to acknowledge Mika Nagamine (Thomson Reuters) and Minya Sheng (Thomson Reuters) for programming assistance.

AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

Irene Fraser, Ph.D., Director
Center for Delivery, Organization, and Markets
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

Demographic Detail Summary

Geography: CBSAMET - Rockford, IL Metro

Population Demographics

	2000		2010		2014A		2019		Percent Change	
	Census		Census		Estimates		Projections		2000 to 2010	2014 to 2019
Total Population	320,176		349,431		344,652		355,776		9.1%	3.2%
Population Density (Pop/Sq Mi)	399.63		444.33		430.18		444.06		11.1%	3.2%
Total Households	122,566		134,006		132,134		136,988		9.3%	3.6%

Population by Gender:

Male	156,676	48.9%	171,386	49.0%	168,882	49.0%	174,552	49.0%	9.3%	3.3%
Female	163,500	51.0%	178,045	50.9%	175,770	51.0%	181,224	50.9%	8.8%	3.1%

Population by Race/Ethnicity

	2000		2010		2014A		2019		Percent Change	
	Census	%	Census	%	Estimates	%	Projections	%	2000 to 2010	2014 to 2019
White	266,727	83.3%	274,376	78.5%	268,268	77.8%	273,569	76.8%	2.8%	1.9%
Black	29,655	9.2%	37,172	10.6%	37,259	10.8%	38,133	10.7%	25.3%	2.3%
American Indian or Alaska Native	931	0.2%	1,163	0.3%	1,170	0.3%	1,218	0.3%	24.9%	4.1%
Asian/Native Hawaiian/Other Pacific Islander	4,725	1.4%	7,590	2.1%	8,014	2.3%	8,847	2.4%	60.6%	10.3%
Some Other Race	11,188	3.4%	19,387	5.5%	19,871	5.7%	22,336	6.2%	73.2%	12.4%
Two or More Races	6,950	2.1%	9,743	2.7%	10,070	2.9%	11,673	3.2%	40.1%	15.9%
Hispanic Ethnicity	24,315	7.5%	43,144	12.3%	44,906	13.0%	50,043	14.0%	77.4%	11.4%
Not Hispanic or Latino	295,861	92.4%	306,287	87.6%	299,746	86.9%	305,733	85.9%	3.5%	1.9%

Population by Age

	2000		2010		2014A		2019		Percent Change	
	Census	%	Census	%	Estimates	%	Projections	%	2000 to 2010	2014 to 2019
0 to 4	22,663	7.0%	23,372	6.6%	22,444	6.5%	22,949	6.4%	3.1%	2.2%
5 to 14	49,150	15.3%	50,185	14.3%	48,650	14.1%	48,463	13.6%	2.1%	0.3%
15 to 19	21,861	6.8%	24,958	7.1%	23,743	6.8%	23,787	6.6%	14.1%	0.1%
20 to 24	18,422	5.7%	20,218	5.7%	20,748	6.0%	21,533	6.0%	9.7%	3.7%
25 to 34	43,450	13.5%	42,464	12.1%	41,718	12.1%	43,143	12.1%	-2.2%	3.4%
35 to 44	52,277	16.3%	46,802	13.3%	44,638	12.9%	43,717	12.2%	-10.4%	-2.0%
45 to 54	43,747	13.6%	52,126	14.9%	50,021	14.5%	46,971	13.2%	19.1%	-6.0%
55 to 64	28,594	8.9%	42,227	12.0%	43,590	12.6%	47,313	13.2%	47.6%	8.5%
65 to 74	20,615	6.4%	25,286	7.2%	26,937	7.8%	33,461	9.4%	22.6%	24.2%
75 to 84	14,729	4.6%	15,151	4.3%	15,136	4.3%	16,842	4.7%	2.8%	11.2%
85+	4,668	1.4%	6,642	1.8%	7,027	2.0%	7,597	2.1%	42.2%	8.1%

Median Age:

Total Population	35.8		37.9		38.6		39.1	
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Households by Income

Demographic Detail Summary

Geography: City - Rockford

Population Demographics

	2000		2010		2014A		2019		Percent Change	
	Census		Census		Estimates		Projections		2000 to 2010	2014 to 2019
Total Population	153,430		153,116		150,891		150,743		0.2%	0.0%
Population Density (Pop/Sq Mi)	2,471.98		2,253.46		2,431.09		2,428.69		-8.8%	0.0%
Total Households	60,336		60,130		59,191		59,537		0.3%	0.5%

Population by Gender:

	2000	2010	2014A	2019	2000 to 2010	2014 to 2019
Male	73,786 48.0%	74,078 48.3%	72,982 48.3%	72,999 48.4%	0.3%	0.0%
Female	79,644 51.9%	79,038 51.6%	77,909 51.6%	77,745 51.5%	0.7%	0.2%

Population by Race/Ethnicity

	2000		2010		2014A		2019		Percent Change	
	Census	%	Census	%	Estimates	%	Projections	%	2000 to 2010	2014 to 2019
White	112,907	73.5%	100,838	65.8%	97,976	64.9%	95,655	63.4%	-10.6%	-2.3%
Black	25,877	16.8%	30,632	20.0%	30,435	20.1%	30,620	20.3%	18.3%	0.6%
American Indian or Alaska Native	495	0.3%	620	0.4%	620	0.4%	631	0.4%	25.2%	1.9%
Asian/Native Hawaiian/Other Pacific Islander	3,003	1.9%	4,325	2.8%	4,586	3.0%	4,859	3.2%	44.0%	5.9%
Some Other Race	7,050	4.5%	11,254	7.3%	11,633	7.7%	12,668	8.4%	59.6%	8.8%
Two or More Races	4,097	2.6%	5,446	3.5%	5,641	3.7%	6,310	4.1%	32.9%	11.8%
Hispanic Ethnicity	15,406	10.0%	23,837	15.5%	25,244	16.7%	27,160	18.0%	54.7%	7.5%
Not Hispanic or Latino	138,023	89.9%	129,278	84.4%	125,647	83.2%	123,583	81.9%	-6.3%	-1.6%

Population by Age

	2000		2010		2014A		2019		Percent Change	
	Census	%	Census	%	Estimates	%	Projections	%	2000 to 2010	2014 to 2019
0 to 4	11,588	7.5%	11,502	7.5%	11,250	7.4%	11,063	7.3%	0.7%	-1.6%
5 to 14	22,624	14.7%	21,457	14.0%	21,460	14.2%	21,340	14.1%	-5.1%	0.5%
15 to 19	10,115	6.5%	10,388	6.7%	9,622	6.3%	9,453	6.2%	2.7%	-1.7%
20 to 24	9,991	6.5%	10,083	6.5%	10,012	6.6%	9,404	6.2%	0.9%	-6.0%
25 to 34	22,137	14.4%	20,838	13.6%	20,352	13.4%	20,413	13.5%	-5.8%	0.3%
35 to 44	23,368	15.2%	19,249	12.5%	18,555	12.2%	17,986	11.9%	-17.6%	-3.0%
45 to 54	19,301	12.5%	20,840	13.6%	19,874	13.1%	18,077	11.9%	7.9%	-9.0%
55 to 64	12,405	8.0%	17,449	11.3%	17,966	11.9%	18,651	12.3%	40.6%	3.8%
65 to 74	10,313	6.7%	10,174	6.6%	10,807	7.1%	12,957	8.5%	-1.3%	19.8%
75 to 84	8,407	5.4%	7,301	4.7%	6,979	4.6%	7,224	4.7%	-13.1%	3.5%
85+	3,177	2.0%	3,829	2.5%	4,010	2.6%	4,168	2.7%	20.5%	3.9%

Median Age:

Total Population	35.1	36.1	36.4	36.9
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Households by Income

1110.530

(g) Performance Requirements

The MS beds meet the minimum number of 100 required in an MSA. OSF SAMC has 190 MS beds, and this will not change.

Imaging

OSF SAMC proposes modernization of its womens' health services, including mammography and ultrasound ("US"). Thus, diagnostic/interventional imaging is involved. There will be no increase in the number of either ultrasound or mammography machines. The modernization is necessary due to deteriorated facilities. The current womens' health space must be vacated to accommodate circulation and connection between the existing and proposed buildings. The new space will allow for private changing rooms, a space to consult with radiologists regarding results of exams and includes exam room for gynecological US and pap smears/routine exams, bone densitometry testing, patient education and consultations. It will be more user friendly and patient oriented.

In 2014 volume for breast US (excluding mobile/portable) was 2,930 procedures. The standard is 3,100 visits per machine. The volume supports two US machines.

The 2014 volume for mammography was 10,125, and OSF SAMC has 4 pieces of hospital based equipment. The state standard is 5,000 visits per machine. The volume supports 3 mammography machines.

US

Equipment*	2014 Volume*	State Standard	Met Standard
2	2,930	3,100 visits per US	Yes (projected 2019)

Mammography

Equipment*	2014 Volume*	State Standard	Met Standard
4	10,125	5,000 visits per machine	Yes (projected 2019)

*Includes equipment and volume of only OSF SAMC based mammography and US used for women's health.

Ultrasound will meet standards based on projected growth to 2019 as the necessity for US for women's health is expected to increase by 21% over the next 10 years (per National Healthcare Consultants SG₂). If the need increases our US volume by just 10% by 2019 this would result in the need for the second machine.

One of the machines is dedicated to needle guided biopsies (468 were performed in 2014) and the 2014 utilization mammography supports the 3 remaining machines.

This is a modernization project and OSF SAMC is not adding equipment. It is relocating equipment. One of the pieces of mammography equipment is dedicated to core needle biopsies, and if it is excluded the volume standard is met.

Ambulatory Care

The proposed clinical space for a new prompt care clinic in the new bed pavilion will be 2,482 dgsf and will consist of 6 treatment rooms, thus meeting the state standard of 800 dgsf per room. The area will be accessible via the first floor lobby and the waiting area and overall design will encourage people to use the prompt care clinic versus the ED, as clinically appropriate.

Utilization

# of Rooms	2014 Volume	Projected 2019 Utilization	State Standard	Met Standard
6	7,183*	14,200	2,000 visits per room	Yes

There is no historical volume, as OSF SAMC does not currently operate a prompt care clinic at the hospital. The projected volume comes from modeled visits using patients seen in the ED, who based on acuity level were appropriate for treatment in a prompt care setting. In addition, OSF SAMC projects approximately 7,000 more visits based on the closure of a walk in clinic in Rockford which had 17,300 visits in 2014. Much of this volume will be absorbed through OSF SAMC physician visits and the ED but it is expected the availability of the prompt care clinic, when it opens, will easily attract at least half of the volume from the closed clinic. The clinic hours are planned for 8:00 a.m. to 8:00 p.m. 7 days a week. Typically, volume for prompt care peaks in the morning and after 3 p.m., and on weekends.

*Current ED prompt care visits only

NOTE:

There will be a retail pharmacy in the bed pavilion. There are no standards for pharmacy.

The projected related fund financing will be issued by the Illinois Finance Authority and the term is 20 years, with two term bonds in 2040 and 2045 with an anticipated interest rate of 4.379%. The bonds support certain clinical aspects of the project, and do not support administrative space, pastoral care, or the pharmacy or coffee shop to be located on the first floor of the bed pavilion.

**Availability of Funds
Financial Viability Waiver**

N/A – See attached proof of Bond Rating of A or better.

RatingsDirect®

OSF Healthcare System; Joint Criteria; System

Primary Credit Analyst:

J. Kevin K Holloran, Dallas (1) 214-871-1412: kevin.holloran@standardandpoors.com

Secondary Contact:

Santo F Barretta, Chicago (1) 312-233-7068: santo.barretta@standardandpoors.com

Table Of Contents

Rationale

Outlook

Enterprise Profile

Financial Profile

Related Criteria And Research

OSF Healthcare System; Joint Criteria; System

Credit Profile

Illinois Fin Auth, Illinois

OSF Hlthcare Sys, Illinois

Series 2007A, 2009A, 2010A, 2012

Long Term Rating

A/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'A' long-term rating on the Illinois Finance Authority's (IFA) series 2007A, 2009A, 2010A, and 2012A fixed-rate bonds. At the same time, Standard & Poor's affirmed its 'A' underlying rating (SPUR) on the IFA's series 2007E, 2007F, 2009B, 2009C, and 2009D bonds. Finally, Standard & Poor's affirmed its 'AAA/A-1+' joint criteria rating on the IFA's series 2009C bonds and its 'AAA/A-1' joint criteria rating on the IFA's series 2007E, 2007F, 2009B, and 2009D bonds. All bonds have been issued on behalf of OSF Healthcare System (OSF).

The ratings on the series 2007E, 2007F, 2009B, 2009C, and 2009D bonds are based on the application of our joint criteria, whereby the long-term component of the rating is based on the 'A' SPUR on OSF and on the short-term ratings on various banks providing letters of credit (LOCs). The ratings are based on our joint criteria with medium correlation for the series 2009B bonds and low correlation for the series 2007E, 2007F, 2009C, and 2009D bonds. Each series has the benefit of a separate LOC: Barclays Bank PLC (2007E and F), PNC Bank N. A. (2009B), Wells Fargo Bank N.A. (2009C), and JPMorgan Chase Bank N.A. (2009D) issued LOCs to back the series 2007E, 2007F, 2009B, 2009C, and 2009D bonds, respectively. The obligation of OSF, as well as the banks' obligations established by the LOCs, to make debt service payments support the joint ratings. The short-term component of the ratings is based solely on the bank ratings.

The 'A' ratings are based on our view of OSF's group credit profile (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP. The outlook is stable.

The 'A' rating reflects our view of OSF's successful implementation to improve the organization's operations during the past year. OSF has been able to improve its balance sheet after the completion of major capital expenditures over a sustained period, and improve its operations at a time when health care reform is being implemented. The solid balance sheet, coupled with leadership's historical ability to implement successful improvement plans, supports the rating.

The 'A' rating further reflects our assessment of OSF's:

- Improvement in unrestricted reserves, with solid days' cash on hand for the rating at 213 as of fiscal 2014 (unaudited nine-month interims through June 30, 2014);
- Operational improvements in fiscal 2014 year-to-date, with a 3.2% operating margin, compared with OSF's weak financial performance in fiscal 2013 (audited results through Sept. 30, 2013), which generated an operating margin of negative 0.5%.

- Dominant business position in the Peoria, Ill., market, where its flagship, Saint Francis Medical Center, is located, and generally good position in its markets despite challenges that include competition and a weak economic environment; and
- Breadth of facilities and services, enhanced by its systemwide strategic priorities focused on specific business-line development, growth in ambulatory care, and enhanced physician alignment.

Partly offsetting the above strengths, in our view, are OSF's still moderately high leverage, with debt to capitalization of 46% through fiscal 2014, and the expectation of some modest capital spending in the next one to two years.

The Peoria-based Sisters of the Third Order of Saint Francis sponsor OSF and operate nine hospitals and other health care-related entities. Eight of the hospitals are located in central and northern Illinois while one hospital is in Michigan. The flagship hospital, Saint Francis Medical Center, is a 609-licensed-bed, tertiary acute care teaching hospital. The obligated group's unrestricted receivables secure all obligations. Our analysis takes into account the consolidated system results, and all figures and ratios in this report reflect the consolidated system unless otherwise stated.

Outlook

The stable outlook reflects our expectation that OSF's improvement plan, which has clearly had operational results thus far in fiscal 2014, will continue for the two year outlook period. We could raise the rating with additional balance sheet accretion and consistent successful operations for a sustained period.

OSF has begun to generate additional flexibility at the current rating. While not expected over the two-year outlook period, we could lower the rating if OSF does not maintain improvements in operations and does not keep maximum annual debt service (MADS) coverage above 3x, or if the balance sheet declines and unrestricted reserves fall to less than 175 days of cash on hand.

Enterprise Profile

Economic fundamentals

We consider Illinois' economy to be broad and diverse, and the state's income levels are well above average. In our view, economic recovery continues at a modest pace but will likely continue to lag the U.S. in the near and medium term as real estate and housing, manufacturing, and the government sector continue to drag on economic performance. The state's unemployment rate remains elevated relative to the U.S. rate but declined to 7.1% in June, which is the lowest rate recorded since October 2008. We expect unemployment rates to remain elevated compared with that of the U.S. based on relatively slow employment expansion. To date, Illinois has only regained about half of its pre-recession employment. Per capita personal income in 2013 was \$46,780, or 105% of the U.S. average, ranking Illinois 15th nationally and first among the Great Lakes states.

Operating entities

OSF Saint Francis Medical Center: OSF Saint Francis Medical Center is a tertiary care, acute medical-surgical teaching hospital located near downtown Peoria. It provides a full range of primary, secondary, and tertiary services, as well as certain specialized services, including Level I (highest) trauma services, life flight helicopter transport services, adult and pediatric open heart surgery, pancreas and kidney transplantation services, neurosurgery and neurology, Level III

(highest) perinatal services, radiation oncology, and specialized services of the Children's Hospital of Illinois (operated as part of the Medical Center).

OSF Saint Anthony Medical Center. OSF Saint Anthony Medical Center is an acute care hospital located in a growing area of Rockford, Ill. Saint Anthony provides primary, secondary, and tertiary care, including open-heart surgery. It is also designated by Illinois as a Level I trauma center and as a regional burn unit.

OSF St. Joseph Medical Center. OSF St. Joseph Medical Center is an acute care hospital located in Bloomington, Ill. St. Joseph provides primary, secondary, and tertiary care, including open-heart surgery. In addition, OSF purchased certain assets of Carle Clinic Assn. P.C. (Carle Clinic) located in or related to its medical office building in Bloomington, and leased the medical office building.

In addition to OSF's three largest facilities (St. Francis Medical Center, St. Anthony Medical Center and St. Joseph Medical Center), OSF also has several smaller facilities in Illinois and one in Michigan. They include OSF St. Mary Medical Center, an acute care hospital located in Galesburg, Ill.; OSF Saint Elizabeth Medical Center, a 91-bed acute care hospital located in Ottawa, Ill.; OSF St. Francis Hospital, a critical access hospital located in Escanaba, Mich.; OSF St. Luke Medical Center, a critical access hospital located in Kewanee, Ill.; OSF Saint James-John W. Albrecht Medical Center, an acute care hospital facility located in Pontiac, Ill. Saint James is the only acute care hospital in Livingston County, with OSF Holy Family Medical Center's 23 acute care beds, which are also certified as swing beds. The facility has been designated as a critical access hospital by Centers for Medicare and Medicaid Services. Also, it operates a provider-based rural health clinic.

The OSF Medical Group consists of approximately 655 physicians and 290 advanced practitioners employed by OSF Healthcare, in approximately 70 office locations throughout Illinois and Michigan with approximately 1.4 million annual patient visits.

Utilization

The OSF system has seen growth in its admissions in fiscal 2013, increasing incrementally to 59,870 admissions in fiscal 2013 from 58,904 admissions in fiscal 2012. OSF is experiencing more of the national trend thus far in fiscal 2014 (nine months through June 30, 2014) with declines in inpatient admissions compared to the same time frame last year (a decline of 6.5%). Leadership is continuing to focus on improving the utilizations statistics through population capture, the maintenance of internal referrals, and also Mayo Clinic alignment. OSF is also well positioned with several key service lines, such as cardiovascular, children's services, neurosciences and oncology, as well as posting excellent quality metrics.

Management

OSF leadership has significantly improved operations over the short term while simultaneously preparing the larger system for the shift from a traditional fee-for-service system to one that is sustainable under population health. Management has clearly taken the lessons it has learned from its participation in the Pioneer Accountable Care Organization (ACO) demonstration and is implementing them to help with future long-term system improvements and population initiatives, including their participation in the Illinois Blue Cross ACO. The OSF system seems to be well prepared to make key transitions towards population management.

Financial Profile

Change in accounting for bad debt

In accordance with our report "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," published Jan. 19, 2012 on RatingsDirect, we recorded OSF's 2014, 2013, and 2012 financial results including the adoption of Financial Accounting Standards Board Accounting Standards Update No. 2011-017 in 2012, but not in prior periods. The new accounting treatment means that OSF's fiscal 2012 and subsequent financial statistics are not directly comparable with the results for 2011 and prior years. For an explanation of how the change in accounting for bad debt affects each financial measure, including the direction and size of the change, please see the above report.

Operations

OSF posted an operating margin of negative 0.5% in fiscal 2013 (audited results through Sept. 30, 2013), compared with just over a 2% operating margin in fiscal 2012. Since fiscal 2013, when management noticed the strain on operations, which appeared during the second and third quarters, leadership began to implement a revenue enhancement and cost-reduction plan. Year-to-date results thus far in fiscal 2014 (through the unaudited nine-month period through June 30, 2014), show that OSF has seen significantly improved operations and cash flow, with a year-to-date operating margin of 3.2%.

One of the key pieces of the plan is to manage referrals within the system. As OSF is better able to internally refer its patients, internal capture rates will improve, which in turn lead to improved operations and will help offset utilization declines stemming from population management. Another piece of the plan will be the education of its medical staff on population health management and the impact of new insurance contracts. This education is also occurring at other entities that we rate. The success of the two steps previously mentioned, coupled with the cost-cutting initiatives, should help continue to improve operations in fiscal years 2014 and 2015.

For the nine months ended June 30, OSF had improved MADS coverage to 4.3x.

Balance sheet

Unrestricted reserves have grown significantly in recent years, providing OSF with some additional flexibility at the existing rating. As of fiscal 2014 year to date, unrestricted reserves stood at just over \$1.1 billion, equal to 213 days' cash on hand. Management reports that liquidity growth remains a part of the system strategy, especially because capital spending declined from recent high levels. Cash to long-term debt has improved to 121% since our last review while leverage declined to 46%, which, although improved, is still high for the current rating. Leadership plans to remain focused on the balance sheet. The leadership team is planning to move forward with a plan to spend no more than 50% of its operating cash flow for capital expenditures. To be allocated money for capital, the various regions will need to generate this cash flow.

There are some modest planned future capital expenditures, the largest piece of which includes an approximately \$55 million project under discussion for a potential new patient tower at the Rockford facility. In addition, OSF has letters of intent with St. Anthony Health System (in Alton, Ill.) and also with Mendota Community Hospital (in Mendota, Ill.), the structure of which would most likely result in OSF absorbing the two entities' debt. OSF's capital expenditure and

potential facility growth plans are manageable, in our view, at the existing rating level.

OSF Healthcare System And Subsidiaries	--Fiscal year ended Sept. 30.--			
	Nine-month interim ended June 30, 2014	2013	2012	2011
Financial performance				
Net patient revenue (\$000s)	1,471,048	1,910,851	1,817,000	1,787,360
Total operating revenue (\$000s)	1,553,329	1,994,993	1,898,976	1,865,885
Total operating expenses (\$000s)	1,504,042	2,004,367	1,857,743	1,845,357
Operating income (\$000s)	49,287	(9,374)	38,233	20,628
Operating margin (%)	3.17	(0.47)	2.02	1.11
Net non-operating income (\$000s)	31,335	39,121	45,982	37,542
Excess income (\$000s)	60,622	29,747	84,215	58,170
Excess margin (%)	5.09	1.46	4.34	3.06
EBIDA margin (%)	11.68	7.71	10.59	10.19
Net available for debt service (\$000s)	185,157	156,921	205,633	193,955
Maximum annual debt service (\$000s)	57,741	57,741	57,741	57,741
Maximum annual debt service coverage (x)	4.28	2.72	3.56	3.36
Operating lease-adjusted coverage (x)	N.A.	1.92	2.40	2.33
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	1,108,226	1,019,550	832,423	759,738
Unrestricted days' cash on hand	212.7	194.5	171.4	158.0
Unrestricted cash/total long-term debt (%)	121.2	115.7	93.9	89.1
Average age of plant (years)	N.A.	12.2	14.3	11.8
Capital expenditures/depreciation and amortization (%)	73.6	127.6	110.8	90.8
Debt and liabilities				
Total long-term debt (\$000s)	914,416	881,390	886,139	853,089
Long-term debt/capitalization (%)	45.7	47.8	54.2	55.1
Contingent liabilities (\$000s)	N.A.	293,320	294,070	280,945
Contingent liabilities/total long-term debt (%)	N.A.	33.3	33.2	32.9
Debt burden (%)	2.73	2.84	2.97	3.03
Defined benefit plan funded status (%)	N.A.	65.19	51.23	56.76

N.A.--Not available.

Related Criteria And Research

Related Criteria

- Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007
- Criteria: Joint Support Criteria Update, April 22, 2009
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios. Oct. 26, 2011
- The Outlook For U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures, Dec. 10, 2013
- U.S. Not-For-Profit Health Care System Ratios: Operating Performance Weakened In 2013. Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties. May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 39 Nonfinancial Corporate Industries, Nov. 20, 2013
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

Ratings Detail (As Of August 14, 2014)

Illinois Fin Auth. Illinois

OSF Hlthcare Sys, Illinois

Illinois Fin Auth (OSF Hlthcare Sys) hosp ins VRDB rev bnds (OSF Hlthcare Sys) ser 2007E RMKTD 09/06/2013 due 09/30/2038

<i>Long Term Rating</i>	AAA/A-1	Affirmed
<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed

Illinois Fin Auth (OSF Hlthcare Sys) hosp ins VRDB rev bnds (OSF Hlthcare Sys) ser 2007F RMKTD 09/26/2013 due 09/30/2038

<i>Long Term Rating</i>	AAA/A-1	Affirmed
<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed

Series 2009B

<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Series 2009D

<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Series2009C

<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed

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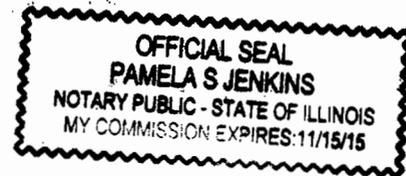
Economic Feasibility

The selected form of debt financing will be at the lowest cost available, or if not it will be more advantageous due to other terms, such as pre-payment privileges, lack of security interest, time of the loan or other reasons.



 David Stenerson
 VP and CFO, OSF Saint Anthony Medical Center

Subscribed and sworn to before me this
 13th day of April, 2015.





 Notary Public

See below chart reflecting the reasonableness of the costs per the State Board standards.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE											
Department (list below)	A	B	C		D	E		F	G	H	Total Cost (G + H)
	Cost/Square Foot New Mod.		Gross Sq. Ft. New Circ.*			Gross Sq. Ft. Mod. Circ.*			Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency											
TOTALS											

* Include the percentage (%) of space for circulation

See Attached

Economic Feasibility

The 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: \$8,664.00 per equivalent patient day (projected 2018).

The total projected annual capital costs (in current dollars per equivalent patient day) for the first full year at target utilization (which is anticipated to be within two years following project completion): \$246.00.

Safety Net Impact

To the applicants knowledge the impact on safety net services will be positive in that this project will maintain them.

The applicants do not have knowledge regarding cross subsidization of services.

Attached is a chart reflecting the prior three years charity and Medicaid care. I hereby certify it is accurate. I also certify that no patient will be turned away due to inability to pay, or any other discriminatory reason.



David Stenerson
CFO, Saint Anthony Medical Center

Subscribed and sworn to before me this
13th day of April, 2015



Notary Public



OSF Saint Anthony Medical Center Only

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	567	626	586
Outpatient	6,807	7,677	7,818
Total	7,374	8,303	8,404
Charity (cost in dollars)			
Inpatient	\$5,409,530	\$4,737,530	\$5,943,400
Outpatient	\$4,404,577	\$4,087,951	\$4,989,626
Total	\$9,814,107	\$8,825,481	\$10,933,026
MEDICAID			
Medicaid (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	952	940	819
Outpatient	40,906	30,507	28,098
Total	41,858	31,447	28,917
Medicaid (revenue)			
Inpatient	\$10,777,056	\$11,656,217	\$15,923,465
Outpatient	\$9,851,530	\$8,881,341	\$7,413,296
Total	\$20,628,586	\$20,537,558	\$23,336,761

OSF Healthcare System

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	3,017	4,373	3,912
Outpatient	43,775	50,575	57,497
Total	46,792	54,948	61,409
Charity (cost in dollars)			
Inpatient	\$24,420,307	\$29,729,121	\$35,055,905
Outpatient	\$23,029,316	\$27,923,208	\$31,817,535
Total	\$47,449,623	\$57,652,329	\$66,873,440
MEDICAID			
Medicaid (# of patients)	Year 2011	Year 2012	Year 2013
Inpatient	8,972	11,413	9,189
Outpatient	191,483	199,181	206,694
Total	200,455	210,594	215,883
Medicaid (revenue)			
Inpatient	\$140,460,419	\$155,838,991	\$170,076,068
Outpatient	\$49,090,756	\$46,794,083	\$59,119,131
Total	\$189,551,175	\$202,633,074	\$229,195,199



Ministry wide	Setting: Organization-wide	Areas/Dept: All
Title: Financial Assistance: Illinois Hospitals		
Category/Chapter: Leadership – AC-29		

PURPOSE:

To provide Financial Assistance guidelines in the tradition of The Sisters of the Third Order of St. Francis and to comply with Federal and State regulatory requirements in a consistent manner.

POLICY:

The Corporation's Illinois hospitals shall provide charitable financial assistance and community services in the tradition of The Sisters of the Third Order of St. Francis.

PROCESS:

OSF Healthcare System ("OSF") affirms its commitment to serve its communities in a manner consistent with the mission and philosophy of OSF and The Sisters of the Third Order of St. Francis. OSF's philosophy is that adequate access to health care is a basic human right for all. OSF is committed to the promotion, preservation, protection, and restoration of wellness, whenever possible. OSF's services will be provided to all persons with compassion.

Financial assistance is available to eligible persons under the Illinois Hospital Uninsured Patient Discount Act and the OSF Charity Assistance Program. Financial assistance means a reduction in the amount due for Medically Necessary Services on the basis of documented financial need and eligibility. Financial assistance will not be denied on the basis of age, sex, race, color, creed (religion), or national origin. Medically Necessary Services shall be available to all persons without discrimination and regardless of their eligibility for financial assistance under this policy. OSF will refer individuals to available community programs and services outside of its facilities and programs as appropriate if OSF does not provide the services needed or is unable to do so in a timely manner. OSF will assist patients in obtaining payment from third parties such as Medicaid and Medicare. OSF will treat individuals seeking financial assistance with dignity, sensitivity, and confidentiality.

Accordingly, this written policy includes:

1. The eligibility criteria for financial assistance, and whether such assistance includes free or discounted care
2. The basis for calculating amounts charged to patients eligible for financial assistance under this policy, which will result in an amount charged that is less than gross charges
3. The method by which patients may apply for financial assistance
4. How the policy will be widely publicized within the community served

5. A limitation on charges for Medically Necessary Services provided to patients eligible for financial assistance under this policy to limit charges to not more than the amounts generally billed to individuals who have insurance covering such care
6. The new requirements adopted by the Office of the Illinois Attorney General under the Fair Patient Billing Act relating to hospital financial assistance application forms and the use of presumptive eligibility criteria.
7. The billing and collection requirements of Section 501(r) of the Internal Revenue Code and applicable law are included in the OSF Billing/Collection Policy

Policy Definitions:

1. Applicant: Means an individual who has submitted a completed OSF Financial Assistance Application, including all information requested, all applicable supplemental schedules, and all applicable verification documents as permitted by law.
2. Application: Means the OSF Financial Assistance Application used by Applicants to apply for financial assistance.
3. Critical Access Hospital: Means a hospital that is designated as such under the federal Medicare Rural Hospital Flexibility Program.
4. Electronic and Information Technology or EIT: Means electronic information, software, systems and equipment used in the creation, manipulation, storage, display or transmission of data, including Internet and intranet systems, software applications, operating systems, video and multimedia, telecommunications products, kiosks, information transaction machines, copiers, printers and desktop and portable computers.
5. Family Income: Means the gross income and cash benefits from all sources before taxes (annualized as of the date of the OSF Financial Assistance Application) of all persons legally obligated to pay the charges incurred, minus child support payments made, but including child support payments received.
6. Family Size: Means the aggregate number of personal exemptions allowed under federal tax law on a federal income tax return which was filed, will be filed, or could have been filed for the most recent calendar year and on which the Patient or Guarantor is one of the persons for whom a personal exemption is allowed, unless a Patient can establish a civil union pursuant to state law.
7. Federal Poverty Income Guidelines: Means the federal poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 USC 9902(2).
8. Guarantor: Means a Patient's spouse or Partner and if the Patient is a minor, means the Patient's parents or guardians.

9. Illinois Resident: Means a Patient who lives in Illinois and intends to continue living in Illinois indefinitely. A Patient who relocates to Illinois for the sole purpose of receiving health care is not an Illinois Resident.
10. Maximum Charge: Means the amount generally billed to individuals who have insurance covering such care and determined by multiplying the gross charges for all emergency medical care and medically necessary services by a percentage calculated annually and equal to (1) the aggregate dollar amount of claims paid for all emergency medical care and medically necessary services during the 12-month period ended on the preceding September 30 by both Medicare Fee-for-Service and all private insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-payments, co-insurance, or deductibles, divided by (ii) the gross charges applicable to all claims included in calculating the amount due under clause (i). No insurance company contract which includes provisions for interim payments subject to later reconciliation shall be included in the calculation of the Maximum Charge. The amount billed to a Patient eligible for financial assistance under this policy will be less than the amount of the gross charges. The Maximum Charge for each OSF Hospital in Illinois for the current fiscal year is identified in the chart attached hereto as Exhibit A.
11. Medically Indigent: Means persons whom OSF has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their Family Income, even though they have income that otherwise exceeds the generally applicable eligibility requirements for free or discounted care under the OSF Financial Assistance Policy.
12. Medically Necessary Services: Means (i) any inpatient or outpatient hospital services if the provider is a hospital, or (ii) other professional services which are normally and customarily rendered by a non-hospital provider, including pharmaceuticals and supplies, covered by Medicare for beneficiaries with the same clinical presentation as the Patient, but not including non-medical services such as social and vocational services and elective cosmetic surgery other than plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.
13. OSF Financial Assistance: Means free or discounted Medically Necessary Services provided to Patients who meet OSF Healthcare's criteria for financial assistance. It does not include bad debt or uncollectible charges recorded as revenue but written off due to a Patient's failure to pay, or the cost of providing that care to Patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived from those programs; or contractual adjustments with any third party payors.
14. OSF HealthCare: Means all legal entities, operating divisions, and health care providers owned by OSF and its subsidiaries which provide hospital, home care, hospice, physician, and other health care services.
15. OSF Hospitals: Means all licensed hospitals operated by OSF within the State of Illinois.

16. Partner: Means a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act or similar state law.
17. Patient: Means the individual receiving services from OSF or any individual who is the Guarantor of the payment for services received from OSF HealthCare.
18. Presumptive Charity: Means eligibility for OSF Charity Assistance determined by reference to categories of presumptive eligibility criteria identified as demonstrating financial need on the part of a Patient and used by OSF to determine eligibility for assistance without a completed Application.
19. Rural Hospital: Means a hospital that is located outside of a metropolitan statistical area as defined by the United States Office of Management and Budget.
20. Uninsured Patient: Means an Illinois Resident who is a Patient of the hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability insurance.

Charity Assistance Programs:

Effective for dates of service on and after September 1, 2012, OSF Hospitals shall determine eligibility for financial assistance under a two-step process. First, eligibility for assistance will be determined under the Illinois Hospital Uninsured Patient Discount Act. Second, eligibility for charity assistance on the remaining balance after insurance payments will be analyzed under the OSF Charity Assistance Programs. Eligible Applicants will receive a discount equal to the greater of the amounts calculated under the First and Second steps or, if eligible under only one step, a discount calculated under that step.

1. Uninsured Patient Discount: An Illinois Resident who is an Uninsured Patient may be eligible for charity assistance for Medically Necessary Services provided by OSF Hospitals. The discount does not apply to any non-hospital services, including but not limited to physician, home care, nursing home or ambulance services.
 - a. An OSF Hospital other than a Rural Hospital or Critical Access Hospital shall provide the following discounts:
 - i. A charitable discount of 100% of its charges for all Medically Necessary Services exceeding \$300 in any one inpatient admission or outpatient encounter to any Uninsured Patient who applies for a discount and has Family Income of not more than 200% of the Federal Poverty Income Guidelines.
 - ii. A discount equal to 135% of the hospital's cost to charge ratio determined from its most recently filed Medicare cost report times the applicable charges to any Uninsured Patient who applies for a discount and has Family Income of not more than 600% of the Federal Poverty

Income Guidelines for all Medically Necessary Services exceeding \$300 in any one inpatient admission or outpatient encounter.

- b. An OSF Rural Hospital or Critical Access Hospital shall provide the following discounts:
 - i. A charitable discount of 100% of its charges for all Medically Necessary Services exceeding \$300 in any one inpatient admission or outpatient encounter to any Uninsured Patient who applies for a discount and has Family Income of not more than 125% of the Federal Poverty Income Guidelines.
 - ii. A discount equal to 135% of the hospital's cost to charge ratio determined from its most recently filed Medicare cost report times the applicable charges to any Uninsured Patient who applies for a discount and has Family Income of not more than 300% of the Federal Poverty Income Guidelines for all Medically Necessary Services exceeding \$300 in any one inpatient admission or outpatient encounter.
2. OSF Charity Assistance: After both the Illinois Uninsured Patient Discount and OSF charity amounts have been calculated (if both apply) the richest benefit will be selected for the Patient for Medically Necessary Services provided by OSF. The OSF charity amount will be adjusted first and if the Illinois Uninsured Patient Discount is greater than the OSF charity amount, all remaining amounts will be allocated to the Illinois Uninsured Patient Discount.
 - a. Straight Charity: Charges will be discounted by the applicable percentage identified on the OSF HealthCare Charity Assistance Guidelines based on Federal Poverty Income Guidelines, subject to income verification procedures, all other charity assistance eligibility requirements, and the Maximum Charge.
 - b. Catastrophic Charity: Charges may be adjusted to provide for discounted care to a Medically Indigent Patient in accordance with the OSF Catastrophic Charity discount when the Chief Financial Officer of the OSF Hospital providing the medical care, or his/her designee, determines that more financial assistance is available with a Catastrophic Charity adjustment compared to Straight Charity. The total unpaid Medically Necessary Services must exceed 25% of Family Income. The amount due will be adjusted to 25% of Family Income, subject to the Maximum Charge, with the remaining balance adjusted to charity.
 - c. Presumptive Charity: Charges may be adjusted to provide for a charity discount of 100% of billed charges for Medically Necessary Services provided to an Uninsured Patient who establishes financial need at time of registration by satisfying one of the following categories of presumptive eligibility criteria.
 - i. Presumptive Charity categories for all OSF Hospitals:

- Homelessness;
 - Deceased with no estate;
 - Mental incapacitation with no one to act on Patient's behalf; or
 - Current Medicaid eligibility, but not on date of service or for non-covered service.
- ii. For OSF Hospitals that are not Critical Access Hospitals or Rural Hospitals, enrollment in any one of the following programs with criteria at or below 200% of the Federal Poverty Income Guidelines shall establish a Presumptive Charity category.
- Women, Infants and Children Nutrition Program (WIC);
 - Supplemental Nutrition Assistance Program (SNAP);
 - Illinois Free Lunch and Breakfast Program;
 - Low Income Home Energy Assistance Program (LIHEAP);
 - Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criterion for membership; or
 - Receipt of grant assistance for medical services.

OSF Financial Assistance Application

Effective January 1, 2014, the Application shall include the following disclosures and limit the information requested as follows:

1. **Opening Statement:** The opening statement on the Application shall include the following paragraphs in the format shown below.

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help OSF determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the Patient is eligible for financial assistance.

2. Certification: The certification on the Application shall be limited to the following paragraph.

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for the hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or Applicant Signature and Date.

3. Information Requested: The information requested on the Application shall be limited to the following.

a. Patient Information:

- i. Patient name;
- ii. Patient date of birth;
- iii. Patient address;
- iv. Whether Patient was an Illinois resident when care was rendered;
- v. Patient Social Security number, unless the Patient is uninsured;
- vi. Patient telephone number or cell phone number;
- vii. If there is a guarantor, the name, address, and telephone number of the guarantor.

b. Family Information:

- i. Family Size; and
- ii. Ages of Patient's dependents.

c. Family Income and Employment Information:

- i. Whether Patient or Guarantor is currently employed;
- ii. If Patient or Guarantor is employed, name, address and telephone number of all employers;
- iii. Gross Family Income from the following sources:
 - Wages and Self-Employment;
 - Unemployment Compensation;
 - Social Security and Social Security Disability Income;
 - Veteran's Pension and Disability;
 - Private Disability;
 - Workers' Compensation;
 - Temporary Assistance for Needy Families;
 - Retirement Income;
 - Child Support, Alimony or other Spousal Support; and
 - Other Income.

OSF Responsibilities:

1. OSF Hospitals shall screen all Uninsured Patients for Presumptive Charity Care at the time of Registration for Medically Necessary Services. No Application shall be required. However, if there is a reasonable basis to believe the Patient may be eligible for insurance coverage under public programs, or if OSF requires documentation to establish a Presumptive Charity category, OSF shall allow the Patient 30 days following registration to apply for insurance coverage and to produce requested documentation. OSF shall determine eligibility for Presumptive Charity and apply the adjustment to the accounts of eligible Patients as soon as possible after receipt of services and prior to the issuance of any bill for such services.
2. All Patients obligated to pay for services provided by OSF Hospitals will be allowed at least 60 days from the date of discharge or date of service to apply for the Uninsured Patient Discount, OSF Straight Charity and OSF Catastrophic Charity. The method for applying for such assistance will include the following procedures.
 - a. The Applicant will need to submit a completed OSF Financial Assistance Application, including all information and documentation requested and as permitted by law, to the applicable designated facility below.
 - i. For OSF Illinois Hospitals:

OSF Patient Accounts and Access Center (PAAC)
P.O. Box 1701
Peoria, IL 61656-1701
(800) 421-5700 or (309) 683-6750
 - ii. For OSF Illinois Medical Group Offices

OSF Medical Group Offices – Patient Accounts
P.O. Box 1806
Peoria, IL 61656-1806
(800) 589-6070
 - b. OSF will determine eligibility for OSF Financial Assistance for Medically Necessary Services in accordance with the financial and documentation criteria defined in the OSF Hospital Procedure Guidelines. Factors such as an individual's good faith efforts to resolve financial obligations, mitigating and unusual extenuating circumstances, and external available data sources that provide information on the Applicant's ability to pay, will be considered.
 - c. OSF will notify an Applicant of eligibility for financial assistance within a reasonable period of time after receiving all necessary financial information and documentation. OSF will further advise the Applicant of the adjusted balance due and OSF's payment policies regarding payment of the balance due on an account after a partial OSF Financial Assistance adjustment. The adjusted balance due shall not exceed the Maximum Charge.

2. OSF will widely publicize the OSF Financial Assistance Policy within the communities to be served using, without limitation, the following measures:
 - a. Posting the policy on the OSF website
 - b. Posting the policy in public areas in the Emergency Department and in public waiting rooms
 - c. Providing the policy to Patients upon request
 - d. Providing a notification of the policy to Patients on admission to the hospital
 - e. Providing a notification of the policy with or on OSF billing statements
3. Staff in the patient financial services and registration departments at OSF Hospitals will understand OSF's Financial Assistance Policy and be able to direct questions regarding the policy to the appropriate OSF representative.
4. The OSF HealthCare Financial Assistance Guidelines will be updated annually in conjunction with the Federal Poverty Income Guideline updates published by the United States Department of Health and Human Services.
5. If an account has been sent to collections, and the Patient decides to apply for OSF Financial Assistance, the entity that billed the Patient will allow the Patient to apply for assistance up to 30 days after the account was sent to collections.

Individual Responsibilities:

1. Before a Patient may receive any OSF Financial Assistance, Patient must fully cooperate with OSF by providing the information and documentation requested to obtain all payments from Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, Family Care, VOC and any other public program, if there is a reasonable basis to believe the Patient may be eligible for benefits. In addition, individuals must fully cooperate in recovering any amounts due under any policy of insurance or health plan, including high deductible health insurance policy or health plan, workers' compensation, accident liability insurance, and any third party liability. Unreasonable failure or refusal to apply for coverage under public programs, or to cooperate in providing information regarding any policies of insurance, within 30 days of request, may make the individual ineligible for any OSF Financial Assistance.
2. The Applicant must submit all of the financial documents requested on the OSF Financial Assistance Application to determine eligibility for the OSF Financial Assistance Programs, excepting Presumptive Charity. The financial documents required to apply solely for the Uninsured Patient Discount will be more limited in scope and quantity. The documents necessary for the Uninsured Patient Discount are insufficient and must be supplemented as requested to determine eligibility for OSF Straight Charity and OSF Catastrophic Charity. Unreasonable failure or refusal to provide the information or documents requested within 30 days of request may make the individual ineligible for financial assistance.
3. Recipients of partial financial assistance must communicate to OSF any material change in their financial situation that may impact their ability to pay the balance due or to honor the

terms of a reasonable payment plan. Failure to do so within 30 days of the changed situation may cause OSF to refer the balance due to collection.

4. Patients who receive Medically Necessary Services from OSF HealthCare after receiving OSF Financial Assistance must inform the applicable OSF provider during subsequent treatment that they are eligible for financial assistance to ensure that OSF collects no more than 25% of Family Income in the applicable 12 month period.
5. OSF may reverse a financial assistance adjustment if it later learns that the Applicant failed to fully disclose Family Income or falsified information submitted to apply for financial assistance. A financial assistance adjustment may be reversed for those who fail to inform OSF of a material change in eligibility within 30 days.
6. Patients may appeal OSF Charity/Illinois Uninsured determinations. Appeal procedures are contained within the OSF Charity/Illinois Uninsured Discount procedures.

OSF HealthCare Reporting Requirements:

OSF Hospitals shall file an annual Hospital Financial Assistance Report with the Office of the Illinois Attorney General at the same time each Hospital files its Community Benefits Report, which shall include the following:

1. A copy of the Hospital Financial Assistance Application, which includes the Hospital Presumptive Eligibility Policy;
2. For Applications received on or after January 1, 2014, Hospital financial assistance statistics, which shall include:
 - a. The number of Hospital Financial Assistance Applications submitted to the Hospital, both complete and incomplete, during the most recent fiscal year;
 - b. The number of Hospital Financial Assistance Applications approved under its Presumptive Eligibility Policy during the most recent fiscal year.
 - c. The number of Hospital Financial Assistance Applications the Hospital approved outside of its Presumptive Eligibility Policy during the most recent fiscal year;
 - d. The number of Hospital Financial Assistance Applications the Hospital denied during the most recent fiscal year; and
 - e. The total dollar amount of the financial assistance the Hospital provided during the most recent fiscal year, based on actual cost of care.
3. For Applications received on or after January 1, 2014, a description of the EIT that the Hospital used in the implementation of the hospital financial assistance application requirements adopted by the Office of Attorney General under the Fair Patient Billing Act, including the source of the EIT. The Hospital shall certify annually that every such

hospital financial assistance application requirement is included in the Applications processed by EIT.

4. For Applications received on or after January 1, 2014, a description of the EIT that the Hospital used in the implementation of the presumptive eligibility criteria requirements adopted by the Office of Attorney General under the Fair Patient Billing Act, including the source of the EIT. The Hospital shall certify annually that every such presumptive eligibility criteria requirement is included in the Applications processed by EIT.

Cross References:

1. Procedures relating to implementation of this Policy are set forth in the OSF Charity – Illinois Uninsured Patient Discount Procedure.
2. Policies and procedures relating to billing and collection of amounts due after application of the Illinois Hospital Uninsured Patient Discount and the OSF Charity Discounts are set forth in the OSF HealthCare Billing/Collection Policy and Procedures.

OSF's Financial Assistance Policy is designed to help uninsured and underinsured persons without financial resources resolve bills incurred to obtain Medically Necessary Services. The policy is intended to advance OSF's philosophy that adequate access to health care is a basic human right.

Exhibit A

Limitation on Charges

The Corporation shall limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the Illinois Hospitals Financial Assistance Policy to the Amount Generally Billed (AGB) to individuals who have insurance covering such care. The AGB shall be determined by multiplying the gross charges for all emergency medical care and medically necessary services by a percentage calculated annually and equal to (i) the aggregate dollar amount of claims paid for all emergency medical care and medically necessary services during the 12-month period ended on the preceding September 30 by both Medicare Fee-For-Service and all private insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-payments, co-insurance, or deductibles, divided by (ii) the gross charges applicable to all claims included in calculating the amount under clause (i).

<u>Hospital</u>	<u>AGB%</u>	<u>Hospital</u>	<u>AGB%</u>
Saint Francis Medical Center 530 NE Glen Oak Avenue Peoria, IL 61637	38.26%	Saint Anthony Medical Center 5666 E. State Street Rockford, IL 61108	42.10%
St. Joseph Medical Center 2200 E. Washington Street Bloomington, IL 61701	44.52%	OSF Saint James-John Albrecht Medical Center 2500 W. Reynolds Street Pontiac, IL 61764	44.59%
St. Mary Medical Center 3333 N. Seminary Street Galesburg, IL 61401	50.01%	OSF Holy Family Medical Center 1000 W. Harlem Avenue Monmouth, IL 61462	64.22%

Approved By: Board of Directors	Revision Approval Dates: December 2013, August 2012, February 2010
Endorsed By: Ministry Finance & Accounting	Revision Effective Dates: January 2014, August 2012, February 2010
Responsible Party: Senior Vice President, Chief Financial Officer, Finance & Accounting	Review Dates:
Original Approval Date: June 2009	Rescinded Date:
Original Effective Date: June 2009	

Charity Care

See below charity care information for OSF Healthcare System for the last three audited fiscal years.

CHARITY CARE - OSF SAINT ANTHONY MEDICAL CENTER ONLY			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	\$320,970,774	\$335,340,100	\$325,772,606
Amount of Charity Care (charges)	\$38,347,083	\$37,342,108	\$48,314,061
Cost of Charity Care	\$9,184,107	\$8,825,481	\$10,933,026

CHARITY CARE - OSF HEALTHCARE SYSTEM			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	\$1,726,920,000	\$1,745,075,000	\$1,823,570,000
Amount of Charity Care (charges)	\$225,910,309	\$285,925,649	\$353,591,840
Cost of Charity Care	\$47,449,623	\$57,652,329	\$66,873,440